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Role Discrepancy, Maternal Hardiness and Depression in Mothers of Toddlers: A Qualitative Exploration

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DISSERTATION

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Dedication

I would like to thank my husband Mark for all of his love and support through this long, challenging journey toward earning my doctorate. I could not reach this point without Mark's ability and willingness to take on whatever came our way so that I could work on my research, and more importantly, his unwavering confidence that I would finish my dissertation, especially when I doubted myself. This is as much your accomplishment as it is mine. I also want to thank my children, my sweethearts, Mason, Joe, Ariacella and Sergio for their support, love and unconditional understanding over the years. I love you all more than you could ever know.

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Abstract

Maternal depression is a serious mental health and public health issue with the majority of research focused on depression occurring within the first postnatal year. Studies exploring maternal depression beyond the postpartum period have been conducted however the focus is typically the negative effects of maternal depression on child development. Thematic analysis was used to understand the subjective experience of mothering a toddler from the perspective of both depressed (n = 5) and non-depressed (n = 16) women with children between 12 to 24 months of age, using Mercer's role transition theory, *Becoming a mother*, Higgin's Self-discrepancy Theory and a material discursive perspective as an integrated theoretical framework. The findings reflected that becoming a mother of a toddler is transformative as suggested by Mercer with identifiable phases of role transition and adaptation evolving in step with toddler development. Participants in the depressed sub-group were more apt to experience incongruences between the ideological expectations and reality of mothering which resulted in a certain degree of emotional distress. Thematic representations of control, commitment and challenge, the three components of the personality trait, hardiness also emerged from the maternal narratives. Mothers in the non-depressed subgroup described use of coping methods in response to stress that were more reflective of high hardiness in contrast to mothers in the depressed subgroup. A

better understanding of how maternal role transition unfolds beyond the first year postpartum, and how maternal hardiness influences coping skills can guide the clinician in the development of psychotherapeutic treatment strategies aimed at minimizing the negative impact of depression on the maternal-toddler dyad and promotion of more effective parenting behaviors for mothers with depression.

Table of Contents

List of Figures

List of Tables

Chapter I

Purpose

The purpose of this dissertation was to explore the subjective experience of mothering a toddler from twelve to twenty-four months of age with a focus on how maternal depression may influence this experience. An abundance of literature supports that maternal depression is a serious mental health and public health issue with risk for long-term consequences, but the majority of research continues to center on depression that occurs within the first postnatal year. Additionally, studies related to maternal depression beyond the first year postpartum focus primarily on the effects of depression on the offspring with minimal focus placed on the experience of maternal depression independent of these effects.

Significant findings support the need for additional research to gain greater understanding of the phenomenon of maternal depression that occurs beyond the first year postpartum. These findings include:

1. Significant correlates between maternal depression and negative cognitive and developmental effects for infants and toddlers during what is considered a crucial time for social and emotional development (Cents, Diamantopoulou, Hudziak, Jaddoe, Hofman et al., 2013; Pilowsky et al., 2008). Compelling evidence also suggests that maternal depression can negatively impact children beyond this period into adolescence (Batten et al., 2012; Korhonen, Luoma, Salmelin & Tamminen, 2012).
2. The developmental transition from infancy to toddlerhood creates parenting challenges that may be more difficult to navigate if a mother is in a depressed state (Kohlhoff & Barnett, 2013). Alternately, mothers who are vulnerable to depression

may become symptomatic if they have difficulty adapting to the developmental changes inherent to toddlerhood (Choi, Henshaw, Baker & Tree, 2005; Horowitz & Goodman, 2004). Gaining a better understanding of the experience of mothering a toddler may further elucidate the synergistic effects depression may have on maternal role adaptation and toddler development.

3. Several characteristics of low hardiness viewed as a personality trait or as a mechanism for coping are consistent with predictors for the development of depression (Eschleman, Bowling, & Alarcon, 2010; Grote, Bledsoe, Larkin, Lemay & Brown, 2007) and provide an additional perspective from which to explore the experience of maternal depression. Exploration of hardiness in mothers of toddlers can provide insight as to why some mothers remain resilient while others become vulnerable to the development of depression.

Study Rational

Postpartum depression.

Postpartum depression (PPD) is generally viewed as a disorder that begins within the first 4 weeks postpartum (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision [DSM-IV-TR], American Psychiatric Association, 2000; Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition [DSM-V], 2013) with a duration limit of 6-12 months. More recently researchers have recognized that PPD can present from 3 months after birth (Chaudron, Kitsman, Szilagyi, Sidora-Arcoleo, & Anson, 2006; Mayberry, Horowitz & Declercq, 2007) and may persist for at least three to five years after symptom onset (Goodman, 2003; Horowitz, Damato, Duffy, & Solon, 2005; McCue-Horwitz, Briggs-Gowan, Storfer-Isser, & Carter, 2009).

The incidence of PPD is estimated at between 10-15% for the United States and other industrialized countries (Beck, 2001; Beck, 2008a; Beck, 2008b, Hutton, 2006; O'Hara, 1995) and may be as high as 20% (Matthey, Barnett, Howie & Kavanagh, 2003; Sichel & Driscoll, 1999). The most recent Pregnancy Risk Assessment Monitoring System (PRAMS) surveillance data (2004-2005) found the prevalence of self-reported PPD symptoms occurring during the first year after birth ranged between 11.7% in Maine to 20.4% in New Mexico based on data analysis from 17 U.S. states (Morbidity and Mortality Weekly Report[MMWR], April 11th, 2008).

Symptom presentation.

Presentation of maternal depressive symptoms can vary with some researchers contending that PPD should be viewed as a symptom continuum, ranging from subclinical dysphoria to severe depression (Clemmens, Watson-Driscoll, & Tetano-Beck, 2004; Nonacs, 2005; Ugarriza, 2002). Symptoms of postpartum depression are congruent with criteria for major depressive episode (see Table 1.1) as defined in the DSM-IV-TR (2000) and DSM-V (2013).

Table 1.1.

Diagnostic Criteria for Major Depressive Episode

Exhibit 5 or more symptoms within a consistent 2 week period with at least one being depressed mood or anhedonia/loss of interest in most activities nearly every day:

- Significant weight loss or weight gain/changes in appetite
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Fatigue/loss of energy
- Possessing a sense of worthlessness or excessive guilt
- Difficulty with concentration/thinking
- Recurrent thoughts of death, suicide ideation, suicide attempt

Adapted from DSM-IV-TR (APA, 2000) and DSM-V (APA, 2013)

Additional symptoms of PPD commonly described by mothers include: (a) feeling overwhelmed by the events of daily life, (b) a persistent sense of hopelessness and/or sadness, (c) periods of increased anxiety and irritability and (d) a persistent undercurrent of feeling tense and stressed (Beck & Indman, 2005; Nonacs, 2005; Sichel, 2000). Mood fluctuations and preoccupation with infant well-being are also frequently exhibited in women with PPD (DSM-IV-TR, 2000). Several of these symptoms with the exceptions of feeling hopeless and sad, could be characterized by health providers and mothers themselves as normal reactions to the daily stress of mothering, thus hindering the proper diagnosis and treatment of depression.

Maternal Depression Beyond Infancy

Maternal depression can develop after the first 6 months postpartum and continue unremitted well beyond the first year after birth (Barker, 2013; Chaudron et al., 2006; Goodman, 2003; NICHD Early Child Care Research Network, 1999). Research on maternal depression beyond the first year postpartum consistently demonstrates (a) prevalence rates that are comparable to rates for depression that occur prior to the first year postpartum (Chaudron et al., 2004; Horowitz & Goodman, 2004; McLennan, Kotelchuck & Cho, 2001); and (b) relatively stable symptom trajectories which start within the first 12 months postpartum and extend well beyond the first year postpartum (Goodman; Mayberry et al., 2007; Mora, Bennett, Elo, Mathew, Coyne, & Culhane, 2009).

Maternal Role Transition

Ideology verses Reality

Becoming a mother is one of the most life-changing milestones a woman can experience. While many women transition into this role with relative ease others do not with some women experiencing significant distress (Mercer 2004). A common factor precipitating such distress is the development of maternal role incongruence between what women thought mothering would

be like verses the actual lived experience (Stoppard, 2000). Maternal role discrepancy may produce psychological distress and a perceived decrease in quality of life both of which have been identified as risk factors for the development of postpartum depression (Beck, 2001; Symon, McGreavy & Picken, 2003).

The dominant maternal ideology in Western Culture is that of the *good mother*, characterized by self-less, intensive child-rearing and nurturing that puts the needs of the child above the needs of the mother (Brown & Small, 1997; Choi et al. 2005; Weaver & Ussher, 1997). Competent handling of housework is also woven into the *good mother* ideology. (Brown & Small, 1997; Choi et al.; Hackel & Ruble, 1992). These images and perceived sociocultural expectations are commonly used by women as a distorted measure of *minimal adequacy* as a mother (Mercer, 1995; Nelson, 2003).

As women begin to experience the realities of mothering, many find that the ideal mother they intended to become simply cannot be attained which may result in a sense of failure as a mother (Ussher, 2006). Role incongruence due to a gap between the ideal image and the actual realities of mothering can negatively impact self-confidence and create feelings of incompetence and emotional distress during the postpartum period (Arendell, 2000; Mercer 1995; Shelton & Johnson, 2006; Sichel & Driscoll, 1999). This phenomenon is not exclusive to mothers in Western culture. Although limited, the literature suggests that that psychosocial stress secondary to the maternal role incongruence is also associated with the transcultural experience of maternal depression (Bina, 2008; Morrow, Smith, Lai, & Jaswal, 2008).

Mercer: Becoming a Mother

Mercer's (1981, 1985, 1995) theory of maternal role attainment (MRA) provides a framework for understanding the complex psychological process that women undergo during

pregnancy and the first year postpartum as they transition into their role as mother. Mercer described MRA as having four distinct phases beginning with *anticipation* which occurs during pregnancy during which time role expectations are formed. Shortly following birth, the new mother enters *the formal/role-taking stage* in which she looks toward professionals for guidance in mothering tasks. As she becomes more comfortable in the role, the mother enters the *informal/role-taking stage* in which she begins to structure the role based on her own experiences and goals. Finally, the *personal role/ identity stage* is reached in which she becomes secure, comfortable and confident in her role and identity as a mother. Mercer (2004) suggested that this last stage which could be achieved from one to nine months postpartum with a typical course of 4 months is influenced by both infant and maternal variables, including the sociocultural context of the maternal environment.

Over time Mercer (2004) concluded that "although the last stage in MRA is achievement of maternal identity, the dynamic transformation and evolvement of the woman's persona are not captured by MRA [and] does not include the continued expansion of the self as a mother" (p. 231). The MRA theory was reformulated and renamed, *Becoming a Mother (BAM)* composed of redefined stages: (a) commitment, attachment and preparation; (b) acquaintance, learning and physical restoration; (c) moving toward a new normal; and (d) achievement of maternal identity. Although the overall time frame for each stage is similar to that of MRA, Mercer contended that the achievement period for the last three stages is highly variable and can overlap significantly (Mercer, 2006, Mercer & Walker, 2006). Mercer also encouraged researchers to utilize BAM to study the maternal role using a lifespan approach in order to find out how women evolve as mothers as their children transition from childhood to adulthood and beyond (Meighan, 2006; Mercer, 2004).

Maternal Hardiness

Kobasa (1979) explored the concept of hardiness within the discipline of existential psychology to gain understanding as to how personality traits affect health in response to stress. Kobasa identified that personality characteristics of people who avoided becoming ill while experiencing high levels of stress differed from those who tended to become sick when highly stressed. This personality trait, *hardiness* is composed of three fundamental elements: (a) a sense of *control* over life events; (b) *commitment* to one's self and active involvement in the social context of life events, and; (c) the perception of change as a *challenge* instead of a threat (Eschleman et al., 2010; Kinder, 2005; Kobasa; Maddi & Kahn, 1982; Maddi, 2002). Several psychological traits associated with low hardiness (LH) correspond with predictors and symptoms of depression. These traits include pessimistic expectations, perceived lack of control over one's situation, a self-perceived increase in the number of negative life experiences requiring significant adaptation, and exhibition of high levels of stress in response to the need to adapt to life and role changes (Grote et al., 2007; Horowitz et al., 2005). Neuroticism, negative affectivity, low self-esteem, negativism, and low self-efficacy were also associated with both low hardiness and depression (Eschleman et al., 2010). Research on LH as a potential risk factor or mediator for maternal depression is sparse and the examination of possible associations between low hardiness and depression in mothers of toddlers is not currently found in the literature.

Scope of Study

Screening, diagnostic and treatment strategies for maternal depression distant from the early postpartum period can be improved upon by developing an increased understanding of the mothering experience both independent of and within the context of depression. Qualitative research is particularly well-suited for the exploration of the subjective human experience

however qualitative data related to the experience of depression in mothers of toddlers is lacking. This exploratory qualitative study was intended to (a) gain understanding of the subjective experience of mothering a toddler from the perspective of both women who are depressed and those that are not depressed; (b) explore how maternal role expectations influence maternal role transition as infants mature into toddlers; and (c) identify characteristics that are consistent with the concept of hardiness within the context of coping with role transition, strain and stress related to mothering a toddler.

Study aims.

The aims of this study were to (a) identify codes, categories and themes that describe whether or not mothers of toddlers experience role transition, strain, or incongruence concomitant with developmental changes that occur as their infants transition into toddlers; (b) explore how maternal depression may influence the subjective experience of mothering a toddler; and (c) identify core dimensions of hardiness (i.e. control, commitment, challenge) that may emerge from the subjective voice of mothers as they describe the experience of mothering a toddler.

Research questions.

A qualitative study design using thematic data analysis was used to answer the following research questions:

1. Do women experience a concomitant maternal role transition as their infants develop into toddlers?
    a. Does maternal role strain occur for some participants during this developmental transition?

   b. Is there a difference in the experience of mothering between the depressed and non-depressed group of participants during this developmental transition?

2. Do women develop ideological role expectations specific to being the mother of a toddler?
   a. Does maternal role incongruence occur if the reality of mothering a toddler does not match maternal expectation?
   b. Does depression mediate the influence of maternal ideology on role expectations?
3. Can characteristics of maternal hardiness be identified in response to stressors related to being the mother of a toddler?
   a. Are the three core elements of hardiness (i.e. control, commitment, challenge) identifiable in the words of participants as they describe the experience of mothering a toddler?
   b. Do descriptors related to hardiness differ in relation to mothering a toddler between depressed and non-depressed participants?

Definition of terms.

Depression (diagnostic definition): A person experiences five or more depressive symptoms in greater than a two week period of time as listed in the DSM-IV-TR. The symptom constellation must include a report of low mood or loss of energy/motivation most days of the week. Refer to Table 1 for full list of DSM-IV-TR and DSM-V diagnostic criteria for a major depressive episode.

Depression (operational definition): Indication of depression based on the Postpartum Depression Screening Scale (PDSS) developed by Beck and Gable (2000) (See Appendix A). A

score between 60 and 80 is indicative of minor depression. A score above 80 is indicative of moderate to severe depression.

Good mother role: The perception of a mother as a woman who provides selfless, intensive child-rearing and nurturing to the extent that she puts the needs of the family above her own.

Hardiness: Possession of a sense of *control* over life events, *commitment* to one's self and active involvement in the social context of life events and the perception of change as a *challenge* instead of a threat are the fundamental components that characterized hardiness. People with increased hardiness tend to view stressful events as less threatening, and use more optimistic, adaptive coping skills to resolve such an event as compared to those with low hardiness.

Maternal ideology: The perceived mothering ideal, shaped in large part by societal and cultural expectations and influences. This idealistic image of mothering is often distorted into becoming a measure of minimal adequacy as a mother.

Maternal-toddler dyad: The synergistic emotional and psychological relationship between the mother and toddler.

Maternal role attainment: "a process in which the mother achieves competence in the role and integrates the mothering behaviors into her established role set, so that she is comfortable with her identity as a mother" (Mercer, 1985, p. 198). Key components of role attainment include acquisition of maternal self-confidence, a sense of role competence and secure maternal-infant/toddler attachment.

Maternal role transition: The complex psychological process that women undergo during pregnancy and the first year postpartum in order to adapt to mothering role. This is also known as maternal role adaptation.

Role incongruence (Feminist framework): A perceptual discrepancy exists between the ideological perception of what mothering is supposed to be and reality of being a mother. Role incongruence is also known as role discrepancy.

Role Strain: The subjective experience of emotional distress (i.e. anxiety, irritability) in response to the difficulty meeting role obligations and/or expectations (Amankwaa, 2005).

Self-discrepancy (Higgins' self-discrepancy framework): A discrepancy between the actual self and the other two self-belief domains (i.e. ought and ideal self) which results in a negative self-evaluation and increased vulnerability to emotional distress, including depression and anxiety. Self-discrepancy is an element of role incongruence.

Delimitations and Limitations

This exploratory research focused on the mothering experience during toddler development and the influence depression may have on this experience. Participation in this study was limited to mothers of toddlers between 12 and 24 months of age in order to capture the subjective experience as it unfolded in the present. As described previously, an abundance of research identifies clear associations between maternal depression and negative influences on child development from infancy through adolescence, however literature related to the experience of maternal depression per se beyond the first year postpartum is sparse. The intent of this research was to focus primarily on the subjective experience of mothering therefore an appraisal of toddler development of children for either maternal group (i.e. depressed versus non-depressed) was not included.

This study was also not intended to focus on the diagnosis of depression independent of the effect the disorder may have on the subjective experience of mothering. No distinction was made between self-reported depressive symptoms or a clinical diagnosis of depression in

mothers who reported a history of postpartum depression. The PDSS was only used for sub-group stratification between depressed and non-depressed mothers with no intention to determine prevalence rates or symptom trajectory for depression in this study population.

According to Sandelowski (1995) an adequate sample size for a qualitative research "is one that permits-by virtue of and not being too large-the deep, case-oriented analysis that is the hallmark of all qualitative inquiry, and that results in-by virtue of not being too small-a new and richly textured understanding of experience"(p.183). The maximum ideal sample size identified in the study protocol was thirty participants with 15 in each of subgroup (i.e. depressed and non-depressed based on PDSS score) in order to obtain a wide range of maternal perceptions and experiences while maintaining study feasibility (Baker & Edwards, 2012).

Assumptions

This qualitative study was conducted based on the following assumptions:

1. The prevalence rate for maternal depression beyond the first year in the Albuquerque metro area is congruent with the national prevalence rate of 10-15% and the prevalence of 20% for New Mexico.
2. Although the researcher was the primary instrument for data collection, the goal was to understand the experience of mothering a toddler from the participant perspective as opposed to that of the researcher.
3. Reality is an individualized construct that varies based on how a person interacts and is influenced by sociocultural expectations and norms which are reflected as such in data collection and analysis.

4. Though not generalizable, the data collected via the subjective voices of mothers may provide relevant and meaningful themes to expand what is currently known about the experience of mothering a toddler.

Study Significance

A greater understanding of (a) the impact maternal ideology and role incongruence may have on role transition and depression vulnerability and, (b) the interplay between maternal role transition and the challenges of parenting a toddler may lead to improved methods of depression screening and development of more effective psychotherapeutic treatment strategies for maternal depression. Inclusion of questions as to how women view their mothering experience may facilitate a more honest disclosure of emotional distress related to role incongruence and need to improve coping and parenting skills (Hall, 2006; Stoppard, 2000). Better understanding of how maternal role transition unfolds beyond the first year postpartum can further refine intervention strategies aimed at minimizing the negative impact of depression on the maternal-toddler dyad and promote more effective parenting behaviors for mothers with depression. Finally, women who participate in this study will have the opportunity to give voice to their individual mothering experiences so that others can understand more clearly how their roles and lives changed over time, in step with the growth and development of their children.

Chapter II Review of Literature

Postpartum Depression

Epidemiologic data from fifteen countries, including the United States collected as part of the World Health Organization (WHO) World Mental Health survey initiative to study gender differences in mental illness, revealed that the cross-national lifetime risk of major depressive disorder (MDD), dysthymic disorder and all anxiety disorders is significantly higher for women compared to men (F:M 1.9 95% CI[1.8-2.0]; 1.9 [1.6-2.2]; and 1.7 [1.6-1.8] respectively) (Seedat et al., 2009). A clear gender difference exists with regard to overall mood disorder prevalence in the U.S with the lifetime prevalence for depression in women twice that of men (Blehar, 2006; Marcus et al., 2005; Piccinelli, Gomez- Homen, 1997) with a peak incidence occurring during the child-bearing years between ages 18-44 (Gaynes et al., 2005; Kessler et al., 2005; Sichel, 2000). The postpartum period is considered a particularly vulnerable point for the onset of depression or increased severity of depressive symptoms (Vesga-Lopez et al., 2008; Seedat et al.).

Prevalence

Postpartum depression is generally viewed as a disorder that begins within the first 4 weeks postpartum (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision [DSM-IV-TR], American Psychiatric Association, 2000) with a duration limit of 6-12 months, however in recent years researchers have recognized that PDD can present from three months after birth (Chaudron et al., 2006; Mayberry et al., 2007; Wisner, Moses-Kolko & Sit, 2010) and linger for at least three to five years after onset (Goodman, 2003; Horowitz et al., 2005; McCue-Horwitz et al., 2009). The incidence of PPD is estimated at between 10-15% for the United States and other industrialized countries (Beck, 2001; Beck, 2008a; Hutton, 2006;

O'Hara, 1995) and may be as high as 20% (Chaudron et al., 2004; Matthey et al., 2003; Sichel & Driscoll, 1999; Uguz, Akman, Sahingoz, Kaya, & Kucur, 2009). The most recent Pregnancy Risk Assessment Monitoring System (PRAMS) surveillance data (2004-2005) found the prevalence of self-reported PPD symptoms occurring during the first year after birth ranged between 11.7% in Maine to 20.4% in New Mexico based on data analysis from 17 States (MMWR, April 11th, 2008). Gaynes et al. (2005) conducted a meta-analytic review of the literature to determine PPD prevalence rates which excluded the use of studies using depression self-report measures. Point prevalence estimates for major depression (i.e. distinct clinical presentation with clear treatment indications) during the first 12 months postpartum ranged from 1.0-5.9%. When prevalence estimates for both minor depression (i.e. less severe depressive symptom constellations) and major depression were combined, point prevalence ranged from 6.5% to 12.9% during the first postpartum year.

Symptom presentation.

Presentation of maternal depressive symptoms can vary with some researchers contending that PPD should be viewed as a symptom continuum, ranging from subclinical dysphoria to severe depression (Clemmens et al., 2004; Nonacs, 2005; Ugarriza, 2002). Postpartum depression is not considered an independent mood disorder in the DSM-IV-TR (American Psychiatric Association [APA], 2000). Instead, depression with an onset within the first four weeks postpartum is considered a qualifier for major depressive disorder (MDD), bipolar disorders I and II, and brief psychotic disorder. The recently published DSM-V (APA, 2013) expanded the postpartum specifier to that of peripartum depression (i.e. depressive symptom onset during pregnancy up to 4 weeks postpartum). Major depressive disorder is categorized as single episode or recurrent. Refer to Table 1.1 for diagnostic symptom criteria for

a major depressive episode. Mood fluctuations and preoccupation with infant well-being are also frequently exhibited in women with PPD (DSM-IV-TR, 2000). Kammerer et al. (2009) evaluated depressive symptom patterns for women who experienced antenatal depression (n = 115), postnatal depression (n = 21) or both (n = 17) versus women who did not score in the depressed range (n = 553) using the Structured Clinical Interview for DSM IV Diagnosis (SCID) instrument. The most discriminating postnatal depressive symptoms identified within the first 6 weeks postpartum were psychomotor retardation/agitation, difficulty with concentration/thinking and fatigue. Symptoms specific to PPD commonly described by mothers include: (a) feeling overwhelmed by the events of daily life, (b) a persistent sense of hopelessness and/or sadness, (c) periods of increased anxiety and irritability, (d) a persistent undercurrent of feeling tense and stressed, (d) difficulty concentrating and (f) poor sleep (Beck & Indman, 2005; Nonacs, 2005; Sichel, 2000). Several of these symptoms with the exceptions of feeling hopeless and sad, could be characterized as normal reactions to the daily stress of mothering a toddler by health providers and mothers themselves, thus hindering the proper diagnosis and treatment of depression.

Etiological Considerations

Although descriptions of PPD have been documented as early as 430 BC by Hippocrates (Thurtle, 1995), the ability to definitively identify why childbearing women continue to remain vulnerable to developing this disorder remains elusive. To date no single physiologic etiological explanation for PPD stands out as most likely due to a lack of conclusive evidence (Groër & Morgan, 2007; Horowitz & Goodman, 2004; Kendall-Tackett, 2007; O'Hara, Schlechte, Lewis, & Varner, 1991; O'Hara, Wisner, Asher & Asher, 2013) in particular with respect to PPD beyond the first year.

Biological Underpinnings

Endocrine variations associated with parturition have long been postulated as having etiologic implications for the development of postpartum depression. Marked postpartum declines in levels of progesterone and estradiol have been considered vulnerability factors for the development of depressive symptoms however no substantial evidence supports a clear association between gonadal steroid fluctuations and PPD (Bloch, Daly & Rubinow, 2003). Thyroid dysfunction may play a role in the development of depressive symptoms in women who develop postpartum thyroiditis with a prevalence of 7% however no consistent, significant correlation between abnormal thyroid function and PPD has been identified in the literature (Basraon & Costantine, 2011). Finally, dysregulation of the neuropeptide hormone, oxytocin which is released in the third trimester of pregnancy and during lactation is has garnered increased interest by researchers as key factor in the development of PPD (Kim et al., 2013).

Dysregulation of the hypothalamic-pituitary-adrenal (HPA) axis has long been implicated in the development of MDD and may also play role in the development of PPD (Glynn, Poggi-Davis, & Sandman, 2013; Hendrick, Altshuler, & Suri, 1998). Researchers have taken strong interest in exploring how the body's neuroendocrinological and immune systems may act as a synergistic catalyst for the development of depression in response to repeated physical and psychosocial stressors (Glynn et al., Irwin & Miller, 2007). Chronic fatigue and prolonged sleep disturbances commonly experienced in the postpartum period may act as stressors which potentiate HPA axis and immune system dysregulation leading to the development of depressive symptoms (Krystal, 2006; Peterson & Benca, 2006; Groër et al., 2005; Groër, Davis, & Hemphill, 2002). Hormones fluctuations may influence mood changes early in the postpartum period however levels normalize within the first few weeks post-birth (Bloch et al., 2003) with

reduced relevance for the development or persistence of depressive systems beyond the third month postpartum.

Genetic Underpinnings

Genetic polymorphisms that may increase the risk for development of PPD have garnered increased research interest as evidence regarding genotypic predisposition for depression continues to emerge in the literature. The serotonin transporter (5-HTT) gene modulates the re-uptake of serotonin which is implicated in the development and treatment of mood disorders, including depression (Levinson 2006; Shapiro, Fraser & Sequin, 2012). The combination of increased frequency of stressful life events and expression of a short allele for the serotonin transporter gene-linked polymorphic region (5-HTTLPR) is identified as a vulnerability factor for the development of depressive symptoms (Drachmann-Buhk et al., 2009; Caspi et al., 2003; Mitchell, Wilhelm, & Parker, 2004) however these results are not entirely consistent (Gillespie, Whitield, Williams, Heath, & Martin, 2005). El-Ibiary, et l. (2013) identified three serotonin 2A receptor (HTR2A) polymorphisms which may have significant influence for PPD vulnerability however no significant association between the short allele of 5-HTTLPR and maternal depression was found. The potential influence of low amounts of omega-3 polyunsaturated fatty acid (n-3 PUFA) on the expression the (5-HTT) as a risk factor for the development of PPD has also been identified (Shapiro et al., 2012). Genotypes do not independently predict the development of depression, rather certain genotypic expressions are thought to be influenced by environmental risk factors which then increase depression vulnerability (aan het Rot, Matthew & Charney, 2009; Levinson).

Risk Factors

Psychological

The strongest risk factors for development of PPD are a family history of depression, a personal history of depression prior to pregnancy or development of depression and anxiety during pregnancy (Beck, 2001; Nonacs, 2005; O'Hara et al., 2013; Sichel, & Driscoll, 1999). Rich-Edwards et al. (2006) conducted a prospective cohort study (n = 1662) to identify socio-demographic risk factors and predictors for postpartum depressive symptoms. The researchers found that the prevalence of depressive symptoms at 6 months postpartum was highest for mothers who reported depressive symptoms prior to or during pregnancy. Moss, Skouteris, Wertheim, Paxton and Milgrom (2009) found that prenatal anxiety was predictive for maternal depressive symptoms in the mid (mean weeks post-birth = 26.55, SD = 1.90) to late (mean weeks = 53.43, SD = 2.24) postpartum period (n = 159). Maternal distress associated with a history of medical complications during pregnancy and/or birth complications was also predictive for PPD (Nelson, Freeman, Johnson, McIntire, & Leveno, 2013; O'Hara, 1995; Sichel, 2000).

Psychiatric diagnoses aside from depressive disorders identified prior to pregnancy are also considered predictive for the development of PPD. Comtois, Schiff, and Grossman (2008) conducted a population-based case-controlled study to evaluate psychiatric risk factor and need for hospitalization due to suicide attempts in the postpartum period for women in Washington State between the years of 1992 and 2001. The researchers reported a significant risk for postpartum suicide attempts among women diagnosed with psychiatric illness (e.g. mood disorders, anxiety, personality disorders) within 5 years prior to pregnancy. Diagnosis of a personality disorder (i.e. dependent, obsessive-compulsive) prior to pregnancy is also associated

with increased risk for developing depressive symptoms in the postpartum period (Uguz et al., 2009).

Interpersonal

Interpersonal risk factors for PPD commonly identified in the literature include marital dissatisfaction and conflict; experiencing high levels of life and childcare stress; and, feelings of low self-esteem (Beck, 2001; Goodman, 2003; O'Hara, 2009; O'Hara et al., 2013). McCue-Horowitz, Griggs-Gowan, Strofer-Isser and Carter (2009) found that women with persistent elevation of depressive symptoms beyond one year postpartum experienced higher levels of parenting distress and lower levels of emotional support beginning early in the postpartum period then women who were not depressed. Maladaptive attachment styles characterized by discomfort with closeness and anxiety over relationships and immature or neurotic defense styles are considered psychosocial predictors for the persistence of depressive symptoms in mothers (n = 100) who scored in the depressed range (score > 16) using the Center for Epidemiological Studies Depression Scale (CES-D; Radloff, 1977) at both 4 months and 12 months postpartum (McMahon, Barnett, Kowalenko & Tennant, 2005).

Sociodemographic

Sociodemographic risk factors for PPD include inadequate social support, younger age and lower socioeconomic status, in particular with regard to amount of income and occupational status (Beck, 2001; Horowitz et al., 2005; Rich-Edwards et. al, 2006). Wisner et al. (2013) conducted a large scale study (n = 9998) to determine episode onset, incidence and characteristics of self-harm ideation and co-morbid psychiatric disorders for women (n = 1396) who screened positive for depression (EPDS score ≥ 10) within the first -6 weeks postpartum. The proportion of women who scored in the depressed range versus non-depressed range were

African American or Asian, reported a lower educational level (i.e. less than high school to some college) and carried public or no medical insurance. Women who were Caucasian or Hispanic, college educated, and who carried private medical insurance scored proportionately higher for EPDS screen-negative scores versus screen-positive scores. Mayberry et al. (2007) found that lower educational level and younger age during pregnancy were significantly associated with increased rate and symptom severity of depression for women who had elevated symptoms of depression throughout the first two years postpartum. Pascoe, Stolfi and Ormond (2006) examined the characteristics of maternal depressive symptoms of U.S mothers (n = 2235) over a 5 year period and identified maternal age ≤ 30 years, African American, non-marital status, lack of high school education and indigent poverty status as significant risk factors for persistent depression beyond the first year postpartum.

