11-23-2020

Demystifying First-Time Mothers' Postpartum Mental Health: A Phenomenological Study of the Transition to Becoming a Mother

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A Phenomenological Study of the Transition to Becoming a Mother

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A Dissertation Proposal Submitted to The Graduate School at the University of Missouri-
St. Louis in partial fulfillment of the requirements for the degree
Doctor of Philosophy in Education in Counseling

December 2020

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Abstract

Becoming a mother is a significant life event that can greatly impact maternal mental health. Understanding maternal mental health is an important interdisciplinary goal because it could lead to mother's receiving better care and support from both mental health and medical professionals. Seven first-time mothers with a baby under the age of one were interviewed for a phenomenological qualitative study, which investigated first-time mothers' postpartum mental health experiences. This study was guided by two research questions: How do new mothers experience their postpartum mental health in comparison to how they experienced their mental health before having their baby, and how do new mothers make sense of their postpartum mental health experiences? Four themes were found using Giorgi (2009) descriptive phenomenological method in psychology as a method for data analysis to comprise the essence of the phenomenon of *postpartum processing*: What Just Happened?: Processing The Childbirth Experience; How Am I?: Processing Personal Well-being; How Are We?: Processing Relational Health; and What Do I Need To Do?: Processing Tasks of Motherhood. Postpartum is a time marked by increased, rapid changes in a mother's life, each of which required processing. This study aimed to expand the conversation around maternal mental health beyond postpartum depression to be reflective of a full range of mothers' own mental health experiences.

Keywords: Maternal mental health, postpartum mental health, counseling paradigms, postpartum depression, becoming a mother, transition to motherhood, motherhood studies, first-time mother, postpartum processing

Acknowledgements

I started this dissertation as a way to make sense of my own postpartum experience. I wanted to immerse myself in research related to what I was experiencing because I craved deeper insight and understanding. Thank you to my husband Paul and my daughter Penny, who made me a mother, which is an experience that has forever changed me for the better. Paul, thank you for being a constant in my life and for your persistent love. You are helping me find my way back to myself by expecting me to dream big and live life passionately. I love you and am lucky to parent with you. Penny, I am in awe of you daily and cannot believe that I get to be your mother. You are an incredible little human. There is nothing that matters more to me than trying to fill our lives with as much love and beauty as possible. To little Lark, the baby in my belly, thank you for keeping me company while I finished this project and for motivating me to get this done. I love you already.

Thank you to the Dooley and Hussmann families who have supported me in so many ways. To my mom and dad who always taught me the importance of education and who nurtured my love for school. Thank you for always encouraging me and believing in my potential. To Cathie and Glen who have seen my family through so much. I am grateful for your continuous support and the ways you care for us. To my sisters Evin, Katie and Ari, thank you for being there for me and for being your own versions of my fairy godmothers who have shown me so much love, especially when I have needed it most. To my brother Michael, it has brought me so much joy to watch you be a loving and tender-hearted father to Emma and Stella. To my brother Jeff, thank you for being living proof that life exists after a Ph.D. program and for being such a wonderful uncle to Penny.

To my dissertation committee, thank you for being with me through this process. To my advisor, Dr. Oliveria, your guidance and patience helped me tremendously. Thank you for your time, your edits, and your pep talks. To Dr. Nelson, thank you for your enthusiasm for research and research methods. Dr. Cottone, thank you for graciously allowing me to use your counseling paradigms in a new way. Dr.Takševa, I am incredibly grateful that you were open to a cold call from someone who admired your work. You helped me be braver in my writing and more precise with my critiques. Thank you for being a part of this and for modeling for me ways that feminist researchers can and should be interested in motherhood.

Agata, thank you for being on this dissertation journey with me! Writing a dissertation and completing this program was not easy. You being a part of my UMSL experience made everything better. To my feminist soul sister, Devon, I am grateful for our ongoing conversations about feminism ever since our Pitzer days. You inspire me and keep me focused on work that matters most. To my adventure soul sister, Erin, who is a tether that keeps me connected to beauty and grace. Thank you for seeing the good in me and reflecting that back to me. I could not have made it through my own postpartum process without you.

Thank you to all of the mothers who have shaped me, helped to raise me, and are mothering me in so many ways. To my own mother who had to overcome so many difficult experiences as a mother and still is filled with boundless love. To the mothers who participated in this study, I am honored that you entrusted me with your experiences. It was a pleasure living deeply in your words and I am so grateful to have gained greater clarity about postpartum mental health because of your contributions to this study.

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Chapter 1

Introduction

There are few developmental milestones that are as abruptly demanding as the transition to becoming a mother. "Few experiences are as intensely personal, as highly public, or as culturally fraught as new motherhood" (Held, 2012, p. 107). A new mother must navigate the transition into the role by balancing personal, relational, and societal desires and expectations, often with the tension of competing values. Becoming a mother is one of the most normal and common experiences that humans can have but to the individual woman it can be an intense and disorienting process (Hjalmhult & Lomborg, 2012). It can also be a transformative time when mother's flourish with experiences of personal growth, positive emotions, and positive coping to the challenges that arise with parenting (Athan, 2011).

Much of the literature on the postpartum mental health experiences of mothers has focused on postpartum depression (Delaney, 2015; Dennis & Hodnett, 2010; Mauri et al., 2010; Stewart & Vigod, 2016; Yim, 2015). More recently, researchers and practitioners have broadened the postpartum scope to also include postpartum anxiety (George, Luz, Tychey, Thilly &, Spitz, 2013 and Leach, Poyser, & Fairweather-Schmidt, 2017) with a move to integrate postpartum mental health under one umbrella of Perinatal Mood and Anxiety Disorders (PMAD) (Sacks & Birndorf, 2019). Additionally, there has been consistent awareness of postpartum psychosis in the psychiatric community as evident by it being the only postpartum diagnosis included in the *DSM-II* and *DSM-III* (Godderis, 2013). Maternal postpartum mental health has primarily been viewed using a medical-model focused on diagnosing negative symptoms, while little attention has been given to

maternal resilience, strength, or holistic mental health, including positive emotions, growth, and coping.

Motherhood is both an identity and an institution (Rich, 1976). Each mother's experience is situated in a specific time, place, and culture, all of which shape the meaning of motherhood from mothers' and society's perspectives. "Mother" is an identity that is informed by and built upon a woman's previous life experiences (Koniak-Griffin, Logsdon, Hines-Martin, & Turner, 2006, p. 671), yet it is an entirely new role that must be made sense of within their current ecological system. Additionally, a mother must form and then integrate their identity as "mother" with their other, pre-existing, intersectional identities. No single identity can be isolated within a person (Crenshaw, 1989). Identities of race, class, gender, sex, age, sexuality, religious and political orientations are just some of the identities that intersect with the identity of mother. Although motherhood is a shared experience, each mother's identity is unique to them, and in many ways determines the ease or difficulty that they might have accessing resources for their self and their family. Unfortunately, most of the literature on mothers has focused on middle-class, educated, white women (Nelson, 2003).

Many concepts that shape the institution of motherhood are socially constructed and internalized by most mothers. Mothers have expressed feeling pressure to be "the good mother," and the demands of a social expectation to engage in intensive mothering (Hays, 1996). They have felt like they should have innate knowledge about motherhood (Miller, 2007) and innate love (Takševa, 2017). They shouldn't have any negative emotions after childbirth (Held, 2012). The general message has been that mothers who can't measure up to the social expectations of motherhood have a character flaw and

something wrong with them (Held, 2012). These patriarchal concepts have been challenged, most notably within the field of motherhood studies, yet they mainly exist unquestioned within popular culture in the United States and can contribute to some of the emotional, psychological, and relational distress that many mothers experience postpartum (Mauthner, 1999).

Mothers come in many different forms and the diversity of motherhood makes the role beautiful, complex, and fluid. There are birth mothers, foster mothers, adoptive mothers, surrogate mothers, lesbian non-biological mothers, and mothers who were pregnant but experienced the loss a child or children either through an abortion or miscarriage. Collins (2000) coined the term, "othermother" to describe the common mothering practices that are done by non-biological mothers specifically in African American communities. Othermothers can be relatives or community members and can be seen as just as influential in a child's life as their biological mother.

Few articles reviewed for this study acknowledged or addressed the gendered nature of motherhood as a construct, which assumes mothers are women. This assumption fails to consider the ways that gender non-confirming folks or transgender men may also give birth to children, who may or may not identify with the term "mother." Hoffkling, Obedin-Maliver, and Sevelius (2017) called attention to the important, yet often neglected fact that some people in need of obstetric care are not women. Although the intersection of gender and motherhood identity is not the focus of this study, it is imperative to note the inherent gendered complexity that motherhood presents.

For the purpose of this study, "mother" is defined as any person who self-identifies as a mother, who was pregnant with and delivered their baby, and who is currently caring for their child or children. This definition is chosen not to discount the important roles that other types of mother's play in children's lives, but to focus this study on the postpartum mental health experiences of those who have been through the physically, emotionally, psychologically, and spiritually arduous tasks of growing a human being, giving birth, and caring for an infant. Additionally, the author will take great care to use gender-neutral pronouns when referring to mothers in this study so as not to assume that all mothers identify as women.

Statement of the Problem

Despite the fact that postpartum mental health has been studied for decades, there are still few definitive findings (Schiller, Meltzer-Brody, & Rubinow, 2015). Upon further investigation for this study, it became clear that the majority of research on maternal mental health was using a medical model perspective. The diagnosis of "postpartum depression" itself is based on minimal evidence and is a diagnosis that has never been included in the *DSM,* which is the professional diagnostic tool for mental health professionals (Godderis, 2013). There are few alternative conceptualizations for mother's postpartum mental health, which results in a lack of understanding about the full spectrum of postpartum mental health experiences that mothers have and it results in a lack of treatment frameworks that mother's themselves can seek out in order to help them make sense of their postpartum experiences.

Too often, research on mother's mental health has been for the ultimate interest of supporting the infant's development (e.g. Dennis & Hodnett, 2007; Koutra, Chatzi,

Bagkeris, Vasilako, Bitsios, & Kogevinas, 2012; Murray, Arteche, Fearon, Halligan, Goodyer, & Cooper, 2011; Muzik, Bocknek, Broderick, Richardson, Rosenblum, Thelen, & Seng, 2012), while demonstrating much less interest in the mother's own development. Research on mother's impact on child development is unquestionably important but there must also be space where research acknowledges that mothers are born at the same time as their children and they too are developing and worthy of interest and support. The following quote from Rich (1976) still resonates today: "We know more about the air we breathe, the seas we travel, than about the nature and meaning of motherhood" (p. 11). Although there has been and currently is a small and marginalized yet lively academic curiosity about motherhood, particularly within the field of motherhood studies which has been producing research on motherhood for 30 years, there is still a lot to learn.

Mothers undoubtedly serve in vital roles for children, families, and society, yet literature has rarely considered mothers as whole individuals, beyond the value they bring to their relationship with others. Their inner lives are worthy of interest during this especially profound moment in time. It can be argued that there are few experiences that call an individual to dramatically change in such a short amount of time. Mothers are worthy of scholarly interest.

There is also an assumption among much of the existing research and popular culture conversations related to maternal postpartum mental health that postpartum depression is an acceptable umbrella term for mothers who struggle with their mental health postpartum. This dissertation is a response to challenge that commonly held assumption based on the lack of existing evidence and unsystematic understanding of mother's postpartum mental health experiences. This researcher has concluded that the

ease with which the concept of postpartum depression is used as a catchall term for mothers who have a difficult time postpartum is irresponsible and can be harmful to mothers due to its lack of clarity and meaning.

The counseling profession in particular has a notable absence of scholarship on mothers and motherhood. A literature review for "postpartum" in each of the nine professional counseling journals produced a total of six articles that were directly related to postpartum mental health (Albright, 1993; Davis-Gage, Kettmann, Moel, 2010; Elliott, Shewchuk, Richeson, Pickelman, & Franklin, 1996; Holm, Prosek, & Godwin Weisberger, 2015; Hassert, & Kurplus, 2011; Pfost, Stevens, & Matejcak, 1990). Only three of the six articles were published in the past decade. This lack of research on postpartum mental health in counseling demonstrates an opportunity to contribute to the field and to advance knowledge on the subject of postpartum mental health.

There has also been minimal research on how the process of becoming a mother impacts a new mother's mental health. Even fewer studies have directly inquired about mother's mental health with mothers themselves (Mauthner, 1999). The transition to motherhood requires a stark shift in identity for new mothers and it requires physical, emotional, and psychological resilience to navigate caring for another human being while simultaneously learning a new way of being.

Significance of the Study

Some existing qualitative work on postpartum mental health considered the transformative nature of postpartum depression (Karraa, 2013), used a relational model to investigate mother's postpartum depression (Mauthner, 1999), interviewed mothers directly about their postpartum depression (Mauthner, 2010), studied the impact of social

support through connection with other first-time mothers (Darvill, Skirton and Farrand, 2010; Alstveit, Severinsson, and Karlsen, 2010), investigated the role of support groups to help mothers cope postpartum (Wilkins, 2006), and focused on factors that helped mothers cope through the transition to motherhood (Churchill & Davis, 2010). Other qualitative work has focused specifically on the transition to becoming a mother (Bailey, 1999; Carolan, 2006; Laney, Hall, Anderson, & Willingham, 2015; Nystedt, Hogberg, and Lundman, 2008; Rogan, Shmied, Barclay, Everitt, & Wyllie; Wojnar & Katzenmeyer, 2013).

This qualitative study approached participants with an interdisciplinary perspective including medical, psychological, and feminist perspectives with that hopes of bridging some of the existing qualitative work on maternal postpartum mental health and mother's transition to becoming a mother by utilizing in-depth interviews to investigate the postpartum mental health experiences of mothers during their transition to motherhood. This study also follows the path of feminist researchers who have challenged harmful patriarchal beliefs about motherhood by deconstructing "universal truths" about motherhood. By interviewing mothers directly and leaving room for them to attach labels and contribute descriptions of their own experiences, this study helped build upon existing qualitative research on motherhood and mental health so as to enrich and expand academic and clinical understanding of postpartum mental health. In part, qualitative phenomenological research methods were chosen because it is an approach that prioritizes the wisdom of participants, which has the potential to empower new mothers through the process of participating in this study.

It is necessary to listen to mothers as they make sense of their individual mental health so as to gain greater awareness about what postpartum mental health is like beyond an arbitrary list of symptoms. By using a qualitative phenomenological approach in this study the researcher created space for individual mothers to make meaning of their own experiences, which then enabled the researcher to glean a greater collective shared meaning between all of the participants. Being aware of the ways in which some "universal truths" about motherhood, such as a mother having inherent mother love, have been used to oppress mothers this researcher approached the data analysis process with a reverence for the uniqueness that each mother experiences motherhood while also considering what macro-elements of motherhood connect diverse mothers to one another. This study strove to include diverse participants as a way to potentially tap into a deep connection between diverse mothers. The participants in this study ended up having many shared identities while also having some diverse identities.

A mother transforms with each birth and has to continuously adapt to the role of mother throughout their lifespan as a mother (Mercer, 2004). This study focused on first-time mothers during the first-year postpartum as a way to target the experience of initially becoming a mother as a distinct experience. This time period is of particular importance because mothers are likely to still be in the process of developing their maternal identity and are adjusting to the role of mother. Asking mothers to process their mental health while still in this process of adjustment provided insight into how mothers themselves are actively experiencing and making sense of their mental health. By talking to new mothers directly about their mental health, this study empowered mothers to be validated as

experts on their own experiences and demonstrated the many things that mothers can teach professionals about postpartum mental health.

One of counseling's greatest strengths is the field's respect for and acceptance of established yet diverse counseling theoretical orientations. Using the framework of counseling paradigms (Cottone, 2012) and applying it to postpartum mental health research helped to challenge the de facto prioritization of the medical model's conceptualization of postpartum mental health, simply because there are few well-known conceptual alternatives. Organizing and expanding the ways that postpartum mental health is conceptualized by taking the perspective of multiple theoretical paradigms helps mental health professionals better support mothers postpartum.

Research Questions

1. How do new mothers experience their postpartum mental health in comparison to how they experienced their mental health before having their baby?

2. How do new mothers make sense of their postpartum mental health experiences?

Chapter Conclusion

There are five chapters for this study. This chapter was an introduction to the study. Chapter Two presents a review of the literature related to counseling paradigms, maternal mental health, and the transition to becoming a mother. Chapter Three focuses on methodology and research design aligned with the research questions. Chapter Four is an analysis of the findings from interviews with participants and Chapter Five offers a discussion which will summarizes conclusions, limitations, implications, and recommendations for further study.

Chapter 2

Review of the Literature

Becoming a mother is a life-altering transition that requires a mother to rapidly adapt to a new way of living and being. Relatively little is known about how mothers experience this transition because once children are born, societal concern has generally transitioned away from the mother to the child (Nelson, 2003). Infant and child development have been prioritized in psychology and counseling, while motherhood development has simply been considered a given (Rich, 1976). A mostly unspoken assumption in the United States is that a mother's love is natural and innate (Takševa, 2017), therefore, becoming a mother has been assumed to be a graceful and instantaneous process occurring once a baby is born, making the usefulness or necessity to study mothers go mostly unnoticed. Motherhood has been an under-researched topic across disciplines, including a notable absence in feminist and women's studies scholarship (Kawash, 2011; Takševa, 2018). Some researchers have clearly stated that first-time mother's mental health is not being cared for (Delaney, Dalmida, & Gaydos, 2015). At the same time, there is a history of strong writers and researchers who have spoken out for generations and continue to speak out against toxic assumptions about motherhood such as mothering being natural and innate (Friedan, 1963; Garbes, 2018; Millwood, 2019; Oakley, 1979; O'Reilly, 2004; Oster, 2014; Rich, 1976; Sacks & Birndorf, 2019). These voices have for the most part existed on the fringe of academia and popular culture.

Most maternal mental health research has been on postpartum depression; with postpartum depression in need of a more clearly defined construct (Albright, 1993; Godderis, 2013; Mauri et al., 2010). Research on maternal mental health in general has

been disjointed and inconclusive due to the diverse range of theoretical and professional

perspectives guiding scholarship on the topic. It has also focused on treating postpartum

depression, falling short of developing a rich understanding of how mothers experience

the full spectrum of their postpartum mental health.

This literature review presents a clearer understanding of the different ways in

which postpartum mental health is being conceptualized by sorting existing research

related to understanding maternal mental health postpartum using Cottone's (2012)

framework of counseling paradigms. Literature presented will focus on the ways in which

maternal mental health is understood within each theoretical framework and will not

focus on postpartum maternal mental health treatment, although treatment elements were

included as they were most relevant to the theoretical framework. Organizing postpartum

maternal mental health research is an important and necessary step to take for this

dissertation because it will help to orient the reader to a new way of thinking about

maternal mental health. This approach is expansive enough to include the full scope of

existing research on maternal mental health and is coherent enough to present a clearer

way to understand the state of maternal mental health research.

The literature review also provides additional contextual information that will

help to orient the reader to some of the major complexities that surround and affect

mother's postpartum mental health. These include a brief overview of preconception and

postpartum mental health as well as a summary of existing literature related to first-times

mothers' transition into motherhood. Much of the literature included in these contextual

sections came from disciplines outside of psychology and counseling.

Preconception Mental Health

Preconception mental health has a small and limited pool of research. The most significant risk factor for pregnancy complications is "poor" preconception mental health, as defined by women's global mental health rating of "fair" or "poor" before conception, (Witt, Wisk, Cheng, Hampton, & Hagen, 2012). Frieder, Dunlop, Culpepper, and Bernstein (2008) reviewed literature on treatment options for preconception care. Frieder et al. (2008) found that women who discontinued medication for anxiety or depression had a 50-75% risk of relapse postpartum. Managing bipolar disorder is especially sensitive during pregnancy. Those who went off their medication spent 40% of pregnancy in a mood episode (Frieder et al., 2008). Women with schizophrenia are among those most at risk during pregnancy. "Psychosis during pregnancy can lead to fetal abuse, neonaticide, and inability to recognize signs or symptoms of labor" (Frieder et al., 2008). In a longitudinal study with 244 women, that lasted 12 years, Hudson et al. (2017) found that women who were diagnosed with personality disorders before conception were three times more likely to experience anxiety while pregnant and twice as likely to become depressed.

Overview of Postpartum Mental Health

Research on postpartum mental health came from a range of theoretical and professional perspectives, each with their own focus. The concepts of postpartum depression (e.g. Dennis, Falah-Hassani, Shiri, 2017; O'Hara & McCabe, 2013; Patel, Bailey, Jabeen, Ali, Barker, & Osiezagha, 2012), postpartum anxiety (e.g. Farr, Dietz, O'Hara, Burley & Ko, 2014; Goodman, et. al., 2016; Leach, 2017), and postpartum psychosis (Doucet, 2011; Sit, 2006; VanderKruik, Barreix, Chou, Allen, Say, & Cohen, 2017) are the most well-known concepts of postpartum maternal mental health.

Postpartum depression is the most commonly referred to aspect of maternal postpartum mental health, both in research and in popular culture. Goodman, Watson and Stubbs (2016) identified a need for a broader understanding of postpartum distress so that anxiety is included. Additionally, few studies focused on resilience or mothers thriving postpartum (Athan, 2011).

Postpartum Depression

It is challenging to define postpartum depression (Mauri et al., 2010; Yim, 2015) because there is no single cause of postpartum depression (Yim, 2015). According to O'Hara and Zekoski (1988) (as cited in Mauthner, 1999) researchers have studied the etiology of postpartum depression by looking at:

biological variables (e.g., hormones, other biochemicals, genetic factors), psychological characteristics (e.g., personality traits, self-esteem, previous psychiatric history, family history, attitudes towards children, deficiencies in self-control, attribution style, social skills), a range of social variables (e.g., unplanned pregnancy, method of feeding the baby, type of delivery, obstetric complications, infant temperament, previous experience with babies, marital relationship, social support, stressful life events, employment status, and socio-demographic characteristics (e.g., social class, age, education, income, parity) (Mauthner, 1999, p. 144).