Depression Beyond the First Year Postpartum

Although clinical awareness and research interest in PPD has increased in the last decade, the focus is commonly on the disorder as it presents in the first few weeks and early months post-birth with respect to etiologic theories, screening, diagnosis, and treatment considerations. This relatively narrow focus persists despite consistent evidence which supports that maternal depression can develop after the first 6 months postpartum and continue unremitted well beyond the first year after birth (Barker, 2013; Chaudron et al., 2006; Goodman, 2003; NICHD Early Child Care Research Network, 1999). Research on maternal depression beyond the first year postpartum consistently demonstrates (a) prevalence rates that are comparable to rates for depression that occur prior to the first year postpartum (Chaudron et al., 2004; Horowitz & Goodman, 2004; McLennan et al., 2001); and (b) relatively stable symptom trajectories which

start within the first 12 months postpartum and extend well beyond the first year postpartum (Goodman; Mayberry et al., 2007; Mora et al., 2009)

Depression Prevalence beyond the first year postpartum

Mayberry et al. (2007) found that prevalence rates for moderate-to-severe depressive symptoms were stable across four postpartum time cohorts (0-6 months, 7-12 months, 13-18 months, 19-24 months) with rates of 17.1% and 20.4% respectively for the 3rd and 4th cohorts. Horowitz and Goodman (2004) found that 36% of women who had elevated depression scores at 2-4 weeks postpartum continued to have depressive symptoms 2 years after birth. These findings are similar to those of Pascoe et al. (2006) who found a 20% prevalence rate of depressive symptomotology among mothers of toddlers. Despite the wide variance of prevalence rates it is notable that the rate of depression for this subset of mothers is higher than the 10-15% prevalence rate for PPD in the first 12 months after birth cited most often in current literature.

McLennan et al. (2001) sought to determine the prevalence and persistence of depression among mothers of young children by analyzing data obtained from the 1988 National Maternal Health and Infant Survey (NMHIS) and the 1991 Longitudinal Follow-up Survey (LF). Only data from participants who completed the CES-D as part of both surveys (n = 7537) were analyzed with collection occurring at mean time periods of 17 months (Time 1) and 35 months (Time 2) postpartum. Twenty-three percent of mothers at Time 1 and 16.6% at Time 2 had elevated CES-D scores (16-22) indicative of a positive screen for depression. A smaller percentage of mothers (12.1%, Time 1; 7.8%, Time 2) who scored > 22 on the CES-D were identified as having severe depressive symptomotology.

Beeghly et al. (2003) measured maternal depression at 2, 3, 6, 12 and 18 months postpartum using the CES-D cut off for depression in a cohort of healthy black women (n = 163) with varied socio-demographic characteristics (mean age = 29 years) and found prevalence rates of 14.1 % and 14.7% at 12 and 18 months respectively. These findings were lower than those of Schmidt, Wiemann, Rickert, and O'Brian-Smith (2006) who measured differences in depressive symptom scores among African American, Causcasian and Hispanic adolescents (age ≤ 18 years; n = 623) at 2, 12, 24 and 48 months postpartum using the Beck Depression Inventory-Short Form [BDI-SF] (Beck, Rial, & Rickels, 1974). The BDI-SF, a 13 item instrument with strong reliability and validity, is used to measure depressive symptoms in the general population with scores between 8 and 39 suggestive of moderate to severe depression. The overall prevalence rates for the participants at 24 and 48 months postpartum were 23.6% (CI 95%, 20.2-27.0) and 21.1 % (CI 95%, 17.7-24.5) respectively. Depression prevalence rates fluctuated at 24 months based on race/ethnicity (Mexican American = 25.5. %; African American = 16.9%, Caucasian = 30.1%) but remained stable at 24 months postpartum (21%, 20%, and 22.2% respectively). Differences in depression prevalence among African American women in the two studies may be related to the influence of age on the maternal experience.

Depression Stability over Time

Monti, Agonstini, Marano, & Lupi (2008) conducted a study to evaluate depressive symptom stability over the course of the first 18 months postpartum in an Italian sample of health mothers using the EPDS at 3, 9 and 18 months post-birth. The latter two time periods were chosen because they were considered key transition periods for infant/toddler development. Depression rates (EPDS scores ≥ 13) of 10.6% and 8.9% were exhibited at 9 months and 18 months postpartum respectively with 46.3% of women scoring ≥ 13 at both time periods.

McCue Horowitz et al. (2007) conducted a longitudinal study using the CES-D to measure depressive symptom prevalence and correlates on a birth cohort of mothers of young children (n = 1053) living on the East Coast of the U.S. The mean maternal age was 31.9 years with over 90% of participants having at least a high school education, 79% having a partner or spouse in their lives and an ethnicity mix of 68% Caucasian, 18.9% African American and 12.2% designated as other. The mean age of the children at follow up (1 year after the initial data collection) was 24.2 months with 72% ≥ 18 months of age. During the initial study, 16.9% of women (n = 165) scored above the CES-D cutoff score for depression with 18.5% (n = 188) scoring ≥ 16 at follow-up. The rate of persistence for those who scored ≥ 16 initially and at follow-up was 46.3% (n = 78) suggesting that the depressive symptoms were not transient in nature.

Perren, Von Wyl, Burgin, Simoni and Von Klitzing (2005) explored both maternal (n = 74) and paternal (n = 58) changes in depressive symptoms and parental psychosocial stress appraisals at four different points after birth (1 month, 3 months, 12 months, 18 months postpartum) using the validated German version of the EPDS. A comparative sample consisting of participants who had prenatal psychopathological symptomotology (e.g. depression, paranoid ideation, anxiety, obsessive-compulsive behaviors) was paired with normative participants. Women scored significantly higher overall then men for depressive symptoms and feelings of stress at all measurement points except at 18 months postpartum with 5-12% of women scoring ≥ 12 at any given measurement point. Post hoc analysis of changes over time using linear mixed models revealed that mothers with psychopathology experienced peak stress levels, a significant effect for increased perception of child difficulty and significantly high depressive symptom scores at 12 months postpartum when compared to mothers without psychopathology. The

authors suggested that the increasingly autonomous nature of toddlers may have been a stressor which partially accounted for this difference in scores between the two groups.

Transcultural Considerations

Transcultural research is currently focused on the phenomenon of PPD as it occurs in the first few weeks and months after birth with particular emphasis on the effects of acculturation and cultural factors on depressive symptom vulnerability (Bina, 2008; Hutton, 2006; Beck, 2008b) however a dearth of literature exists specific to the experience of maternal depression during the transition to and course of toddlerhood. Future research specific to maternal depression past one year postpartum is called for in order to determine prevalence rates, risk factors and the effects of cultural rituals and practices on depression vulnerability for this subpopulation.

Infant-toddler transition.

The toddler years occur from the first to the third year of life with developmental milestones centered on gaining autonomy (Gerber, Wilks & Erdie-Lalena, 2010). Gross and fine motor skills advance rapidly, enabling many children to walk and even run independently by 18 months of age and accomplish very basic self-help tasks (see Table 2.1).

Table 2.1

Toddler Development

Normal Development: 12-24 Months of Age	
Physical	Begins to walk, creep up and down stairs and climb furniture. Begins to spoon-feed self, begins to hold and use a cup. Takes off clothing that can be pulled off easily.
Intellectual	Learns via senses and very curious. Begins to speak and use one word sentences. Understands simple directions.
Social	More interactive, imitates and copies behavior. Becomes more assertive, independent and demanding. Becomes possessive of own things. Relationship with mother remains very important.
Emotional	Begins to learn trust. Needs warmth and security from an adult. Generally happy but also has temper tantrums. Becomes frustrated when unable to articulate wishes
Moral	Inward sensitivity to special adult approval and disapproval.
Normal Development: 24-36 months	
Physical	Runs, climbs, kicks, throws a ball, plays rough and tumble. Able to manipulate small objects and easily uses a spoon to self-feed. Assists with dressing self. Begins to control bowel movements followed later by bladder control.
Intellectual	Learns via senses and very curious. Speaks in 3-4 word sentences and can cite simple rhymes and sing simple songs.
Social	Does not trust strangers. Mother very important Imitates adult tasks/behaviors. Can participate in simple play activities with other children
Emotional	Developing sense of self. Tests power of saying "no". Displays a wide range of emotions including throwing temper tantrums. Fearful of loud noises, quick movements. Becomes upset when mother leaves.
Moral	Wants to be independent and more mature but can't consistently carry this out.

Adapted from Washington State Department of Social and Health Services Website Retrieved on 12/20/13 from http://www.dshs.wa.gov/ca/fosterparents/training/chidev/cd06.htm

Language acquisition and social integration also begin to occur at a rapid pace (Wilks et al., 2010). These developmental acquisitions provide the toddler with the ability to interact more independently with his environment however her ability to cope with frustration related to developmental mastery and emotional regulation related to parental attachment and separation is slower to develop which can lead to daily struggles within the maternal-toddler dyad (Carey, Crocker, Coleman, Elias, & Feldman, 2009; Coleman & Karraker, 2003; Colson & Dworkin,

1997). Evidence supports that mastering these developmental milestones along with learning how to control actions and emotional impulses is clearly influenced by the degree of emotional security and attachment present within the maternal-toddler dyad (Carey et al.; Martin, Clements, & Crnic, 2002) which in turn can be negatively impacted by the effect of maternal depression (Forman et al., 2007; Kingston, Tough, & Whitfield, 2012).

Transactional Model of Development

Sameroff and Chandler (1975) challenged that developmental outcomes were not the product of nature (e.g. genetic or biological traits) versus nurture (e.g. parental responsiveness) and instead proposed a bidirectional, dynamic model of child development in which parental and child characteristics were interactive with reciprocal influence and change over time. Their transactional model helped change the landscape of child psychology and is now frequently used as a framework to better understand how children and parents influence each other in the developmental context of cognitive, psychological, social and behavioral traits (Sameroff & Mackenzie, 2003a). Prior research supports that (a) child behavior and temperament reciprocate with parental expectations, skills and maternal mood dimensions to influence child adjustment and development (Elgar, Waschbusch, McGrath, Stewart & Curtis, 2004; Fanti, Panayiotou, & Fanti, 2013), and (b) dyadic discordance of these contextual variables over time can trigger feelings of distress and conflict in the mother and behavioral disruption in the child (Elgar et al., 2003; Sameroff & Mackenzie, 2003b).

Elgar et al. (2003) examined correlations between maternal depressive symptoms and child adjustment problems (i.e. hyperactivity, aggression, emotional problems) for mothers (N = 20,849) and their children between the ages of 4 and 11 who participated in the Canadian National Longitudinal Survey of Children over the course of 4 years. The goal was to examine

temporal relationships between maternal depressive symptoms and adjustment problems across and between three time cycles (C1, C2, C3) over a four year period. Cycle 1 prevalence was at least two times higher for hyperactivity, aggression and emotional disorder in children of depressed mothers (n = 2279, 26.7%, 26.1%; and 28.8% respectively) as compared to non-depressed mothers (n = 18,159, 13.3%, 12.4%, and 12.0% respectively). Hierarchical regression analysis was used to predict bi-directional dyadic risk for future development of maternal depression at C3 based on the presence of child adjustment problems at C1 and conversely the risk for future development of child adjustment problems at C3 based on the presence of maternal depression at C1. Child aggression and emotional problems at C1 were significantly associated with the risk for development of maternal depression at C3, $\beta = 0.46$, $p < .01$, $OR = 1.59$, 95% CI [1.21-2.08] and $\beta = 0.69$, $p < .001$, $OR = 2.0$, 95% CI [1.54-2.58] respectively. The presence of maternal depression at C1 was significant for risk of developing child hyperactivity, $\beta = 0.40$, $p < .05$, $OR = 1.49$, 95% CI [0.98-2.25] and child emotional problems $\beta = 0.75$, $p < .001$, $OR = 2.11$, 95% CI [1.47-3.02] at C3 with the bi-directional correlation highest for maternal depression and child emotional problems.

Fanti et al. (2013) conducted a longitudinal study to investigate the transactional interrelationship between parental depressive symptoms and child internalized (i.e. withdrawal, anxiety/depressive symptoms, somatic complaints) and externalized (i.e. delinquent/aggressive behavior) psychological symptoms from pre-school through adolescence. The study sample consisted of 1098 families recruited as part of the National Institute of Child Health and Human Development (NICHD) Study of Early Child Care with participants recruited from multiple hospitals in nine States. The researcher found that transactional parent-child effects were identified during early childhood and adolescent when key developmental transitions occur but

not during middle and late childhood. Significant positive predictive correlates over time between self-reported increased maternal symptoms of depression and maternal reports of both externalized and internalized child psychological symptoms were identified.

Impact of maternal depression on toddler development

Strong evidence exists for the deleterious effects of maternal depression on the cognitive, developmental, psychological and behavioral development of children that extend well-beyond infancy and childhood (Brand & Brennan, 2009; Cents et al., 2013; Hay, Pawlby, Waters, & Sharp, 2008; Pilowsky et al., 2008). Children of depressed mothers have greater impairment of social, behavioral and academic skills from infancy through adolescence compared to non-depressed mothers (Essex, Klein, Miech, & Smider, 2001; Hay, 1997; Luoma et al., 2001). Specifically, children of depressed mothers are more prone to having issues with problem-solving and deficits in social skills, demonstrate less active and explanatory play, display increased negative affect toward peers, poor emotion-regulation strategies, lower self-esteem and not surprisingly an increased risk for developing psychopathological conditions (Lyons-Ruth, Wolfe & Lyubchik, 2000). Toddlers of depressed mothers tend to respond more aversively to peers displaying sad affect, exhibit compromised cognitive development, difficulty using maternal contact to decrease their stress responses and exhibit heightened levels of anxiety in response to mildly stressful situations (Goodman & Gotlib, 1999; Forman et al., 2007; Kingston et al., 2012; Lyons-Ruth et al.).

A meta-synthesis of research on atypical brain activity of infants and toddlers of depressed mothers showed that these children tended to exhibit decreased frontal lobe activity compared to children of non-depressed mothers, which was associated with increased aggressiveness and the tendency for an increase in tantrums (Dawson et al., 2003). Infants and

preschoolers of depressed mothers were more likely to exhibit disorganized, less coherent attachment behaviors and attachment insecurity within the maternal-child dyad (Forman et al., 2007; Teti, Gelfand, Messinger & Russell, 1995) not accounted for by additional social contextual risks (e.g. family conflict, marital discord, higher stress levels and lower social support levels) common in families of depressed parents (Cicchetti, Rogosch and Toth, 1998; Hay et al., 2008; Yates, Obradovic, & Egeland, 2010).

Impact of Postpartum Depression on Maternal Parenting

Maternal depression that persists over time may act as a mediator for maladaptive parental responses to normative developmental behaviors exhibited by toddlers (Brand & Brennan, 2009; Taaffe-McLearn, Minkovitz, Strobino, Marks & Hou, 2006; Wai Wan & Green, 2009) which subsequently trigger exaggerated or maladaptive behavior patterns, cognitive development and social maturation of the toddler (Essex et al., 2001; Goodman & Gotlib, 1999; Lyons-Ruth, et al., 2000; Martin, et al., 2002; Paulson, Dauber, & Leiferman, 2006). Maternal depression combined with high levels of parental stress may mediate maternal disengagement and diminished sensitivity to toddler cues which lead to dyadic bonding and attachment issues (Carter, Garrity-Rokous, Chazen-Cohen, Little, & Briggs-Gowan, 2001; Cornish et al. 2006; Forman et al., 2007; Wai Wan & Green, 2009).

Mothers with depressive symptoms had a tendency toward increased negative interactions and exhibited more negative parenting behaviors toward their children (≤ age 3) including yelling, spanking and increased feelings of annoyance (Lyons Ruth et al., 2000). Depressed mothers were also less likely to create an environment conducive to the development of positive social and cognitive behavioral strategies such as providing a predictable, less stressful daily living environment for their children (Leiferman, Ollendick. Kunkel, & Christie,

2005), or consistently providing positive enrichment activities such as reading, telling stories or singing songs (Paulson et al., 2006). In a study to ascertain maternal emotions in response to both positive and negative toddler affect, Martin et al. (2002) found that an increase in negative maternal emotion was inversely associated with a decrease in positive toddler affect. Mothers who responded in this manner were more likely to exhibit less sensitive, more disorganized and disruptive parenting behaviors. A decline in maternal self-confidence and self-efficacy with an increase in emotional distress may develop in response to negative interactions with the toddler (Horowitz et al., 2005; Lyons Ruth et al., 2000; Martin et al., 2002; Sevigny & Loutzenhiser, 2010). Negative perceptions of maternal self-confidence and a self-perceived lack of competence are commonly identified as risk factors for the development of postpartum depression (Beck, 2001; Goodman, 2003; Horowitz et al., 2005). Irrespective of how maternal depression functions to negatively influence toddler development, the predominant focus of research on this subject is directed toward the effect of maternal depression on the toddler as opposed to the experience of maternal depression per se.

Maternal Depression: Conceptual Considerations

The Concept of Hardiness

Kobasa (1979) explored the concept of hardiness within the discipline of existential psychology to gain understanding as to how personality traits affect health in response to stress. Kobasa contended that the personality structure of persons who avoided becoming ill while experiencing high levels of stress differed from those who tend to become sick when highly stressed, with the term hardiness best characterizing this personality difference. Kobasa hypothesized that a sense of control over life events, commitment to one's self and active involvement in the social context of life events and the perception of change as a challenge

instead of a threat were the three fundamental components that characterized hardiness. Theoretically, persons with increased hardiness tend to view stressful events as less threatening, and use more optimistic, adaptive coping skills to resolve such an event as compared to persons with low hardiness (Kobasa, Maddi & Kahn, 1982; Cohen & Edwards, 1989). Pollack (1989) expanded this concept to describe personality characteristics that foster the process of physiological and psychological adaptation to chronic illness. Persons with chronic illness who demonstrated health related hardiness (HRH) were: (a) more apt to display confidence and a sense of self-mastery in response to a health stressor (i.e. control); (b) reshape cognitive appraisal to view the health stressor in a more positive light and as an opportunity for growth (i.e. challenge); and (c) were motivated to act in a more health-promoting manner (i.e. commitment) (Pollack & Duffy, 1990). Subsequent research has explored how HRH characteristics impact adaptation to several types of chronic illness including non-insulin dependent diabetes mellitus, chronic obstructive pulmonary disease, and heart disease (Vasquez-Brooks, 2003) but a notable gap exists with regard the influence of HRH on the development/prevention of psychiatric disorders.

Women and hardiness.

Gender-based research on hardiness has been conducted using Kobasa's model of hardiness as a framework. Rhodewalt and Zone (1989) sought to compare cognitive appraisal characteristics between hardy and non-hardy female subjects (n = 212) who experienced comparable levels of undesirable life change to test the hypothesis that the appraisal process was a mediator between hardiness and mental/physical well-being. The authors found that non-hardy women reported experiencing a higher incidence of undesirable life events and required a higher level of adjustment in order to cope with such events than those considered hardy (40% and 27%

respectively). Although depressive symptoms were generally higher for participants who reported higher magnitudes of negative life, the relationship was comparatively stronger for woman who were considered non-hardy versus hardy. These findings are supported by Priel, Gonik and Rabinowitz (1993) who conducted a prospective, quantitative study to compare the maternal level of hardiness and negative/positive affectivity to participant (n = 73) appraisals of birthing outcomes and newborn infants. Women with higher scores for hardiness viewed labor as having been less difficult and exhibited higher scores for positive infant perception. The strongest variables associated with lower hardiness in this study were negative affect and negative maternal perception of the newborn.

Weiss (2002) compared hardiness scores among mothers of autistic, developmentally delayed and typical children and found that the first group exhibited the lowest levels of hardiness. The variables, low hardiness and decreased adequacy of social support, were most prominent in mothers of autistic children and were predictive of maternal depression. Hardiness may be positively influenced by increased age, higher perception of self-confidence, possession of a general optimistic outlook and the ability to be flexible in response to increased stressors. Conversely, negative traits associated with low hardiness may negatively influence the emotional and physical well-being of women (Kenney, 2000).

Low hardiness and depression.

Several psychological traits associated with low hardiness (LH) correspond with predictors and symptoms of depression. Grote et al. (2007) identified significant correlations between LH characteristics (i.e. pessimistic expectations, perceived lack of control over situation) and increased depression risk. The researchers studied the psychological traits of a group of low income African American women (n = 97) who experienced a high incidence of

acute and chronic stressors. Grote et al. found that women who were optimistic and had a sense of control over their stressors were significantly less prone to developing clinical depression than those who were pessimistic or perceived that they had little control over their stressors. Horowitz et al. (2005) found that mothers (n = 143) with a mean time of 11 weeks post-delivery who reported a self-perceived increase in the number of negative life experiences requiring significant adaptation, and exhibited high levels of stress in response to the need for adaptation related to life and role changes were at higher risk for development of PPD then their counterparts.

Personality trait correlates for low hardiness are consistent with psychological risk factors and traits for depression. Eschleman et al. (2010) conducted a meta-analysis of hardiness literature and identified personality traits and dispositions characteristic of hardiness that acted as buffers against or mediators for the effects of stressors. Traits that negatively correlated with hardiness included neuroticism (p = -.44, k = 10, n = 2848) negative affectivity (p = -.45, k = 6, n = 3115), anxiety (p = -.39, k = 7, n = 917) and anger (p = - .40, k = 4, n = 378). Traits such as self-esteem (p = .53, k = 14, n = 2610), optimism (p = .58, k = 7, n = 1290) and self-efficacy (p = .29, k = 6, n = 206) were positive correlates for hardiness. Psychological attributes that negatively correlate with hardiness included psychological distress (p = -.46, k = 33, N = 9103), depression (p = -.52, k = 19, n = 3050), emotional exhaustion (p -.39, k = 12, 4638), and state anxiety (p = -.44, k = 11, n = 1648). Exploration of LH as a potential risk factor or mediator for the development of maternal depression is sparse in the literature. Furthermore, exploration of possible associations between LH and risk for depression in mothers of toddlers is currently not found in the literature.

Role incongruence.

As women begin to experience the realities of mothering, many find that the ideal mother they intended to become simply cannot be attained and for some women this may result in feelings of failure (Ussher, 2006). Role incongruence due to a gap between the ideal image and the actual realities of motherhood can negatively impact self-confidence and create feelings of incompetence and emotional distress during the postpartum period (Mercer 1995; Sichel & Driscoll, 1999). This phenomenon is not exclusive to mothers in Western culture. Although limited, the literature suggests that psychosocial stress secondary to the maternal ideal and role incongruence are also associated with the transcultural experience of maternal depression (Bina, 2008; Morrow et al., 2008).

Maternal ideology.

An abundance of psychology, counseling and nursing literature related to the development of maternal depression centers on how women can become psychologically distressed after bearing children in response to maternal role strain and incongruence (i.e. a discrepancy between the ideology and reality of the mothering role) (Arendell, 2000; Amankwaa, 2005; Hall, 2006; Harwood, McLean, & Durkin, 2007; Mercer & Walker, 2006). One underlying reason for this distress is the pressure women put on themselves to become the ideal mother as shaped by societal and cultural expectations (Arendell; Choi et al., 2005; Shelton & Johnson, 2006). Magazine advertisements, television and cinema often portray a mother as a woman who cares for her children with humor, grace and ease; successfully maintaining her household while remaining thin, neatly dressed with stylish hair and make-up. This societal image is absorbed by girls starting at an early age (Ussher, 2006) and plays a significant role in the development of the idealogic good mother role in which a woman provides self-less,

intensive child-rearing and nurturing that puts the needs of the family above her own needs (Choi et al.; Stoppard, 2000). These idealistic images and perceived societal expectations are commonly used by women as a distorted measure of minimal adequacy as a mother (Mercer, 1995; Nelson, 2003).

Becoming a Mother.

Mercer's (1981, 1985, 1995) initial theory of maternal role attainment (MRA) provided a framework for understanding the complex psychological process that women undergo during pregnancy and the first year postpartum as they adapt to their role as mother. Mercer (1985) described this as "a process in which the mother achieves competence in the role and integrates the mothering behaviors into her established role set, so that she is comfortable with her identity as a mother" (p.198). Mercer recently revised her theory to reflect the role transition process as a continuum over time as opposed to an endpoint (Meighan, 2006; Mercer, 2004). Mercer proposed using a lifespan approach for her revised theory, *Becoming a Mother* (BAM) to explore how women evolve as mothers in response to their own developmental growth, as well as that of their children. The acquisition of maternal self-confidence, a sense of role competence and secure maternal-infant attachments are key components of a successful role transition (Mercer, 2006; Mercer & Walker, 2006). Refer to Chapter III for an in-depth methodological discussion of BAM.

Role incongruence and maternal depression.

Even when a mother appears to have achieved role adaptation in the first few months postpartum, the physical, psychological and logistical responsibilities inherent to mothering can again become overwhelming as the infant develops into a toddler (Mercer, 1985; Mercer & Ferketich, 1990). Some women cope with this change less effectively than others to the extent

that they are at risk for experiencing depressive symptoms (Choi et al., 2005; Horowitz & Goodman, 2004). Ussher (2006) suggests that a perceived inability to meet idealized role expectations can lead women to silently blame themselves for failing to meet such high expectations while other mothers *appear* to cope so effectively and easily. As stated earlier, maternal responses to role incongruence include psychological distress, anxiety and a perceived decrease in quality of life, all of which have been identified as risk factors for the development of maternal depression (Beck, 2001; Polasky, & Holahan, 1998; Symon et al., 2003).

Alternately, the BAM components of maternal self-confidence, competence and maternal-child attachments may become distorted or may not develop adequately in mothers of toddlers who are depressed, leading to a maladaptive role integration (Mercer, 2006; Mercer & Walker, 2006) and maladaptive maternal response to toddler behavior. This maternal response may result in (a) an exaggerated or maladaptive behavioral responses by the toddler, and (b) negatively impact the cognitive, emotional and behavioral development and well-being of the toddler. Such outcomes may in turn mediate the persistence of maternal depressive symptoms (Essex et al., 2001; Goodman & Gotlib, 1999; Lyons-Ruth et al., 2000; Martin et al., 2002; Paulson, et.al., 2006).

Summary

This chapter provided a review of the prevalence, etiological considerations, risk factors and clinical implications of PPD with particular focus maternal depression as it presents beyond the first 12 months postpartum. The transactional model of child development was utilized as a framework for exploring how the dynamic, bi-directional maternal-toddler dyad is negatively influenced when mothers are depressed. The deleterious effects that maternal depression may have on child development were reviewed. Maternal depression was contextually explored from

the perspective of ideological role incongruence and maternal hardiness. Finally, the middle range theory, *Becoming a Mother* was expanded to provide a framework for exploring the process of maternal role transition in response to developmental changes that occur during the transition from infancy to toddlerhood.

This literature review supports that (a) the majority of research on maternal depression continues to focus on the first year postpartum; (b) maternal depression beyond the first postpartum year, explored from the context of maternal hardiness and ideological role is lacking, and; (c) maternal depression can negatively impact child development well beyond infancy. This study aimed to address these gaps in the literature by studying the subjective experience of mothering a toddler (i.e. age 12-24 months) from the perspective of both depressed and non-depressed women. Refer to Chapter III of this dissertation for an in-depth methodological discussion and study description.

Chapter III Methods

Methodology

Material Discursive Orientation

> Women's pain is real-we need to listen to it, without blaming the woman, or her reproductive body. It is only when we are able to listen, to really hear, and take women's distress seriously, that we can begin to offer a way out of the vortex of despair (Ussher, 2006, p. 124).

A feminist social constructionist epistemology emphasizes that the subjective perception of women is the basis for an authentic exploration, derivation and interpretation of their experiences without being tainted by the preconceived biases of the researcher (Scattolon & Stoppard, 1999). Discursive research approaches are used to illustrate how subjective perceptions and roles are shaped, sustained or resisted in the socio-culturally informed context of daily life. Discourse analysis provides a deeper understanding of an experience or issue due to the richness and detail of narrative data however the socio-linguistic focus does not readily account for the physical (i.e. material) dimensions of health and illness (Yardley, 2002). This dichotomy can be readily addressed by using a material discursive lens to mutually explore both the material and socio-linguistic dimensions of health and illness. Yardley (1997) described the guiding principle of the material discursive perspective based on the tenets of Heidegger and Merleau-Ponty:

> Because we are intrinsically social *and* embodied beings, the material dimension of human lives is always socialized—mediated by language and consciousness and modified by social activity—while the discursive dimension is inevitably physically manifested, in our speech and behavior, institutions and technology (p. 15).

When viewed from a material discursive lens, the experience of being a woman is one in which the material embodiment (i.e. physical realities) of femininity (e.g. menstruating, giving birth, breastfeeding, childrearing, entering menopause) is constructed or influenced by the social

context and cultural discourse of the individual (Erskine et al., 2003, Lafrance and Stoppard, 2007). Researchers have used a material discursive approach to explore how the discourse of femininity based on shared cultural imperatives informs the socially constructed ideal of the *good woman* (Stoppard, 2000; Stoppard & McMullen, 2003). *Good woman* activities are reflective of sociocultural assumptions of what women are expected to do as wives and mothers (e.g. nurturing family members, managing the household) in their everyday lives (Choi et al., 2005; Lafrance & Stoppard). If the high expectations inherent to this discourse of femininity cannot be tempered to reflect a more realistic role, the result may be an increase in emotional distress, physical exhaustion, and reduced morale, leading to an increased vulnerability for the development of depressive symptoms (Lafrance & Stoppard, Scattalon & Stoppard, 1999; Stoppard; Ussher, 2006, Yardley, 1997).

Maternal depression viewed only from a psychosocial lens, rarely captures how material embodiment influences this experience. Conversely, maternal depression studied from the biomedical perspective, focuses only on physical symptoms and biological/neurochemical mechanisms while excluding sociocultural and gender related considerations (Lafrance & Stoppard, 2007; Stoppard, 2000; Ussher, Hunter, & Cariss, 2002). The exploration of maternal depression using a material discursive lens avoids this duality by recognizing that depression is an integrated, biopsychosocial phenomenon composed of socio-linguistic and material or embodied dimensions which are intricately intertwined (Wilde, 1999; Yardley, 2002). The methodological framework for the present study was developed using a material discursive lens to explore how the discourses of femininity and material embodiment of being a mother with or without depression influenced the experience of mothering a toddler. In keeping with the material discursive framework, the term *depressive experience* will be used instead of depressive

symptomotology or depression as diagnostic reference, for the remainder of this study in order to emphasize that the focus of inquiry is on the individual, subjective material discursive experience of the study participants.

BAM Framework

As described previously, Mercer (2004) proposed using a lifespan approach to explore and better understand how women evolve as mothers in response to their own developmental growth in tandem with that of their children. Mercer argued that "the dynamic transformation and evolvement of the woman's persona are not captured by MRA [and it] does not include the continued expansion of the self as a mother" (2004, p. 231). She subsequently revised her theory to reflect this evolutionary process which she entitled Becoming a Mother (BAM) (Meighan, 2006; Mercer, 2004).

Stages

The four stages of BAM in relation to the first year postpartum are: (a) commitment, attachment and preparation (pregnancy); (b) acquaintance, learning and physical restoration (the first 2 weeks postpartum); (c) moving toward a new normal (2nd week to 4 months postpartum); and (d) achievement of maternal identity (approximately 4 months postpartum). In the first stage of BAM, the mother commits to the pregnancy by exhibiting health promoting behaviors aimed at providing an optimal fetal environment and begins her attachment to the fetus by fantasizing about her role as mother (Mercer, 2004; 2006; Mercer & Walker, 2006). In a meta-analysis of 9 qualitative studies on maternal role transition, Nelson (2003) discovered that the first step in the process was development of a commitment to become a mother, characterized by deciding to become pregnant or accepting an unplanned pregnancy followed by improved health behaviors and planning ahead in preparation for the birth experience. Similar findings were found in

maternal role transition research on first-time mothers over age 35 (Carolan, 2005) and African American mothers of higher socio-economic and educational status (Sawyer, 1999). Although pregnant adolescents experienced increased challenges due to their age, socioeconomic status and lack of social support, limited research supports that for some teens, pregnancy was a time to improve their self-identity and lifestyle in an effort to become responsible mothers (Lesser, Koniak-Griffin, & Anderson, 1999).