In research and clinical practice, postpartum depression is a term used to identify depression that occurs anytime from birth to 4 years after childbirth (Stewart & Vigod, 2016). Literature on postpartum depression has found that anywhere between 3% and 25% of women experience postpartum depression sometime in the first year after

delivery (Dennis & Hodnett, 2010). Postpartum depression can impact maternal suffering, the quality of marital relationship, a mother's ability to care for her child, "as well as increased risks of impaired emotional, social, and cognitive development in the child, and in rare cases, suicide or infanticide" (Stewart, 2016, p. 2177). In a 2015 study, Delaney et al. conducted focus groups with 92 new mothers and found that new mothers were more likely to consider their stress and depression to be a normal part of motherhood. It was also found that new mothers rarely disclosed overwhelming feelings with healthcare providers (Delaney, et al., 2015).

Postpartum Anxiety

Postpartum anxiety has also been found to be prevalent in mothers (George, Luz, Tychey, Thilly &, Spitz, 2013: Leach, Poyser, & Fairweather-Schmidt, 2017) but it has been missed or misdiagnosed as postpartum depression (Goodman, et al., 2016). In one quantitative study with 296 participants, 32% of mothers were found to experience moderate to severe anxiety during the first month after childbirth (Britton, 2008). Leach et al. (2017) conducted a review of prevalence and occurrence of maternal perinatal anxiety. They concluded that postpartum anxiety is common but that it is challenging to have an accurate idea whether women experience postpartum anxiety at a different rate than at other time period of life due to the variability of research tools currently being used to assess postpartum anxiety (Leach et al., 2017). Postpartum anxiety is more common than what was previously understood however there is still a need for increased research on postpartum anxiety (Goodman, et al., 2016).

Postpartum Psychosis

Postpartum Psychosis affects 1-2/1000 women who have children (Sit, Rothschild, & Wisner, 2006). The onset for this disorder appears as early as 2-3 days after giving birth (Sit, et al., 2006). A patient with postpartum psychosis "develops paranoid, grandiose, or bizarre delusions, mood swings, confused thinking, and grossly disorganized behavior that represent a dramatic change from her previous functioning" (Sit, et al., 2006, p. 354). Sit et al. (2006) found that postpartum psychosis presents as bipolar disorder after delivery. "Puerperal hormone shifts, obstetrical complications, sleep deprivation, and increased environmental stress are possible contributing factors to the onset of illness" (Sit, et al., 2006, p. 354). Lithium is commonly used to treat this but there has been minimal research on its effectiveness for postpartum psychosis (Doucet, Jones, Letourneau, Dennis, & Blackmore, 2011). In general, little is known about the effectiveness of any interventions for postpartum psychosis (Doucet, et al., 2011).

Coping with the transition to becoming a mother

Mothers cope with their postpartum mental health in a variety of ways. Taubman-Ben-Ari, Shlomo, Sivan, & Dolizki (2009) conducted a study with 102 new mothers and found that in order to maintain postpartum mental health, mothers needed internal and external resources and they needed to perceive the transition to motherhood as being nonthreatening. Internal resources included self-esteem, self-mastery, ability to regulate emotions and secure attachments while external resources were social support. Social support has been found to play a major role in helping new moms cope with becoming a mother (Emmanuel, Creedy, St. John, & Brown, 2011; Negron, Martin, Almog, Balbierz, & Howell, 2012; Reid & Taylor, 2015; Surkan, Peterson, Hughes, & Gottleib, 2006;

Webster, Nicholas, Velacott, Cridland, Fawcett, 2011; Xie, He, Koszycki, Walker, Wen, (2009)

Churchill and Davis (2010) found, in a qualitative study with 70 women, that mothers who had a realistic orientation were better able to cope through their transition to motherhood (Churchill & Davis, 2010). A realistic orientation is the ability to think through both positive and negative potential outcomes so that one is better prepared to react to and integrate negative experiences. In a longitudinal study with 1626 women, non-depressed mothers could be differentiated from depressed mothers by their ability to cope with new motherhood by using positive reframing and acceptance (Gutiérrez-Zotes, et al., 2016). In a qualitative study of five mothers with children ages 0-5, women were asked to identify varying methods they used to maintain a sense of wellness in their life during the transition to motherhood (Currie, 2009). The methods included obtaining help, establishing routines, and accessing time-out (Currie, 2009, p. 665). These efforts to integrate wellness into everyday life helped these women counterbalance the many demands of becoming a new mother (Currie, 2009). Exercise helped mother well-being and the support of close relationships played a role in mother's participation in postpartum exercise (Blum, Beaudoin, & Caton-Lemos, 2004). Any increase in dispositional mindfulness might also improve a mother's well-being by decreasing depression (Khan & Laurent, 2019).

Maternal Growth Postpartum

While some mothers are able to cope with their mental health postpartum others are able to thrive during the transition to motherhood. As a distinct construct, Taubman-Ben-Ari, et al. (2009) found that mothers experienced personal growth postpartum if they

viewed motherhood as a challenge during pregnancy and if they specifically had maternal grandmother's support. The term personal growth, "is used not simply to denote a return to baseline, but to indicate an experience of improvement that may sometimes be profound" (Taubman-Ben-Ari, et al., 2009). Similarly, Athan (2011) surveyed 467 women, both primiparas (first-time mothers) and multiparas (mothers with more than one child), and found that 20% of mothers experienced "flourishing," which is higher than the national standard for this category. Flourishing is the presence of positive emotions or satisfaction. Flourishing mothers can be a model for future research to help increase understanding around how mothers grow in positive ways during the postpartum period. Karraa (2013) found that even some mothers who went through postpartum depression reported that the experience of postpartum depression was also an experience of growth that landed them in a place of being a transformed self and transformed self in the world (Karraa, 2013).

Becoming confident as a mother is something that most mothers are capable of doing eventually (Nystedt, Hogberg, and Lundman, 2008), however it is a complicated and often emotionally-intense experience. Not every mother grows through the experience of becoming a mother, but mothers who are actively involved in being present with their baby and who make a commitment to their role as mother can be transformed (Nelson, 2003). Prinds, Hvidt, Mogensen, & Buus (2014) conducted a review that focused on existential meaning-making during the transition to motherhood and found that the beginning of motherhood, from an existential perspective, is a time that naturally lends itself to encouraging questions and reflections about the status of one's self and life. During their transition to motherhood, women are presented with an opportunity to get to

know themselves better, in a way different than what was possible before giving birth

(Prinds et al., 2014). Some women described the transition to motherhood as, "a rebirth

of self," (Prinds et al., 2014, p. 740). Some new mothers described profound changes in

their value systems and what they prioritized in their life and some women described

their childbirth experience as a spiritual experience (Prinds et al., 2014).

Marginalized Identities and Postpartum Mental Health

Systemic racism and discrimination across identities is a reality of the

motherhood experience. These systemic inequalities shape the ways in which different

mothers experience motherhood at the intersection of their identities. There is limited

research on how diverse women experience their postpartum mental health and there has

been minimal focus on how mothers' identities as mothers intersect with other existing

identities such as class, race, and sexuality. The few studies reviewed on minority

mother's postpartum mental health almost unanimously found that mothers with a

minority identity are at greater risk of experiencing postpartum depression, with several

exceptions. A number of studies reviewed focused on racial, ethnic and economic

disparities in mothers being able to access postpartum mental health care (Abrams,

Dornig, & Curran, 2009; Wei, Greaver, Marson, Herdon, & Rogers, 2008). Kozhimannil,

Trinacty, Busch, Huskam, and Adams (2011) found that there were racial and ethnic

disparities in postpartum mental health care based on data from New Jersey's Medicaid

program and that all low-income women receive less quality of care than higher-income

women. Dolbier, Rush, Shadeo, Shaffer, and Thorp (2013) did not observe racial

disparities in a study of 299 rural non-hispanic white women and African American

women, although they did observe that socioeconomic status was a predictor of

postpartum depression symptoms, which has also been found by O'Hara and Swain (1996) and Rich-Edwards, et al. (2006). Mothers who are immigrants are at a greater risk for postpartum depression than native-borne mothers (Falah-Hassani, Shiri, Vigod, & Dennis, 2015). Women with disabilities are at a greater risk of experiencing postpartum depression symptoms than women who do not have disabilities (Mitra, Iezzoni, Zhang, Long-Bellil, Smeltzer, & Barton, 2015). In a study with 655 white, African-American, and Hispanic mothers, Howell, Mora, Horowitz, and Leventhal (2005) found that African-American and Hispanic mothers were at a higher risk of reporting symptoms associated with postpartum depression than white mothers. Conversely, Wei et al. (2008) found Native American and white mothers had higher rates of postpartum depression than African American and Hispanic mothers. Mollard (2015) critiqued the narrow lens that postpartum mental health has been viewed by and makes the call for theories that are inclusive of mother's experiences on a global level.

Flanders, Gibson, Goldberg, and Ross (2016) found that there has been limited research on postpartum depression among sexuality minority women and that sexual minority women are not a homogenous group. This finding aptly reinforces the understanding that no group of mothers is a homogenous group. Flanders' et al. (2016) study included 70 sexual minority mothers and concluded that invisible sexual minority women, who are women currently partnered with men but have a sexual history that included more than one gender, reported higher postpartum depression as measured by the EPDS than women who were partnered with men and had only had sex with men in the past five years. This intergroup difference was not found in women currently partnered with women (Flanders, et al., 2016).

Although Light, Obedin-Maliver, Sevelius, and Kerns (2014) studied transgender men who experienced pregnancy after female-to-male gender transitioning, there are no existing studies on postpartum depression within the transgender community. In a quantitative study with 41 self-described transgender men, Light, et al. (2014) found that, "transgender men desire children and are willing and able to conceive, carry a pregnancy, and give birth. Participants repeatedly expressed a desire for… access to reproductive health care providers who respect, support, and understand their gender identity" (p. 1126).

Overview of Counseling Paradigms

Cottone (2012) organized existing counseling theories into four paradigms: (a) the organic-medical paradigm; (b) the psychological paradigm; (c) the systemic-relational paradigm; and (d) the social constructivism paradigm. Each paradigm has a specific professional, political and philosophical influence (Cottone, 1992). A paradigm is distinct from a theory and it is larger than one theory (Cottone, 1992). Counseling theories are comprised of a single framework used to conceptualize elements of therapy whereas a counseling paradigm is an umbrella perspective that houses multiple related yet distinct counseling theories (Cottone, 1992).

Cottone (1992) provided a summary for each paradigm. The organic-medical paradigm looks at an individual as a patient and aims to treat biological symptoms that can be observed and measured. Treatment typically focuses on how to reduce or eliminate symptoms. Professionals working within the organic-medical paradigm consider themselves to be experts who use their education, training and knowledge to diagnose and treat patients. The psychological paradigm also looks at individuals,

however, treatments target non-biological issues related to thinking, feeling or behavior.

Change occurs when a professional is able to alter the presenting non-biological issues

that have been targeted for treatment. The systemic-relational paradigm concentrates on

relationships. Within this paradigm it is understood that both problems and change occur

through relationships. Relational stability is the result of a good "fit" within the system

and its rules. Lastly, the social constructivist paradigm pays attention to consensus.

Truths are co-constructed in a community and in relationship with others. The goal of

therapy with this paradigm is consensus-building between therapist and client (Cottone,

1992).