The remaining BAM stages occur in the postpartum period and consist of a short period of physical restoration followed by the transition toward becoming a mother, with a culmination in the achievement of the maternal role which occurs at approximately 4 months (Mercer, 2004; 2006; Mercer & Walker, 2006). Rogan, Shmied, Barclay, Everitt, & Wyllie (1997) conducted a longitudinal grounded theory analysis of first-time mothering experiences for fifty-five women to explore how this transition impacted their lives, with a specific focus on how the realities of mothering compared to the expectations of mothering held during pregnancy. The authors found that the process was a continuum starting with the initial phase*, this isn't my life anymore*, as the realization occurs that a new life norm is being created which led to feeling unready for the new, *unknown role*. The characteristics of both phases were similar to Mercer's BAM phase of *moving toward a new normal*. The final phase, *in a certain tune*, was characterized by finding ways to work out this unknown new life and role which had similarities to Mercer's last BAM phase, *achievement of maternal identity*. In keeping with Mercer's (1995) conclusions, the authors found that stage trajectory was non-linear, but instead moved within a role transition continuum. Infant behavior, social support and previous experience caring for infants were found to be mediating factors in this process. The authors coincidently called this theoretical framework *becoming a mother*.

Carolan (2005) also found primiparas over the age of 35 also experienced maternal identity development in stages. The first four months postpartum were characterized by the stages of *the nightmare of early mothering*, which occurs in the first four weeks postpartum, and *struggle and ambivalence* which occurs between 1-4 months postpartum. Internalization of the maternal role started at approximately 4 months postpartum, with mothers describing the concept of *finding my own way of becoming a mother*. The last stage, *feeling like a mother*, occurred between 4-6 months postpartum and was characterized by "a general understanding of the magnitude of the maternal role and a changing appreciation of what it meant to be a mother" (p. 778), which is congruent with Mercer's last stage of maternal identity achievement.

Key Components and Variables

The acquisition of maternal self-confidence, role competence and development of secure maternal-infant attachments are key components of successful role transition (Mercer, 2006; Mercer & Walker, 2006). Several maternal and infant variables can have a positive or a negative influence on this process. Maternal variables that are particularly relevant to this discussion include life stressors, external support, spousal relationship, personality traits, core self-concept, role strain, level of anxiety, and depressive symptoms (Coleman & Karraker; 2003; Meighan, 2006; Mercer, 2004, Mercer & Walker). Infant variables include responsiveness toward mother and general temperament (Martin et al., 2002; Mercer, 2004, Mercer & Walker).

Spheres of Influence.

Mercer and Walker (2006) created a model of BAM to depict how external environmental factors influence the trajectory of maternal transition and infant development at three different levels. Social support and maternal-infant care guidelines are provided to both the mother and father by their *family and friends*. This more intimate environment is embedded

within the *community* which offers parental resources and health care services which in turn is encompassed by the *society-at-large* which "provides aid to families, transmits cultural consistencies, and establishes law affecting family life"(Mercer & Walker, 2006, p. 569). Mercer posits that this model may be useful as a means of developing interventions to promote an optimal environment for becoming a mother.

BAM Stages: Toddler Transition.

Three of the four BAM stages can be modified to explore maternal role transition beyond the first year postpartum. The first stage is viewed within the context of maternal preparation for marked changes that will occur as her infant develops into a toddler (Paulson et al., 2006). Does she read books on toddler development and care? Does she begin to baby-proof the household in anticipation of her child's new found ability to ambulate? Is she preparing herself for the parental frustration that often occurs in response to toddler behaviors that emerge as the developmental stage of gaining autonomy unfolds? The second stage, which represents a time of acquaintance with the newborn and physical recovery, is unique to the early postpartum period, and does not lend itself to being used within the context of maternal transition during toddlerhood. The third stage, moving toward a new normal, is a time of maternal role transition and parenting adaptation to meet the emotional, social and physical needs of the developing toddler (Coleman & Karraker, 2003). The final stage, achievement of a new identity as the mother of a toddler, occurs when the mother has successfully navigated her way through the changes and challenges to the point that "the mother feels self-confident and competent in her mothering and expresses love for and pleasure interacting with her [toddler]" (Mercer & Walker, 2006, p.569).

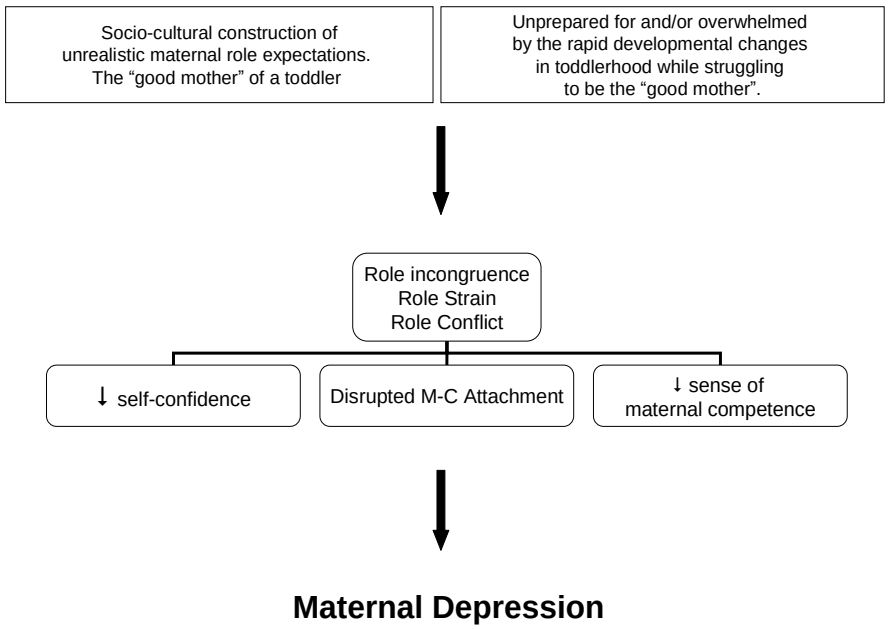
Depression and Self-Discrepancy

Higgins (1987, 1999) developed a psychological framework for understanding the relationship between self-discrepancy and the development of depression. He proposed that three self-belief domains influence a person's emotional state: (a) the actual self or self-perception of possessed attributes; (b) the ideal self or those attributes that a person hopes to possess; and, (c) the ought self or attributes that one believes he or she is obligated to possess. The ideal and ought self-beliefs (i.e. self-guides) are heavily influenced by the perceptions of those considered significant to the individual. Self-discrepancy develops when a gap exists between the actual self and the other two domains which in turn results in a negative self-evaluation and increased vulnerability to emotional distress, specifically depression and anxiety (Scott & O'Hara, 1993). Oatley and Bolton's (1985) social-cognitive theory of depression adds depth to Higgins' theory by proposing that when a role reflective of personal attributes, goals and expectations is disrupted to the extent that little or no alternatives exist to maintain one's sense of self, the outcome is depression. Depression is subsequently manifest by a loss of sense of self, a self-perceived lack of worth and/or helplessness and waves of dysphoric emotions (e.g. sadness, anger, anxiety, longing). A term that can be used in place of self-discrepancy is role incongruence.

Theoretical Integration

The alignment of Higgins' self-discrepancy theory with Mercer's BAM lifespan framework using a material discursive methodological approach creates a conduit for the exploration of issues related maternal role transition beyond the first year postpartum (see Figure 3.1).

Figure 3.1. Theoretical Integration



The maternal ideal, both self-defined and molded by the BAM environmental spheres, that women draw support and role guidance from can become a source of distress for a mother who is vulnerable to depression or already depressed (Bina, 2008; Choi et al., 2005; Weaver & Ussher, 1997). Ongoing discrepancies between the actual sense of self and the ought and/or ideal self can create distress which can also lead to the development or increase in severity of maternal depression. In mothers of toddlers who are depressed, the BAM components of maternal self-confidence, competence and maternal-child attachments which are imbued in the key elements of hardiness (i.e. confidence, control, commitment) may become distorted or may not develop adequately, leading to a maladaptive role integration.

Research Design

The theoretical and epistemological foundations of the material discursive approach emphasize that qualitative inquiry is key to capturing the subjective perspective and experience

of the phenomenon of interest. An exploratory qualitative research design was used to (a) gain understanding of the subjective experience of mothering a toddler from the perspective of both depressed and non-depressed women; (b) explore how maternal role expectations influence maternal role transition as infants mature into toddlers; and (c) identify characteristics that are consistent with the concept of hardiness with respect to coping with role strain and stress related to mothering a toddler. Briefly restated, the research questions were:

1. Do women experience a concomitant maternal role transition as their infants develop into toddlers?
    a. Does maternal role strain occur for some participants during this developmental transition?
    b. Is there a difference in the experience of mothering during this developmental transition between the depressed and non-depressed group of participants?
2. Do women have ideological role expectations specific to being the mother of a toddler?
    a. Does maternal role incongruence occur if the reality of mothering a toddler does not match maternal expectation?
    b. Does depression mediate the influence of maternal ideology on role expectations?
3. Can characteristics of maternal hardiness be identified in response to stressors related to being the mother of a young toddler?
    a. Are the three core elements of hardiness (i.e. control, commitment, challenge) identifiable in the words of participants as they describe the experience of mothering a toddler?
    b. Do descriptors related to hardiness differ in relation to mothering a toddler between depressed and non-depressed participants?

The subjective experience of mothering was elicited by asking three probative open-ended questions:

a) Can you tell me about your experience of being a mother of a toddler?
b) Can you tell me what you thought being a mother would be like before you had the baby?
c) Can you tell me how becoming a mother influenced your life?

These questions provided a focus or guide during the interview process to provide improved comparability and organization of data analysis but were not intended to limit or derail participant discourse. This researcher took care to avoid leading the participant toward a particular perspective during the dialogue in order to capture authentic subjective responses. Reflective listening, reframing and non-leading interview questions/prompts (e.g. tell me more) were used to elicit more in-depth narratives from each participant (See Appendix B). Codes, categories and themes related but not limited to role transition, role discrepancy, depressive symptom experience and descriptors for hardiness were anticipated to emerge from the data based on the theoretical frameworks introduced previously.

Study participants.

A purposive, criterion-based sample was utilized for this study. First-time mothers who were between 12-24 months postpartum were identified by trained clinical personnel as potential study participants during scheduled well-baby visits to participating pediatric clinics and private pediatric practices located in Bernalillo and Sandoval counties that composed the greater Albuquerque area. Please refer to the subsequent section on recruitment for further details. The sample was initially composed of first-time mothers as one of the central themes was that of role discrepancy between the real and ideal mothering role. The premise for this decision was two-fold. First, previous experience in mothering might have potentially transformed this perspective

over time. Secondly, the perception of competence, self-confidence and dyad attachment as delineated in Mercer's BAM framework and the elements of hardiness might change based on having more than one child. Due to slow recruitment using the initial criteria, the study design was subsequently changed to include mothers with more than one child. Additional inclusion/exclusion criteria included:

- participant age between 18-35 years. Women >35 years of age of pregnancy onset of may be considered at risk for perinatal or birth complications due to advanced maternal age and were excluded.
- a history of an uncomplicated perinatal course (i.e. did not experience physiologic perinatal complications or non-pregnancy related co-morbidities which categorized pregnancy, birth or the postpartum period as high-risk).
- an uncomplicated vaginal or cesarean birth (i.e. did not experience a traumatic vaginal birth or a cesarean section for fetal distress, dystocia or failure to progress).
- birth of a full-term neonate without medical complications (i.e. did not require newborn intensive care or treatment for neonatal/pediatric complications during the 1st year of life). Mothers who adopt neonates (i.e. within the first 30 days of life) who meet this criteria were also included.
- participants who considered their living situation and socioeconomic status as stable.
- English-speaking as the principal investigator (PI) is not bilingual, and the cost of using interpreting services was prohibitive.

Finally, to understand the experience of both depressed and non-depressed mothers, women without a history of postpartum depression and those with self-reported or clinically diagnosed history of depression which emerged within the first twelve months postpartum were

included in the study, irrespective of treatment history. However, women diagnosed with a psychotic or bipolar disorder were excluded from the study irrespective of treatment history due to the psychiatric complexity of these disorders, and potential impact on insight and perspective secondary to pathological reality distortion.

Recruitment

After gaining approval from the University of New Mexico Human Research Review Committee (HRRC), a purposive sample of mothers who were between 12-24 months postpartum were recruited from private pediatrician offices and pediatric clinics which provide pediatric well-baby visits within the greater Albuquerque area (See Appendix C). Administrative personnel responsible for appointment booking/registration and clinical nursing staff who were educated on the study purpose and design assisted in the identification of potential candidates via appointment calendar coding for 12-24 month well baby visits and identification as first-time mothers via pediatric medical records. Each potential candidate was provided written literature on the study goals, data collection process and eligibility requirements by clinical staff nurses and/or medical assistants (See Appendix D). Women who expressed initial interested in participating were given a brief form to fill out requesting contact information and a convenient date and time to be contacted via phone by the PI. This contact information remained in possession of clinic staff and were only be released to the PI. A subsequent phone interview was conducted by the PI to provide the potential participant with more in-depth information regarding the study, ascertain eligibility, and set up an interview date, time and location if the mother elected to participate.

Study setting.

Initial screening for inclusion in the study took place via telephone between the PI and potential participants. Face to face interviews took place at a time, and setting that was most convenient and comfortable for the participant which may have included her private residence. The ideal setting was one with minimal distractions however, to avoid requiring that a mother seek childcare for the interview, it was likely that the toddler was present during data collection.

Although the toddler may have been present, the focus remained on the mother, thus developmental, cognitive and behavioral traits exhibited by the toddler were not included as part of data collection. A small recruitment incentive of a $20.00 gift card to a national chain general merchandise store was offered at the end of the interview.

Sample stratification.

The PDSS was used to stratify mothers into either a depressed or non–depressed subgroup to strengthen comparative data analysis and interpretation (Onwuegbuzie & Leech, 2007). The PDSS, an instrument composed of qualitatively derived items, was chosen as a stratification tool in keeping with the material discursive theoretical orientation of this qualitative study. Beck and Gable developed the PDSS based on Beck's (1993) seminal phenomenological research on the lived experience of postpartum depression. The self-report instrument is composed of 35 items designed to assess for symptoms of depression within seven dimensions constructed from themes that emerged from Beck's findings (i.e. disturbances of sleep and eating; feelings of anxiety and insecurity; emotional lability; cognitive impairment; loss of self; feelings of guilt and shame; and contemplation of self-harm). A likert scale using a 1-5 rating system is used to score each item. The PDSS scoring range is from 35-175 with a score of 60

designated as the threshold for minor depression and score of 80 indicative of major depression. The authors designated the first 7 questions as a short form of the PDSS, to quickly identify women who are most likely experiencing normal adjustment (PDSS score of <14) as opposed to depressive symptoms. If a woman exceeds a score of 13 using the short-form PDSS, the long form should be administered to further evaluate for depressive symptoms using the scoring system described above (Beck & Gable, 2002).

The PDSS demonstrated strong construct validity via confirmatory factor analysis with high alpha internal consistency (0.83 - 0.94) for items representing each dimension (Clemmens et al., 2004). When compared to the EPDS, the only other instrument specifically designed to screen for postpartum depression, the PDSS was found to have the highest combined percentage for sensitivity and specificity of major depression (score ≥ 80) or minor depression (score ≥ 60 < 80) (Beck & Gable, 2001). Hanna, Jarman, and Savage (2004) also identified a statistically significant correlation between total scores for the PDSS and EPDS ($r = 0.83$, $p = 0.001$) with high internal consistency for the PDSS for all seven dimensions ($\alpha \geq 0.90$) in a sample of women at 8 weeks postpartum.

The PDSS is considered a valid and reliable depression screen in the postpartum population but it has not been utilized beyond the first year postpartum. This would be considered a limitation in quantitative research; however in this qualitative study the PDSS was intended only for participant stratification purposes and was not be used to determine depression prevalence or treatment outcomes. Participants who scored < 14 on the PDSS short form were placed in the non-depressed group and those that scored >13 were subsequently administered the PDSS long form (i.e. the remaining 28 questions). Women who scored ≥ 60 on the PDSS were placed in the depressed group, however those with scores >13 and < 60 were not placed in either

group and were dropped from interview consideration in order to maintain a clear delineation between the two groups for data analysis and interpretation. The need for this degree of delineation was required because a woman scoring just below the threshold for minor depression (e.g. PDSS score = 58), suggestive of normal adjustment (Beck & Gable, 2002) may still experience a constellation of depressive symptoms that could negatively influence maternal self-perception and experience. Women who may not be experiencing a major depressive episode, but could have disorders with a depressive component such as dysthymia, adjustment disorder with depressive features or depression not otherwise specified could also conceivably fall into such a category.

It was also possible that a participant who was clinically diagnosed with depression in the first 12 months postpartum could score in the non-depressed range using the PDSS short form. The criteria for depression remission is symptom relief for a period of at least six months (DSM-IV-TR) however the PDSS is designed to screen for depressive symptoms that occur within the past two weeks and is not intended to measure for depression remission. A participant who fell into this category was asked if she has been in depression remission for at least six months. If the answer was yes, she was placed in the non-depressed group. If she has not had at least six months of symptom remission, she was asked to complete the remaining PDSS questions. Mothers who scored at or above the threshold for depression were included in the depressed group while those that score >13 and < 60 did not go forward with the face to face interview for the reasons mentioned earlier.

Sample size

According to Morse (2000), the scope of a research question is one key to determining a qualitative study sample size. Research questions that are broad will require a higher sample size

to reach data saturation or redundancy, while those that are more focused and goal-oriented may require a smaller number of participants to reach the same point. A second determinant is the number of analysis units needed to assure sufficient data richness and quality (Kuzel, 1999). This depends in large part on the willingness and degree of participant disclosure (Morse) and an effective purposive sampling strategy. The latter was addressed in this study design by identification of clear inclusion and exclusion criteria and stratification into depressed and non-depressed subgroups. The former could vary based on the comfort level of the participants to disclose thoughts and feelings related to mothering and was difficult to determine in advance. The use of active listening skills and open-ended, neutral interview techniques may have increased the likelihood of obtaining increased, information rich participant disclosure.

According to Sandilowski (1995) at least ten to fifty interviews are needed to adequately capture a target experience based on the above considerations however, data collected from a large sample size may prove to be too unwieldy to manage and interpret for a qualitative design (Ayres, 2007). Kuzel (1999) suggests that for qualitative study designs using criterion-based, homogenous, stratified sampling strategies, the recruitment of five participants for each research question within each subgroup may suffice to capture information rich data without becoming overwhelming for the researcher to analyze. The target sample size for the present study, based on the above considerations, was determined to be 15 participants per sub-group for a total of 30 participants. It was estimated that at least 200 preliminary contacts (i.e. mothers are provided with a study flyer and give permission to be contacted by the P.I) would be required to obtain a total sample size of 30 which is the equivalent of a recruitment rate of 15%.

Informed Consent.

Women meeting eligibility criteria who agreed to participate in the study were provided with informed consent documentation electronically or via traditional mail per their preference which was then collected at the face to face interview (See Appendix E). In the event the informed consent form was lost or not completed, or the participant has further questions, the researcher allowed adequate time for: (a) the participant to review of the form; (b) additional questions the participant may have regarding the study; and (c) obtaining the required signatures prior to the start of data collection. Each interview was digitally recorded and then transcribed verbatim into written text for analysis. In order to maintain participant confidentiality, names were replaced with a numerical identifier for data analysis.

Data analysis and interpretation.

Thematic analysis

Thematic analysis (TA), a core method for conducting qualitative analysis, was used to identify repeated patterns in data which are rich with detail and meaning (Braun & Clarke, 2006). This method is flexible and can be used as a singular analytic approach or as part of another qualitative methodology such as grounded theory to identify repeated patterns in data which are rich with detail and meaning, culminating in theme identification (Braun & Clarke). Data analysis and interpretation using TA can be a theoretical (i.e. theory or prior research driven) or inductive (i.e. data driven) process, and is conducted in three phases: a) recognition of a significant moment; b) labeling or encoding the moment so that others can see it; and c) interpretation of that moment (Boyatzis, 1998; Braun & Clarke). Theoretical TA was used to analyze and interpret data for the present study to (a) identify and/or disconfirm elements of BAM, maternal ideology and hardiness and (b) explore the experience of mothering a toddler from the perspective of both depressed and non-depressed women.

The TA process is composed of several steps which are iterative and overlapping. First, identification of categories and code generation occurs via multiple readings of the interview transcripts. The goal is to extract patterns and categories from the transcripts; and then collate, name and define codes that emerge. During this process it is important to leave verbatim text intact to avoid losing the underlying context of the codes and themes (Boyatzis; Braun & Clarke). Themes emerge from the data by identifying repeating patterns (i.e. codes and categories) that appear to be thematic representations. Thematic labels should provide a self-explanatory description of the thematic meaning thus in vivo phrases that emerge from participant narratives will be used to label and/or defined a theme (Miles & Huberman, 1994). Patton (2002) suggests that thematic clusters of codes be analyzed using two criteria; internal homogeneity (i.e. coded data maintain shared thematic meaning) and external heterogeneity (i.e. differences in the clusters are clearly demarcated). Development of a thematic map can further elucidate the contextual plausibility and association of the themes. Interviewer reflexivity (i.e. interviewer observations and perspectives) related to interactions with the participants during data collection was also be incorporated into the analysis (Scattolon & Stoppard, 1999). MAXQD qualitative data analysis software was used to aid in qualitative data analysis and management. SPSS was used for quantitative analysis of demographic information.

Quality of rigor.

Whittmore, Chase and Mandle (2001) developed a method for determining qualitative rigor utilizing a synthesis of widely used contemporary criteria (see Table 3.1) using a primary and secondary tier system which was adopted to evaluate the rigor of the present study.

Table 3.1 *Contemporary Criteria for Qualitative Rigor*

- Pausibility, Relevance, Credibility (Altheide & Johnson, 1994)
- Credibility, confirmability, saturation, transferability (Leininger, 1994)
- Truth value, applicability, consistency, neutrality (Lincoln & Guba, 1985; Guba and Lincoln 1989)
- Descriptive, interpretive, theoretical and evaluative validity (Maxwell, 1992, 1996)
- Credibility, fittingness, auditability, confirmability, creativity (Sandelowski, 1986, 1993)
- Moral and ethical components (Smith, 1990)
- Methodological integrity, representative credibility, analytic logic, interpretive authority (Thorne, 1997)

Whittemore, Chase, & Mandle (2001). Adapted from Table 1: Validity Criteria Development

According to Whittmore et al., the primary criteria to determine qualitative rigor are authenticity, credibility, criticality and integrity. Credibility (i.e. the findings accurately reflect the experience and are believable) and authenticity (i.e. the researcher remains true to the participant's voice and readily differentiates between her perceptions the experience versus those of the participants) are key elements of qualitative rigor that were readily addressed within this research design. Evidence that the researcher conducted systematic critical appraisal of the study design (i.e. identification and exploration of alternative hypotheses, bias and contrary findings) and iterative checks and verification of data interpretation describe the elements of criticality and integrity respectively (Whittemore et al.). The use of sample stratification and a detailed description of how data was analyzed using TA were two methods for addressing criticality and integrity in the present study.

Secondary criteria which contribute to rigor such as vividness, explicitness, creativity, thoroughness, congruence and sensitivity were also considered during each phase of data collection, analysis and interpretation in the present study. Vividness (i.e. presentation of rich, clear descriptions) and explicitness (i.e. clear delineation of data analysis and interpretation

techniques) create a methodological audit trail that can be used by the research consumer to independently evaluate rigor. Innovative methods for data collection, analysis and interpretation (i.e. creativity) using a clear scientific approach and theoretical saturation and full development of meaningful themes (i.e. thoroughness) provide evidence of data adequacy and comprehensive analysis. Qualitative congruence is determined by creation of a logical, clear relationship among the theoretical underpinnings, design, and findings of the study. Finally, sensitivity is demonstrated by clear incorporation of methods for addressing ethical issues and sociocultural considerations as well as the assurance that participants are treated with respect and dignity, within the study design (Whittemore et al., 2001).

Ethical considerations.

The researcher's role.

A researcher who designs and implements a qualitative study takes on the role of a human instrument by virtue of the subjective experiences and perceptions he or she brings to the process of data collection, analysis and interpretation. The development of researcher assumptions or bias is inevitable, thus it is important to identify and explore how they may influence the research process (Richards, 2005).

This researcher experienced postpartum depression with two out of four children which developed within the first few weeks post-birth. The last depressive episode remained unremitted past the first year postpartum and eventually required the use of antidepressants to achieve treatment remission. This researcher's experience of depression between 12-24 months postpartum was difficult and challenging with respect to issues of self-esteem and parental competence in response to the developmental changes inherent in toddlerhood and is a key motivation for conducting the proposed research. Care was taken to differentiate researcher and

participant agency during data collection, data interpretation, and thematic development to assure data authenticity. This was accomplished by ongoing development of research memos and log trails to identify and record potential sources of researcher bias and personal influence (Richards, 2005).

Data safety management.

Demographic information was collected and the PDSS was implemented during the pre-screening telephone interview. The face to face interview lasted approximately 30 minutes to one hour. No specimen collection or access to participant medical records were required for data collection purposes. Personal identifiers were replaced with identification numbers to assure confidentiality during the process of data analysis and interpretation. Computer files and digital recordings were stored using a secure, encrypted server provided by UNM Health Sciences Center. Written or printed notes used for data analysis and interpretation were held under lock and key in a secure file cabinet located within the UNM College of Nursing. A full description of the data safety management plan can be found in Appendix F.

Risk vs benefits.

No physical risks were associated with participation in this study. It was anticipated that some participants may experience some mild distress while answering instrument questions or during the interview which would most likely be transient and self-limiting. If the participant's depression screen score placed her at high risk for depression or present with clinical symptoms of depression during the interview process, a referral to a licensed therapist was offered. A local mental health care center that provided therapy using a sliding scale fee system, and in kind therapy via counseling interns under the supervision of licenses therapists was identified as a resource for participants who could benefit from therapy services but might not have been able to

access such services due to lack of insurance or financial limitations. There was no known direct benefit for women who elect to participate in this research study.

Summary

Viewing maternal depression from a wider perspective as opposed to only a biophysical one may promote more effective mental health care for women and their families by (a) developing an increased understanding and appreciation of how socio-cultural role expectations influence the development or persistence of maternal depression; (b) initiating or enhancing therapeutic dialogue by exploring the subjective view of mothering with the client or patient (Hall, 2006; Stoppard, 2000); (c) developing greater understanding of the interplay between maternal hardiness and the challenges of parenting a toddler; and (d) facilitating honest, full disclosure of emotional distress by taking the focus of inquiry off depression and onto stress in response to role transition and role incongruence. Currently no research has been published which uses the BAM framework to explore maternal role transition beyond the first year postpartum. This framework can be used to develop intervention strategies aimed at minimizing the negative impact of depression on the maternal-toddler dyad and promote more effective parenting behaviors for mothers in this high-risk population. Finally, women who participate in this study were provided the opportunity to give voice to their individual embodied experiences of becoming mothers, enabling us to understand more clearly what aspects of this role and their lives change over time, in step with the growth and development of their children.

Chapter IV Findings

Introduction

The purpose of this study was to explore the subjective experience of mothering a toddler from twelve to twenty-four months of age with a focus on how maternal depression may influence this experience. The study aims were to (a) identify codes, categories and themes that describe whether or not mothers of toddlers experience role transition, strain, or incongruence concomitant with developmental changes that occur as their infants transition into toddlers; (b) explore how maternal depression may influence the subjective experience of mothering a toddler; and (c) identify core dimensions of hardiness (i.e. control, commitment, challenge) that may emerge from the subjective voice of mothers as they describe the experience of mothering a toddler. Thematic analysis was used to answer the following research questions:

4. Do women experience a concomitant maternal role transition as their infants develop into toddlers?
    a. Does maternal role strain occur for some participants during this developmental transition?
    b. Is there a difference in the experience of mothering between the depressed and non-depressed group of participants during this developmental transition?
5. Do women develop ideological role expectations specific to being the mother of a toddler?
    a. Does maternal role incongruence occur if the reality of mothering a toddler does not match maternal expectation?
    b. Does depression mediate the influence of maternal ideology on role expectations?

6. Can characteristics of maternal hardiness be identified in response to stressors related to being the mother of a toddler?
    a. Are the three core elements of hardiness (i.e. control, commitment, challenge) identifiable in the words of participants as they describe the experience of mothering a toddler?
    b. Do descriptors related to hardiness differ in relation to mothering a toddler between depressed and non-depressed participants?

Methodological Approach: Thematic Analysis

Theoretical thematic analysis (TA) was used to analyze and interpret data to (a) identify and/or disconfirm elements of BAM, maternal ideology and hardiness and (b) explore the experience of mothering a toddler from the perspective of both depressed and non-depressed women. Multiple readings of the interview transcripts led to code generation, category identification and subsequent elucidation of thematic representations. Interviewer reflexivity (i.e. interviewer observations and perspectives) related to interactions with the participants during data collection was also incorporated into the analysis. MAXQD v.10 qualitative data analysis software was used to aid in qualitative data analysis and management. This software was particularly useful in the development of thematic maps which further elucidated the contextual plausibility and association of the themes (See Appendix G). Demographic analysis was completed using SPSS software.

Researcher Interest

This researcher has ten years of experience in psychiatric nursing in the inpatient setting and as a psychiatric/mental health nurse practitioner and previously practiced in obstetrical nursing for 18 years, initially in labor and delivery/postpartum settings and later as a perinatal clinical nurse specialist and women's health nurse practitioner. The interest in maternal

depression beyond the first year postpartum was developed due to both professional and personal experiences with PPD.

While working in a high-risk obstetrical setting, this researcher noticed a gap in care with regard to coordination of post-natal obstetrical and psychiatric care for women with a history of PPD with previous births or who had experienced antenatal depression in past or current pregnancies. The same observation was noted while this researcher was working as a nurse on an inpatient psychiatric unit. The coordination of care for mothers within the first year postpartum who were admitted for acute psychiatric conditions including major depressive disorder, bipolar disorder or psychosis was not optimal. Issues related to breastfeeding, disruption in the dynamics of the maternal-infant dyad or the potential impact of maternal mental illness were minimally addressed at best in treatment planning. Another key motivator was personal in that this researcher developed PPD after the birth of both her second and fourth child. The depression experience extended into the second postpartum year with the last child, and required the use of antidepressants for symptom remission.

These experiences subsequently prompted this researcher to enter the doctoral program at UNM College of Nursing to develop a greater understanding of PPD and explore how to improve the care and treatment for women who experience perinatal psychiatric co-morbidities with a particular interest in maternal depression. It became clear during the course of study that literature on PPD focused on the first few weeks and months post-birth was abundant but research on maternal depression unremitted beyond one year postpartum focused on the negative impact the disorder had toddler development as opposed to focusing on the maternal experience independent from the effects depression may have on the toddler.

Descriptive Characteristics

Recruitment

A total of forty-two mothers indicated initial interest in study participation with the vast majority (n = 40) providing contact information via one of the recruitment sites. Two mothers made initial contact with the researcher by answering to recruitment wall posters. Ten mothers did not respond to voicemails requesting further contact with this researcher to arrange an initial telephone screening. Two mothers were reached and opted not to participate in the initial telephone screening. Two mothers could not be reached due to incorrect contact information. Three mothers participated in the initial telephone screening and met inclusion criteria but attempts to schedule and complete the follow-up interview were not successful Four mothers responded to the initial telephone screening but did not meet inclusion criteria. A total of twenty-one mothers elected to participate in this study.

Demographics

The age range of the participants was between 23-35 years with a median age of 29 years. Initially only first time mothers of children between 12-18 months were included in the study however this age range proved to be too narrow in terms of recruitment and the inclusion criteria was expanded to include mothers with one or more children. The upper age range for toddlers was also expanded from 18 to 24 months to improve the chances for study recruitment. The majority of participants were first time mothers (n = 15), followed by mothers with two children (n = 4), three children (n = 1) and five children (n = 1). The toddler age range was between 12 and 22 months (M = 17 months) with 14 boys and 7 girls. The majority of participants were married (n = 15), worked full or part-time (n = 14) with a median household income of $35,000-49,999 per year. The majority of participants identified themselves as White (n = 12), followed by Hispanic ethnicity (n = 5), Native American (n = 1), White/Asian (n = 1), White Hispanic (n

= 1) and White Native American (n = 1). The educational level of the participants ranged from high school diploma to PhD candidate, with a median of education level of 16 years. Participants designated themselves as homeowners (n = 12), renters (n = 8) or other (i.e. living with other family members). Please see Table 4.1 for full details.

Table 4.1. *Participant Demographics (n = 21)*

Maternal Age	Age Range: 23-35 years Median: 29 years
Number of children at time of interview	1 (n = 15) 2 (n = 4) 3 (n = 1) 5 (n = 1)
Age of Toddler at time of interview	Age range: 12-22 months Median age: 17 months
Gender of Toddler	Male: (n = 14) Female: (n = 7)
Marital Status	Married: (n = 16) Never married: (n = 3) Engaged: (n = 2)
Income Level	Per year: < 25,000 (n = 5) 25,000-34,999 (n = 3) 35,000-49,999 (n = 5) 50,000-74,999 (n = 6) 75,000-99,999 (n = 1) >150,000 (n = 1) Median Income = $35,000-49,999 per year
Race/Ethnicity	Hispanic: (n = 5) Native American: (n = 1) White: (n = 12) White/Asian: (n = 1) White/Hispanic: (n = 1) White/Native American: (n = 1)
Education Level	Education total in years: Range: 12-20 years Median: 16 years
Employment Status	Employed (n = 14) Homemaker (n = 5) Student (n = 1) Unemployed (n = 1)
Housing	Rental Apartment (n = 3) Home: (n = 5) Homeowner (n = 12) Other: (n = 1)

Grouping based on PDSS Score

The PDSS was administered to place participants in either the depressed or non-depressed subgroup. Participants who scored less than 14 on the short form were placed in the non-depressed subgroup. If a PDSS score greater than 14 was achieved on the short form, the long form PDSS was administered. Participants who scored 60 or greater were placed in the depressed subgroup (see Table 4.2).

Table 4.2 *PDSS Scoring Process*

PDSS Scoring

- Total score on short form <14 = negative depression screen
- If the total score on PDSS short form is >13 then administered long-form PDSS
  - Score 60-80 = Significant Symptoms of PPD
  - Score > 80 = Positive Screen for PPD

Maternal Scores:

<14	(n = 16)
60-80	(n = 2)
>80	(n = 3)

Non-depressed Subgroup

The majority of mothers (n = 16) achieved a PDSS score of less than 14, indicating no symptoms of depression. The non-depressed subgroup was comprised of twelve first-time mothers and four mothers with more than one child.

Participant #1 (P.1) was a 25 years old, Native American with an 18 month old boy. She and her husband had been married for 4 years and they had recently reconciled after a separation of several months. She was a high school graduate and had just finished a certified nursing assistant program. She recently started working full-time after completing school with a current income of less than $25,000 per year. The family resided in a rented apartment. She had no pregnancy or birth complications, nor did she experience postpartum depression. She had a PDSS score of 12.

Participant #2 (P.2) was 33 years old, White, married with a college education plus 2 years and was employed part-time as a Registered Nurse. She had two boys, ages 3 years and 13 months respectively, at the time of the interview. She and her husband were homeowners with an income between $50,000-74,999 per year. She had no antepartum complications but did experience a postpartum hemorrhage with the birth of her son after a scheduled cesarean section. She did not experience PPD and had a PDSS score of 11.

Participant #3 (P.3) was 32 years old, White, married homemaker and had completed graduate engineering coursework to the level of a Ph.D. candidate. She had three children, a boy (age 6), girl (age 3) and a 19 month old boy. She and her husband were homeowners with a yearly income between $75,000-99,999. She had no complications during pregnancy and had planned on having her baby at a family centered birthing center however she experienced a prolonged labor that necessitated a transfer to a hospital. Her birth was further complicated by a cord prolapse which had no lingering effect on her newborn. She and her family moved from another State to New Mexico when her infant was 6 weeks old. She reported having PPD which resolved after six months with psychotherapy and acupuncture treatments. She had a PDSS score of 11.

Participant #4 (P.4) was a 33 years old, White, married, college educated, homemaker. She had two children, a girl (age 3) and boy (age 18 months). She and her husband were homeowners with an income between $50,000-74,999 per year. She had no antepartum complications but did have a postpartum hemorrhage. She did not experience PPD and had a PDSS score of 9.

Participant #5 (P.5) was 24 years old, Hispanic, high school graduate with 2 additional years of education and was employed full-time as a certified nursing assistant. She had one child,

a girl, age 18 months. She was engaged to be married, owned a home with her fiancé, and had a household income between $25,000 and 34,999 per year. She had gestational diabetes during pregnancy and had a cesarean section due to breech presentation with no report of postpartum depression. Her PDSS score was 11.

Participant #6 (P.6) was 27 years old, White, married, college education plus two years and employed full-time as a physical therapy technician. She had one child, a 15 month old girl. She and her husband were homeowners with an income between $50,000 and $74,999 per year. She had high blood pressure during pregnancy and experienced extensive perineal tearing during birth which resulted in dyspareunia that started to resolve shortly before this interview. She did not experience PPD and had a PDSS score of 13.

Participant #7 (P.7) was 27 years old, Hispanic, single, with a high school education plus one year. She was periodically employed with an income less than $25,000 per year and was living in a rented apartment. She had two children, a 5 year old girl with autism, and a 15 month old boy. She experienced first trimester bleeding and required weekly progesterone injections until she gave birth via cesarean section at 36 weeks gestation. She did not have any birth complications. She reported having PPD which resolved after 8 months without treatment. She had significant interpersonal stressors related to previous domestic violence issues with the father of her children which resulted in his incarceration. Her PDSS score was 8.

Participant #8 (P.8) was 35 years old, White, college educated plus 8 years and employed full-time as a physician and married. She and her husband were homeowners with an income greater than $150,000 per year. She had one child, a 12 month old boy. She had no antepartum or birth complications and did not experience postpartum depression. She had a PDSS score of 8.

Participant #9 (P.9) was 25 years old, White, college educated, married and a homemaker. She had one child, a 13 month old boy. She and her husband rented an apartment and had an income less than $25,000 per year. She had an uncomplicated pregnancy and birth and did not report a history of postpartum depression. Her PDSS score was 12.

Participant #10 (P.10) was 27 years old, Hispanic, married with a high school education. She was a full-time student, studying medical billing and coding. She had one child, a 21 month old boy. She and her husband were homeowners with an income less than $25,000 per year. She had no antepartum or birth complications but was induced due to a prolonged rupture of membranes. She did not experience PPD and had a PDSS score of 7.

Participant #11 (P.11) was 25 years old of White/Chinese descent, single, employed with a high school education plus one year. She had one child, an 18 month old boy and lived with her boyfriend in a rented home in which she was responsible for paying utilities. Her income was less than $25,000 per year. She had no pregnancy or birth complications and did not experience postpartum depression. She was 34 weeks pregnant at the time of the interview. Her PDSS score was 13.

Participant #12 (P.12) was 27 years old, Hispanic, married with some college education and employed part-time as a cashier. She was a homeowner with an income between $35,000 and $49,000 per year. She had one child, an 18 month old boy and was 14 weeks pregnant at the time of the interview. She did not have pregnancy complications until 36 weeks gestation when she required a cesarean section to avoid an umbilical cord accident. She did not experience PPD and had a PDSS score of 10.

Participant #13 (P.13) was 27 years old, Hispanic and a college graduate with a master's degree. She was single and employed full-time as a special education teacher. She rented a

home and had a yearly income of between $25,000 and $34,999 per year. She had one child, a 19 month old girl. She had hypertension during pregnancy but no birth complications. She did not experience PPD and had a PDSS score of 8.

Participant #14 (P.14) was 26 years old, of White/Hispanic descent and a high school graduate with two years of college education. She was employed full-time as a loan office at a bank. She was engaged and a homeowner with an income of between $50,000 and $74,999 per year. She had one child, a boy age 13 months. She did not have any pregnancy or birth complications. She did not experience PPD and had a PDSS score of 10.

Participant #17 (P.17) was 35 years old, of White/Native American descent, married and college educated. She described herself as a homemaker who worked periodically as a doula. She was a homeowner with an income between $35,000 and $49,999 per year. She had five children, ages 15, 10, 7, 5 and the youngest a 17 month old girl. She had no pregnancy complications but had a difficult delivery resulting in a hip fracture due to fetal malposition. She reported experiencing PPD which resolved with counseling and support from other mothers. She had a PDSS score of 13.

Participant #21 (P.21) was 27 years old, White college educated, married and recently became unemployed. She rented a home and had an income between $35,000 and $49,000 per year. She had one child, a boy age 12 months. She had no pregnancy complications but did have a postpartum hemorrhage. She did not experience postpartum depression and had a PDSS score of 7.

Depressed Subgroup

Five participants scored in the depressed range and composed the depressed subgroup. The PDSS scores for two participants were between 60 and 80, suggestive for significant

symptoms of postpartum depression. Three participants scored above 80 on the PDSS indicative of a positive screen for postpartum depression. Mothers in this subgroup have the letter D placed next to their participant identification number.

Participant #19 (P.19D) was 35 years old, White, married and college educated. She recently became self-employed as a speech-language therapist after staying home for one year after the birth of her baby. She is a homeowner with an income of $50,000-74,999 per year. She has two girls, ages 3 years and 14 months. She did not have any pregnancy complications. She had to be induced at 42 weeks. She had early postpartum complications due to a retained placenta. She did not report experiencing PPD however she scored a 68 on the PDSS.

Participant # 20 (P.20D) was 29 years old, White, college educated and employed full-time as a technical editor. She rented a home and had an income between $35,000 and $49,000 per year. She had one child, a 22 month old boy. She had no pregnancy complications but had an emergency cesarean section due to fetal distress. She reported having depression within the first year postpartum which resolved with counseling. The participant described experiencing intermittent depressive symptoms related to the stress of being the primary wage earner for the family while her husband attended school on a full-time basis. She had a PDSS score of 79.

Participant #15 (P.15D) was 35 years old, White, married, college educated and a homemaker. She was a home owner with an annual income between $50,000 and $74,999 per year. She was first-time mother of a 15 month old girl and did not have pregnancy or birth complications. She did not report a history of PPD in the first 12 months postpartum however she had a PDSS score of 100.

Participant #16 (P.16D) was 30 years old, White, married, college educated and worked full-time as a nutritionist. She was a home owner with an income between $35,000 and $49,999

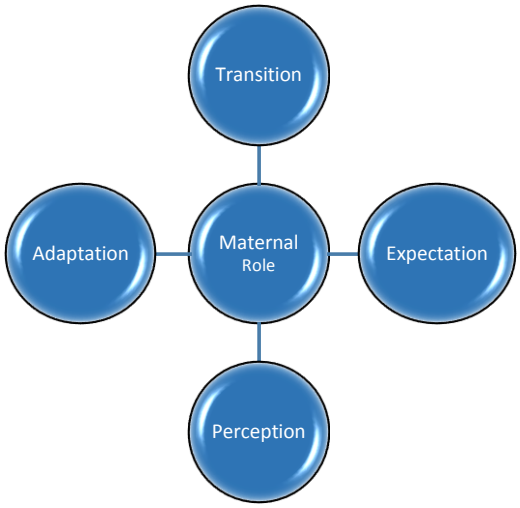
per year. She had one child, a girl age 15 months and had no pregnancy or birth complications. She did not report a history of PPD during the first year postpartum however she had a PDSS score of 83.

Participant #18 (P.18D) was 23 years old, White, married, a high school graduate and a homemaker. She rented a home with an annual income between $25,000 and 34,999 per year. She had one child, a boy age 14 months and had no pregnancy or birth complications. She reported experiencing PPD in the first year which resolved by 9 months postpartum with counseling. She scored an 84 on the PDSS.

Findings

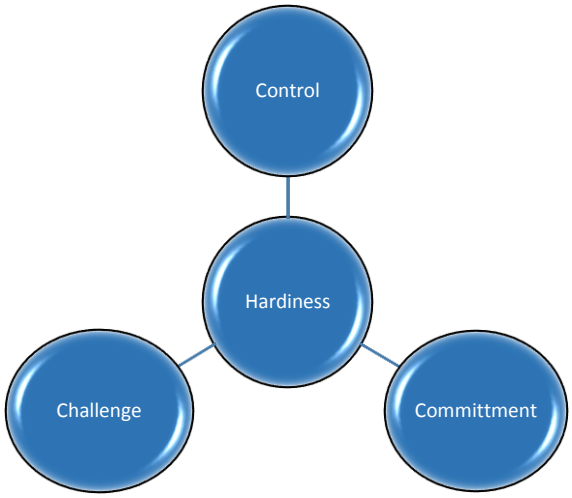
Thematic representations of four key facets of role development (i.e. transition, adaptation, expectation, perception) in the context of mothering a toddler emerged from qualitative analysis of participant narratives (see Figure 4.1).

Figure 4.1. Facets of Maternal Role Development



Thematic representations for the three conceptual components of hardiness (i.e. control, challenge, commitment) were also identified (see Figure 4.2).

Figure 4.2. Conceptual Components of Hardiness



A more extensive description of coding, categories and themes related to role development and hardiness in the context of mothering a toddler will follow in the remainder of this chapter.

Maternal Role Transition

The themes, *A New Transition* and *Taking Everything in Stride* were identified in relation to maternal role transition congruent with the developmental transition from infancy to toddlerhood for participants in both the depressed and non-depressed subgroups. Refer to Figure 4.3 for themes and their associated categories.

Figure 4.3. Themes/Categories for Maternal Role Transition

A New Transition	Taking Everything in Stride
•Transition with my toddler •My Focus has changed •Taking care of my own needs	•Staying flexible •My issue. Not my toddlers •Trying to develop patience

A New Transition

Participants from both subgroups described changes in maternal roles, focus and priorities that occurred as their infants transitioned into toddlers. Table 4.3 summarizes the codes for the first category *transition with my toddler*.

Table 4.3.

Coding for *Transition with My Toddler*

Depressed Subgroup	Non-depressed subgroup
• Caring allows unimportant stuff to fall away • Aware of how my behavior effects my toddler • Weather the storm of different transitions • My environment changes as she does • A little sad that I don't have a little baby anymore • Only human doing the best you can	• Dress to be prepared to care for a toddler • Weaning brought relief • Transition can be difficult • Difficult transition due to maternal health issues • Mothering role more distinctive now • Transition similar to postpartum

Participant #15 and #21, two first-time mothers described this transition as similar to that experienced in the early postpartum period.

> I think the hardest thing about it is that...the transition is similar to postpartum, no one ever talks about it. Oh it's so wonderful, yadda yadda yadda, but they are opinionated people. So it is certainly sort of a shock and sort of cool because now I can see a lot in him of his own personality and his own uniqueness….But it's hard because it's like a new relationship and how do you balance it? More challenges. How to deal with discipline and how he starts to challenge what you thought about parenting, and your ability to handle stress and frustration with them. (P. 21)

> I have had to find every 8-10 weeks I have to re-visit what these various websites and my books and different things because it's like…how do you do this? When she turned about a year...I don't know how to parent. Well why would I know how to parent a toddler in any form? (P.15D)

Two mothers in the depressed subgroup who had 22 month old toddlers described this transition as a reiterative process triggered by the changing needs and development of their children. Participant # 20D described having to constantly evolve along with her son.

> It could be better I could be a better mom, I could be a worse mom. It's just constantly evolving because my daughter is constantly evolving and I'm constantly trying to grow and figure out and today here's another different person. I make her sound schizophrenic, she's not really.

Participant # 15D also described her transition as an evolution in response to her daughter's development which was overwhelming for her at times.

> Yeah and you know I'm also...she's not very high needs but she still...I think...I don't know how I can put what I'm thinking into words but...it's not so much how do I manage how she is evolving, it's that along with her evolving you realize that your whole environment is changing. Your mindset...she is having her needs or developing and changing. I'm having to reassess. Ok now I have to do this differently. Am I doing enough for her now? How can I change our life routines...that's just overwhelming sometimes.

Several mothers described being much more conscious of how their behavior may influence toddler development. Participant # 5 stated "I'm more cautious about things I say or things I do. Like if the TV's on if it's like a lot of cursing or sex or anything like that I change it. I try not to get her exposed to any of that…um just definitely more cautious". Another mother, a pediatric medical professional described her 12 month old as a "developmental sponge".

> You know I feel like everything I do is modeling to him in some ways. I feel like you always have to be cognizant of how you are speaking not just to him but to one another, everything. The way which you conduct yourself 100% of the time is something he's gonna learn. (P.8)

The category, *my focus has changed* emerged as mothers described a shift in focus back toward themselves, their relationships with their spouses or change focus in daily life in response to toddler changes (see Table 4.4).

Table 4.4.

Coding for *My Focus Has Changed*

Depressed subgroup	Non-depressed subgroup
• Relationship with husband • Everything I was interested in has changed • What's best for her (toddler)	• Less time for each other (husband) • My whole life has changed • I put myself last and my kids first • Always focused on him (toddler) • Other things are petty compared to being a parent

Participants remarked that their spousal relationship was coming back into focus but difficult nurture. One mother described how she and her husband were trying to tend to their relationship with the help of her family.

> … everything that we do she's always like the first thought. We put ourselves second but we try and work with each other and still make time for each other. So like the time I tell you when she goes with her grandparents, that's like our date night. Before every one would tell us about dates and stuff and we wouldn't really think about it but then as she kept getting older we were like, we really don't have time for each other and we were losing who we fell in love with. So now that she goes with her grandparents, that's like our time together. (P.8)

A change in focus in terms of daily coping also emerged for some mothers. One participant found that her spiritual perspective became a more prominent element of daily coping as her child moved into toddlerhood.

> Um some external factors have happened just in my relationship and in my life that have caused me to do some soul searching and some self-exploration and um finding a spiritual side that I've never really been active in so especially in the last 6 months. I guess since he's become a toddler, not because he became a toddler. Just the environmental factors have um caused me to look deeper for meaning and uh comfort and acceptance in myself. And so uh that I think, has given me more patience and understanding with where he is and um just being able to take time in the day to pray and meditate on something instead of just feeling out of control and don't know where to turn. Don't know who to talk to. (P.4)

Another mother described a change in focus from wanting to be with others outside the home toward being present with and enjoying the company of her toddler. "I don't have to have you know five people in the room to be talking to. I talk to him <laugh> so it's kind of weird at

the same time. You're perfectly content just sitting there perfectly sitting there painting or doing odd little projects" (P.12).

The category *Taking Care of My Own Needs* emerged as mothers described the increased importance of considering their own needs as well as that of their toddlers. This was repeatedly characterized as "me time" or "taking a breather". Some mothers were successful at finding such time while others had difficulty doing so (see Table 4.5).

Table 4.5.

Coding for *Taking Care of My Own Needs*

Depressed subgroup	Non-depressed subgroup
• Don't want to ask my husband to do more • Don't have time	• Stay up late for me time • Me time could be anything • Good to have downtime • I take care of myself less • Feel more tired • Husband encourages me to go • Try to relax • Need something for myself now • It's a balancing act • Working on my career • Need a break • Not get lost in their lives

Taking a shower, watching TV or eating a meal alone were identified as methods for taking time for self or "me time" which was often taken at the end of the day even at the expense of sleep. Some mothers were encouraged and supported by their husbands to take time for themselves while others did not want to burden their spouses with having to care for their toddler in order to do so. Participant # 4 remarked that mothers were too quick to judge themselves for wanting to take time out and that it was important to do so to maintain a more positive perspective on life in the present. "Today is all we have so just saying I'll be miserable for these 5 years and then it will get better. I can't see how that makes anyone happy."

Many of the mothers expressed feeling guilty about wanting to take time out for themselves. Participant # 11, a single mom, described feeling guilty about this because she was away all day at work. It is notable that she also considered going to work as another source of "me time" even though she sometimes felt guilty about working outside the home. Participant #10, a stay at home mom, started to think about returning to work to fulfill her need for "me time" but felt conflicted about it.

> I think now that he's older I'm allowed to do more things, I don't know if allowed is the right word. I'm able to do more things. Like before he was born I got my Masters and then I started looking for a job and I got pregnant. I can't look for a job now [because] I'm pregnant. Then it was I have a baby and I can't start that new job. Now he's a little bit older. I can maybe go back to work full-time. I can go do a job on my own because he doesn't need me. I think that's kind of where I am at. Kind of more me time because I don't have to give him as much attention and sometimes I feel kind of guilty about that.

Participant # 19D, a mother of two described wanting to take up modern dance again, but felt guilty asking her husband to help out with the children so she could do so. Another mother, who was living in a safe house with her children after escaping domestic violence stated "It's like I'm more…I'm a lot more protective of them and it kind of sort of makes me feel guilty if I want some time to myself because I just feel like the time I have to myself, I could be dedicating to the kids. But then like my [domestic violence] DV counselor tells me, you need to make time for yourself too. I'm like I understand that but…".

Taking Everything in Stride

The theme *taking everything in stride* emerged from the data as participants described their ability to cope with the daily challenges they experienced in mothering toddlers. The categories, *my issue, not my toddlers* and *trying to develop patience* were identified from interviews with participants both subgroups. The category, *staying flexible* emerged only from the interview data from the non-depressed subgroup of mothers.

Several mothers understood that their negative reactions to normal but challenging toddler behaviors were internally derived as opposed to being purposefully motivated by their children (see Table 4.6).

Table 4.6

Coding for *My Issue. Not My Toddler's*

Depressed Subgroup	Non-depressed Subgroup
• A work in progress • It's my issue, not hers	• Don't let my kids feel my frustration • Up to me to figure it out • Couldn't enjoy her growth because it reflected my problem • Having a toddler shows that time is passing

Participant # 14 stated "… because I know he's not trying to do anything just to make me angry. He needs something and he can't talk so it's up to me to figure it out." One mother, a first-time mom in the depressed subgroup described the development of such insight as a work in progress.

> Reminding myself that this will pass, this is going to change. Reminding myself to take a moment, to take a breather, especially when she is being particularly challenging. She's not doing this to me, she's not doing this to make me mad or annoy me. There is a reason behind it. I have to remind myself sometimes and that helps me to stop and reframe it. Oh wait, she needs something, she's trying to communicate something. She's trying to tell me something. Maybe that helps her to perk up a little bit or sleep better. (P.20D).

Frustration with the daily challenges of mothering a toddler was common for several participants who described *trying to develop patience* as an important aspect of coping (see Table 4.7)

Table 4.7

Coding for *Trying to Develop Patience*

Depressed Subgroup	Non-depressed Subgroup
• Demand on my patience	• Self-exploration • More patience now • Get frustrated and not always patient • Have to develop a different kind of patience

Participant # 19D, a mother of two stated that her level of patience was less with her own children than that of autistic children she works with in her profession. "It's too much of a demand on my patience <laugh>. I can't be quite as objective as I am in my work. Touches me personally and more emotionally where it might not with other kids". Another participant compared her ability to have patience to her image of the maternal ideal.

> I've always wanted to be a mother. um and I yeah I just imagined it being a very patient person who would always take care of their children and not get frustrated which is not me all the time. I do get frustrated and I'm not always as patient as I'd like to be. Umm yeah. Yes the ideal is just kind of still there. (P.9)

Another mother attributed her ability to have more patience with her toddler to improved communication between the two of them.

Mothers considered the ability to stay flexible as a means of coping more effectively with the challenge of mothering a toddler. Codes related to the category *staying flexible* emerged from interviews with participants in the non-depressed subgroup only (see Table 4.8)

Table 4.8

Coding for *Staying Flexible*

Non-depressed subgroup
• Can start your day over at any point
• Everything is a gray area
• Flexible so I don't have a meltdown
• Stop judging myself
• Take everything in stride
• Don't want to set myself up for failure
• Have to stay flexible because he changes so fast
• Deal with it and move on

Participant # 12, a first-time mom, stated "I like to be flexible because if something doesn't work out the way it's gonna work out then I don't want to have a meltdown....If something doesn't go your way, you have two choices. You deal with it and move on or you fester on it and what started out as little pea sized problem is now a watermelon." Several mothers described the need

to remain flexible in their daily routines and for frequent modification of parenting responses to accommodate the constant changes in toddler development. One mother stressed the importance of not judging herself if she was having a particularly difficult time coping.

> Just to allow and not judge it. That's something that I'm learning too. It's OK to be angry and I shouldn't beat up on myself because I got angry today. And it's OK to be sad and I shouldn't judge myself for not being in the moment with my children and wanting to get down on the floor every second of every day and play house and like just allow that feeling to come and move through you and move onto the next moment because if you get stuck judging yourself for not being perfect you are missing the moment in front of you. (P.4)

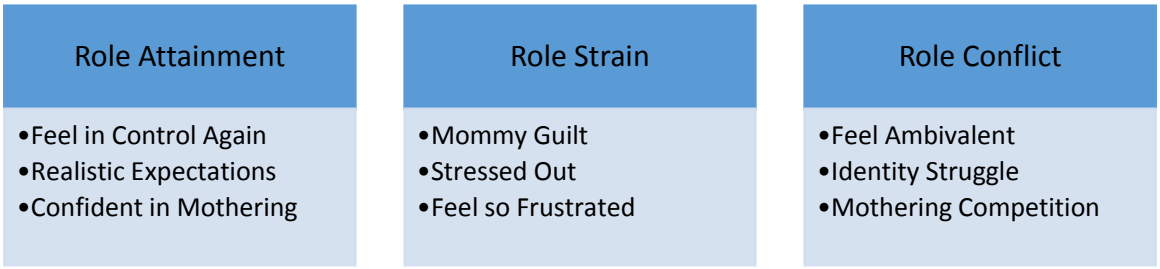
Participant # 4 used cognitive restructuring to cope when she started to become overwhelmed with daily challenges. "You can start your day over at any point of the day. You can choose to say this has been a horrible day or I can start over right now and say this is going to be a great day and not let that…in the morning when an entire gallon of milk was spilled on the carpet at 9:00am, that doesn't have to be the rest of the day and you can start your day over".

Role transition related to mothering a toddler was experienced by both first-time mothers and mothers with more than one child. No distinct differences in the experience of maternal role transition related to variations in maternal age, socioeconomic status or parity emerged from the narratives.

Maternal Role Adaptation

Themes related to variations in maternal role adaptation concomitant with the transition to toddlerhood emerged from interviews with mothers in both the depressed and non-depressed subgroups. The categories identified were *role attainment, role strain* and *role conflict* (see Figure 4.4). The majority of codes identified for maternal role attainment emerged from the non-depressed subgroup. Codes related to maternal role strain and conflict were identified more often in the depressed subgroup.

Figure 4.4. Themes/Categories for Maternal Role Adaptation



Role attainment

Participants who were successfully adapting to mothering a toddler described *feeling in control again* (see Table 4.9)

Table 4.9

Coding for *Feeling in Control Again*

Non-depressed subgroup
• Happy now
• Better equipped
• In control again
• Strong faith
• Be there no matter what

Participant # 13, a single first-time mom who reported having depression during the first postpartum year which eventually resolved, stated "after she was born I didn't feel that way at all and it was relieving and shocking to me that I could even feel this way. I didn't realize that I could be this person again. I'm happy now". Another mother stated that she felt in control of her role as both a mother and a nurse because of her strong religious faith. A first-time mother of a 13 month old boy acknowledged that it is more challenging to care for a toddler compared to an infant "but I think I'm better equipped to deal with it because I know I made it through all that other stuff so I can make it through this" (P.13). Participant # 7 felt confident and in control in the context of taking care of her toddler and older daughter after making significant changes in her life as a survivor of domestic violence.

> Yeah doing what needs to be done you know like I…we didn't have very much with their Dad but what we did have, I made work for us. And now that I have more it's like it just feels good to know that I am in control of myself again. You know like I say it feels nice to actually walk into my closet and see that there is a good supply of pull-ups for her, wipes for him, diapers for him. You know I have food in the fridge and the…I have you know…I still stay with extra money left in my account now.

Mothers who were successfully adapting to their new role described having *realistic expectations* for the experience of parenting a toddler (see Table 4.10)

Table 4.10

Coding for *Realistic Expectations*.

Non-depressed subgroup
• They are doing fine
• 50% easy, 50% hard
• Not going overboard on mothering
• Not letting kids walk all over me
• Most of the time I love it
• Not so worried after the first child
• Deal with drawbacks
• More realistic now
• I still have to be strict even though I love him

The importance of being consistent when responding to toddler needs and challenging behavior was frequently expressed by participants. One mother stated that she would stop what she was doing in order to attend to her son's needs but "within reason…everybody in the family has needs and you can't always give everything to the kids." (P.9). Another mother reconciled the fun she had watching her son grow with the need to be strict when her son demonstrated challenging behaviors. Participant # 12, a first-time mother, described the process of learning how to understand and cope with normal toddler behaviors.

> You know you have little set-backs where, oh my god she is throwing huge temper tantrum or oh my god she just smacked this kid for taking his toy. You know you have your little draw backs but you deal with them. You can learn off them. Every day they do something wrong or do something right. You have to learn off that because if you don't see that and you don't understand that then you aren't understanding your child.

Several mothers also described staying grounded and not overreacting to behavioral challenges. Participant #3 compared her reaction to such behavior as a first time mother to her reactions now, as a mother of three.

> … I would have been at the doctor [asking] how do I make him eat fruits and vegetables? Now I sort of realize that this is her thing and this is her palate and we will keep offering. It's our job to offer healthy food choices and it's her job to decide what she wants to eat and if she doesn't, she doesn't. She's not going to starve herself to death.

Codes for the category *confident in mothering* emerged for participants in both subgroups however the majority of coding came from interviews with mothers in the non-depressed subgroup (see Table 4.11).

Table 4.11

Coding for *Confident in Mothering*

Depressed subgroup	Non-depressed subgroup
• Confident in role • I'm working…I'm bad ass • Sense of strength	• Doing something right • Confident in role • These boots are definitely worn • Not a young mom anymore • Able to be a good mom • Clear about role • Satisfied most of the time • Trust instincts • I'm doing pretty good • I feel competent • Confident in major life change

Three mothers of the five in the depressed sub-group described feeling confident. One mother stated that she had developed a sense of inner strength as her child developed "because you are always going to stand up for your child and I think it seeps into standing up for yourself too" (P.15D). Participant # 20D, a first time mother, developed self-confidence in her role by working outside the home which was not congruent with the Christian fundamentalist expectations of mothering espoused by her own mother. The participant described having a

difficult relationship with her mother due to the participant's decision to go to college, become a professional and continue working after she had her first child. Despite this, her confidence in her decision to work outside the home did not waver. "Yeah…I'm working. I'm bad ass <laughing>". Participant # 18D described herself as a confident person in general. "I feel like I'm doing the absolute best I know how to do so I don't really compare myself much to other moms. And he seems pretty happy so…".

The majority of coding for *confident in mothering* was elicited from participants in the non-depressed subgroup. Participant # 6, a first time mother, described feeling more self-confident in response to her toddler's development. "It is very validating, helping the confidence as a mom. My daughter is figuring out where her nose and mouth and ears and eyes [are], and this stuff you are working on…you finally get to see some of it pay off". Other reasons for given for feeling confident in mothering a toddler included making a conscious decision to wait for financial and professional stability prior to having children, being mature, feeling secure about handling daily challenges and viewing mothering a toddler as a positive learning experience.

One mother attributed her maternal confidence to simply having common sense while another attributed her role confidence to having a strong sense of independence and ability to persevere in response to past adversity. Participant # 2 described feeling more confident in her mothering role even though she has struggle at times with it because she was no longer a first time mother.

> Oh yeah I think it's a lot better now. I think anytime you have an infant you are learning what they want and what they need so you can feel like you're not doing it right, so that works into your self-esteem. I 'm not as good as I should be. I should be doing better. I have done this before. I should know how to do this by now. I don't remember what happened years ago. <laugh> so yeah I think myself esteem is a lot better now.

Role Strain

The categories, *mommy guilt*, *stressed out* and *feel so frustrated* emerged in the context of the theme, role strain for both the depressed and non-depressed subgroup. The majority of codes for *mommy guilt* emerged with mothers in the non-depressed subgroup (see Table 4.12).

Table 4.12

Coding for *Mommy Guilt*

Depressed Subgroup	Non-depressed Subgroup
• Visceral reaction	• Feel guilty about working • Not having a father around • Mommy guilt • Feel guilty having/taking more time for self • Wanting down time

As described earlier, several participants felt guilty for taking time to tend to their own needs. Working outside the home also created guilt feelings. One mother felt guilty because her own mother cared for her toddler while the participant worked. She sometimes worried that her daughter saw the grandmother as her mother instead of the participant because so much time was spent with the grandmother. Another participant was conflicted about going back to work now that her toddler was getting older and expressed guilt about not having to give him as much attention.