    Cottone (1992) also introduced a concept that makes exploring the four

counseling paradigms possible. Bracketed absolute truth is the social constructivist

assumption that there is no universal truth (Cottone, 1992). There are bracketed

communities, however, which are communities that have shared beliefs, such as the

medical field or the Catholic Church. Each bracketed community holds beliefs that they

hold to be truth (Cottone, 1992). For example, within the organic-medical paradigm an

accepted truth is that knowledge is discovered using the scientific method, whereas a

social constructivist believes that knowledge is consensual and can only be made sense of

by those who are in community together. The concept of bracketed absolute truths from a

social constructivist perspective removes judgment or competition between different

bracketed absolute truths. This gives space for a variety of communities of thought to

exist without needing to prove that one "truth" is superior to another. Different

communities can hold different truths that are neither right nor wrong, they simply exist

within those communities.

Counseling Paradigms and Conceptualizing Postpartum Maternal Mental Health

Cottone's (2012) conceptualization of counseling paradigms was originally presented as a tool for understanding counseling theories. For this study, Cottone's (2012) conceptualization will be used as a way to organize interdisciplinary knowledge from maternal mental health research by grouping like-minded thinkers together. Although the research being reviewed here is not focused on counseling theories, the same theoretical and professional distinctions can be seen across postpartum maternal mental health research. Cottone's paradigm framework is an important and useful intellectual framework that can help to organize the vast array of perspectives on how postpartum maternal mental health could be understood.

By organizing research being done from a range of valid, yet theoretically distinct perspectives and academic vantage points, this chapter helps to demonstrate the competing truths within maternal mental health research that are currently creating an opaque understanding of what maternal mental health is. This section attempts to demonstrate ways in which different theoretical orientations interact with one another. Critiques made between theoretical orientations can help to strengthen a general understanding of how postpartum mental health works. Feminist researchers have played a major role in challenging ways that postpartum mental health is being conceptualized mostly by challenging patriarchal "truths" about motherhood. Other authors have attempted to present a comparative analysis of theoretical perspectives of postpartum depression (Abdollahi, Lye, & Zarghami, 2016; Beck, 2002; Lloyd & Hawe, 2003; Mauthner, 2010; Mollard, 2015; Yim, et al., 2015) but none so far have utilized Cottone's (2012) counseling paradigms theory.

Organic-Medical Paradigm

The organic-medical paradigm considers the biological factors that influence maternal mental health and is a commonly used paradigm for postpartum mental health research. This perspective understands postpartum depression as a "disease" or "illness" (Mauthner, 1999). Within this paradigm, postpartum mental health has been studied by looking at the role of hormones (Glynn & Sandman, 2014; Rich-Edwards, Mohllajee, Kleinman, Hacker, Majzoub, Wright & Gillman, 2008; Schiller, Meltzer-Brody, & Rubinow, 2015; Soares & Zitek, 2008); genetics (Corwin, Kohen, & Jarrett, 2010; Corwin, Kohen, Jarrett, & Stafford, 2010; El-Ibiary, Hamilton, Abel, Erdman, Robertson, & Finley, 2013; Figueiredo, Parada, Araujo, Silva, & Del-Ben, 2015; Mitchell, et al., 2010) and poor sleep quality (Goyal, Gay, & Lee, 2009; Lawson, Murphy, Sloan, Uleryk, & Dalfen, 2015; Okun, Luther, Prather, Perel, Wisniewski, & Wisner, 2011; Park, Meltzer-Brody, & Stickgold, 2013; Sloan, 2011).

The medical profession has accepted postpartum depression as a unique construct as demonstrated by the American College of Obstetricians and Gynecologists's (ACOG) call for doctors to be proactive in screening for and diagnosing postpartum depression. The recommendation by ACOG was for doctors to screen for postpartum depression "using a standardized, validated tool" (ACOG, 2018). The most commonly used tool to screen postpartum depression is the Edinburgh Postnatal Depression Scale (EPDS) (Cox, Holden, & Sagovsky, 1987).

Medical doctors use the International Classification of Diseases (ICD-10) (World Health Organization, 1992), to make diagnoses. The ICD-10 does include a postpartum depression diagnosis, but it does not include diagnostic criteria. Based on the

recommendations made above by the ACOG (2018) it appears that the EPDS or another

scale is the primary tool used to diagnosis postpartum depression. In addition to the

diagnosis of postpartum depression, the ICD-10 (World Health Organization, 1992)

includes a postpartum mood disturbance diagnosis.

      The Centers for Disease Control and Prevention (CDC) and the National Institute

of Mental Health (NIMH) identify symptoms for postpartum depression. The CDC

website lists, "crying more often than usual; feelings of anger; withdrawing from loved

ones; feeling numb or disconnected from your baby; worrying that you will hurt your

baby; and feeling guilty about not being a good mom or doubting your ability to care for

your baby" (CDC, 2019). The NIMH websites lists the following symptoms of

postpartum depression: "feeling sad, hopeless, empty or overwhelmed; worrying; feeling

moody, irritable or restless; oversleeping, or being unable to sleep even when her baby is

asleep; having trouble making decisions; experiencing anger or rage; losing interest in

activities that are usually enjoyable" (NIMH, n.d.) Although the CDC and NIMH both

list symptoms for postpartum depression it is not clear where, how, or by whom the listed

symptoms were determined.

      Challenges to the organic-medical view. There is an abundance of research on

postpartum depression from an organic-medical perspective despite the cultural

influences that impact the manifestation of postpartum depression (Ramadas & Kumar,

2016). Ramadas and Kumar (2016) advocated for providers to demonstrate greater

awareness of their patient's cultural backgrounds while treating mothers for postpartum

depression. Their review of literature found that some cultural influences had a positive

affect on postpartum depression while others had adverse affects so it is important for

individual providers to know more about the patient's specific culture and how their culture might influence their experience of postpartum depression (Ramadas & Kumar, 2016).

A pure understanding of the organic-medical model would exclude any psychological concepts, however, in practice the medical field has embraced postpartum depression as something more than just a biological illness. The ACOG (2018) recommended that doctors treat postpartum depression medically and/or refer patients to behavior health resources. Treatment of postpartum depression is where the overlap between the organic-medical view and psychological view is most evident. It is important to note however, that in a systemic review, Goodman and Tyler-Viola (2010) found that a low proportion of postpartum women who screened positive for depression or anxious symptoms found treatment or referrals through their obstetrical providers. Although there is awareness within the medical field that postpartum depression is not a purely biological illness there might be a gap in doctor's abilities to help connect patients with psychological care.

It is challenging to define postpartum depression (Mauri et al., 2010) and to treat it purely from an organic-medical model perspective. A major reason for these challenges is that there is not a sound standard methodological approach used to detect postpartum depression. Self-reports are less reliable than interviews in detecting postpartum depression (Mauri et al., 2010). Although the Edinburgh Postnatal Depression Scale (EPDS) is the most commonly used screening tool for postpartum depression (ACOG, 2018), EPDS can detect but not distinguish anxiety from depression (Mauri et al., 2010; Rowe, Fisher, Loh, 2008) and the EPDS, which is the most trusted measure, has a 50%

chance of detecting a false positive (Eberhard-Gran, Garthus-Niegel, Garthus-Niegel, & Eskild, 2001; Mauri et al., 2010). Additionally, Sharma and Sommerdyk (2013) found that the effectiveness of antidepressants to treat postpartum depression is inconclusive due to a lack of rigorous empirical evidence. Frequently, when asked, pregnant women who met the DSM diagnostic criteria for depression attributed many of the symptoms to pregnancy and did not report a depressed mood (Matthey & Ross-Hamid, 2011).

Psychological Paradigm

Formally, there are few distinctions made between postpartum maternal mental health and mental health in general within this paradigm. Postpartum depression and postpartum anxiety are diagnoses that have never been included in the *Diagnostic and Statistical Manual for Mental Disorders* (*DSM)* (American Psychiatric Association, 2013), which is the standard diagnostic tool used by mental health professionals. There are three diagnoses in the *DSM-5 (*American Psychiatric Association, 2013) that include the specifier, "With Peripartum Onset:" Major Depressive Disorder, Persistent Depressive Disorder (Dysthymia), and Brief Psychotic Disorder. This specifier can be applied to women who meet the diagnostic criteria of these diagnoses sometime during the timeframe of pregnancy through 4 weeks after delivery (American Psychiatric Association, 2013). Beyond the "With Peripartum Onset" specifier, there is no additional focus on pre or postnatal mental health in the *DSM-5*. Currently, generalized anxiety disorder (GAD) does not include "With Peripartum Onset" as a specifier in the *DSM-5*, which means that mothers need to experience GAD symptoms for six months before they can receive a formal diagnosis (Misri, Abizadeh, Sanders, & Swift, 2015). Additionally,

there are no other diagnoses in the *DSM-5,* which include the option to specify, "With

Peripartum Onset," and there are no specifiers that can be used with fathers.

A major reason that "postpartum depression" was not included in the *DSM-IV* was

due to a lack of scholarship that could support postpartum depression being a distinct

diagnosis from Major Depression Disorder (Godderis, 2013). This doesn't necessarily

mean that the *DSM* committee researching postpartum depression as it existed in the

literature concluded that postpartum depression is not a distinct diagnosis from Major

Depression Disorder (Godderis, 2013). The committee simply did not find enough

compelling evidence to support making postpartum depression a unique diagnosis

(Godderris, 2013).

Although the *DSM* has never included a diagnosis for postpartum depression, the

American Psychological Association (APA) provides an overview of postpartum

depression on their website. The APA lists similar symptoms that are also outlined by the

CDC and NHI and also does not provide information about where or how they

determined these symptoms:

A loss of pleasure or interest in things you used to enjoy, including sex; eating too

much, or less, than you usually do, anxiety-all or most of the time- or panic

attacks; racing, scary thoughts; feeling guilty or worthless-blaming yourself;

excessive irritability, anger or agitation- mood swings; sadness, crying

uncontrollably for long periods of time; fear of not being a good mother; fear of

being left alone with the baby; misery; inability to sleep, sleeping too much,

difficulty falling or staying asleep; disinterest in the baby, family, and friends;

difficulty concentrating, remembering details, or making decisions; thoughts of

hurting yourself or the baby. (APA, n.d.).

The APA website also recommends that mothers seek treatment if they experience

symptoms for more than 2 weeks.

The discrepancy between postpartum depression not being a formal diagnosis in

the *DSM-V* yet the use of the term by the APA demonstrates the confusion and

disconnect surrounding professional consensus and understanding of postpartum

depression. In practice, maternal postpartum mental health is often conceptualized as a

unique experience as evident by the persistent use of language like postpartum depression

and postpartum anxiety. However, in a review of research on postpartum depression,

O'Hara et al. (2013) concluded that existing research on postpartum depression suggests

that the structure of postpartum depression is similar to depression that women

experience at other times of their lives, although a small percentage of women might only

experience depression as a result of the hormonal changes associated with childbirth.

This was a similar finding that was the basis for the decision to exclude a postpartum

depression diagnosis from the *DSM*.

Challenges to the psychological view. Social science and feminist researchers

have challenged the psychological and organic-medical models by critiquing their

insistence on pathologizing individual women instead of considering the institutional and

relational systems that mothers are a part of (Mauthner, 1999). From a feminist

perspective, postpartum depression is considered a social construct and not an empirical

label. When considering the medicalization of childbirth, childcare that is difficult to

access, the stress of inadequate parent leave, the societal loss of status, increased

gendered division of work in the home (Mauthner, 1999) and potentially negotiating how to maintain a pumping schedule at work, it is not surprising that mother's present as being depressed. In fact, depression then appears to be quite normal when considering the systemic issues surrounding mothers.