> Now he's a little bit older I can maybe go back to work full-time. I can go do a job on my own because he doesn't need me. I think that's kind of where I am at. Kind of more me time because I don't have to give him as much attention and sometimes I feel kind of guilty about that. (P.10)

Participant #3 coped with mommy guilt by reminding herself that being perfect was not an achievable goal.

> Oh I definitely still do but I again try to tell myself that nobody is perfect. You are doing the best you can and you are still there for them and you love them the best that you can and I try to move on cause we could have mommy guilt over a thousand different things

> and it's it can be overwhelming so at a certain point you just have to just decide to give up and you just acknowledge you are doing the best you can and then that's it that's all you can do.

Participant # 15D, a first-time mother experienced a deep sense of guilt in response to a recent episode in which she had become so overwhelmed and upset with her toddler that she had to walk out of the house to compose herself. "…I felt guilty because I thought…well I need…or not that I want her to understand that I'm angry and I need the space. I don't know if I can express it. I was thinking about why I felt guilty but I just thought how can I have such a visceral reaction at that moment with her. She doesn't quite understand it <crying>".

The majority of codes for the category, *stressed out*, emerged from interviews with participants in the non-depressed subgroup (See Table 4.13).

Table 4.13

Coding for *Stressed Out*

Depressed Sub-group	Non-depressed Sub-group
• No one creates pressure except for me	• Medical issues • Feel more tired • Going through a lot with their dad • Balancing act

Several mothers described feeling stressed out and fatigued because they were trying to work and care for their toddlers at the same time. Participant # 15D described feeling very stressed because she was rebuilding her life and dealing with legal issues with her husband who was incarcerated on a domestic violence conviction.

> I'm still going through a lot with their dad. Like it's just like I honestly like you know I'm being pulled in 10 different directions One of them is legal matters, the other one is my health, the other one is them <looking toward her daughter>, bills, my housing, my job...

Another mother was stressed secondary to the lingering effects of a severe perineal tear she received during the birth of her baby.

> Oh my gosh I am still dealing with stuff from the delivery. Your 13 months old. I think it's having the child become a toddler really shows that time is passing. That was kind of the hardest thing because the older she got and became a toddler oh my gosh. I'm no longer the mom of an infant. I'm the mom of a toddler and I'm still having these issues. As she started learning and growing and doing new things it almost magnified and made it more difficult for me to deal with the [medical] issues because she made it obvious of how long I have been dealing with this stuff. (P.6)

Participants from both subgroups described feeling *frustrated at times* in caring for their toddlers even though they had an overall sense of role confidence (See Table 4.14).

Table 4.14

Coding for *Feel So Frustrated At Times*

Depressed Subgroup	Non-depressed Subgroup
• Doesn't flow with my expectations • Get frustrated with myself • Can't get stuff done • I get angry	• Frustration and rewards are high • Look for support when get frustrated • Figuring out how to keep him safe • Tired after work • Putting him down for a nap

Participant # 16D a first time mother who worked full-time, discussed at length the periods of frustration she experienced as she mothered her toddler. She described becoming upset with herself when she would become frustrated at her toddler's normal developmental behavior. "…there's time when she's just being herself and independent and it just doesn't flow with what my expectations were." Some of the frustration was related to having difficulty getting daily tasks done because of the time taken to address her daughter's needs. She admitted that at times her frustration reached a point that she has an urge to hit her daughter but denied ever having given in to this urge.

> I think that the biggest thing is like I get frustrated to the point where I just get angry with yourself because of the want to like hit at times...and I think that's the biggest issue for me...and it's not something that she deserves at all...and she hasn't done anything wrong but still it gets to the point where it makes me want to do those things and that really bothers me.

Participant # 21, a first time mother with a young toddler described becoming frustrated during the daily challenges related to her toddler's newfound independence, "…like getting him to not climb the stove. I still haven't figured out a way to do that. It's frustrating…how do you teach them hot and dangerous when they don't seem to want to listen to you?" Another mother stated that she would become frustrated with herself because she would come home from work feeling fatigued and even though she missed her toddler during the day, she would tire out after a couple of hours of caring for him. Participant # 11 stated that although she could get very frustrated caring for her toddler who was demonstrating his growing autonomy. "…the rewards are still really high so it's so worth it <laugh>. You're so worth it little man." The first-time mother of an 18 month old girl described how she coped with such frustrations.

> Um I just try like I get down to her level and trying to explain things to her so that she won't think I'm just like mad at her. I'll try to explain like this is why we can't do this. Um or like if like I'm frustrated I'll call friends or my mom or sometimes um like she'll go spend the night with her grandma or something so that helps. (P.5)

Role Conflict

The categories, *feel ambivalent*, *identity struggle* and *mothering competition* emerged in the context of the theme, maternal role conflict. Codes descriptive of maternal role ambivalence were identified from interviews with participants from only the non-depressed subgroup (see Table 4.15)

Table 4.15

Coding for *Feel Ambivalent*

Non-depressed Group
• Conflicted about staying home vs. working
• Hard to switch roles
• Not a mom all the time
• Feel guilty both ways
• Can't defend wanting to work
• Hard to separate watching from enjoying

Several mothers expressed a sense of ambivalence about being a mother who worked outside the home versus a homemaker. One mother stated "I don't know...that's been the hardest part, the expectation of...what is it to be a professional and to support your family and…uh…to sort of be a modern lady with advanced degrees and yet still choose to stay home. Participant # 21 described the tug she felt between working to contribute income versus staying home to be the primary caregiver for her toddler.

> Right now I'm struggling with the challenge of balancing how I feel about staying home and taking care of him and the expectation of me working. What that means...because I just got my Master's degree and I have a bunch of student loans, I feel incredibly guilty about expecting my husband pay my loans for me when I'm not working. At the same time feeling like I do want to stay home and I do know it's important for at least one of us to stay home. And the hardest part is that even now, it's hard to separate the jobs of watching a kid from enjoying being with your child. Because you can't complain about the job of being home…cause everyone is like well you can always just get a job. No that's not the point, sometimes you just want to complain. So that's been hard recently.

Participant # 11, a first-time mother described having difficulty transitioning from the maternal role to other roles in her daily life. "It's hard for me to be daughter, mom, lover, and friend. It's really hard for me because I'm constantly so much in the mom mode that I kind of transfer that to over to the other roles. I know it bothers a lot of people so I'm trying to get that. It especially bothers my fiancé."

Several participants in both subgroups experienced an *identity struggle* in the context of mothering a toddler (see Table 4.16).

Table 4.16

Coding for *Identity Struggle*

Depressed Subgroup	Non-depressed Subgroup
• If I could accept this I'd feel better • Have other aspirations • Miss pre-baby life • It's my job • Value harder for others to see • Motherhood is constant struggle	• Clothing congruent with being a mother • How to look my age • Trying to look older but not too old • How do I validate myself • Now I want my other roles • Not much of an identity anymore other than mother

Participant #15D stated "I just think that motherhood it's a constant struggle, not necessarily with her, it's a struggle with me and motherhood." She subsequently became very emotional as she described the difficulty she had accepting her role as a stay at home mother after putting her career plans on hold.

> If I could just say OK you are a mother. This is what you do now. I would probably be perfectly happy and content and not feel like I'm missing something or like I've let go of something or I have sacrificed something. If I could just accept it and it would all be so much easier. So it's like I think that is what it is. So why not accept it and would it be so bad to just accept it and accept who you are now or is the right thing to do to just continue to find a way to meld this notion of mother…these other things…at some point define you in your life. (P.15D)

Participants from both groups struggled with finding validation of their role as mothers. "I feel like I struggle with this. I feel like I don't have much of an identity anymore other than a mother and a wife" (P.9). Participant # 21 described her struggle with developing internal role validation instead of searching for it externally. "Or just being like, obviously you have done sufficiently, here's a grade. Even just in general, this is the first time in my whole life I'm not in school. So how do I validate myself? I haven't really come to a conclusion. I want to get past needing that". Participant # 15D struggled with the self-perceived reduction in power experienced as she shifted into the traditional mothering role.

> I'm the wife. I stay home. I cook dinner, I do the laundry. I take care of the baby. It just seems to have happened. I supposed if I sat down with [my husband] and expressed all that. I'd tell him I feel like I'm in this place of not having a lot of power because you

> know <crying> I guess even though we are doing the hardest job in the fricken world the value of it is just really hard for people to see and even for us to see as mom's you know.

Mothers from both subgroups observed or were negatively impacted by interactions with other mothers in what was often described as a *mothering competition* (see Table 4.17).

Table 4.17

Coding for *Mothering Competition*

Depressed Subgroup	Non-depressed Subgroup
• Tension between moms • It can get pretty ugly • Mommy wars are ridiculous • Being a mom is not easy • Animosity between moms	• Hard to defend decisions comfortably • Important to have mommy base • Competition between moms • Didn't sign up for this

Differences of opinion on what represented good mothering and the importance of staying at home versus being a working mother were two primary areas that triggered what one mother called "mommy wars". Participant #18D, a first-time mother was surprised at the conflict she experienced when talking about her mothering choices with other mothers.

> Why does it bother someone so much that you nursed longer than they did or don't nurse or do this or do that? For me it doesn't matter so I don't know why other people would fight and have so much strife in their life...like why would you want to add that to your life when you are already dealing with all the new things that come along with being a mom?

Another mother in the depressed subgroup had become very defensive because the group of mothers that she interacted with were using their toddler's developmental milestones as a benchmark for mothering competence. "You know…oh your kids doesn't have 50 words by 15 months. What kid does have 50 words by 15 months? And you're like really...these are things that you just get judged on...like a competition. Almost like it's become a sport that you have to compete in" (P.16D). Participant # 21, a first-time mother also experienced this type of competition.

> Some of the moms right now, always sort of feels like we are competing on our knowledge or ability to handle a situation. That's not fair. I didn't sign up for competition. Potty train my son at 14 months and tell everyone about it. Mine walked at 11 months. Yours isn't walking yet? Maybe he isn't interested. It's hard because it continually comes up.

Several mothers stated that identification of oneself as a either a working or stay at home mother often created a sense of competition among mothers. One mother who espoused the elements of attachment parenting and also worked full-time was very surprised by the judgmental attitude of her peers toward mothers who opted to or had to work outside the home. "You think they are loving and gentle with their children but there is a lot of animosity about working parents with that approach. Honestly, if anybody needs the support, it's the parents that have leave their children to work…reestablishing the bond because they have to be apart" (P.20D). Participant #4, a stay at home mother contended that having strong support from other mothers helped to offset the negativity associated with such competition. "I'm not saying that the working moms have it any easier or harder either way but um like I talk about having that mommy base. Having that loving mothering community is important but um I see a lot of moms of young kids uh not stay connected with friends or family".

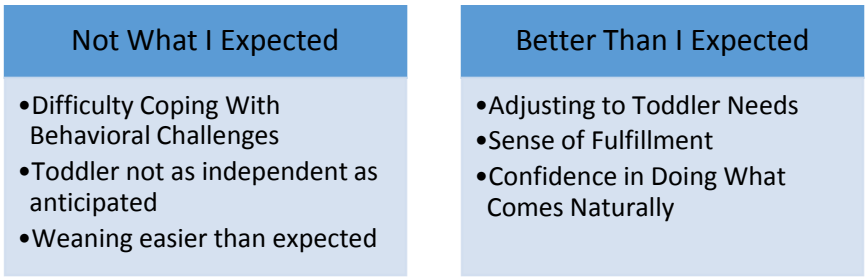
No clear differences emerged in the themes for maternal role adaptation with regard to age or socioeconomic status. However some of the mothers with more than one child were surprised that coping with challenging toddler behavior was difficult at times despite having gone through the experience at least once before.

Maternal Role Expectation

Themes describing maternal role expectations related to caring for a toddler emerged from interviews with mothers in both the depressed and non-depressed subgroups. The themes identified were *not what I expected* and *better than I expected* (see Figure 4.5). Categories

identified for the first theme emerged consistently from both subgroups however those related to the theme, *better than I expected* were identified more often in the non-depressed subgroup. Marked differences in the above themes did not emerge from the narratives based on demographics or parity.

Figure 4.5. Themes/Categories for Maternal Role Expectation



Not what I expected

Several mothers from both subgroups found themselves having more *difficulty coping with behavioral challenges* than they had anticipated (see Table 4.18).

Table 4.18

Coding for *Difficulty Coping with Behavioral Challenges*

Depressed Subgroup	Non-Depressed Subgroup
• She wants it when she wants it • She was so easy up until recently	• We were so naïve • She's my most challenging so far • 20 minutes of screaming up and down • It's hard to get used to • He is learning "no" real fast

Participants noticed a distinct difference in temperament with toddler transition. One mother in the non-depressed subgroup described being very surprised this change. " …just because he was such a good baby. I just assumed that he was going to be a great toddler <laugh> I mean he's not a bad toddler, it's just a lot different" (P.11). A mother in the depressed subgroup also noticed a distinct change in her toddler which she had not anticipated. "She was so easy up until recently. I'm not saying she's hard but it just wasn't the same. She went from being my easy

sweet wonderful baby to a bit challenging now" (P.19D). Participant # 7, a mother of five, described her toddler as being the most challenging of all her kids.

> I have this theory that if I didn't have milk she wouldn't have a lot to do with me. She's my meanest, most independent child. She's my hardest. I can't believe that 5 children down the road I finally have one that is that challenging. She is the most challenging child I have had by far.

Other mothers had anticipated changes in toddler temperament but were still surprised by how much this change impacted daily life. Participant # 11 had become accustomed to taking her infant with her on her daily outings.

> He was such a good baby in restaurants and everywhere shopping. He's always just been so good and now that he is getting his own personality he is just getting so stubborn and will not do what I ask him to do anymore. He gets so bored sitting in the shopping cart and so bored at the restaurants and will just scream. He's a very loud kid and it's just like completely opposite of what he was like as a baby, hard to get used to.

Another mother quipped at how naïve she had been prior to having her child "I felt like you know my kids would listen to me all the time and they would have such good behavior all the time no matter what and you know obviously that didn't pan out the way we had hoped <laugh>"(P.7).

Several mothers in both subgroups thought that their *toddlers were not as independent* as anticipated (see Table 4.19).

Table 4.19

Coding for *Toddler Not as Independent*

Depressed Subgroup	Non-Depressed Subgroup
• Expected more independence • Short attention span • I thought he would grow up more by now • More hesitant now about nursing in public • Still nurses a lot • Still not sleeping through the night	• Have to interact more instead of just letting him play • Very clingy • I thought it was going to be easier

Conflicts related to nursing a toddler emerged for some mothers in the depressed subgroup but not for those in the non-depressed subgroup. Participant #16D, a first-time mother who was also a staunch breastfeeding advocate stated "…there are times when I don't want to just go and sit somewhere and nurse because I don't want to have to deal with the explaining that this is what's normal and this is what people are". Another mother who described herself as being very passionate about the right to breastfeed in public admitted that she was feeling more hesitant about doing so now that her son was a toddler "feel a little more judged I guess"(P.18D). Participant #20D was surprised that her toddler still wanted to nurse so frequently.

> She wants to nurse when we wake up and when we first get together. Definitely at bed. Definitely all night long. Sometimes....during the day. Sometimes she wants to and sometimes not at all, varying...but always consistent in the morning, at night, at nap time. When she stubs her toe...somebody looked at me funny so I want the boobs.

Mothers from both groups described their toddlers as clingy or needing more attention than anticipated. "… like when he was a baby I would have a lot of time to do whatever I wanted. I could get chores done around the house. He wasn't so needy and now he's more needy for my attention" (P. 11). Participants were also surprised that they were still dealing with sleep deprivation. One mother in the depressed subgroup had anticipated that sleep would improve for both of them once her infant transitioned into a toddler.

> But I could have never imagined the total sleep deprivation that you have and I think it changes too when...maybe you would expect that with a newborn but now that he is considered a toddler and still have a lot of those same things. I guess I expected things to change and progress more, like for him to grow up more. (P.18D)

Three first time mothers and one mother of with three children, all in the non-depressed subgroup expressed relief that *weaning was easier than expected* for both themselves and their toddlers. (see Table 4.20).

Table 4.20

Coding for *Weaning Easier Than Expected*

Non-Depressed Subgroup
• I was mentally exhausted • She pretty much decided • No heartbreaking experience

Participant # 6 described a sense of relief upon weaning which had become mentally exhausting for her.

> …it was easier than I expected because she was ready so she was just done and so it wasn't that she never asked for it. You know even before that she was to the point where I'm like do you want milk? And she'd come up and she'd poke my breast and she wanted milk but once she was done, she was done and she never asked for it so I never had that heartbreaking experience of having to tell her no. There was the frustration around it but then it was such a relief like alright we're done. She's ready to be done. I'm mentally you know exhausted and it was just a relief. (P.6)

Mothers also described having newfound sense of freedom from not having to plan for breastfeeding in their daily routine and feeling more rested because their toddlers could be put to bed more easily by their fathers. "…his Dad has such an easier time putting him to sleep… everybody else has an easier time putting him to sleep. So it was kind of like, Ok well…he is not a baby anymore. He's independent" (P.14).

Better than I expected

The majority of codes that comprised the category, *adjusting to toddler needs* emerged from interviews with mothers in the non-depressed subgroup (see Table 4.21).

Table 4.21

Coding for *Adjusting to Toddler Needs*

Depressed Subgroup	Non-Depressed Subgroup
• I'm adjusting better to having a toddler	• I'm not that scared mom • My patience is longer now • I'm confident in taking care of his needs

Participant # 18D, a first-time mother who experienced PPD until her infant was 9 months old indicated that she was much more prepared for toddlerhood than caring for an infant. "I feel like I'm adjusting better to having a toddler because I love toddlers. I always joked that I was not a baby person so to have a baby was like why did I do this thing? But I like having a toddler a lot. <laugh>." Mothers in the non-depressed subgroup described having more patience and being less scared and worried about their toddlers getting hurt as they navigated about with their newfound sense of independence. "I thought I was going to be that scared mom who didn't let her kids do anything and that's not the case <laugh>" (P.11). Participant # 4 experienced inner turmoil as she figured out how to care for her infant, compared to her mothering experience with her toddler. She attributed this to increased patience congruent with an improved ability to communicate with her toddler.

Several participants from the non-depressed subgroup described a distinct *sense of fulfillment* in their role despite the challenges of mothering a toddler (see Table 4.22).

Table 4.22

Coding for *Sense of Fulfillment*

Non-Depressed Subgroup
• More fulfilling than I thought it would be
• Turned our lives upside down in a good way
• Great way to spend life

Participant # 4 was surprised by how content she was not returning to work. "It's more fulfilling than I thought it would be. I thought I would really want to go back to work and I really don't want to go back to work <laugh>." Other mothers described a strong sense of doing what they had always wanted to do and enjoying their role while still acknowledging the daily challenges of caring for a toddler. "It's turned our lives upside down but in a good way" (P.8).

Mothers in the non-depressed subgroup expressed *confidence in doing what comes naturally* in caring for their toddlers (see Table 4.23).

Table 4.23

Coding for *Confidence in Doing What Comes Naturally*

Non-Depressed Subgroup
• Doing what feels natural • Feels more natural than I thought it would be • I trust my instincts

Participant # 14, a first-time mother was surprised at how confident she felt about her parenting skills and decisions. " OK I'm just doing what feels natural to me and it's nothing that I, you know. I didn't think that he would sleep in the bed with me ever and I didn't think that when I first got pregnant… I didn't think I would breastfeed let alone still breastfeeding at 13 months". A mother of three learned to trust her instincts "no matter what the books [or] experts say" (P.3) while a first-time mother recalled worrying that she wouldn't be able to keep her toddler safe. She eventually found that it came quite naturally as time went on. Participant # 6 described an increased sense of confidence in tandem with the growth and development of her toddler.

> You know when they start getting to be a toddler you start actually seeing how their personality is manifesting and um so I think in some ways that helps my confidence as a mom. Because you know when I…when we are playing some place public and I see other kids constantly eating or hitting or throwing toys at other kids it kind of helps my confidence of like OK I'm doing something right.

Maternal Role Perception

Participants described how they viewed their mothering experience from both an internal and societal perspective. The themes identified from both subgroups were *perfect mothering* and *realistic mothering* (see Figure 4.6). Marked differences in the above themes did not emerge from the narratives based on demographics or parity.

Figure 4.6. Themes/Categories for Maternal Role Perception

Perfect Mothering

Two dichotomous categories, *supermom* and *nobody is perfect* emerged from interviews with participants in both subgroups. Coding for both categories indicated that maternal perceptions were influenced by sociocultural expectations (see Table 4.24)

Table 4.24

Coding for *Supermom*

Depressed Subgroup	Non-Depressed Subgroup
• Inadequate if not perfect • Mothering extreme • Holistic perfect mommy • Living up to someone else's vision	• A supermom takes care of the house and the baby • Always takes care of the kids and never gets tired • I don't know what that looks like

Participants in the depressed subgroup were more inclined to integrate *supermom* characteristics into the development of their own benchmarks for adequate mothering. Participant # 16D who advocated attachment parenting and a more holistic way of living was particularly troubled by what she perceived as a judgmental attitude by other mothers in her social circle. She described their parenting as extreme and admitted to feeling inadequate at times because she wasn't living up to the idealized image of mothering.

> [They] idealize this the image of being the holistic perfect mommy [and] will be completely judgmental if you are in disposables. And god forbid you can't afford organic diapers if you are in disposables. And that's the thing too, like you know if your kids have anything but organic food then like my god. This is not how it's supposed to be and it's hard because they all idealize that vision.

One mother became very emotional as she compared herself to her mother, whom she described the ideal mom. “I definitely think I use that as a standard in some ways. And so I had kind of an idea of what especially when I knew I was going to have a little girl. And um...so I kind of had an idea of what I hoped our family would be and how my interactions with her would be” (P.18D). Another mother who worked outside the home described her perfect image of a mothers as one who has no other aspirations other than mothering. Mothers in the non-depressed subgroup did not infuse the mothering ideal into their own role to this extent. Participant # 11 described herself as functioning like a supermom for the first 10 months postpartum until she went back to work. She was very lighthearted in her recollection of this and was not troubled by the subsequent change in her role. “I stayed home for 10 months and I was supermom….I just took care of the whole house and the baby all the time. Supermom. <laugh>”. Other mothers in this group stated that they did not have a perception of what an ideal mother was. “I don't know what that looks like. I don't think anyone has it. It's not a goal. It's not a goal” (P.4).

Mothers from both subgroups recognized that *nobody is perfect* with regard to mothering (see Table 4.25).

Table 4.25

Coding for *Nobody is Perfect*

Depressed Subgroup	Non-Depressed Subgroup
• Other people pretend to be	• Perfect moms are not flexible
• Too exhausting	• A good mother is not perfect
• Reality finally hit	• Give the idea of being perfect up

Participants stated that mothers often pretended to be perfect “they put on that face” (P. 20D) and also linked perfection to being inflexible. The pursuit of trying to be a perfect was also described as exhausting. “I just had this idea that it would just be able to do it, Why couldn't you? Then

reality hits and you're working on 5 hours of sleep and one thing and the other and that's not reality. It's rough" (P.20D). Participant # 12 described the characteristics of a good mother compared to that of a perfect mother, based on the maternal response to the individual differences of each child.

> I don't think there's such thing as a perfect mother and um you know there's good mothers but it's different. Every kid is going to be different. My relationship with my mom is different than my sister's relationship with our mom. You know see. You know they went down different paths together. You're born at different points in your parent's lives. The maturity level might be different. The experiences will be different. So you never know what exactly is going to be your relationship with your parents. So I don't you know. A perfect mother for him might not necessarily be a perfect mother for our next kids. So I don't I can' really say that there's a perfect mother.

Two of the participants paralleled doing the best you can as a mother with that of being a perfect mother.

Realistic Mothering

The categories, *I don't expect to be perfect*, *finding balance*, and *nurturing and loving* represented the theme realistic mothering. The categories and codes that emerged for this theme were more reflective of the actual mothering self-perceptions of participants as opposed to role expectations in the context of societal influence. The majority of codes for the first category were derived from interviews of mothers in the non-depressed group (see Table 4.26).

Table 4.26

Coding for *I Don't Expect To Be Perfect*

Depressed Subgroup	Non-Depressed Subgroup
• Perfection wasn't going to happen	• Sometimes they just have to be messy • Just be the best mom you can be • Asking for help is not a sign of inadequacy • Remind myself I'm doing fine

Participant # 16D described how she and her husband were motivated by their intention to be better parents then their own instead of trying to be perfect parents as defined by society. “That's been… our vision to do better than what we had and I don’t know if other people have a better expectation of having the perfect child and the perfect expectations but that wasn't what we figured was going to happen”. Some mothers were very quick to modify their self-expectations once they had children which remained consistent during the transition from infancy to toddlerhood.

> Things change all the time. There is no way I can say I'm going to be a perfect mom and I'm doing to do this and this and this. Even with him now if I say I'll do this that and the other, you don't know what's going to happen with it. You can't. There's no way that you can do that. You just have to be the best mom that you can for your baby. (P.14)

Participant # 12 realized that asking for help to figure out how to be a better mother did not negatively reflect on her role competence. “…just because I have to ask for help doesn't mean that I am not doing everything that I need to do….I had to come to the realization I'm not being inadequate. You just need some help”.

Finding balance was an important component of realistic mothering for the participants (see Table 4.27).

Table 4.27

Coding for *Finding Balance*

Depressed Subgroup	Non-Depressed Subgroup
• I wish I could manage it all better	• A good mother finds balance in the middle • Balance society expectations with reality • Ongoing process, always changing

Mothers in the depressed subgroup primarily described having difficulty organizing their daily routines to meet their family needs and recognized the importance of developing a sense of

balance in their daily lives. Participant # 15D had been struggling with managing her home and daily routine while caring for her toddler. “Um if I could just manage it better then I'd find more of my… I'd have a little bit more peace in my emotional experience and [decrease] these moments of anxiety that I have to go through”. Mothers in the non-depressed subgroup recognized the need to maintain a sense of balance between the reality of mothering and societal role expectations. Participant # 9 stated “there's a fine line between being able to keep myself sane and my child happy and my family happy and so sometimes that can be hard to <pause> kind of find a balance between what society has put, this image in my mind of what a perfect mother is and what is in reality possible to be”.

Participants in both subgroups described a good mother as one who was fundamentally *nurturing and loving* toward her toddler (see Table 4.28).

Table 4.28

Coding for *Nurturing and Loving*

Depressed Subgroup	Non-Depressed Subgroup
• Allows the unimportant things to fall away	• It’s basic. Love them • Take care of their needs • Spend time working on it

One participant gave a succinct description a mother who is *nurturing and loving*. “I think really someone who is attentive, available and nurturing is what kids need in a way it's very basic. You have to love them and care for them” (P.5). Another mother described a perfect mother as one who was *nurturing and loving* as well as “making sure they eat right and making sure they are clean and not real dirty you know and making sure they are just taken care of” (P.10). Participant # 7, who was rebuilding her life with her two children as a survivor of domestic violence included having a regular income to provide small extras for her children (e.g. new clothing, toys, bubble bath) as part of her definition of what it meant be *nurturing and loving* as

she had not been able to provide what she considered luxuries to her kids in her previous situation. Participant # 11 summed this up by saying stating that "Overall a good mom is just someone that [let's her] children know that she loves them right and that they love her."

Hardiness

According to Kobasa (1979) people who are considered to have a hardy personality trait display a sense of *control* over life events, the perception of change as a *challenge* instead of a threat, and *commitment* to one's self and active involvement in the social context of life events. Please refer to Chapter II for a literature review of the characteristics of hardiness (i.e. control, commitment, challenge) in the context of gender and depression vulnerability. Thematic representations of all three components of hardiness emerged from participant interviews. Marked differences in descriptors for the above themes did not emerge from the narratives based on demographics or parity.

Hardiness: Participant Definitions

Participants were asked to describe what came to mind when they thought about what it meant to be a hardy mother. The descriptors were divided into three categories: *weather the storm, strong and resilient* and *roll with the punches*.

Participant # 20D described a hardy mother as "A mom who can weather all the challenges with grace and patience. Who doesn't get frazzled easily and still manages to make stuff happen". Another participant in the depressed sub-group associated hardiness with being adaptable to toddler transitions.

> One who kind of *weathers the storm* of different transitions because as soon as you get out of a difficult transition with a child, you're into another one. You transition out of newborn things that are difficult into toddler things that are difficult. (P. 18D).

Several mothers in the non-depressed subgroup describe a hardy mother as one who was *strong and resilient* in the context of coping with pressure and stress. "I guess that describes the mom who perseveres you know…it's not always smooth but just being able to collect your wits back about you and…being persistent and you know not giving in because it's easier" (P. 6). Participant # 5 provided a similar description.

> A hardy mother [is] um somebody who sticks to their word if she tells their child that they can't have something then she won't give it to them….Um I don't know, just sticks to like what you believe and how you want to raise your child.

One mother used the analogy of a rich and hardy stew to describe hardiness while another compared a hardy mother to "those sort of pioneer women, kind of homesteading, farm steading. That kind of resolve, and yet they were so warm and gentle" (P.17).

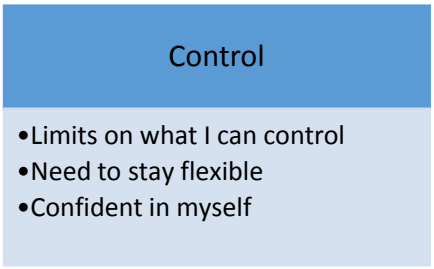
Hardy mothers were also described as being able to *roll with the punches* in response to the daily challenges of child-rearing. "No matter what life throws at you, you're going to deal with it. We just roll with it and deal with things that life throws at us" (P.3). Participant # 4 provided a rich scenario of how a hardy mother copes with the unexpected.

> A mom that can deal with the screaming on aisle three over a lollipop and not yell back at her kids or hit them. That can take the fact that you get everyone in the car and you drive everyone to the zoo and it's closed that day for whatever reason and you are there 2 hours too early which happens when you have toddlers that get up at 6 o'clock in the morning. And you're like I have nowhere to go. I'll go here. What do you mean you are closed! So being able to roll with the punches and uh not take things personally. Life is not beating up on me out of spite.

Control

Three categories representative of the theme, control, emerged from participant narratives in both the depressed and non-depressed subgroups (see Figure 4.7). The categories identified were *Limits on what I can control*, *Need to stay flexible*, and *Confident in myself*.

Figure 4.7. Theme/Categories for Control



Participants from both subgroups recognized that there were *limits in what they could control* in their daily lives with regard to caring for their toddlers. Some were more at ease than others with this realization (see Table 4.29).

Table 4.29

Coding for *Limits on What I can Control*

Depressed subgroup	Non-depressed subgroup
• Have to go with the flow/frustrating • Not molding into my day/frustrating • Changes in routine are overwhelming	• Not in always in control/not worried • Stay calm and re-center

Clear differences in responses were noted between the two sub-groups. Participants in the depressed sub-group had difficulty coping at times with a decreased ability to maintain control of their daily routines in the context of mothering a toddler. Participant # 16D described how her daughter's burgeoning autonomy would often conflict with her plans for the day.

> …there's times when she's just being herself and independent and it just doesn't flow with what my expectations were and that I think is the hardest part but overall I mean I try to go with the flow…. She's not trying to be frustrating. She's just trying to be herself and grow up and it can just be difficult to try to release that idea that they're not going to mold into your day to day...they're going to do what they want to do. So that's been the most frustrating part but it's been something I have actively been trying to make myself more aware of. Just take deep breaths and just sort of do it.

Another participant described feeling overwhelmed at times by the need to be flexible in planning her family routine based her toddler's changing development. This was made even

more challenging for the participant as she saw herself as being primarily responsible for managing their daily routine. “How can I change our life routines...that's just overwhelming sometimes. My husband he is really a great Dad but I don't...it doesn't seem like that burden falls on him in the way that it does on me” (P.15D). Participants in the non-depressed group were more comfortable with the recognition that they would not be able to have full control over all aspects of their daily lives with their toddlers. Participant # 21 described the importance of not trying to maintain total control of her daily routine in the context of toddlerhood.

> There are certain things that I can't control and if I worry too much. I don't know how I managed to do it but I'm a lot less stressed out than I thought I would be. Before I had him I would have described myself as a worrier.

Another mother in the non-depressed subgroup described her method for coping as she recognized having less control over the course of her day in the context of meeting her toddler’s needs. “It's just like that trying to re-center yourself. Calm down because if we keep going like this we aren't getting anywhere” (P.6).

The *need to stay flexible* with regard to mothering a toddler emerged from interviews with participants in both subgroups (see Table 4.30).

Table 4.30

Coding for *Need to Stay Flexible*

Depressed subgroup	Non-depressed subgroup
• Not a very scheduled person	• Everything always changes • Forced to roll with it • Able to change my default behavior

Mothers described toddlerhood as one of perpetual change which required that they “roll with it because there is no other way to handle it” (P. 21). Participant # 18D had many transitions in her life since the birth of her child due to moves across the country and did not consider herself to be a schedule oriented person.

> It's kind of whatever works for that day is what we do. I'm not a very scheduled person so probably just flows over to how I am with him. And he's pretty much what's the word...he's been pretty against scheduling since he was born. (P.18)

Another mother was learning to maintain balance between keeping her toddler safe and letting her explore her world. "An infant you can control what they are doing and a toddler you really have to watch. You gotta let them explore so they learn at the same time really watch him so he doesn't do anything bad" (P.10).

Participants in both subgroups described feeling *Confident in Myself* in the context of having a fundamental sense of control in mothering a toddler (See Table 4.31).

Table 4.31

Coding for *Confident in Myself*

Depressed subgroup	Non-depressed subgroup
• Fell into attachment parenting and research supported it	• Clear about my expectations and responsibilities • Parents are the experts • I'm in control of myself again

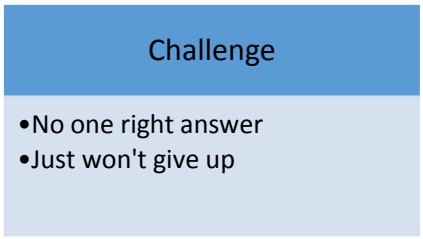
Participant # 20D felt a fundamental sense of confidence in her choice to use attachment parenting strategies for her toddler despite struggling with role strain and conflict. "I kind of sort of started to fall into it. It just was in my heart, felt right. Continued to research it and that just reinforced it. Kind of a combination of the two". One mother was very clear about her self-expectations and responsibilities of being both a mother and medical professional which in turn increased her ability to maintain balance and control in her life. Participant # 7 had a newfound sense of control in her life after successfully escaping a violent domestic relationship.

> I'm still going through a lot with their dad. Like it's just like I honestly like you know I'm being pulled in 10 different directions. One of them is legal matters, the other one is my health, the other one is them. Bills. My housing. My job. My, you know, friends like I was never allowed to have friends and now that I do it's like something that like my mind is being reprogrammed to actually be in control of myself again.

Challenge

Two categories representative of the theme, Challenge, emerged from participant narratives (see Figure 4.8). The category, *No one right answer* was identified for both the depressed and non-depressed subgroup. The category, *Just won't give up* emerged from interviews with the non-depressed subgroup only.

Figure 4.8. Theme/Categories for Challenge



Several participants experienced times when they had *no one right answer* with regard to mothering a toddler (see Table 4.32).

Table 4.32

Coding for *No one right answer*

Depressed subgroup	Non-depressed subgroup
• Stop and reframe • Trying to manage better	• No one right answer • No instruction manual • Learn from drawbacks

One mother admitted that this was difficult for her however she was able to take it in stride.

> … there are so many factors into play and we have so much imperfect information. Lots of times that you just have to, you know do whatever research you can or you have time for but then accept that there might not be one right answer and you might just have to pick the best thing and go with it and that has been hard for me <laugh> just because of my nature, my personality. (P.3)

Participant # 20D described coping with her toddler's more challenging behaviors by taking a moment to "take a breath" to remind herself that the issue is temporary and will pass. "…that

helps me to stop and reframe it. Oh wait, she needs something. She's trying to communicate something. She's trying to tell me something". Another mother in the depressed subgroup focused on "trying to find something so I feel like I'm managing a lot better (P.15D). Participant # 12 aptly described her response to change in the context of Kobasa's definition of hardiness.

> You know you have your little draw backs but you deal with them. You can learn off them. Every day they do something wrong or do something right [and] you have to learn off that. Because if you don't see that and you don't understand that then you aren't understanding your child. (P.12)

Participants in the non-depressed subgroup described themselves as determined individuals *who just won't give up* in the context of mothering (See Table 4.33).

Table 4.33

Coding for *Just Won't Give Up*

Non-depressed subgroup
• Won't let things hold me back
• I've always been determined
• I just do it
• Just deal with challenges

One mother succinctly stated that "You deal with challenges every day no matter if you are a Mom or if you are not a Mom" (P.12). Participant # 13 described herself as a hardy individual even in the midst of past depression.

> I would say I'm really hardy and driven. I would describe myself as that. I wouldn't let things hold me back no matter if it's really terrible. I will always keep going forward. I know that I could get sad about it or depressed like I used to but even then when I was depressed I never really stopped doing what I had to do so…

Participant # 21 stated that she would not give up on trying to come up with ways to keep her toddler safe as he became more agile.

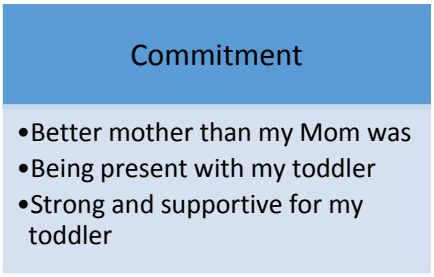
> Mostly I currently just won't give up. If something doesn't work. If I can't get him to do it after a while I'll stop trying and do it again later. Go into a different room or keep taking him off the stove until I'm done with what I'm doing, or use the back burners. I

have to modify what I do because I can't get him to modify his. That's certainly a challenge when they start walking or climbing.

Commitment

Participants in both sub-groups described having strong commitment to improve their mothering skills and roles by becoming *a better mother then their own moms* were to them, *being present with their toddlers* and *being strong and supportive* to meet the needs of their children (see Figure 4.9). The overall frequency of coding for this theme was less than that of the other two themes for hardiness.

Figure 4.9. Theme/Categories for Commitment



Participants in both subgroup had a goal to become a *better mother than my mom was* (See Table 4.34).

Table 4.34

Coding for *Better Mother than My Mom Was*

Depressed subgroup	Non-depressed subgroup
• Stop the cycle of hitting	• Focus on trying to be a better Mom • Change how I was raised

Two mothers described having clear goals for stopping the perpetuation of yelling and hitting out of frustration and anger. “My parents were screamers I remember as a child being terrified when they would scream …. I really have had to try to change that default behavior and it's not easy

obviously but I think so worth it even from the memories that I have" (P. 3). Participant # 16D described wanting to stop the cycle of hitting that both she and her husband endured in their own childhoods.

> I feel that way because I was hit out of frustration as a child and I don't want her to have that and my husband had the same issue and we don't' want her to have that because it's not necessary. There's no reason to do it and it just perpetuates that cycle and we want to do our best to stop that cycle.

Two mothers described their commitment to reduce distractions around them so that more time could be spent *being present with my toddler* (See Table 4.35).

Table 4.35

Coding for *Being Present with My Toddler*

Depressed subgroup	Non-depressed subgroup
• She just needs my time	• Put my phone away • Hang out and play

Participant # 3 changed her daily pattern in order to accomplish this.

> On day the older two are at school, let's [not] just run errands because that's not what she needs. That may be what I need but that can wait or we can find some other time to do it. But to really say OK. Yeah we'll just come back home and we'll hang out and we'll play. That's really what she needs at this stage in time.

Participant # 15D described the importance of making a conscious move to stop what she was doing if she started to get irritated with her daughter's insistence for attention. "Then she'll touch me and I'll realize I need to be a little more present and I'll sit down on the floor with her and do whatever it is she wants to do. She just needs my time"

Mothers in both subgroups described the importance of being *strong and supportive for my toddler* (See Table 4.36).

Table 4.36

Coding for *Strong and Supportive for my Toddler*

Depressed subgroup	Non-depressed subgroup
• Will always stand up for my child	• Want to be what he needs me to be • Give them the life deserved • Make sure they have everything they need

This was a particularly important goal for participant # 7 who was re-establishing herself as both a woman and mother after rising above domestic violence. "And I'm able to be a good mom still, to keep them happy. That's all I'm trying to do now is show them a life that they deserve. And that's why I think that with my [boy]". Another participant described the importance of being strong and yet flexible in order to provide essential support for her son.

> I want to be, I just want to be what he needs me to be for him. Whether or not it's always supporting him. Whether it's me going in the background and just making sure he doesn't do anything wrong <laugh>. You know it's whatever he needs me to be. I'm not always going to do the right thing but hopefully I do it well enough that he turns out OK in society I guess. (P. 12)

A mother from the depressed subgroup was resolute that she would always stand up for her child which in turn "…seeps into standing up for yourself too" (P.15D).

Summary and Conclusion

Twenty-one participants were interviewed and qualitative data analysis was conducted to identify codes, categories and themes describing the experience of mothering a toddler. Themes representing four facets of maternal role development: transition, adaptation, expectation and perception, emerged from the data. Two themes, *A New Transition* and *Taking Everything in Stride* described the subjective experience of maternal role transition as infants moved into toddlerhood. The themes, *Role Attainment, Role Strain* and *Role Conflict* described variations in maternal adaptation in response to becoming the mother of a toddler. Maternal role expectation

related to caring for a toddler were described via two themes: *Not what I Expected* and *Better Than I Expected*. Two themes, *Perfect Mothering* and *Realistic Mothering* characterized how participants perceived their roles in the context of mothering toddlers. Thematic representations of *control*, *challenge* and *commitment*, the three elements of the concept, hardiness emerged from qualitative analysis of the study narratives. Participants described a hardy mother as *strong and resilient*, one could *weather the storm* and *roll with the punches*.

Several aspects of all three research questions were addressed in this chapter. First, several participants did experience a concomitant maternal role transition as their infants transitioned into toddlers and some mothers did experience associated role strain. Further discussion of how this transition may differ between mothers who are depressed versus those who are not will take place in Chapter V. Several participants expressed ideological role expectations specific to being the mother of a toddler. An exploration of 1) how ideological role expectations influence role development based on the degree of congruence to the realities of mothering a toddler; and 2) how depression may mediate role expectations will be discussed in Chapter V. Finally, the core elements of hardiness in the context of mothering a toddler did emerge from the words of the participants. A discussion of how hardiness may differ for mothers who are depressed versus those who are not will take place in Chapter V.

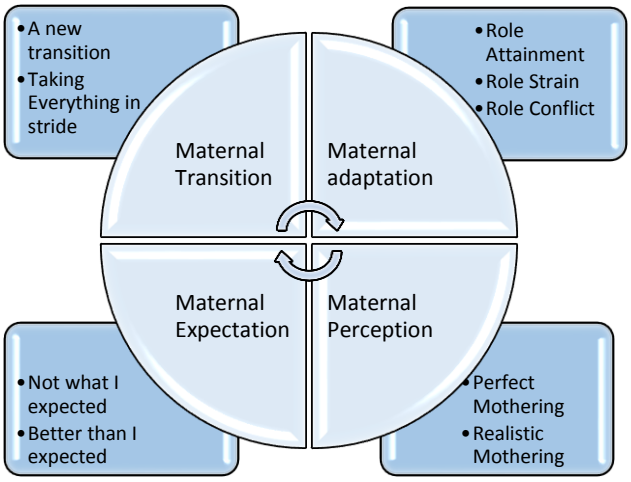
Chapter V Discussion and Summary

The purpose of this study was to explore the subjective experience of mothering a toddler from twelve to twenty-four months of age with a focus on how maternal depression may influence this experience. The study aims were to (a) identify codes, categories and themes that describe whether or not mothers of toddlers experience role transition, strain, or incongruence concomitant with developmental changes that occur as their infants transition into toddlers; (b) explore how maternal depression may influence the subjective experience of mothering a toddler; and (c) identify core dimensions of hardiness (i.e. control, commitment, challenge) that may emerge from the subjective voice of mothers as they describe the experience of mothering a toddler. This chapter provides a summary and interpretation of study findings, discussion of study strengths and limitations, clinical implications and considerations for future research.

Summary of the Findings

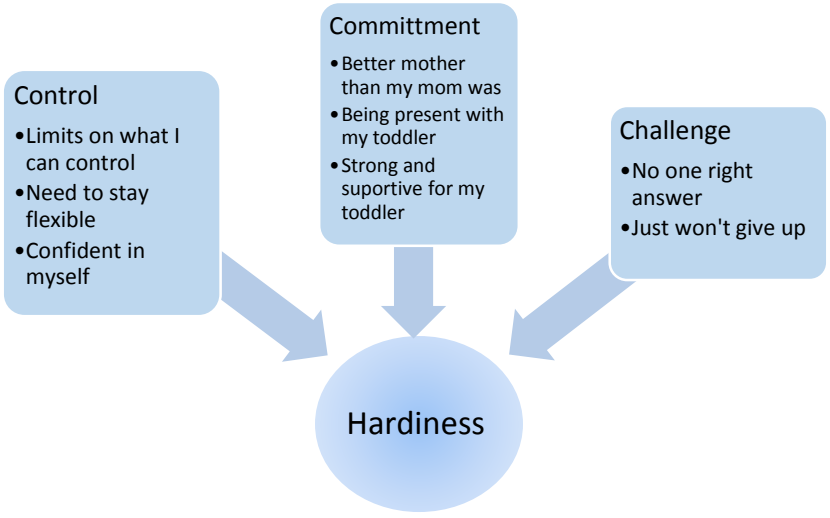
Multiple themes describing the experience of becoming the mother of a toddler emerged from the narratives of women in both the depressed and non-depressed subgroups. Several mothers experienced role transitions of their own as their infants developed into toddlers with variations in adaptation ranging from role attainment to role conflict. These findings bolster the supposition that a woman's role as mother changes in step with her child's growth and development beyond the first postnatal year. The findings also reflect that the reality of mothering a toddler was often incongruent with maternal expectations and that maternal ideology was a significant influence on maternal self-perception for several participants (see Figure 5.1).

Figure 5.1. Maternal Role: Thematic Representations



Thematic representations of the three components of the personality trait, hardiness as defined by Kobasa (1979) also emerged from interviews with mothers in both subgroups. The findings were reflective of Kobasa's description of hardy people as those who a) display a sense of *control* over the events that occur in their lives, b) perceive change as *a challenge* as opposed to a threat, and c) demonstrate *commitment* and belief that life events are meaningful and valuable (Ssee Figure 5.1).

Figure 5.2. Hardiness Thematic Representations



RQ1. Do women experience a concomitant maternal role transition as their infants develop into toddlers?

As discussed previously, Mercer (2004) proposed that a lifespan approach be used to explore how mothers transition over time in response to both their own developmental growth and that of their children. She revised her original middle range theory, Maternal Role Attainment, to reflect the evolution of the maternal role over time which she re-titled, Becoming a Mother (BAM). The narratives of role transition described by several of the mothers in this study were congruent with the BAM stage, *moving toward a new normal* (Coleman & Karraker, 2003; Mercer & Walker, 2006), a time in which maternal adaptation of daily life patterns and parenting skills must occur at some level to meet the emotional, social and physical needs of the toddler (Coleman & Karraker). Mothers from both subgroups irrespective of age or parity, experienced a new transition of their own as their infants developed into toddlers and those who could take everything in stride appeared to be more at ease during this role transition. A change in focus was an integral part of this process for several mothers as the intense physical energy required to care for an infant shifted in response to toddler developmental changes. Focal changes included taking more *me time*, working on spousal relationships and becoming more acutely aware of how maternal behavior influenced toddler development. Mothers also described having to become more patient and flexible in response to normative but challenging toddler behaviors, continually reminded themselves that negative maternal responses to such behaviors were internally derived and not child motivated. Some of the mothers with more than one child were surprised that coping with challenging toddler behavior was difficult at times despite having gone through the experience at least once before.

a. Does maternal role strain occur for some participants during this developmental transition?

A distinction between role transition and role adaptation emerged from the narratives in both subgroups. Themes for maternal role adaptation ranged from *role strain* or *role conflict* to *role attainment*. Mothers who successfully adapted to becoming the mother of a toddler (i.e. role attainment) described having a sense of being in control again, developed realistic expectations about taking care of a toddler and felt confident in mothering their toddlers which was congruent with the final BAM stage, *achievement of a new identity* as the mother of a toddler. According to Mercer and Walker (2006) this stage occurs when the mother has successfully navigated her way through the changes and challenges to the point of feeling self-confident and competent in her mothering role and having clear sense of enjoyment in the daily interactions with her toddler.

Amankwaa (2005) developed a theory of maternal role collapse composed of three elements: role stress, characterized by maternal worry and concern in response to life situations; role strain, an emotional reaction to postpartum stress; and role collapse, defined as a maladaptive response to role stress and strain. Several mothers in the present study experienced periods of role strain, similar to Amankwaa's definition, becoming *stressed out* and *frustrated* in response to the daily challenges of mothering a toddler and experiencing *mommy guilt* for wanting time to themselves.

Some participants described having an identity struggle and sense of ambivalence about being the mother of a toddler, encompassed by the theme, role conflict. These findings are similar to those of Nysrom and Ohrling (2004) who conducted a literature review to better understand the transition in the first year of being a parent. Their analysis revealed that having primary responsibility for childrearing was often overwhelming for mothers and role strain was expressed as feeling powerless, inadequate, guilty and ambivalent about their mothering role. A

more detailed discussion regarding role conflict will occur in the subsequent section on maternal role adaptation.

b. Is there a difference in the experience of mothering between the depressed and non-depressed group of participants during this developmental transition?

Maternal Role Transition.

Mothers often develop feelings of guilt at wanting to take time to care for their own needs or work outside the home (Barclay et al., 1997; Nystrom & Ohrling, 2004; O'Reilly, 2004) and participants in both subgroups expressed guilt feelings in this context. Mothers in the non-depressed subgroup were more apt to move forward with taking *me time* despite feeling guilty as compared to those in the depressed subgroup who acknowledged the importance of taking time for themselves but had great difficulty making it a priority or asking for spousal support so they could do so. Currie (2009) used a grounded theory approach to understand how mothers of young toddlers maintained a perception of wellness. Taking time for self, away from the normal mothering and home routine was considered a necessary part of feeling well and in control but also felt a sense of guilt about doing so, similar to that of the mothers in the present study.

Methods of coping with the everyday challenges of mothering a toddler also differed between the two subgroups. The ability to be flexible in order to effectively respond to the daily challenges of caring for a toddler emerged from the narratives of mothers in the non-depressed subgroup only, which is similar to previous findings (Ambrosini & Stanghellini, 2012; Haga, Lynne, Slinning & Kraft, 2012). Mothers in the non-depressed subgroup were also more apt to identify the need to develop greater patience in order to cope more easily with normal toddler behaviors while feeling overwhelmed in response to typical toddler behavior was more prevalent for mothers in the depressed subgroup. Cornish et al. (2006) found that chronically depressed mothers reported clinically significant levels of parenting stress at 15 months postpartum

compared to non-depressed mothers in the context of having difficulty coping with toddler behaviors and a lower sense of competence as caregivers as compared to mothers who were non-depressed or briefly depressed early in the postpartum period.

Maternal Role Adaptation.

The process of integration of the role as the mother of a toddler is achieved through maternal feelings of competency and self-confidence in parenting and caretaking along with a positive sense of attachment and love toward the toddler (Mercer, 2004). Coding for the theme *role attainment* emerged primarily from the narratives of mothers in the non-depressed subgroup. Only mothers in the non-depressed subgroup described *feeling in control* again and having *realistic expectations* of the challenges associated with mothering a toddler. Despite disproportionate coding in the non-depressed subgroup for the aforementioned categories, mothers from both subgroups described feeling confident in mothering.

Two out of the three categories for role strain emerged more frequently from the narratives of mothers in the non-depressed subgroup. The majority of coding for mommy guilt was in the context of having guilt feelings about working outside the home, being a single mother and wanting some down time. Only one mother from the depressed subgroup described a sense of guilt which was quite different in context. In this case, the mother described a deep sense of guilt related to a recent episode in which she had become so overwhelmed and upset with her toddler that she had to leave the house to compose herself. Mothers in both subgroups described feeling frustrated at times with toddler caregiving however mothers in the non-depressed subgroup were more apt to also describe how they changed the situation in order to reduce their frustration levels compared to those in the depressed subgroup. The narratives from

mothers in the non-depressed subgroup suggest a more adaptive response to role strain compared to those in the depressed subgroup.

Participants from both subgroups experienced *role conflict* with respect to mothering a toddler. Positive effects of maternal peer support including role validation, occur when women feel safe being themselves and talking openly and honestly about how they feel (Jones, Jomeen, & Hayter, 2014) however mothers from both subgroups described feeling conflicted in their roles due to the tension and animosity generated by *mothering competitions* with their peers. Both subgroups described having *identity struggles* in the context of role validation, looking the part of mother, loss of identity beyond that of being a mother and missing pre-baby life. This echoed the findings of Fouquier (2011) who conducted a phenomenological study to understand the definition of motherhood among African American women spanning three generations. Becoming a mother was described as hard, often under-appreciated with some women admitting that the role change created a sense of lost identity. Mothers in the depressed subgroup in the present study described feeling more emotionally distressed by such struggles compared to the non-depressed subgroup. The category, *feel ambivalent*, emerged only from non-depressed subgroup narratives, primarily in the context of working outside the home and having difficulty transitioning to roles outside of mothering.

RQ2: Do women develop ideological role expectations specific to being the mother of a toddler?

Literature on mothering is replete with evidence that women frequently experience a discrepancy between ideologically influenced role expectations and the reality of mothering which may negatively impact maternal role development and increase psychological distress (Arendell, 2000; Amankwaa, 2005; Choi et al., 2005; Hall, 2006; Harwood et al., 2007; Mercer & Walker, 2006; Nelson, 2003; Shelton & Johnson, 2006; Stoppard, 2000; Ussher, 2006). The

majority of participants in the present study described a similar role discrepancy for mothering a toddler. Categories for the theme, *not what I expected* emerged consistently for both subgroups however the categories for *better than I expected* emerged primarily from the narratives of mothers in the non-depressed subgroup. Two of three categories (i.e. adjusting to toddler needs, a sense of fulfillment) for the latter theme emerged only from the narratives of mothers in the non-depressed subgroup. Only one participant in the depressed subgroup described herself as adjusting better than expected to becoming the mother of a toddler. No marked differences in themes emerge from the narratives based on demographics or parity.

a. Does maternal role incongruence occur if the reality of mothering a toddler does not match maternal expectation?

Maternal Role Expectations.

Mothers from both subgroups described being surprised by how challenging it was at times to care for a toddler. They did not anticipate how difficult it would be to cope with normal but challenging changes in toddler temperament and behavior and were surprised that their toddlers were not as independent as anticipated (e.g. still frequently nursing, increased neediness). Role incongruence can increase psychological distress as previously discussed. However in the present study, incongruence between the expectation and reality of caring for a toddler on an everyday basis did not appear to be significantly distressing for mothers in either subgroup despite being frequently coded for.

Maternal Role Perceptions.

Liss, Schiffrin, and Rizzo (2013) explored the associations between role self-discrepancy and the development of guilt and shame among mothers with children under age five in the context of trying to live up to the ideological myth of mothering. Maternal self-discrepancy was found to be a significant predictor of both guilt ($\beta = 0.22$, $p < 0.0$) and shame ($\beta = 0.74$, p

<0.001) in response to not living up to internalized standards or external expectations of the ideological good mother. The researchers found that women who had more realistic expectations of mothering were much less apt to experience guilt and shame with respect to mothering ideology. Participants in both subgroups for the current study also described their mothering role related to both socio-cultural influences (i.e. perfect mothering) and internally derived perspectives (i.e. realistic mothering). Mothers in the non-depressed subgroup described the concept of supermom using the traditional good mother ideology however they did not appear to be heavily influenced by this perspective. Mothers in the depressed subgroup also used supermom descriptors to define their role, and in keeping with previous research (Ambrosini & Stanghellini, 2012; Choi et al., 2005; Ussher, 2006) they were more inclined to integrate such characteristics into their own benchmarks for adequate mothering which were difficult to achieve. A few mothers in both subgroups acknowledged that the concept of the perfect mother was faulty and could not be attained and did not appear to incorporate this into their self-expectations for mothering a toddler.

b. Does depression mediate the influence of maternal ideology on role expectations?

Current research supports that mothers who have more realistic role expectations are less likely to experience depressive symptoms (Buultjens & Liamputtong, 2007; Harwood et al., 2007; Mauthner, 2003; Sword, Clark, Hegadoren, Brooks & Kingston, 2012). Several mothers in the depressed subgroup experienced ideological conflicts and some degree of emotional distress more frequently than those in the non-depressed subgroup specific to nursing a toddler. These mothers described themselves as having strong ideological views regarding extended breastfeeding but admitted to actually feeling very conflicted about nursing their toddlers. Outwardly they espoused the benefits of breastfeeding a toddler and strongly advocated for the

right to nurse in public in keeping with that of their peers but were beginning to feel self-conscious about nursing their toddlers, especially in public. Considerations regarding weaning were also mentioned in the non-depressed subgroup with a small segment of mothers in the describing how they had worried that weaning their toddlers would cause dyadic emotional distress. The mothers were very surprised that the process of weaning was much easier than anticipated and by the great sense of relief that occurred once they were no longer nursing.

The categories that emerged for the theme, realistic mothering, were more reflective of actual mothering self-perceptions as opposed to societal expectations and were coded mostly from non-depressed subgroup narratives. Participants in the non-depressed subgroup readily expected not to be perfect mothers and recognized the need for finding balance between the mothering reality and ideology. These findings are similar to those of Haga et al. (2012) who conducted a qualitative study to gain insight on how first-time mothers described their postpartum experience in the first year after birth with specific focus on why some mothers had a harder time with this transition than others. Mothers who were more relaxed in their approach to motherhood had more realistic expectations about what being a mother would be like and did not react with negative emotions if their expectations were not met. The need to find balance also emerged from the narratives of mothers from the depressed subgroup in the current study, but differed contextually as they described being stressed secondary to having difficulty finding a sense of balance in their daily routines. Mothers in both subgroups recognized that nurturing and loving their children were fundamental components of realistic mothering.

Perren et al. (2005) found that mothers who experienced depression early in the postnatal period with symptom reduction or remittance at 3 months, experienced a resurgence of depressive symptoms at 12 months postpartum in response to the stress associated with the

challenge of caring for an infant who was becoming more autonomous. Three out of five mothers in the depressed subgroup reported having not experienced depression in the first year postpartum and the other two had a history of PPD with self-reported symptom remittance prior to twelve months postpartum. This group of mothers experienced either symptom recurrence or new onset depressive symptoms during this period of maternal role transition and appeared to be more negatively impacted by expectancy incongruence compared to those in the non-depressed subgroup which is consistent with previous studies (Eastwood et al., 2013; Ambrosini & Stanghellini, 2012; Haga et al., 2012). Findings in the present study suggest that role expectancy incongruence and associated maternal stress may have acted as a mediator for the development of depressive symptoms however presence of depressive symptoms did not appear to mediate the influence of ideology on expectancy incongruence.

RQ3: Can characteristics of maternal hardiness be identified in response to stressors related to being the mother of a toddler?

Participants in both subgroups were fairly consistent in their responses when asked to describe maternal hardiness. Mothers considered hardy were described as being able to *weather the storm, roll with the punches* and remain *strong and resilient* when under stress. Descriptors specific to characteristics of hardiness in mothers of toddlers included being adaptable, being persistent, not giving up easily, coping with difficult transitions, not giving in (to tantrums), and simply dealing with life's daily challenges as they unfolded. No marked differences in themes emerge from the narratives based on demographics or parity.

a. Are the three core elements of hardiness identifiable in the words of participants as they describe the experience of mothering a toddler?

Control.

The control dimension of hardiness represents the perception of control a person believes she has to influence her life events even in the face of difficulty (Eschleman et al., 2010; Lambert & Lambert, 1999; Maddi, 2007). Mothers in both subgroups acknowledged that there were limits on what could be controlled in their daily lives with respect to caring for a toddler however there were clear differences between the two subgroups in terms of coming to this realization. Mothers in the depressed subgroup were more apt to be distressed by this recognition compared to mothers in the non-depressed subgroup who described this as stress buffer. Mothers in the non-depressed subgroup also described the need to maintain flexibility in their daily lives and expressed a general sense of self-confidence, suggestive of high hardiness (Soderstrom, Dolbier, Leiferman & Steinhardt, 2000) more frequently compared to mothers in the depressed subgroup.

Challenge.

Challenge in the context of hardiness represents the ability to see change as an opportunity for growth as opposed to a threat which increases the ability to be more flexible and adaptable in response to stressors (Eschleman et al., 2010; Maddi 2002). Mothers from both subgroups recognized the importance of understanding that there is *no one right answer* to parenting a toddler and that reframing and learning from drawbacks were integral to successfully meeting the daily challenges of toddlerhood. However only mothers in the non-depressed subgroup described themselves as having a tenacious attitude in terms of *just not giving up* when it came to dealing with difficult challenges which is congruent with high hardiness traits (Soderstrom et al., 2000).

Commitment.

Commitment in the context of hardiness is characterized by being engaged in various life domains (e.g. self, family, work) leading to a strong sense of purpose in times of stress (Eschleman et al., 2010). Although coding for commitment emerged less frequently than those for control and challenge, maternal narratives from both subgroups elicited substantive descriptors for this element of hardiness. According to Stroderstrom et al. (2000) hardy individuals "have a sense of meaning and purpose in work and relationships and are deeply involved rather than alienated out of fear, uncertainty or boredom" (p.312). Mothers in the present study described having a strong sense of commitment to become better mothers than their own mothers with respect to avoiding yelling and hitting out of frustration or as a form of discipline. They were also committed to being strong, supportive and more present, or in the moment with their toddlers in keeping with the relationship between hardiness and cognitive appraisal characterized by a strong sense of meaningfulness and purpose in relating to the events and people in one's life (Craft, 1999; Kobasa et al., 1982; Maddi, 2006)

b. Do descriptors related to hardiness differ in relation to mothering a toddler between depressed and non-depressed participants?

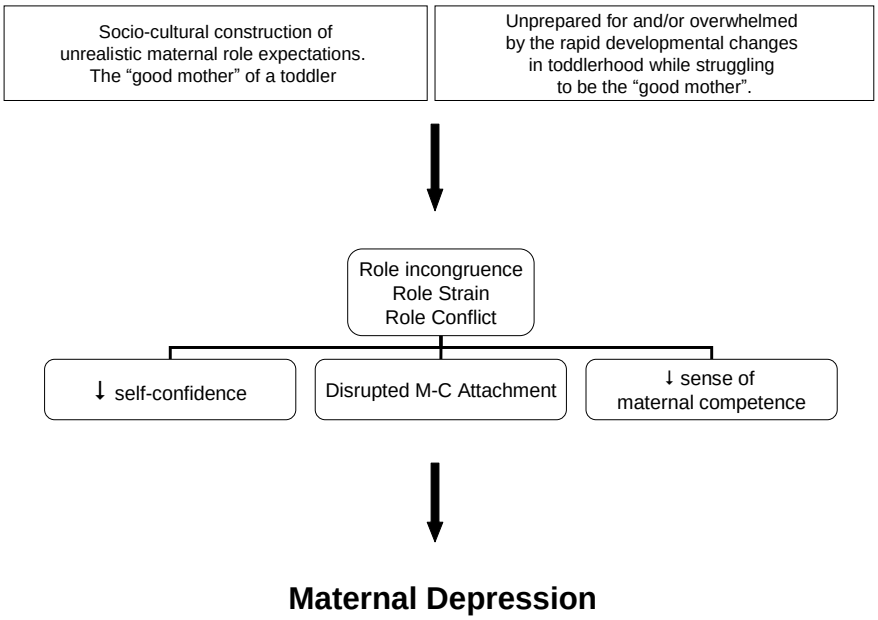
The differences in descriptors between the two subgroups may primarily reflect a difference in cognitive appraisal and adaptability of mothering a toddler. Rhodewalt and Zone (1989) found that non-hardy women appraised similar life events as being more difficult to adjust to, harder to control and having a greater impact compared to hardy women. The recognition of limits on what could be controlled with respect to coping with normative toddler challenges appeared to be strong coping mechanism for mothers in the non-depressed subgroup in the present study. They were realistic about what could and should be controlled which reduced maternal frustrations. Conversely, this recognition was a source of frustration for

mothers in the depressed subgroup who expressed difficulty coping with unexpected changes in routine in the context of daily toddler care. Maintaining a sense of flexibility related to parenting was coded for most frequently from the non-depressed subgroup narratives which echoed findings from Kiehl, Carson and Dykes (2007) who identified that mothers considered resilient or hardy were highly adaptable and flexible with regard to the challenges of parenting infants and young children. As described previously only participants in the non-depressed subgroup described not giving up when it came to dealing with difficult challenges. Maternal self-descriptors included being hardy, driven and having a strong sense of determination in the context of coping with the daily challenges of mothering a toddler. No significant differences in descriptors for commitment were noted between the two subgroups.