If mothers are not able to access clinical diagnoses for their mental health needs then they are likely to suffer (Godderris, 2013). Some women might not be able to access postpartum mental health care if they are unable to get a diagnosis for their mental health condition, which at this time is limited to diagnoses other than postpartum depression. By excluding postpartum depression from the *DSM*, women are being mistreated and denied access to mental health services that many mothers need (Godderris, 2013).

Based on the literature review for this study, there is still a lack of conceptual psychological understanding about how mothers experience their mental health postpartum. This review yielded no recent studies or papers that have investigated or offered a conceptualization of the psychology of postpartum depression, although there have been several attempts to conceptualize postpartum mental health within the systemic-relational and social constructivism paradigms, which will be reviewed later in this paper. The only relevant study found from a psychological paradigm was a cognitive-behavior model of PPD published in 1982 by O'Hara et al. In a review of postpartum depression research, O'Hara et al. (2013) recognized that there has been little recent work done on producing new models of postpartum depression and recommended that further research in this area should be done.

Systemic-Relational Paradigm

Maternal mental health within this paradigm considers the systems and relationships that surround new mothers. In the systemic-relational paradigm, the mother does not exist in isolation because relationships and systems are the subject of interest. Therefore, maternal mental health is situated within the relational contexts that surround the mother. Existing research on the relationships/systems and maternal mental health have mostly focused on the mother's relationship with their baby and social support with particular attention to partner support.

Attachment and maternal mental health. Attachment theory, developed by John Bowlby and Mary Ainsworth, has shaped the culture of motherhood in several important ways. One of Bowlby's most influential conclusions was that, "the infant and young child should experience a warm, intimate, and continuous relationship with his mother (or permanent mother substitute) in which both find satisfaction and enjoyment" (Bowlby, 1951, p. 13). In a study that reviewed the origins of attachment theory, Bretherton (1992) stressed that, "later summaries [of Bowlby's work] often overlook the reference to the substitute mother and to the parents' mutual enjoyment. They also neglect Bowlby's emphasis on the role of social networks and on economic as well as health factors in the development of well-functioning mother-child relationships" (p. 761).

One of Ainsworth's most profound contributions to attachment theory was the concept of maternal sensitivity (Pederson, Bailey, Tarabulsy, Bento, & Moran, 2014). Although Ainsworth acknowledged the, "interacting spiral" where both mother and infant play a role in the mother-infant relationship, Bretherton (2013) acknowledged that the dyadic nature of the mother-infant relationship has often been unrecognized which has

left a misunderstanding that mother's are solely responsible for forming attachment within the mother-infant relationship, although some more recent researchers have embraced the dyadic and dynamic nature of the mother-infant relationship (Beebe & Steele, 2010; Pederson, Bailey, Tarabulsy, Bento, & Moran, 2014). Bretherton (2013) also pointed out that Ainsworth's concept of maternal sensitivity was applied to infants' positive social behaviors classified as, "secure base and safe haven behaviors." (p. 464) suggesting that Ainsworth's original intention was not to use maternal sensitivity as a way to judge mothers, but to instead observe the ways in which maternal behaviors drew out positive social behaviors in their child. Admittingly though, maternal sensitivity has not always been referenced this way in literature citing Ainsworth (Bretheron, 2013). Pederson's (2014) study found a strong association between maternal sensitivity and mother-infant attachment security. "Within a relationship perspective, mothers don't reward infant secure based and safe haven behavior by being sensitive. Rather… sensitivity is a description of the mother's role in fostering a relationship in which her infant experiences her as a secure base from which to explore and a safe haven for comfort and assurance" (Pederson, et al., 2014).

Attachment theory has been used as an influential way to conceptualize the importance of maternal postpartum mental health. A popular belief in the literature reviewed was that a primary purpose of supporting postpartum mental health is to increase the capability of mothers to build healthy attachments with their child or children (Ainsworth, 1979; Lyons-Ruth, Zoll, Connell, & Grunebaum, 1986; Atkinson, Paglia, Coolbear, Niccols, Parker, & Guger, 2000; Coyl, Roggman, & Newland, 2002; Martins & Gaffan, 2000; Wan & Green, 2009; Teti, Gelfand, Messinger & Isabella,

1995). From an attachment theory perspective, mothers who suffer from postpartum

mental illness are less likely to form a secure attachment with their infant (Martins &

Gaffan, 2000). Attachment is important and has been of great interest to child-

development researchers because attachment-style shapes the child's development over

the course of the child's life (Sroufe, 2005; Thompson, 2008). Kruse, Williams, and Seng

(2014) tested a relational model for postpartum depression and found that impaired

bonding might be the cause of postpartum depression and not just a symptom of

postpartum depression. This finding offers a new and novel way to think about

postpartum mental health and the ways that mothers bond or struggle to bond with their

children.

Research has shown that children's social, emotional, and cognitive development

can be impaired if they do not have a secure attachment with their primary caregiver,

often assumed to be their mother (Ainsworth, 1979; Bowlby 1982). In a review of

literature on attachment, Benoit (2004) concluded that the quality of the infant-parent

attachment can be a predictor for the child's social and emotional outcomes later in life.

Moutsiana, Fearon, Murray, Cooper, Goodyer, Johnstone, and Halligan (2014) conducted

a 22-year longitudinal study with 54 participants and found that disturbances in the

mother-infant relationship might alter the infant's neurodevelopment as it relates to their

ability to regulate emotion with the potential for lasting impacts through adulthood.

It was also found that a mother's own attachment-style can affect her postpartum

mental health, however, few studies have researched postpartum depression and mother's

attachment (Wilkinson & Mulcahy, 2010). In a study of 115 mother with an infant 12

months or younger, Wilkinson and Mulcahy (2010) found that mothers who were

diagnosed with postpartum depression were more likely to, "display insecure adult attachment styles, describe poorer marital functioning and inadequate social supports and less attachment to their infant" (p. 260). The transition to motherhood is shaped by past attachments, which are associated with current attachment to the mother's current partner (Behringer, Reiner, and Spangler, 2011, p. 214). In a study with 77 couples in Germany, Behringer, Reiner, and Spangler (2011) found that mothers who have a secure attachment with their partner have more space and security to regulate the challenging emotions that come along with becoming a mother.

Stern was a psychoanalyst who specialized in infant development and coined the concept, motherhood constellation, which was a similar but also an alternative conceptualization of mother-infant bonds and postpartum mental health. Stern (1998) saw motherhood as something distinct from a life phase and suggested, "that with the birth of a baby, especially the first, the mother passes into a new and unique psychic organization, (p. 172)" called the motherhood constellation. The motherhood constellation is made up of a trilogy of preoccupations, each distinct but also are inter-related: "the mother's discourse with her own mother, especially with her own mother-as-mother-to-her-as-a-child; her discourse with herself, especially with herself-as-mother; and her discourse with her baby" (p.172). Barlow and Cairns (1997) called this transition *encountering the ghosts of motherhood,* which involves anticipating one's new role as mother and looking at the experiences of their own childhood and the way one was mothered.

Social support and maternal mental health. Social support during the postpartum time was the most consistent finding for supporting maternal postpartum mental health. In a longitudinal, quantitative study in Ireland with 367 mothers, Leahy-

Warren, McCarthy, and Corcoran (2011) found that structural support and emotional support were the best predictors of postnatal depression at 12 weeks for first-time mothers. Structural support was defined as the mother's network of relationships and emotional support was defined as, "emotive sharing of experiences" (Leahy-Warren, et al, 2011). Darvill, Skirton and Farrand (2010) conducted a grounded theory study with 13 women who gave birth to their first child and found that being connected with other pregnant women and new mothers was an important source of social support for first-time moms (Darvill, Skirton, & Farrand, 2010). Based on a qualitative study with nine mothers, Alstveit, Severinsson, and Karlsen (2010) found that the most important social relationships that new mothers found during maternity leave were with other new mothers. Chavis (2016) analyzed surveys from 86 first-time mothers and concluded that helping mothers increase their social support and feel more competent in their role as mother can help to decrease anxiety.

In a grounded theory with eight first-time mothers, Wilkins (2006) found that when mother's came together in support groups, the transition to motherhood was normalized when they were given "permission" by one another to not know what they are doing as a mother, to make mistakes, and to ask for help. This helped mothers through their transition to eventually reach a level of expertise. Not knowing and wanting to ask for help was found to be a natural part of the process of becoming a mother.

While social support has been found to assist mother's positively through their adjustment to motherhood, not having social support has been found to contribute to challenges postpartum. Mothers who lacked social support experienced childbirth as requiring more of a transition than women who felt like they were surrounded with social

support (Aber, 2013, p. 348). In a study of socioeconomically disadvantaged postpartum women, Landy, Sword, & Valaitis (2009) found that a lack of social support contributed to daily challenges. Mauthner (1999) used a relational perspective to conceptualize postpartum depression in a qualitative study with 40 mothers and found that despite being a diverse sample of mothers with a variety of postpartum experiences they shared a similarity that, "they silently struggled to fulfill their ideals while at the same time concealing their needs and feelings from other people" (p. 155). The silence was socially supported by those in their private and public lives who struggled to give space to the women's experiences of challenges of motherhood, because it conflicted with the cultural assumption that motherhood should be joyous and void of negative emotions. The result was that mothers struggled to find spaces where their "emotional and practical needs," could be met (Mauthner, 1999, p. 155). In Mauthner (1999), women welcomed the label "postpartum depression" because they felt it validated their experiences and confirmed that they were not just "crazy." Mauthner (1999) found that women were "engaged in an *active* struggle with themselves, and the people and social world around them" (p. 156). The mothers who Mauthner (1999) interviewed found that the difference between low mood and depression stemmed from mother's ability to access supportive relationships where they felt comfortable disclosing their feelings. Mothers who "withdrew into silence" (p. 158) experienced feelings of depression beyond the typical "sadness" that seems to accompany postpartum (Mauthner, 1999). Mauthner (1999) concluded that postpartum depression might be avoided by providing supportive and accepting spaces for mothers to talk about the full range of their emotions early on in the postpartum period.

A mother's relationship with her partner also plays a major role in her postpartum mental health. The literature reviewed only investigated heterosexual relationships. In a study with 102 first-time mothers, Taubman-Ben-Ari, Shlomo, Sivan, and Dolizki (2009) found that the better the marital relationship, the greater the level of personal growth that mother's reported during their transition to motherhood. Dennis and Ross (2006) conducted a quantitative study with 396 mothers and found that women who had depressive symptoms reported having significantly lower perceptions of their partner wanting them to get help or seek assistance to be able to cope with their difficulties. Gottman and Gottman (2007) found that 67% percent of the 222 couples they studied who had babies were very unhappy with their partner during the three years after having a baby, suggesting that maintaining a quality partnership after the birth of a baby is challenging for most couples. A quantitative study with 1578 women, using the Edinburgh Postnatal Depression Scale (EPDS) found that partnered mothers who were in an unsupportive or under-supportive relationship were at an increased risk of elevated EPDS scores when compared to single/unpartnered-mothers (Bilszta, Tang, Meye, Milgrom, Ericksen, & Buist, 2008). Collectively, the data on partner's influence on postpartum mental health suggests that being in a positive relationship is beneficial to a mother's mental health while being in an unsupportive relationship has a worse affect on maternal mental health than having no partner support at all.