Study Findings: Theoretical Integration

Findings in the present study suggest that role expectancy incongruence and associated maternal stress may have acted as a mediator for the development of depressive symptoms which is congruent with the theoretical integration of Higgins' Self-Discrepancy Theory (HSDT) and Mercer's middle range theory, Becoming a Mother (BAM). As previously described in Chapter III, the alignment of HSDT with BAM using a material discursive methodological approach created a framework for exploration of maternal role incongruence, role strain and depression (see Figure 3.1).

Figure 3.1 Theoretical Integration



The *good mother* role, both self-defined and molded by the BAM environmental spheres (i.e. family and friends, community, society-at-large) that women draw support and role guidance from can become a source of distress for a mother who is vulnerable to depression or already depressed (Bina, 2008; Choi et al., 2005; Weaver & Ussher, 1997). Ongoing discrepancies between what Higgins (1987) described as the actual sense of self and the ought and/or ideal self can also create psychological distress. Finally, psychological traits associated with low hardiness (LH) correspond with predictors and symptoms of maternal depression. Maternal perceptions of an increased incidence of negative life experiences requiring adaptation, and negative stress appraisals are representative of both LH traits and PPD predictors (Horowitz et al., 2005; Kenney, 2000; Rhodewalt & Zone, 1989). Eschlemann et al. (2010) contended that role overload, ambiguity and conflict were positively correlated with LH while having an increased sense of life satisfaction, positive state affect, and a general sense of personal growth

were positively associated with high hardiness. Integration of the theoretical constructs of BAM, HSDT and the conceptual elements of maternal hardiness provide the framework for positing that maternal self-confidence, self-competence and maternal-child attachment, may become distorted or inadequately develop in response to role incongruence, strain, or conflict in the context of mothering a toddler, culminating in maternal depression.

Certain aspects of this integrative theoretical framework were identified in the narratives of the present study. The traditional good mother ideology was described by several mothers however those in the non-depressed subgroup did not appear to be heavily influenced by this perspective while those in the depressed subgroup were more inclined to integrate such characteristics into their own benchmarks for adequate mothering. Participants in the non-depressed subgroup readily expected not to be perfect mothers and recognized the need for finding balance between the mothering reality and ideology. Mothers in both subgroups described feeling frustrated at times with toddler caregiving. Those in the non-depressed subgroup were more adaptable to change in order to reduce their frustration levels compared to those in the depressed subgroup. Mothers in the depressed subgroup also described feeling more emotionally distressed by such struggles compared to the non-depressed subgroup. Mothers from both subgroups experienced periods of role incongruence, role strain and role conflict however those in the depressed subgroup were more apt to experience a certain degree of psychological distress while mothers in the non-depressed subgroup described more adaptive responses to role strain. Only mothers in the non-depressed subgroup described feeling in control again and having realistic expectations of the challenges associated with mothering a toddler. Despite these differences, mothers from both subgroups were generally confident in their

mothering with no indication of disrupted maternal-child attachment or an overt decrease in the maternal sense of self-competence for participants in the depressed subgroup.

Study Strengths and Limitations

The strength of this study centers on the use of a qualitative research design to gain a rich understanding of the subjective experience of mothering a toddler from the voices of mothers themselves. Data analysis and interpretation using thematic analysis provided rich detail and contextualization of the maternal experience based on the participants' own categories of meaning that to date has not been well studied. Although not generalizable, the findings provide a framework for further study of the mothering experience in the context of developmental and life transitions. The rich detail of the narratives will allow clinicians and researchers to determine the degree of potential transferability to their own populations of interest. The ability to use the results as a framework for further study is also bolstered by the broad demographics of the participants and the relatively large sample size for a qualitative design. Authenticity of the findings was achieved by the use of open ended questions, non-leading prompts, and active listening skills. The use of reflection and reframing provided mothers an opportunity to disclose thoughts and feelings that they might not otherwise verbalize to peers or family members. The majority of mothers who participated in the study were quite willing to share sensitive, sometimes emotionally charged subject matter with this researcher which further strengthened study rigor. Credibility was enhanced by member checking (i.e. validation of findings) between this researcher and dissertation committee subject matter experts and informally by asking participants for interpretive clarification and elaboration during each interview in order to portray an accurate account of their experiences. Finally, qualitative congruence was demonstrated by

identification of a clear, logical relationship between BAM and HSDT theoretical underpinnings and the study findings.

Potential study limitation include the disparity between the sample size for the depressed subgroup (n = 5) and non-depressed subgroup (n = 16) and the degree of difference between self-reported versus clinical diagnosis of depression. Recruitment difficulties for this subgroup may have occurred because mothers with depressive symptoms might not have had the energy or motivation to participate in the study or may have felt uncomfortable admitting to depressive symptoms beyond the first 12 months postpartum. Data saturation could have been achieved had the sample size for the depressed subgroup (n = 5) approached a sample size of 15 participants as suggested by Kuzel (1999). The novice status of this researcher may have been another study limitation, resulting in less effective elicitation of data during the initial interviews. Over time this researcher became more confident and at ease while interacting with participants, resulting in the collection of rich narratives from mothers in both sub-groups. Secondary interviews with mothers of younger toddlers could have identified changes in the mothering experience as toddlers matured but were not conducted as part of the research design due to time constraints for study completion. Finally, the study results may not be consistent with the perspectives of all women who are mothers of toddlers as the majority of participants were married, employed and financially stable, and spiritual or religious influences were not taken into demographic consideration.

Study Significance

Screening, diagnostic and treatment strategies for maternal depression distant from the early postpartum period can be improved by developing an increased understanding of the mothering experience both independent of and within the context of depression. Currently there

are no published studies that specifically explore the subjective experience of mothering a toddler from the perspectives of both depressed and non-depressed mothers using the BAM framework. Research specific to maternal hardiness in the context of role transition is also lacking in the literature. The women who participated in this study were provided the opportunity to give voice to their individual embodied experiences of becoming mothers, enabling us to understand more clearly what aspects of this role and their lives change over time, in step with the growth and development of their children. The results of this study suggest that mothers do experience a transition of their own as their infants mature into toddlers. Themes representing four facets of maternal role development: transition, adaptation, expectation and perception, emerged from the words of the participants. Additionally, differences in how mothers experienced this transition appeared to be influenced by ideological role expectations and to a certain degree by the presence or absence of depressive symptoms. The three components of hardiness (i.e. control, challenge, commitment) also emerged from the narratives with participants describing a hardy mother as strong and resilient, one could weather the storm and roll with the punches. The characteristics of high hardiness were identified more readily for mothers in the non-depressed subgroup compared to those in the depressed subgroup.

Clinical Implications

Viewing maternal depression from a wider biopsychosocial perspective as opposed to only a biophysical one may promote more effective mental health care for women and their families on several levels. First, a better understanding of how maternal ideology, role incongruence and maternal hardiness influence role transition and depression vulnerability may lead to improved methods of depression screening for mothers beyond the first year postpartum. Second, inclusion of clinical interview questions asking how women view their mothering

experience may facilitate a more honest disclosure of emotional distress related to role incongruence and identify methods to improve coping and parenting skills (Hall, 2006; Stoppard, 2000). Finally a clear understanding of how maternal role transition unfolds beyond the first year postpartum can guide the clinician in the development of psychotherapeutic treatment strategies aimed at minimizing the negative impact of depression on the maternal-toddler dyad and promotion of more effective parenting behaviors for mothers with depression.

Recommendations for Future Research

As discussed previously, much of the research on maternal role transition and attainment focuses on early weeks and months during the first year postpartum. The findings in this study support Mercer's (2004) challenge for researchers to investigate maternal role transition using a lifespan approach. Longitudinal research focusing on pivotal periods of childhood transition (e.g. starting elementary school, entering adolescence, high school graduation) using the BAM framework would provide a better understanding of how mothers cope both with the developmental changes of their children and their own role changes over time. Questions for consideration include the following: a) Does maternal role incongruence also occur during these transitions? b) How does maternal ideology influence this experience? c) How do maternal depression and hardiness influence role adaptation during pivotal childhood transitions? Additional research regarding the influence of single parenting, socioeconomic variations, and differences in religious/spiritual beliefs on the process of maternal role transition beyond the first year postpartum is also needed. Researchers have recently started to focus on how both mothers and fathers adapt to becoming parents in the first year postpartum. Thematic analysis could be used to explore the subjective experience of being the father of a toddler, with a focus on

identification of potential differences in role transition based on the presence of depressive symptoms and degree of hardiness.

Conclusion

The purpose of this qualitative study was to (a) gain understanding of the subjective experience of mothering a toddler from the perspective of both depressed and non-depressed women; (b) explore how maternal role expectations influence maternal role transition as infants mature into toddlers; and (c) identify characteristics that are consistent with the concept of hardiness with respect to coping with role strain and stress related to mothering a toddler. The findings reflect that becoming a mother of a toddler is transformative, with identifiable phases of role transition and adaptation which continue beyond the first year postpartum, in step with the transitions associated with toddler development.

Key thematic differences between the two sub-groups emerged from the narratives. Mothers in the depressed sub-group were more apt to experience incongruences between the maternal ideal and reality of mothering which resulted in a certain degree of emotional distress. Mothers in the non-depressed subgroup described use of coping methods in response to parental stress that were reflective of high hardiness traits in contrast to mothers in the depressed subgroup.

To date, no research using the theoretical underpinnings of BAM to explore maternal role transition beyond the first year postpartum in the context of maternal depression and hardiness exists in the literature. The women who participated in this study gave voice to their individual experiences of becoming mothers of toddlers which enabled us to understand more clearly what aspects of this role and their lives changed over time in step with the growth and development of their children. The generous contribution of time and authentic dialogue with each study

participant resulted in the development of substantive themes that can be used in the future to develop intervention strategies to reduce the negative impact of depression on the maternal-toddler dyad and promote more effective parenting behaviors for mothers with depression vulnerability.

The words of Kelly and Parsons, authors of The Mother's Almanac (1992) which aptly describe the complexity of becoming a mother using a lifespan perspective, provide a poignant, fitting end to this research.

> Motherhood brings as much joy as ever, but it still brings boredom, exhaustion, and sorrow too. Nothing else ever will make you as happy or as sad, as proud or as tired, for nothing is quite as hard as helping a person develop his own individuality especially while you struggle to keep your own (p.xiii).

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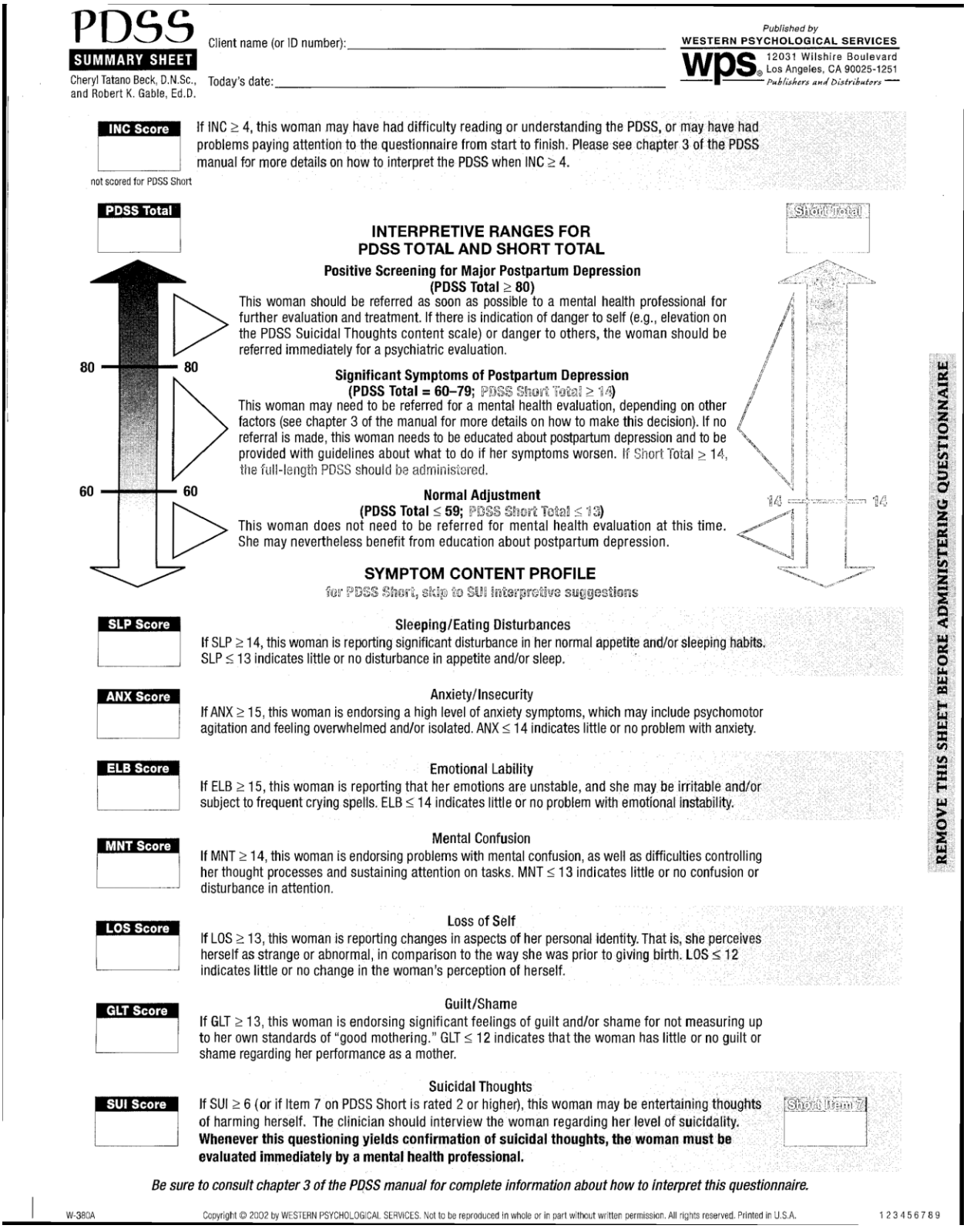
Appendices

Appendix A. Postpartum Depression Screening Scale



PDSS
SUMMARY SHEET
Cheryl Tatano Beck, D.N.Sc., and Robert K. Gable, Ed.D.

Client name (or ID number): _____
Today's date: _____

Published by
WESTERN PSYCHOLOGICAL SERVICES
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INC Score
not scored for PDSS Short

If INC ≥ 4, this woman may have had difficulty reading or understanding the PDSS, or may have had problems paying attention to the questionnaire from start to finish. Please see chapter 3 of the PDSS manual for more details on how to interpret the PDSS when INC ≥ 4.

PDSS Total

Short Total

INTERPRETIVE RANGES FOR PDSS TOTAL AND SHORT TOTAL

80 — 80
60 — 60
14 — 14

Positive Screening for Major Postpartum Depression
(PDSS Total ≥ 80)
This woman should be referred as soon as possible to a mental health professional for further evaluation and treatment. If there is indication of danger to self (e.g., elevation on the PDSS Suicidal Thoughts content scale) or danger to others, the woman should be referred immediately for a psychiatric evaluation.

Significant Symptoms of Postpartum Depression
(PDSS Total = 60–79; PDSS Short Total ≥ 14)
This woman may need to be referred for a mental health evaluation, depending on other factors (see chapter 3 of the manual for more details on how to make this decision). If no referral is made, this woman needs to be educated about postpartum depression and to be provided with guidelines about what to do if her symptoms worsen. If Short Total ≥ 14, the full-length PDSS should be administered.

Normal Adjustment
(PDSS Total ≤ 59; PDSS Short Total ≤ 13)
This woman does not need to be referred for mental health evaluation at this time. She may nevertheless benefit from education about postpartum depression.

SYMPTOM CONTENT PROFILE
for PDSS Short, skip to SUI interpretive suggestions

SLP Score
Sleeping/Eating Disturbances
If SLP ≥ 14, this woman is reporting significant disturbance in her normal appetite and/or sleeping habits. SLP ≤ 13 indicates little or no disturbance in appetite and/or sleep.

ANX Score
Anxiety/Insecurity
If ANX ≥ 15, this woman is endorsing a high level of anxiety symptoms, which may include psychomotor agitation and feeling overwhelmed and/or isolated. ANX ≤ 14 indicates little or no problem with anxiety.

ELB Score
Emotional Lability
If ELB ≥ 15, this woman is reporting that her emotions are unstable, and she may be irritable and/or subject to frequent crying spells. ELB ≤ 14 indicates little or no problem with emotional instability.

MNT Score
Mental Confusion
If MNT ≥ 14, this woman is endorsing problems with mental confusion, as well as difficulties controlling her thought processes and sustaining attention on tasks. MNT ≤ 13 indicates little or no confusion or disturbance in attention.

LOS Score
Loss of Self
If LOS ≥ 13, this woman is reporting changes in aspects of her personal identity. That is, she perceives herself as strange or abnormal, in comparison to the way she was prior to giving birth. LOS ≤ 12 indicates little or no change in the woman's perception of herself.

GLT Score
Guilt/Shame
If GLT ≥ 13, this woman is endorsing significant feelings of guilt and/or shame for not measuring up to her own standards of "good mothering." GLT ≤ 12 indicates that the woman has little or no guilt or shame regarding her performance as a mother.

SUI Score
Suicidal Thoughts
If SUI ≥ 6 (or if Item 7 on PDSS Short is rated 2 or higher), this woman may be entertaining thoughts of harming herself. The clinician should interview the woman regarding her level of suicidality. **Whenever this questioning yields confirmation of suicidal thoughts, the woman must be evaluated immediately by a mental health professional.**

Short Item 7

REMOVE THIS SHEET BEFORE ADMINISTERING QUESTIONNAIRE

Be sure to consult chapter 3 of the PDSS manual for complete information about how to interpret this questionnaire.

W-380A

1 2 3 4 5 6 7 8 9

SCORING INSTRUCTIONS

1. Calculate the Inconsistent Responding (INC) index score (skip to step 2 if using Short Form).

Enter the response value for each item in the designated space. If the responses for an item pair differ by 2 or more points make a check mark in the blank space in the right-hand column. When you have done this for all 10 INC item pairs, count the number of check marks and enter the result into the space labeled "INC Raw Score."

INC Item Pairs		Difference ≥ 2
3_____	17_____	____
4_____	18_____	____
5_____	26_____	____
6_____	34_____	____
7_____	14_____	____
8_____	29_____	____
11_____	32_____	____
12_____	19_____	____
15_____	22_____	____
24_____	31_____	____

INC Raw Score: _____

2. Use the Scoring Worksheet to calculate raw scores for the PDSS Total and the seven symptom content scales.

For full PDSS: On the Scoring Worksheet, check for any items where no response was marked, and circle the median response value (printed in bold type) for these items. Next, transfer the circled response for each item to the corresponding box printed in the same row. These boxes are arranged in columns labeled with the names of the seven PDSS symptom content scales. Add the values in the boxes going down each column, and enter the raw score for each symptom content scale in the space at the bottom of the column. Then sum these scores to obtain the raw score for PDSS Total, and enter this value in the corresponding space at the bottom right.

For Short Form: *Items 1 through 7 must be completed. If there are any missing responses, the Short Form may not be used.* Transfer each circled response for Items 1 through 7 to the corresponding box printed in the same row. Sum the values in these boxes and enter the total in the box labeled *Short Total* (on the right side below the row for Item 7).

3. Transfer the raw scores to the PDSS Summary Sheet (other side of this form).

Enter the woman's name (or ID number) and the date on the Summary Sheet.

For full PDSS: Enter the INC index score in the labeled box at the upper left of the Summary Sheet, and follow the interpretive suggestions. Enter the PDSS Total score in the box on the upper left side of the Summary Sheet. Below this box is a "thermometer" scale representing the three interpretive ranges for the PDSS Total score. Mark an "X" in the triangle next to the range that corresponds to the respondent's score. The triangle points to interpretive suggestions for that range. Enter the raw scores for the seven PDSS symptom content scales in the corresponding boxes on the lower left of the Summary Sheet, and refer to the corresponding interpretive suggestions.

For Short Form: Enter the PDSS Short Total score in the box on the upper right side of the Summary Sheet. Below this box is a "thermometer" scale representing the two interpretive ranges for the PDSS Short Total score. Mark an "X" in the triangle next to the range that corresponds to the respondent's score. The triangle points to interpretive suggestions for that range. Enter the value from Item 7 (highlighted on the Scoring Worksheet) in the appropriate box at the bottom right of the Summary Sheet. Refer to the corresponding interpretive suggestions.

Please refer to chapter 3 of the manual for complete instructions on interpreting the PDSS.

Below is a list of statements describing how a mother may be feeling after the birth of her baby. Please indicate how much you agree or disagree with each statement. In completing the questionnaire, please circle the answer that best describes how you have felt over the past 2 weeks. Read each item carefully. Then circle the number that best fits your answer. Please give only one response for each statement, using the following scale:

1	2	3	4	5
Strongly Disagree	**Disagree**	**Neither Agree nor Disagree**	**Agree**	**Strongly Agree**

If you wish to change your response, completely mark through your first response with an "**X**." Then circle the response that best fits your new choice.

Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	
					During the past 2 weeks,
1	2	3	4	5	**1.** I had trouble sleeping even when my baby was asleep.
1	2	3	4	5	**2.** I got anxious over even the littlest things that concerned my baby.
1	2	3	4	5	**3.** I felt like my emotions were on a roller coaster.
1	2	3	4	5	**4.** I felt like I was losing my mind.
1	2	3	4	5	**5.** I was afraid that I would never be my normal self again.
1	2	3	4	5	**6.** I felt like I was not the mother I wanted to be.
1	2	3	4	5	**7.** I have thought that death seemed like the only way out of this living nightmare.
					Stop here if you were asked to complete only the Short Form.
1	2	3	4	5	**8.** I lost my appetite.
1	2	3	4	5	**9.** I felt really overwhelmed.
1	2	3	4	5	**10.** I was scared that I would never be happy again.
1	2	3	4	5	**11.** I could not concentrate on anything.
1	2	3	4	5	**12.** I felt as though I had become a stranger to myself.
1	2	3	4	5	**13.** I felt like so many mothers were better than me.
1	2	3	4	5	**14.** I started thinking that I would be better off dead.
1	2	3	4	5	**15.** I woke up on my own in the middle of the night and had trouble getting back to sleep.
1	2	3	4	5	**16.** I felt like I was jumping out of my skin.
1	2	3	4	5	**17.** I cried a lot for no real reason.
1	2	3	4	5	**18.** I thought I was going crazy.
1	2	3	4	5	**19.** I did not know who I was anymore.
1	2	3	4	5	**20.** I felt guilty because I could not feel as much love for my baby as I should.
1	2	3	4	5	**21.** I wanted to hurt myself.
1	2	3	4	5	**22.** I tossed and turned for a long time at night trying to fall asleep.
1	2	3	4	5	**23.** I felt all alone.
1	2	3	4	5	**24.** I have been very irritable.
1	2	3	4	5	**25.** I had a difficult time making even a simple decision.
1	2	3	4	5	**26.** I felt like I was not normal.
1	2	3	4	5	**27.** I felt like I had to hide what I was thinking or feeling toward the baby.
1	2	3	4	5	**28.** I felt that my baby would be better off without me.
1	2	3	4	5	**29.** I knew I should eat but I could not.
1	2	3	4	5	**30.** I felt like I had to keep moving or pacing.
1	2	3	4	5	**31.** I felt full of anger ready to explode.
1	2	3	4	5	**32.** I had difficulty focusing on a task.
1	2	3	4	5	**33.** I did not feel real.
1	2	3	4	5	**34.** I felt like a failure as a mother.
1	2	3	4	5	**35.** I just wanted to leave this world.

Appendix B. Interview Guide and Screening Protocol

Telephone Screening Script

Investigator: My name is Angela DelGrande and I am a doctoral candidate at the UNM College of Nursing. Thank you for providing me with your contact information and giving me permission to speak with you by phone. The purpose of today's interview is to explain the purpose of the study and what to expect if you decide to participate; and to find out if you are eligible to participate in the study.

[Provide opportunity for subject to respond]

Investigator: I will ask you questions about yourself that are commonly found on surveys (e.g. education level, income level, race, ethnicity).

[Provide opportunity for subject to respond/ask questions]

Investigator: Then I will ask questions that relate specifically to this study (e.g. pregnancy and birth history, newborn health history, mental health history). I will ask some questions that clearly tell me if you are eligible or not to be in the study. If you are not eligible to continue I will let you know immediately and our telephone interview will end.

[Provide opportunity for subject to respond]

Investigator: Finally I will read to you a list of statements describing how a woman may be feeling after becoming a mother. I will ask you to rate how much you agree or disagree that each statement describes how you have felt within the last 2 weeks. Your score will be used to determine study eligibility. Some women will get a score that suggests they may be depressed. I will let you know today if this is the case and we can talk about what this score means, and if you could benefit from a mental health referral. If you are not eligible to continue based on your score I will let you know immediately and our telephone interview will end. Do you have any questions or concerns so far? Are you willing to continue?

[Provide opportunity for subject to respond]

Investigator: If you meet the study criteria and are interested in participating then we will set up a date, time and place to meet of your choosing for a face-to-face interview. Please stop this interview at any point if you have concerns or questions. You also have the right to at any point if you feel that you no longer want to continue. Are you ready to begin?

[Provide opportunity for subject to respond]

Demographic Questions

1. Age at last birthday

2. Marital Status
   a. Married
   b. Widowed
   c. Divorced
   d. Separated
   e. Never Married
   f. Other

3. Education: What is the last year of school you have completed?

<8 9 10 11 12 13 14 15 16 17 18 19 20

4. What is your ethnicity?
   a. African American
   b. Asian
   c. Hispanic
   d. Native American
   e. Pacific Islander
   f. White
   g. Other (Please specify)

5. Employment status
   a. Employed If yes, what is your occupation?
   b. Unemployed/looking
   c. Unemployed/not looking
   d. Homemaker
   e. Student
   f. Unable to work

6. Housing
   a. Rent Home
   b. Own Home
   c. Apartment
   d. Rent Mobile Home
   e. Own Mobile Home
   f. Other

7. Income Level
   a. <$25,000
   b. $25,000 to $34,999
   c. $35,000 to $49,999
   d. $50,000-$74,999
   e. $75,000 to $99,999
   f. $100,000 to $149,999
   g. >$150,000

Perinatal Criteria Questions

1. Is this your first child YES NO

2. Are you an adoptive mother? YES NO If so, how old was your baby when the adoption took place? AGE_____
3. Did you have complications while carrying the baby? YES NO If yes please describe.
4. Did you have birth complications? YES NO If yes please describe.
5. Did you have medical conditions not related to pregnancy while carrying your baby? YES NO If yes please describe.
6. Did your child have complications after birth that required a stay in the NICU? YES NO If YES please describe.
7. Did your child have complications from birth that required ongoing medical care in the first 12 months of life? YES NO If yes please describe.
8. Did you experience depression in the first 12 months postpartum? YES NO If Yes, did you seek treatment? YES NO If yes, what type?

   How are you doing now?
9. Were you diagnosed with a psychiatric illness during or after your pregnancy, aside from depression? YES NO If yes what was/is the diagnosis?

   If Yes, did you seek treatment? YES NO If yes what type?

   How are you doing now?

An answer of yes to the following criteria will exclude participation in this study:

- Adoption took place > than first 30 days of life.
- Maternal complications that required hospitalization in the hospital > 48 hours, significant medical intervention and/or surgical treatment.
- Experienced a difficult course of labor, traumatic birth or complications in first 4 hours after birth.
- Experienced a medical condition categorized as high risk for perinatal complications, required intensive prenatal care secondary to the medical condition, and/or required hospitalization >48 hours during their prenatal course.
- Describe a neonatal complication that required a duration of stay in the NICU >4 hours post-birth.

- Pediatric complications that have required ongoing medical care in the first 12 months of life?
- Diagnosis of a psychotic or bipolar disorder.

The participant will be thanked and the interview will be terminated at this point.

PDSS Instrument

If the participant is not excluded based on the above criteria the PDSS will be administered for group placement. Please see the section on sample stratification located in the HRRC application or study protocol for details.

Investigator: I will read to you a list of statements describing how a woman may be feeling after becoming a mother. I will ask you to rate how much you agree or disagree that each statement describes how you have felt within the last 2 weeks. Your score will be used to determine study eligibility. Some women will get a score that suggests they may be depressed. I will let you know today if this is the case and we can talk about what this score means, and if you could benefit from a mental health referral. If you are not eligible to continue based on your score I will let you know immediately and our telephone interview will end. Do you have any questions or concerns so far? Are you willing to continue?

[The PDSS will be administered if the participant gives verbal consent].

PDSS short form score:_____ PDSS long form score:_____
Place participant in Depressed group Non-depressed group
The interview will be terminate for a PDSS score between 14-59 or if the participant declines to answer the instrument questions.

Qualitative Questions: Face to Face Interview

The data collector must take care to avoid leading the participant toward a particular perspective during the dialogue in order to capture authentic subjective responses. Therefore reflective listening, reframing and non-leading prompts (e.g. tell me more) will be used to elicit more in-depth narratives from each participant.

The subjective experience of mothering will be elicited by asking three primary open-ended questions:

1. Tell me about your experience of being the mother of a toddler? Probative questions could include:

    - Tell me about your everyday experience of being a mother?
    - What's it like to take care of a toddler?
    - What do you do to get through the tough patches in a day?

Topics that could be explored further during the course of the interview include:

- The description of stressors and methods for coping that were effective or ineffective
- Experiences related to maternal role transition.
- Descriptors suggestive of hardiness as a coping mechanism.

2. Tell me how you saw mothering before you had the baby? Probative questions could include:
    - What did you think being a mother would be like before you gave birth?
    - How is being a mother now different or simoliar to what your thought it woud be like back then"

    Topics that could be explored further during the course of the interview include:
    - Descriptors for the "perfect mother"
    - Self-expectations of being a mother
    - Descriptors consistent with role incongruence between the ideological expectations versus the reality of mothering

3. Can you describe has becoming a mother influenced your life? Probative questions could include:
    - Has anything about you changed since becoming a mother?
    - Has anything about you changed since your infant has become a toddler?

    Topics that could be explored further during the course of the interview include:
    - Descriptors for hardiness as a personality trait
    - Changes in self-concept, self- confidence or sense of self-competence

Appendix C. HRRC Approval and Recruitment Site Agreement

THE UNIVERSITY OF NEW MEXICO
HEALTH SCIENCES CENTER

Human Research Review Committee
MSC 08 4560 BMSB Room B71
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http://hsc.unm.edu/som/research/hrrc/

14-Feb-2012

Lobo, Marie L, Ph.D.
College of Nursing

SUBJECT: HRRC Approval of New Research Protocol
HRRC#: 12-015
Study Title: The First-time Experience of Mothering a Young Toddler: A Qualitative Exploration of Role Discrepancy, maternal Hardiness and Depression in Mothers of Toddlers
Type of Review: Expedited Review
Approval Date: 14-Feb-2012
Expiration Date: 13-Feb-2013

Dear Dr. Lobo:

The Human Research Review Committee (HRRC) has reviewed and approved* the above-mentioned research protocol including the following:

1. Expedited study application dated 01/10/2012

2. Study protocol dated 2/13/2012

3. Informed Consent Form dated 2/13/2012

4. Request for Study Volunteers dated 01/10/2012

5. Recruitment Flyer dated 01/10/2012

6. Telephone Screening Script dated 01/10/2012

7. PDSS Summary Sheet dated 01/10/2012

Consent decision:
Requires a signed consent form
HIPAA Authorization Addendum not applicable

If a consent is required, we have attached a date stamped consent that must be used for consenting participants during the above noted approval period.