Challenges to the systemic-relational view. Attachment research has been helpful in bringing greater understanding to the many ways in which humans are shaped and influenced by our ability to emotionally connect with others but attachment research has also been harmful to mothers. Sociologists and feminist scholars have spoken out

against attachment theory specifically concerned that it is a way to police families. "Sociologists and feminist scholars have described attachment research as a pretext deployed by clinicians and social care professionals for constructing mothers as solely responsible for infants and then for policing this caregiving" (Duschinsky, Greco, & Solomon, 2015). Additionally, a primary focus on attachment theory undermines important alternative ways that mothers care for their children, such as ensuring their safety in situations of domestic violence. Attachment theory fails to recognize or consider the difficult decisions that vulnerable mothers need to make while caring for their children (Buchanan, Power, & Verity, 2014). It was challenging to find any attachment literature that focused on the affect of the mother-infant bond on the mother herself, which appears to be a credible research interest since Bowlby and Ainsworth conceptualized the mother-infant relationship as being dyadic.

Caplan and Hall-McCorquodale (1985) investigated 125 articles published in clinical journals that discussed the etiology of psychopathology and found that mother-blaming was a common practice. "Mental health professionals have legitimized the tendency of both lay-people and professionals to blame mothers for whatever goes wrong with their offspring" (Caplan & McCorquodale, 1985). This concept of mother-blaming helps to name one of the harmful ways in which mother's have been of interest within academia and illuminates some of the tremendous growth that needs to be done around scholarship on motherhood. It also speaks to the mostly unspoken assumption that mothers are singularly expected to provide for and meet all of their children's psychological needs, which is a heavy burden for mothers. Although the effects of mother-blaming on mother's own postpartum mental health have not been studied, it is a

valuable piece of data to consider when thinking about how mother's experience their mental health.

Based on the expansive and definitive research on attachment it is undeniable that individuals who can form secure attachments have better well being outcomes than individuals who struggle to develop and maintain meaningful relationships. The ways in which attachment theory singles out mothers or mother substitutes however contributes to the patriarchal problem that has held mothers to an impossible standard and isolated them from larger systems. The literature reviewed here in this section reflects the undisputed value of being able to form secure attachments both as a child and as a adult, and there is a culturally significant gap in information about the potential for alternative figures to form secure attachments with children so that this burden does not rest with mothers alone.

Social Constructivism Paradigm

Social constructivists have attempted to tease apart the ways that socially constructed concepts have negatively influenced maternal mental health. The expectations of intensive mothering (Hays, 1996) and the idea of the "good mother" are both strong cultural forces that can cause many mothers to feel inferior, incompetent, and like they are failing, while concepts like "good enough mothering" (Pedersen, 2016; Silva, 1996; Winnicott, 1953) offer an alternative narrative that is supportive of mothers. Different cultures think about the postpartum period differently (Mauthner, 2010), which further supports the social constructivist assumption that the postpartum period is culturally bound and reinforces the idea that there are certainly cultural elements that affect postpartum mental health.

Feminist theory straddles the systemic-relational and social constructivism paradigms. Within the social constructivism paradigm, feminist theorists have challenged the ways that patriarchy has utilized motherhood as a way to oppress women and offer a competing truth as an alternative way to understand the postpartum experience. Rich (1986) explained that motherhood is both an identity and an institution. As an identity motherhood has the potential to be a liberating experience in which mothers are empowered to use their identity as mothers to challenge social norms and claim greater power and space to be fully human. As an institution, motherhood is a patriarchal system that is inherently oppressive because it sets women up to fail by idealizing unattainable visions for who the ideal mother is. Rich named patriarchal motherhood and she explained that motherhood is not a fixed condition. The concept of motherhood as a patriarchal institution has a history and ideology that, "has ghettoized and degraded female potentialities" (Rich, 1986, p. 13). As an alternative to patriarchal motherhood, motherhood studies founder, Andrea O'Reilly focused her research on the concept of empowered mothering: "Empowered mothering- in affirming maternal agency, authority, autonomy, and authenticity- makes motherhood more rewarding, fulfilling and satisfying for women. Such mothering allows women selfhood outside of mothering and affords them power within motherhood… Mothers, once empowered, are able to care for and protect their children" (O'Reilly, 2004, p. 26). Empowered mothers are in a better position to raise children who are empowered themselves (O'Reilly, 2004). Mollard (2015) investigated paradigmatic philosophies as they relate to researching postpartum depression and concluded that feminist pragmatism should be a preferred paradigm. "Feminist pragmatism can take the biological and physical characteristics that are

commonly emphasized with postpositivism and combine these with social issues such as power, oppression, and culture that are more common in critical theory and constructivism" (Mollard, 2015, p. 389).

Based on an analysis of 50 years of popular press coverage of the postpartum experience, Held (2012) studied the ways that images and media shaped society's opinions on motherhood. Held (2012) wrote, "this material reveals an intense ambivalence in mid-to-late 20th-century American culture toward situating motherhood as a cause of emotional distress and a persistent prescription to distressed mothers to fix themselves so that they can be good mothers" (p. 108). The focus in the reviewed popular media was consistently on changing individual women instead of considering how the institution of motherhood might be a cause for emotional distress. It wasn't until 1952 that a magazine article focused on "baby blues" (Held, 2012, p. 108) and popular media since that time has failed to acknowledge that motherhood can be filled with paradoxes, seemingly contradictory emotions felt at the same time like love and resentment and joy and loss. (Held, 2012). A general theme has been that mothers should not experience negative emotions after childbirth and if they do, then it is a character flaw of the individual mother instead of considering how it might illuminate systemic failures. Held (2012) attributed the pathologizing of individual mothers in the second half of the twentieth century to, "the role of child-rearing experts, the medicalization of childbirth, and the influence of psychoanalytic ideas on the importance of the mother–infant relationship" (Held, 2012, p. 109).

Mauthner (2010) studied postpartum depression by speaking to women themselves. Her research was based in feminism and postfoundationalism. She

interviewed 40 women in the UK and 17 women from the US. Some of the women she spoke with self-diagnosed as having postpartum depression while others were formally diagnosed by a healthcare provider. The women that Mauthner spoke to described trying to be the perfect mother and equated falling short of their idealized vision as being "bad" mothers. Mauthner (2010) found that, "while the mothers were trying to conform to cultural standards and expectations of motherhood, they were simultaneously questioning and resisting the very norms they were struggling to fulfill" (p. 471). These mothers also described feeling like they had lost their voice to others- healthcare providers, family, friends- who had opinions about their mothering. Mothers experiencing postpartum depression reported that relationships with other young mothers were important to them. Relationships with their partners were challenging because some women felt like their partners reinforced their sense of failure when they did not get emotional or practical support. Other mother's reported struggling in their relationship because their partner was supportive and positive, which made them less inclined to disclose feeling weak or like they were failing. Women from this study were able to recover once they could accept what they perceived as "imperfections" about their self and embraced their strengths and positive qualities (Mauthern, 2010).

Challenges to the social constructivism view. A direct critique of O'Reilly's concept of "empowered mothers" (O'Reilly, 2004, p. 15) was that the perspective of feminist mothering seems to describe, "educated, middle to upper-middle class women with access to financial and human resources to assist in raising their children" (Middleton, 2006, p. 73-74). Middleton (2006) described how women who are "mothering under duress" (p. 74) are subjected to judgment and monitoring by social

support systems, which makes feminist mothering as described by O'Reilly challenging.

Additionally:

> Mothers who do not have access to resources such as substantial finances and
> good childcare, or women who are mothering under other difficult circumstances,
> such as an abusive relationship, illness or addiction problems, are likely to find it
> difficult to achieve agency, authority, autonomy and authenticity as described by
> these feminist mothering theorists (Middleton, 2006, p. 74).

Middleton (2006) advocated for feminist mothering scholars to consider a more inclusive population when theorizing about mothers, which should include mothers who experience economic and social hardships.

There is an astounding absence of feminist research on motherhood (Takševa, 2018). Gender and women's studies have distanced the field from mothering and has mostly conceptualized motherhood negatively, contributing to an academic struggle to established research on mothers as credible and worthwhile (Takševa, 2018). Motherhood studies, a field distinct from gender and women's studies, has played a significant role in legitimizing scholarship on mothers and in making motherhood more complex than something that should simply be accepted or rejected. As a result of gender and women's studies neglect of mothers as academic subjects, the experiences of mothers have mostly been silenced and marginalized within a field that would greatly benefit from including motherhood when considering the ways that women can gain empowerment and equality. Takševa (2018) advocated for maternal theory to be embraced by feminist researchers.

The Transition to Becoming a New Mother

The transition to motherhood is a complicated and dynamic process. It has been challenging for researchers to create a unifying theory to understand the complete process of what becoming a mother is like. Instead, many scholars have offered insight into specific aspects of the transition to becoming a mother. This section is an attempt to provide the reader with a way to contextualize different elements of postpartum experiences by focusing on scholarship related to the transition to motherhood for first-time mothers.

"Matrescence" is a term first coined by medical anthropologist Dr. Dana Raphael, who named the developmental time when women transition to motherhood and is a term that has just recently entered popular culture. Similar to adolescence, this time of transition is filled with rapid changes, "in a woman's physical state, in her status within the group, in her emotional life, in her focus of daily activities, in her own identity, and in her relationships with those around her" (Raphael, 1975, p. 66). Culturally, the United States is much more familiar with and well-versed with the experiences of adolescence, yet there is a mostly unrecognized developmental time for mothers that is almost entirely overlooked by society (Sacks, 2018).

It takes great resilience and strength to transition to a new identity while also being in the midst of the major life change that having a child sets into motion. With the birth of a child is a birth of a mother (Stern, 1998). Mothers start to build their identity in pregnancy by imagining, "the perfect baby"; experiencing an "altered mode of being"; and striving for family communion (Bondas & Eriksson, 2001). In a qualitative study, Bailey (1999) found that pregnancy became a time when women were introspective and reflective about their identity. Bailey posited that women do not completely reinvent

themselves during pregnancy but they became more aware of different aspects of themselves and how they relate to the world in a "process of refraction" (Bailey, 1999). In a similar fashion to the way that a prism refracts light into distinct, bold, rays of light, women used pregnancy as a time to refract and illuminate aspects of themselves. "...The transition to motherhood offered many a new sense of cohesion and direction" (Bailey, 1999, p. 351).

Becoming a mother can affect women's identities. Many women felt a sense of, "self-loss when they become mothers" (Laney, Hall, Anderson, & Willingham, 2015, p 132.) but once they got beyond their children's infancy stage, they began to return to a core self that was a part of their identity before motherhood (Laney et al., 2015). Rubin (1967) found that there was an end to the transition of becoming a mother, which she named "maternal role attainment." Rubin was a maternity nurse theorist, teacher, and clinician who developed the concept of maternal role attainment and was one of the first to specialize in maternity nursing (Mercer, 1995). Maternal role attainment was believed to typically occur eight to nine months after childbirth, "when she feels like herself again" (Rubin, p. 127, 1967). Mercer (2004) adapted Rubin's (1967) understanding of maternal role attainment to be a transition that occurs throughout the lifespan of a mother, as new challenges emerge.

The start of motherhood is filled with a constant demand to recalibrate and integrate new learning. In a grounded study with 55 first-time mothers during their first seven-months postpartum, Rogan, et al. (1997) found that mothers move from feeling like, "this isn't my life anymore" (Rogan, et al., 1997, p. 881) to "being in a certain tune" (Rogan et al., p. 881, 1997). In order to go through this process of becoming a mother,

which Rogan et al. (1997) presented as a new theory of early motherhood, mothers reported having to constantly learn new information. This left them feeling overwhelmed, exhausted and unsure of their identity (Rogan et al., 1997). By "working it out" (Rogan et al., p. 882, 1997) mothers integrated new information with their sense of self to arrive at a more secure identity as a mother. In a year-long, mixed-method study with 17 white women in the United Kingdom, Linton (2018) concluded that there is a "push and pull of motherhood" (Linton, p. 76, 2018) that included a tremendous sense of responsibility, felt external pressure, and joy (Linton, 2018). The push and pull can be best described as a mother feeling torn between her sense of identity as "self" and that of "mother" (Linton, 2018). Miller (2007) also noted the tremendous responsibility that women felt as they became mothers and that they felt like they had not acquired "innate mothering knowledge" (Miller, 2007, p. 349-350).

Nelson (2003) conducted a meta-synthesis that included nine articles that focused on maternal transition in North America and Australia. From the meta-synthesis, Nelson (2003) found that "engagement" was the primary process that shaped a mother's transition into motherhood. Engagement involves "actively striving to adapt to the mothering role" (Barlow & Cairns, 1997, p. 238). Initially, women try to enact what "experts" direct them to do, however over-time, they learn through trial and error their own way to mother (Nelson, 2003).

Brunton, Wiggins, and Oakley (2011) produced an extremely thorough systematic review of research on women's views on the experience of first time motherhood. They focused their review on 60 studies that were UK-specific and found that the three most popular topics were identity, mental health, and maternity care (Bruton, et al., 2011).

They found that searching for literature on, "first-time motherhood was challenging, due to poor descriptions by authors in title or abstracts, and poor indexing in social and medical electronic databases" and that there were gaps in the literature and a need to focus on older first time mothers, first versus second time mothers and diverse groups of women (Brunton, 2011, p. 34).

There has been minimal research that unpacks the experiences of women from diverse economic and racial backgrounds, and different sexual orientations (Nelcon, 2003) as they become a mother. Most of the studies on the transition to becoming a mother focused on white women of economic means or omitted detailed demographic information. Research on motherhood more broadly has focused greater attention on race, class and sexuality (Collins, 1994; Gibson, 2014; hooks, 2001; Roberts, 1993) while research specifically on the transition to becoming a mother is lacking a focus on diverse experiences. There is a need for scholarship on the transition to motherhood to focus on sociopolitical and cultural factors (Rogen et al., 1997) and to recruit more diverse research participants (Nelson, 2003). Existing literature on the experiences of marginalized mothers as they transition to motherhood was limited and included the experiences of single, unpartnered, medicaid-eligible, first-time mothers (Keating-Lefler & Wilson, 2004) and nonbiological lesbian mothers (Wojnar & Katzenmeyer, 2013). Keating-Lefler and Wilson (2004) interviewed 20 single, unpartnered first-time mothers who were Medicaid-eligible and found that these women "grieved multiple losses" in their transition to motherhood which affected their mental, physical and environmental health. The women who participated in this study reported lack of support and financial resources, which left them feeling isolated. Wojnar and Katzenmeyer (2013) conducted a

qualitative study with 24 nonbiological lesbian mothers. The study found that the non-biological lesbian mothers included in the study had a difficult transition into their mothering role and were thought of as "the other mother" during childbirth and the recovery time afterwards in the hospital. The transition to motherhood for nonbiological lesbian mothers was isolating throughout the birth experience of their child (Wojnar & Katzenmeyer, 2013). The healthcare setting, although not overtly unaccepting, made consistent microaggressions that undervalued the nonbiological mother's role as mother.

Challenges to the Transition to Motherhood

Nelson (2003) found that women are prepared for childbirth but not for the reality of what it means to be a new mom to an infant and the new mother's needs are mostly unmet after the birth of their child. New mothers felt "unprepared and overwhelmed" (Choi, Henshaw, Baker and Tree, 2005, p. 176) and were underexposed to diverse motherhood narratives. As a result, women felt lost and an inability to resist myths of motherhood that assume women should be able to cope easily with having a new baby, caring for others, and caring for a home (Choi et al., 2005, p. 177). In a quantitative study with 77 couples from Germany, Behringer, et al., (2011) found that mothers who were in relationships for less than five years before becoming a mother experienced greater anger during their transition to motherhood than mothers who were in more long-term relationships perhaps because couples who have been together longer have had more time to fully establish an attachment before becoming parents.

Carolan (2006) conducted a qualitative study with 22 women and found that mothers who were over the age of 35, and therefore considered to have high-risk pregnancies due to their age, were more emotionally distant from their babies in utero in

an effort to protect themselves from greater pain that may result from the risk of pregnancy loss so it took longer for them to build their maternal identity. These mothers made great efforts to be informed and educated about pregnancy and childbirth so that they could do things the "right way," and feel in control, but it was difficult for them to start identifying with being a mother until they actually gave birth to a healthy baby. Eventually these women "found their way" and released some of the pressure to do things "right" and allowed themselves to start trusting and using their own intuition (Carolan, 2006).

A traumatic birth experience makes the transition to becoming a mother more challenging. Women who suffered from the trauma of childbirth that resulted in an unplanned cesarean section or assisted vaginal delivery after prolonged labor had early memories that focused on the traumatic experience (Nystedt, Hogberg, and Lundman, 2008). "...They had lost feelings of competence and self-confidence in becoming a mother, and the continuing transition of motherhood was disrupted" (Nystedt, Hogberg, and Lundman, 2008, p. 256). These women were so overwhelmed, trying to make sense of the experience of childbirth, that there wasn't much emotional space leftover for them to engage with the identity work of motherhood. It is challenging for women to develop a maternal identity if they experienced trauma during pregnancy or childbirth although most women do eventually "achieve confidence in being a mother" (Nystedt, Hogberg, and Lundman, 2008). In general, Emmanuel, Creedy, St. John., & Brown (2011) speculated that maternal distress, distinct from postpartum depression or anxiety, most likely impacts the development of the maternal role, however, this relationship has not been explored.

Chapter Conclusion

Organizing existing research on postpartum mental health using Cottone's (1992) counseling paradigms illuminated the diverse ways in which postpartum maternal mental health is being conceptualized. The range of scholarship on postpartum mental health has led to a muddled research landscape but each paradigm had something important to offer when considering postpartum mental health. Scholarship on the transition to becoming a mother helped to contextualize the postpartum time frame beyond mental health and included a fuller range of experiences that mothers have.

Chapter Three

Methods

The transition to motherhood is a heightened time of change in a mother's life. As a way to provide a platform for new mothers to speak about and make-meaning of their mental health experiences, this study investigated how new mothers experience their mental health postpartum. A qualitative study allowed mothers to describe, from their own perspective, what their mental health experiences are like while becoming a mother. The study was guided by two research questions: (1) How do new mothers experience their postpartum mental health in comparison to how they experienced their mental health before having their baby? (2) How do new mothers make sense of their postpartum mental health experiences?

Qualitative Research

Qualitative methods are used to answer questions that seek to understand experiences (Merriam & Tisdell, 2016). Qualitative researchers focus on "*understanding the meaning people have constructed*; that is, how people make sense of their world and the experiences they have in the world" (Merriam & Tisdell, 2016, p. 15). Qualitative methods make use of an inductive process, which means that, "researchers gather data to build concepts, hypotheses, or theories rather than deductively testing hypotheses as in positivist research" (Merriam & Tisdell, 2016, p. 17.) A foundational assumption in qualitative research is a constructivist understanding that meaning is socially constructed and that there is no single, universal truth or reality (Merriam & Tisdell, 2016). "Researchers do not 'find' knowledge; they construct it," (Merriam & Tisdell, 2016, p. 9). For this study, I co-created meaning with new mothers to better understand how

maternal mental health was experienced during the first year postpartum, including a comparative reflection on their preconception and postpartum mental health.

Phenomenological Research Design

Within qualitative research, there are different methods than can be used to design a study. This study will use phenomenological methods. Phenomenology is a philosophy and an approach to qualitative research that focuses on capturing the essence of a lived experience and a phenomenon (Merriam & Tisdell, 2016). Patton (2002) proposed that the foundational question for phenomenological research is, "what is the meaning, structure, and essence of the lived experience of this phenomenon for this person or group of people?" (p. 104).

Phenomenology is most appropriate for researchers who want to bring a phenomenon into consciousness by encouraging a person to retrospectively reflect on an experience that they might not ordinarily be reflective about because of its nature being an everyday lived experience. Phenomenological methods are ultimately used to capture the "essence" of an experience, as individuals understand it (van Manen, 1990). An important assumption with phenomenological methods is that, "there are core meanings mutually understood through a phenomenon commonly experienced" (Patton, 2002, p. 106). Therefore, by creating space for an individual to explore and deepen their own understanding of an experience, a phenomenological researcher believes that there will see shared connections among people with similar experiences. These shared connections are the essence of the experience.

Descriptive Phenomenology

Under the umbrella of phenomenological research methods there are two approaches: descriptive phenomenology and interpretive phenomenology (Lopez & Willis, 2004). This study will use descriptive phenomenology. Giorgi (2009) summarized how Husserl conceptualized phenomenology as a "descriptive science (p. 77)." The goal of descriptive phenomenology is to describe what is "seen." There is no theory to develop, no hypothesis to prove, and no generalizations to be made. "The essence is not interpreted, but precisely described" (Giorgi, 2009). Girogi (2009) contrasted description with interpretation, construction. and explanation. In descriptive phenomenology, "the exhibition of the given is the basis of its accountability" (p. 89).

There are several important concepts of descriptive phenomenology. Giorgo (2009) explained how Husserl understood lifeworld. "By 'lifeworld,' Husserl wishes to designate the common, everyday world into which we are all born and live. It is usually a world of ordinariness" (p. 10). Something that makes descriptive phenomenology distinct from other qualitative methods is its interest in "normal" experiences that can easily be overlooked as being insignificant. Attention to lifeworlds allows the phenomenological researchers to explore the depths of our most intimate, lived experiences that are with us daily. There is an understanding that our everyday experiences are sacred and notable because they are so much a part of how we live. It is unusual to spend time reflecting on our lifeworlds because they are easily taken for granted. Descriptive phenomenology taps into this and allows time and attention to be spent on that which is ordinary so as to bring greater consciousness to a specific phenomenon.

Free imaginative variation is a technique used to distill the essence of the phenomenon (Giorgi, 2009). "Free imaginative variation requires that one mentally

remove an aspect of the phenomenon that is to be clarified in order to see whether the removal transforms what is presented in an essential way" (Giorgi, 2009, p. 69). If removing the aspect makes a significant difference then the aspect is probably essential (Giorgi, 2009). If it can be removed without losing the main meaning of the experience than it probably should not be included as part of the essence. Giorgi (2009) explained that free imaginative variation, "offers both openness and rigor" (p. 70). It is open because the researcher has discretion to select what the essence is and can consider any pieces of data to be potentially significant. It is rigorous because the technique is also a tool that can be used to weigh the significance of data.