If HIPAA authorization is required, the HIPAA authorization version noted above should be signed in conjunction with the consent form.

UNM HEALTH SCIENCES CENTER

Human Research Review Committee
Human Research Protections Office

February 13, 2013

Marie Lobo

mlobo@salud.unm.edu

Dear Marie Lobo:

On 2/13/2013, the IRB reviewed the following submission:

Type of Review:	Continuing Review
Title of Study:	The Experience of Mothering a Toddler: A Qualitative Exploration of Role Discrepancy, maternal Hardiness and Depression in Mothers of Toddlers
Investigator:	Marie Lobo
Study ID:	12-015
Funding:	None
Grant ID:	None
IND, IDE, or HDE:	None
Documents Reviewed:	• Progress Report submitted 02/06/2013; • Protocol v11/07/2012; With acknowledgment of: • Study Investigator List submitted 11/14/2012.

The IRB approved the study from 2/13/2013 to 2/13/2014 inclusive. Before 2/13/2014 or within 30 days of study closure, whichever is earlier, you are to submit a continuing review with required explanations. You can submit a continuing review by navigating to the active study and clicking Create Modification / CR.

If continuing review approval is not granted before the expiration date of 2/13/2014, approval of this study expires on that date.

Category:	Expedited
Determinations/Waivers:	HIPAA does not apply

To request continuing review approval or closure, you are to submit a completed 'FORM: Continuing Review Progress Report and required attachments 45 days prior to 2/13/2014.

Approval of this protocol will expire if the IRB does not grant continuing review approval before 2/13/2014.

Recruitment Site Agreement

I (full name)_____

have reviewed the study protocol entitled:

HRRC#: 12-015. The First-time Experience of Mothering a Young Toddler: A Qualitative Exploration of Role Discrepancy, Maternal Hardiness and Depression in Mothers of Toddlers

I agree to allow Angela DelGrande, Doctoral Candidate at the University of New Mexico College of Nursing to recruit research participants at the following location:

Signature_____ Date_____

Program directors for the following programs signed the above recruitment site agreement Form:

- University of New Mexico Young Children's Health Center. Albuquerque NM
- Jurgen H. Upplegger MD, Private Pediatric Clinic. Albuquerque NM
- Westside WIC Program. Albuquerque NM
- Southeast Heights WIC Program. Albuquerque NM
- Stanford WIC Program. Albuquerque NM
- Northwest Valley WIC Program. Albuquerque NM
- Northeast Heights WIC Program, Albuquerque NM

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Appendix D. Recruitment Letter

UNM College of Nursing
Request for Study Volunteers

Hello,

My name is Angela DelGrande. I am a PhD student at the University of New Mexico College of Nursing. I am studying the experience of mothering toddlers. I am doing this as a requirement for my doctoral degree in Nursing. I am being supervised by Marie L. Lobo PhD, RN, FAAN.

We are seeking mothers of toddlers between the age of 12-24 months to volunteer in this study. We know a lot about what it is like to be a mother during the first 12 months after birth. This study looks at mothering toddlers. We want to talk with you about what you thought it would be like to mother a toddler and what it is like now. We want to know how you cope as your child becomes older and more mobile.

If you agree to volunteer the following will happen:

You will take part in a telephone interview which may last up to 30 minutes. You will be asked several questions about yourself , your pregnancy and birth, and about the health of your baby. This will help us to know if you meet the requirements for continuing in the study. If so, you will also be asked to do a survey about how you feel. You will then participate in a face to face interview which will take place at a time, date and location of your choosing. The interview will be recorded and last up to 60 minutes.

There is no cost to you except for your time. You will receive a $20.00 gift card from Target, Walmart or Smith's Grocery at the end of the face to face interview in appreciation for your time and effort.

I would like to assure you that the study has been reviewed and received ethics clearance through the UNM Human Research Protections Office who can be reached at (505) 272-1129.

If you are interested in volunteering, please fill out the contact information form. Then place it in the envelope provided and hand it to the medical assistant or the front office as you leave.

Thank you so much for your consideration.

Sincerely,

Angela DelGrande MSN, CNP, CNS

505-239-2887 adelgrande@salud.unm.edu

(page 2)

My name is _____ and I am interested in participating in your study on the experience of mothering a toddler.

I am a first time mother ____ Yes ____ No If no, how many children do you have?___

My child is between 12-24 months of age ___ Yes ____ No

I can be contacted at:

Phone Number_____

Email Address_____

Home Address_____

The best time of day to contact me is _____

The best days of the week to contact me are _____

Appendix E. Informed Consent Document

The University of New Mexico Health Sciences Center
Consent to Participate in Research

The Experience of Mothering a Toddler

7/18/12

Introduction

You are being asked to take part in a study that is being done by Angela DelGrande MSN, CNP, supervised by Marie L. Lobo PhD, RN, FAAN, principal investigator, from the University of New Mexico College of Nursing.

This study focuses on the experience of mothers of toddlers. We are also trying to determine the difference in this experience between mothers who are having a harder time adjusting and those who are not. This study is being done by Angela DelGrande as a requirement for her Doctor of Philosophy in Nursing.

We will study mothers of toddlers. We know a lot about being the mother of an infant. This study focuses on what it is like to be the mom of a young toddler. We are interested in the experience mothers have as their infants change to toddlers. We want to understand how you feel about being a mother of a toddler. We want to know how you cope as your baby becomes more mobile and independent.

You are being asked to take part in this study because you may or may not be having a hard time adjusting and are the mother of a toddler between 12 and 24 months of age. You have met the requirements for this research. Approximately 30 people from New Mexico will take part in this study through the University of New Mexico. There is no sponsor funding this study.

This form will explain the study, possible risks and possible benefits to you. We encourage you to talk with your family and friends before you decide to take part in this study. If you have any questions, please ask one of the study investigators.

What will happen if I decide to participate?

If you agree to participate, the following will happen:

You will take part in a telephone interview with Angela DelGrande. This may last up to 30 minutes. You will be asked several questions about yourself, your pregnancy and birth and about the health of your baby. You will also be asked to do a feelings survey. This will help us know if you meet the requirements for taking part in this study.

If you meet the study requirements, a face to face interview will take place at a time, date and location of your choice. This consent form will be reviewed and questions you may have about taking part in this study will be answered. If you have questions prior to this meeting, please contact Angela DelGrande at 239-2887.

You will be asked about your experience as the mother of a toddler. The conversation will be audio recorded. You will be given your choice of a $20.00 gift card from Target, Walmart or Smith's Grocery at the end of this interview.

How long will I be in this study?

This study will last between 30 and 90 minutes. You will have one telephone interview that will last about 30 minutes. You may also be asked to have one face to face interview that will last up to 60 minutes.

What are the risks or side effects of being in this study?

The risks of taking part in this study are minimal. There is a chance that you might feel some stress while talking about your mothering experience. These feelings will most likely be short-lived and mild. There is also a risk for of loss of privacy and confidentiality by taking part in this study. Every effort will be made to avoid this. For more information about risks and side effects, ask the investigator.

What are the benefits to being in this study?

You should expect no direct benefits from being in this study. Taking part in this study will help us understand what it is like to be the mother of a toddler. It will also help us understand what coping methods you use as the mother of a toddler.

What other choices do I have if I do not want to be in this study?

You do not have to be in this study.

How will my information be kept confidential?

We will make every effort to protect the security of all your personal information. But we cannot completely guarantee confidentiality of all study data.

Information contained in your study records will used by Angela DelGrande and members of her dissertation committee. The University of New Mexico Health Sciences Center Human Research Review Committee (HRRC) that oversees human subject research may also be permitted to see your records.

There may be times when we are required by law to share your information. However, your name will not be used in any published reports about this study.

All of your personal information will be kept confidential. Your name and consent form will be stored in a different place than your data. All information will be reported as group data. No one individual can be identified. Your interview recording will be downloaded to a secure computer. A number, not your name, will be used to identify your interview.

The study information will be stored in a secure area of the College of Nursing at UNM. Only the investigators will have access to the interview and personal information that you voluntarily provide.

What are the costs of taking part in this study?

There are no costs to you except your time.

What will happen if I am injured or become sick because I took part in this study?

The most likely side effect of taking part in this study is emotional stress. You will be given information about whom to contact for support if you need it.

The need for medical care as a result of taking part in this study is not anticipated. If you show signs of extreme stress or depression, you will be given a list of resources where help can be found.

It is important for you to tell the investigator immediately if you have been injured or become sick because of taking part in this study. No commitment is made by the University of New Mexico Health Sciences Center (UNMHSC) to provide free medical care or money for injuries from this study.

If you have any questions about these issues, or believe that you have been treated carelessly in the study, please contact the Human Research Review Committee (HRRC) at the University of New Mexico Health Sciences Center, Albuquerque, New Mexico 87131, (505) 272-1129 for more information.

Will I be paid for taking part in this study?

You will be paid for your time and inconvenience by receiving your choice of a $20.00 gift card from Target, Walmart or Smith's Grocer at the end of your face to face interview.

How will I know if you learn something new that may change my mind about participating?

You will be informed of any changes in the risks or benefits resulting from taking part in the study. We will tell you if there are alternatives to participation that might change your mind about participating. You may also request that a copy of the study abstract be sent to you once

the study has been completed. If you request this, you will be asked to complete a separate form which will be kept in a separate place from your interview.

Can I stop being in the study once I begin?

Your participation in this study is completely voluntary. You have the right to choose not to take part. You have the right to withdraw your participation at any point in this study. If you choose to withdraw or not participate it will not affect your future health care or other services to which you are entitled.

Whom can I call with questions or complaints about this study?

If you have any questions, concerns or complaints at any time about the research study, Marie Lobo PhD, RN, FAAN, or her associates will be glad to answer them at 505-272-2637. If you need to contact someone after business hours or on weekends, please call (505)-239-2887 and ask for Angela DelGrande.

If you would like to speak with someone other than the research team, you may call the UNMHSC HRRC at (505) 272-1129.

Whom can I call with questions about my rights as a research subject?

If you have questions regarding your rights as a research subject, you may call the UNMHSC HRRC at (505) 272-1129. The HRRC is a group of people from UNM and the community who provide independent oversight of safety and ethical issues related to research involving human subjects. For more information, you may also access the HRRC website at http://hsc.unm.edu/som/research/hrrc/.

CONSENT

You are making a decision whether to participate in this study. Your signature below indicates that you read the information provided. By signing this consent form, you are not waiving any of your legal rights as a research subject.

I have had an opportunity to ask questions and all questions have been answered to my satisfaction. By signing this consent form, I agree to participate in this study. A copy of this consent form will be provided to you.

_____	_____	_____
Name of Adult Subject (print)	Signature of Adult Subject	Date

INVESTIGATOR SIGNATURE

I have explained the research to the subject or his/her legal representative and answered all of his/her questions. I believe that he/she understands the information described in this consent form and freely consents to participate.

_____
Name of Investigator/ Research Team Member (type or print)

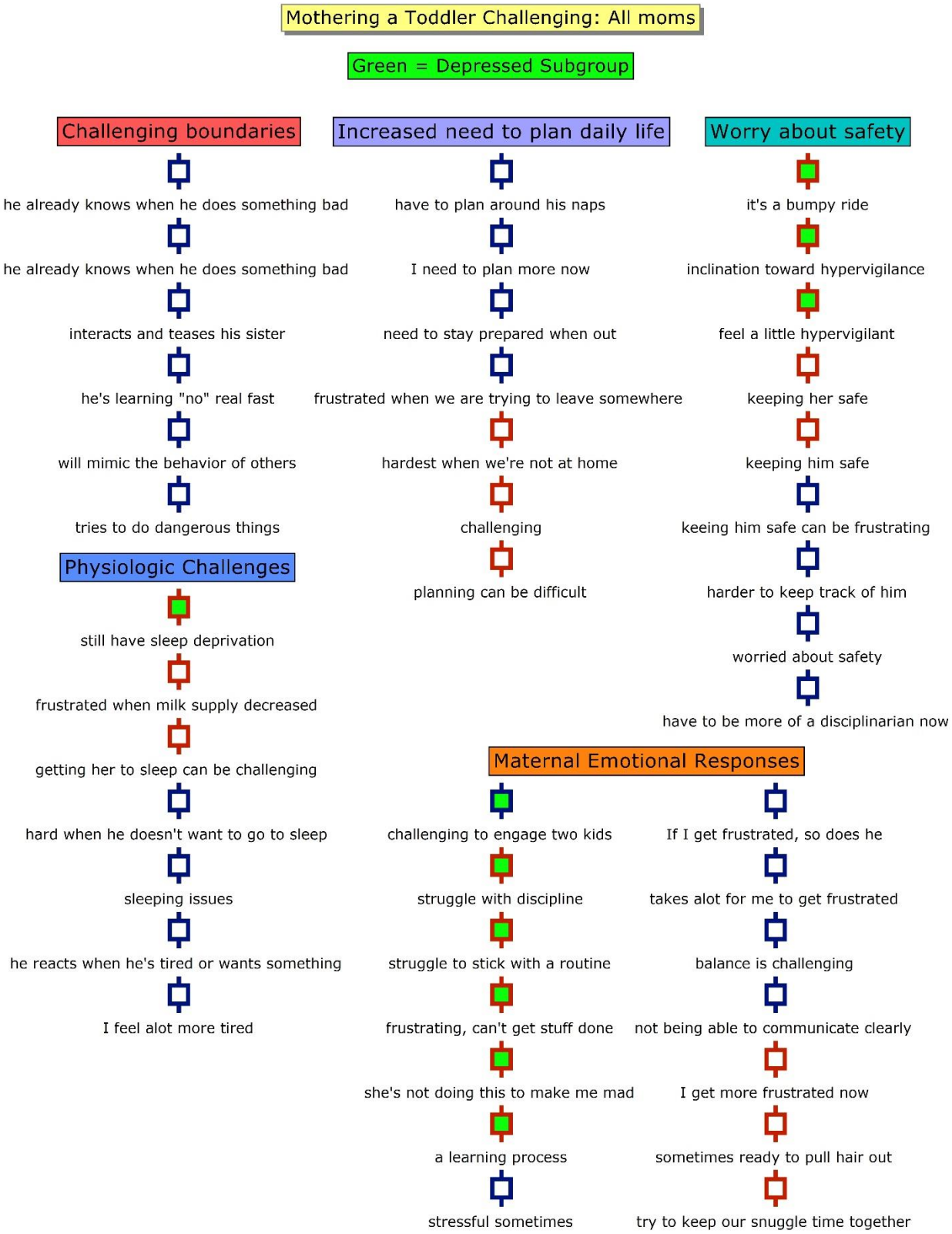
_____	_____
(Signature of Investigator/ Research Team Member)	Date

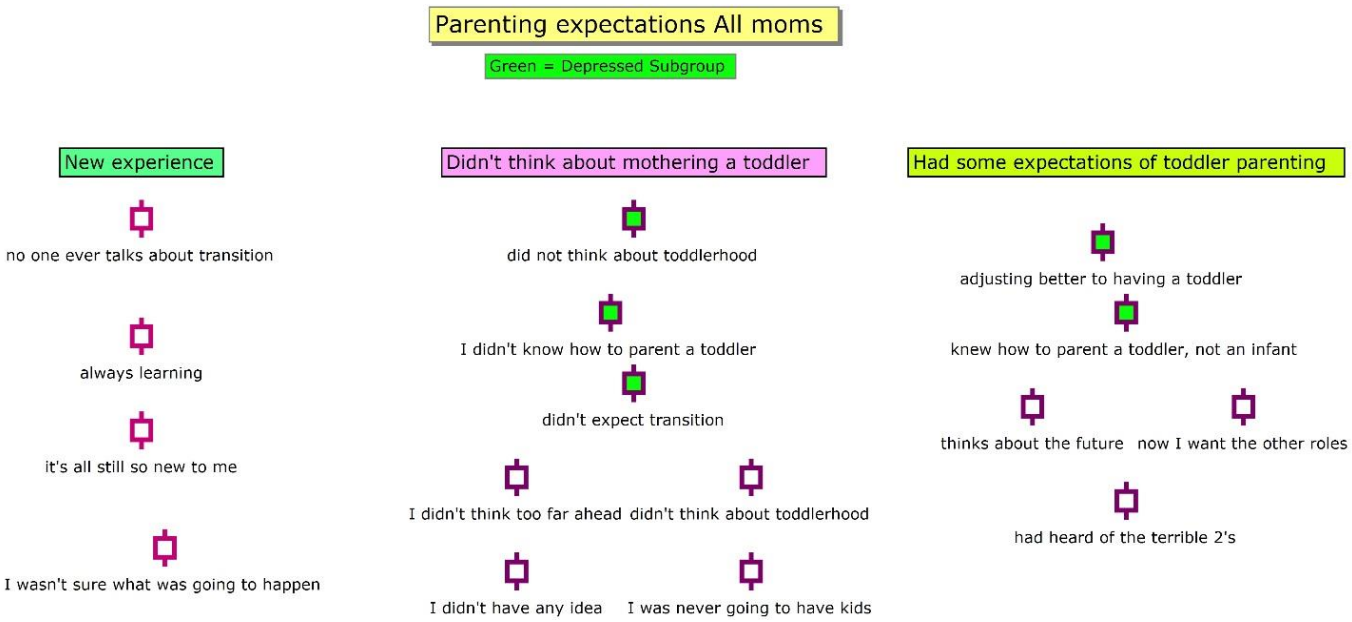
Appendix F. HRRC Data Safety Management Plan

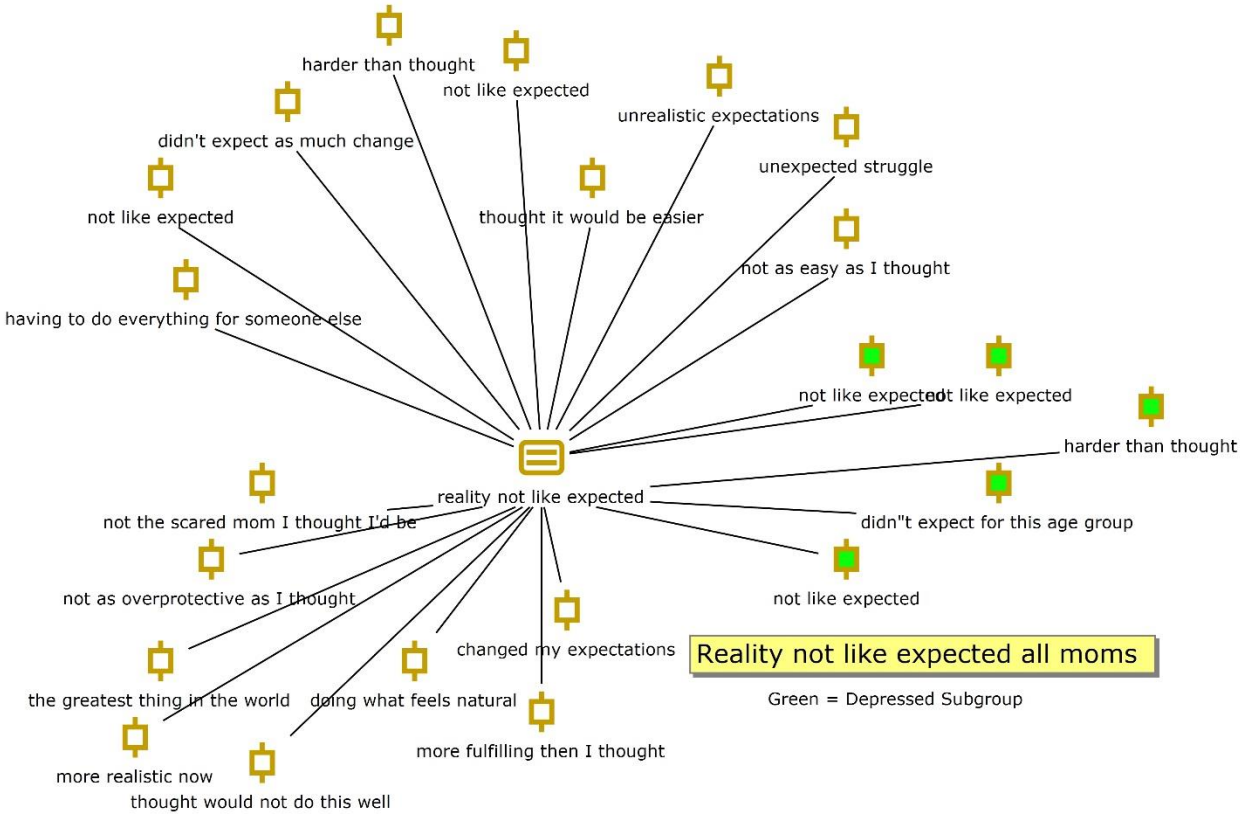
Members of the caregiving team who have access to medical information on potential subjects will screen the record for the child's age/ maternal parity and offer the mother information on study participation as described in section V. **The investigator will have no access to PHI**. The above mentioned personnel will have no access to research data. No specimen collection or access to participant medical records is required for data collection purposes.

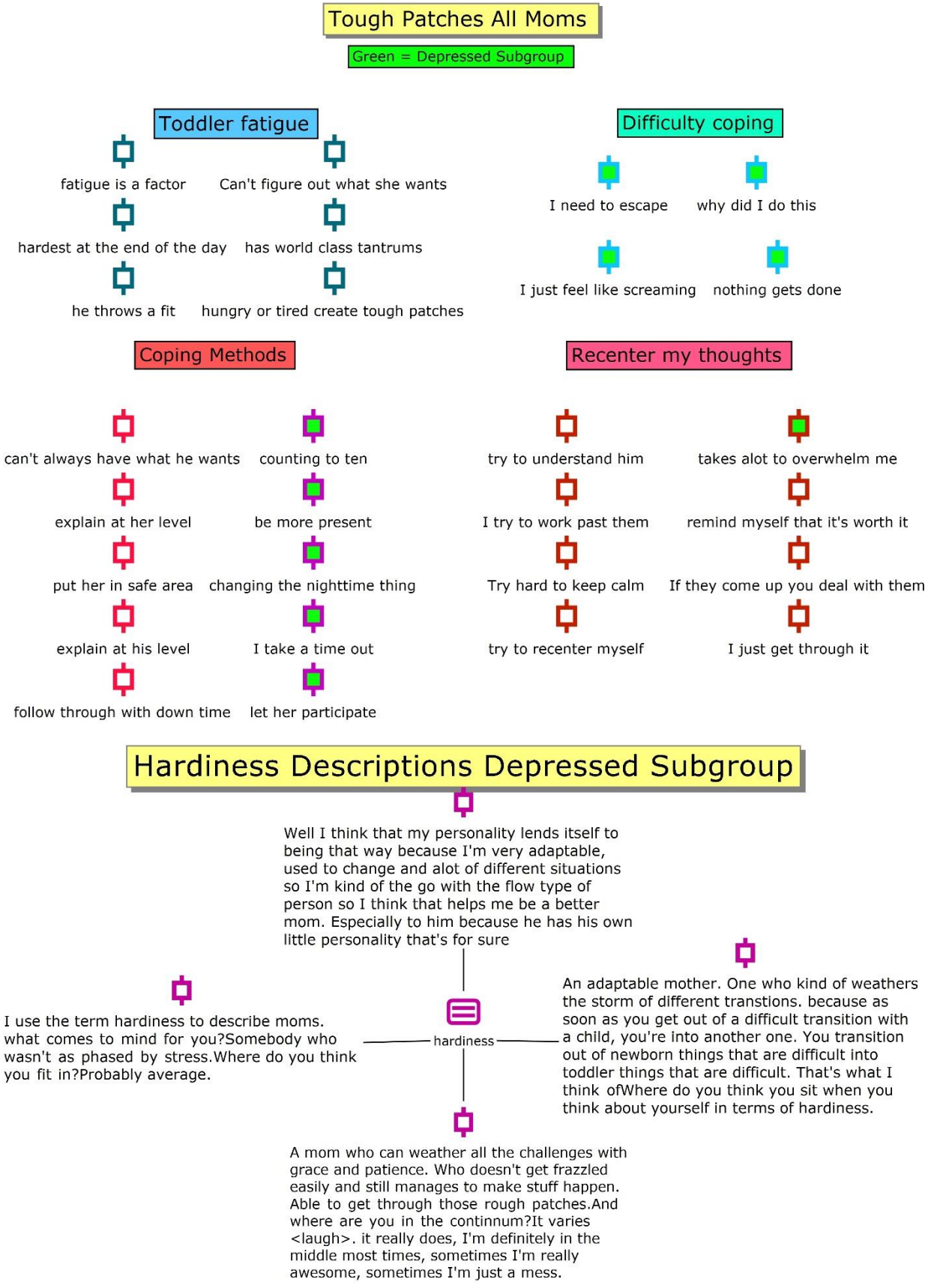
a. Personal identifiers are not needed for data analysis and will be replaced with identification numbers to assure confidentiality during the process of data analysis and interpretation.
b. Computer files and digital recordings will be stored using a secure, encrypted server provided by UNM Health Sciences Center.
c. The digital audio-recordings will be uploaded onto a computer and the file will be numerically coded and dated. The audio files will be saved using an encrypted UNM server and subsequently transcribed only by the investigator. The transcript will also be saved using an encrypted UNM server.
d. No persons aside from Dr. Lobo, Dr. Tinkle, Dr. Robbins or Dr. Liesveld will have access to the research data.
e. Written or printed notes used for data analysis and interpretation will be held under lock and key in a secure file cabinet located within the UNM College of Nursing or in a locked file cabinet in the researcher's home office.
f. Documents that contains personal identifiers will be shredded, and digital recordings will be deleted from the computer at the conclusion of the study or if a participant withdraws from the study.

Appendix G. Thematic Map Exemplars

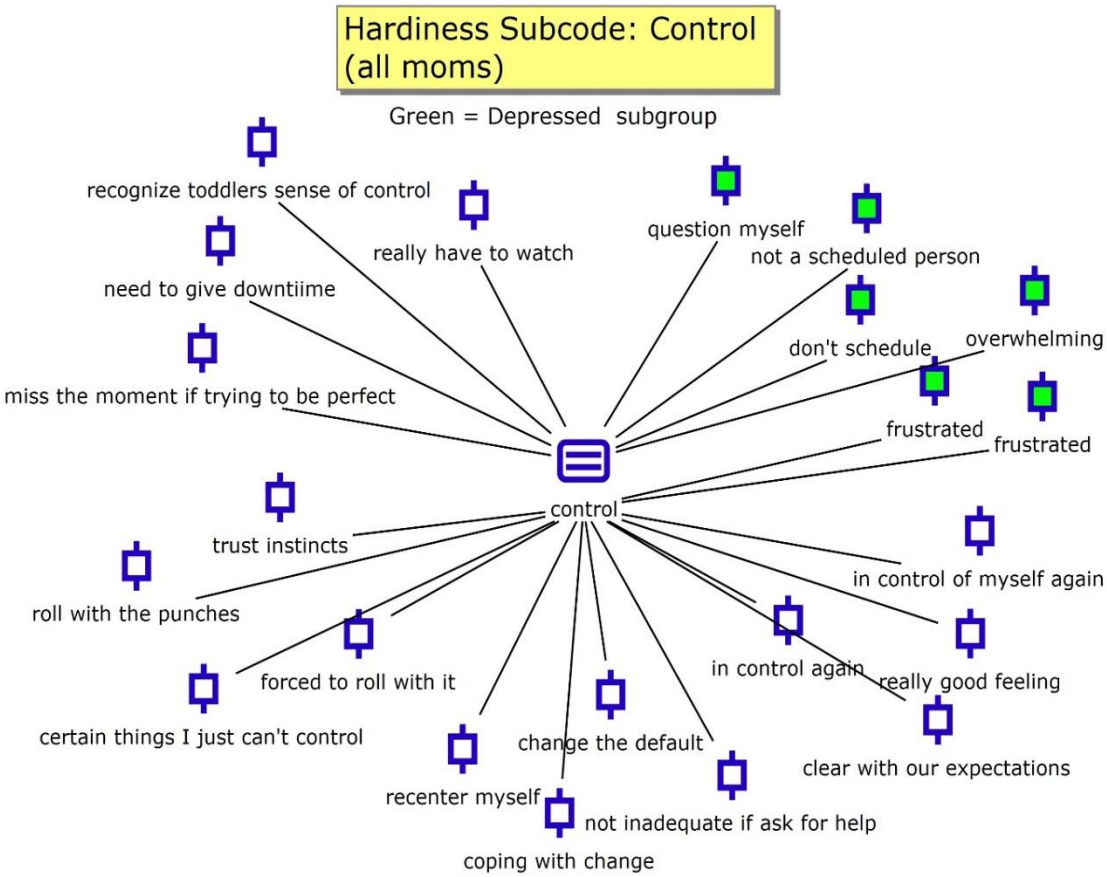



Parenting expectations All moms
Green = Depressed Subgroup
New experience
no one ever talks about transition
always learning
it's all still so new to me
I wasn't sure what was going to happen
Didn't think about mothering a toddler
did not think about toddlerhood
I didn't know how to parent a toddler
didn't expect transition
I didn't think too far ahead
didn't think about toddlerhood
I didn't have any idea
I was never going to have kids
Had some expectations of toddler parenting
adjusting better to having a toddler
knew how to parent a toddler, not an infant
thinks about the future
now I want the other roles
had heard of the terrible 2's


harder than thought
not like expected
didn't expect as much change
unrealistic expectations
unexpected struggle
not like expected
thought it would be easier
not as easy as I thought
having to do everything for someone else
not like expected
not like expected
harder than thought
reality not like expected
not the scared mom I thought I'd be
didn"t expect for this age group
not as overprotective as I thought
not like expected
changed my expectations
the greatest thing in the world
doing what feels natural
more realistic now
more fulfilling then I thought
thought would not do this well
Reality not like expected all moms
Green = Depressed Subgroup


Tough Patches All Moms
Green = Depressed Subgroup
Toddler fatigue
fatigue is a factor
Can't figure out what she wants
hardest at the end of the day
has world class tantrums
he throws a fit
hungry or tired create tough patches
Difficulty coping
I need to escape
why did I do this
I just feel like screaming
nothing gets done
Coping Methods
can't always have what he wants
counting to ten
explain at her level
be more present
put her in safe area
changing the nighttime thing
explain at his level
I take a time out
follow through with down time
let her participate
Recenter my thoughts
try to understand him
takes alot to overwhelm me
I try to work past them
remind myself that it's worth it
Try hard to keep calm
If they come up you deal with them
try to recenter myself
I just get through it
Hardiness Descriptions Depressed Subgroup
Well I think that my personality lends itself to being that way because I'm very adaptable, used to change and alot of different situations so I'm kind of the go with the flow type of person so I think that helps me be a better mom. Especially to him because he has his own little personality that's for sure
I use the term hardiness to describe moms. what comes to mind for you?Somebody who wasn't as phased by stress.Where do you think you fit in?Probably average.
hardiness
An adaptable mother. One who kind of weathers the storm of different transtions. because as soon as you get out of a difficult transition with a child, you're into another one. You transition out of newborn things that are difficult into toddler things that are difficult. That's what I think ofWhere do you think you sit when you think about yourself in terms of hardiness.
A mom who can weather all the challenges with grace and patience. Who doesn't get frazzled easily and still manages to make stuff happen. Able to get through those rough patches.And where are you in the continnum?It varies <laugh>. it really does, I'm definitely in the middle most times, sometimes I'm really awesome, sometimes I'm just a mess.


Hardiness: Committment
Green = depressed subgroup
want to stop the cycle
take care of their needs first
we are committed to this
Trying to learn and grow
keep my problems from the kids
strong faith
in my heart-just felt right
focus on being a better mom
give kids the right message
she needs my time
my needs can wait
committed to changng parenting style
stand up for child and self
I want to be what he needs me to be
show them a life they deserve


Hardiness Subcode: Control (all moms)
Green = Depressed subgroup
recognize toddlers sense of control
really have to watch
question myself
not a scheduled person
need to give downtiime
don't schedule
overwhelming
miss the moment if trying to be perfect
frustrated
frustrated
control
trust instincts
in control of myself again
roll with the punches
in control again
really good feeling
forced to roll with it
certain things I just can't control
change the default
clear with our expectations
recenter myself
not inadequate if ask for help
coping with change