Another important concept in descriptive phenomenology is bracketing. "Husserl was motivated to introduce 'bracketing' of past knowledge *about* the phenomenon being researched so that critical attention could be brought to bear on the present experience" (Giorgi, 2009, p. 91). This is also known as epoché (Giorgi, 2009). It is common to look at our present by comparing it to our past experiences (Giorgi, 2009). This "natural attitude", (Giorig, 2009, p. 91) should be put aside while working as a phenomenological researcher in favor of being completely present and focused on the experience of the person we are engaged with.

Descriptive phenomenology was a good fit for this study because the research questions of this study were focused on understanding the postpartum experience, especially as it relates to mental health. New mothers are thrown into a lifeworld where there is little room for reflection and meaning making after babies are born. Essentially, this study was interested in capturing the essence of postpartum mental health for new moms.

Participants

Participants for this study were recruited through social media (Facebook,

Instagram and LinkedIn) and word of mouth. Purposeful sampling was used for this study

in order to gain insight from the expertise that new mothers developed about the

transition to motherhood and the ways in which becoming a mother impacted their

mental health. Purposeful sampling was a way to gain as much information and

understanding as possible by selecting a sample of participants who have the most to

teach (Merriam & Tisdell, 2016). Because existing research on the transition to

motherhood has lacked efforts to include culturally diverse participants, this researcher

attempted to recruit participants who were both culturally diverse and who had diverse

postpartum mental health experiences through maximum variation. Maximum variation

sampling is a strategy used, "(1) to document diversity and (2) to identify important

common patterns that are common across the diversity (cut through the noise of

variation) on dimensions of interest" (Patton, 2015, p. 267). By attempting to include

mothers with diverse cultural backgrounds and who had diverse mental health

experiences before pregnancy and postpartum I hoped be able to understand, "the core

experiences and central, shared dimensions of a setting for a phenomenon" (Patton, 2015,

p. 283). Due to time limits for this study, the researcher transitioned from purposeful

sampling to convenience sampling to find the final couple of participants for this study.

The method of interviewing participants who are available is known as "convenience

sampling" (Merriam & Tisdell, 2016).

To be eligible for this study, participants had to meet the following criteria: (a)

identify as a mother, (b) gave birth to their first and only child in the past year, (c) and were currently caring for their child. The first four participants who expressed interest in the study and who scheduled an interview were selected to be a part of the study. The researcher emailed the informed consent form to any mother who said they were interested in the study and were told that they could schedule the first interview at their convenience. After the initial four participants were selected, the researcher attempted to recruit more diverse participants by targeting specific identities and experiences through social media posts. The researcher struggled to find socioeconomic and racial diversity within her participant pool and broadened her participant criteria again to the initial criteria included for this study by utilizing convenience sampling. She was able to recruit an additional two participants to reach a saturation point in the data.

Seven participants were a part of two interviews spaced between four and seven days apart. Each interview lasted 60-90 minutes. Participants were compensated for their time with a $20 gift card to a vendor of their choice. Each participant was emailed the informed consent form and either electronically signed the informed consent form and emailed it back to the researcher or printed the informed consent form on their own, signed it, and emailed it back. Once informed consent forms were returned, the researcher scheduled interviews and sent the participant a HIPAA compliant Zoom link. The researcher also communicated to each participant that they could have their baby with them during the interview, that it wasn't a requirement, but if it made participating in the interview easier than it was welcomed. Only one participant had her baby with her during the interviews.

The researcher scheduled the second interview at the conclusion of the first interview. Each second interview took place between four and seven days after the first interview. At the end of the second interview the participants were told that they would be emailed preliminary findings as a way to conduct member checks and they were asked if they had a preference for where their $20 gift card was from. Each participant was emailed a $20 gift card from either Amazon or Target. They were also emailed a list of demographic questions that they were told were optional and something that they did not need to complete if they didn't want to. The researcher also emailed mental health resources to one participant who was not already connected to a mental health professional.

Before the start of each interview the researcher inquired about any questions, especially regarding the informed consent form. She reminded participants that their interview was being audio recorded only, even though the actual interview included audio and visual. She also reminded participants that they could choose not to answer any questions that they didn't want to answer.

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The Phenomenological Interview

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Seidman Interview Model

Each interview was semi-structured, consisting of open-ended questions, and designed based on an adaptation of Seidman's (2019) "in-depth interviewing." The adaptation of Seidman (2019) included using two interviews instead of the three interviews recommended by Seidman. The decision to combine the first and second interview outlined by Seidman into one interview was decided by the researcher and her dissertation committee as a way to make participating in this study more easily accessible

for new mothers and as way to make this dissertation achievable and manageable within

the expectations of a dissertation. The interview protocol that was used for this study is

included as Appendix B. Semi-structured interviews provided a general framework to

guide the study while allowing for flexibility to explore unique aspects of the participant

as they became relevant to the research. In-depth interviewing through two separate

interviews provided a rich and robust understanding of how participants experienced their

postpartum mental health and provided participants an opportunity to make meaning of

their mental health as it related to the transition of becoming a mother. "At the root of in-

depth interviewing is an interest in understanding the lived experience of other people

and the meaning they make of that experience" (Seidman, 2019, p. 9). Seidman's in-

depth interviewing provided participants with the space required to reflect deeply about a

part of their self that participants likely have not had the time or space to process aloud

with someone else. In-depth interviewing allows for a slow excavation of understanding

and self-awareness over time (Seidman, 2019). Prinds et al. (2014) found that mothers

had difficulty even putting their experience of becoming a mother into words. Prind et al.

(2014) speculated that the challenge to describe the experience of transitioning into

motherhood may in part be due to the Western health-care system's disconnection from

any meaning making processes. This is why it was especially important to give mother's

the time in between interviews to reflect on and further process their experiences.

Each of the two interviews in the series of in-depth interviews focused on specific

objectives as outlined by Seidman (2019). The interviews were organized in a specific

manner so that the researcher could help the participant sift through their experiences and

so that they were able to best interpret the meaning of their experiences during the final

interview. The following outline highlights the main points that the researcher tried to gather in each interview:

Interview One (focused life history and the details of the experience): The first part of the first interview focused on life history as it related to participant's mental health and motherhood. This initial interview allowed the data collected to be contextualized within the life of each participant. What was the participant's life like up to the point of becoming a mother as it relates to motherhood and mental health? The second part of the first interview focused on the details of how participants experienced their mental health in the here and now. The goal of this part of the interview was to better understand the participant's lived experience by collecting as much detail as possible about the experience. What are the details of how the participant is experiencing their postpartum mental health? What is a typical day like for them and how do they experience their mental health?

Interview Two (reflection on the meaning): The second interview asked participants to reflect on the meaning of their experience. After being a part of the first interview and having some time between the interviews, participants had the opportunity to share their own insights about how they made sense of their experience. What does the mother's current mental health mean to them? Is there anything unique about their mental health postpartum compared to their mental health before getting pregnant? How do they make sense of anything unique about their mental health postpartum?

Data Organization

Each interview lasted between 60 and 90 minutes (Seidman, 2019). The two interviews were spaced between four days and one week apart as suggested by Seidman

(2019). Interviews took place virtually, as this study was conducted at a time when the CDC recommended social distancing as a way to slow the spread of the COVID-19 pandemic. Interviews were audio recorded via Zoom and stored in the Zoom cloud. The researcher also used her laptop as a backup recorder. The audio recording on Zoom included transcriptions, which included the participant's name. The researcher copied the Zoom transcript into a word document and deleted all identifying information throughout the interview. The researcher then listened to the audio of the interview while reviewing the transcript to correct errors from the Zoom transcript. Each transcript was saved on a personal password protected laptop with a number and letter to identify each participant and which interview the transcript included, i.e. 1A. The researcher created final transcriptions after each interview. Each participant was assigned a number. A list of each participant's initials and their corresponding number were kept on a password protected laptop.

Data Analysis

Data analysis for this study was completed using Giorgi (2009) descriptive phenomenological method in psychology. Before even starting data analysis, Giorgi (2009) referred to Husserl's first step, which, "is that the researcher has to assume the phenomenological attitude" (p. 87). This attitude required looking "at all objects from the perspective of how they are experienced whether or not they actually are the way they are being experienced" (Girogi, 2009, p. 87-88). A descriptive phenomenological researcher starts by preparing to listen closely to how the participant experiences their consciousness. The researcher is merely listening to hear what the participant is communicating and tries to situate themselves as closely as possible to the heart of what

the participant is saying. Giorgi (2009) listed five concrete steps for data analysis: (1)

read the sense of the whole, (2) determination of meaning units, (3) transformation of

participant's natural attitude expressions into phenomenological psychologically sensitive

expressions, (4) develop a situated meaning structure; and (5) create a thematic

structure.

Once all of the interviews were completed, the researcher read through the

entirety of each finished transcript to read the sense of the whole, which was the first step

of data analysis (Giorgi, 2009). Although most qualitative researchers will start by

reading the text of the data, a phenomenological researcher reads the transcriptions to get

a sense of the whole, "while sensitively discriminating the intentional objects of the

lifeworld descriptions provided by the participant" (Giorgi, 2009, p. 129). The

phenomenological researcher doesn't do anything with this information at this point in

the data analysis process. Instead, the researcher was open enough during this initial read

to allow reading the transcriptions to leave a light impression in regards to the

participant's consciousness as presented through their interview.

The second step of data analysis was the determination of meaning units (Giorgi,

2009). Meaning units are marked on the transcript anytime there is a new shift in

meaning. This process is subjective and it is recommended that the researcher work freely

on this step without agonizing over how meaning units are established. Each researcher

can come up with different meaning units, which is acceptable, because meaning units

themselves, "carry no theoretical weight" (Giorgi, 2009, p. 130) What matters most is

how the meaning units are "transformed… and how, and to what extent, they are

reintegrated into the structure of the experienced phenomenon, if at all" (Giorgi, 2009, p.

130). Creating meaning units is simply an initial way to mark notable sections of the

transcript so that the researcher is prepared to use the meaning units in order to identify

the essence of the phenomenon. For this study, the researcher marked meaning units in

each transcript and copied the meaning units into a coding document, which housed a

complete list of meaning units of all of the interviews. 1498 meaning units were

identified. Due to the large volume of meaning units, the researcher transitioned coding

to an excel sheet. Each meaning unit was assigned a number in the coding document and

the assigned numbers were put into the excel sheet.

     The third step was the transformation of participant's natural attitude expressions

into phenomenological psychologically sensitive expressions. This step is a process. "The

researcher starts integrating each meaning unit to discover how to express in a more

satisfactory way the psychological implications of the lifeworld description" (Giogi,

2009, p. 131). Psychology here is thought of as, "how individual human subjects present

the world to themselves and how they act on the basis of that presentation" (Giorgi, 2009,

p. 135). While sorting through the meaning units, the researcher stayed close to the

participant's lifeworld in order to stay connected to the lived experience of the

participant, but also, the researcher was curious about how the participant communicates

their experience of the phenomenon through their consciousness. "The researcher is

reading the participant's description, but within the reduction he or she awakens the

phenomenal characteristics of the description, which in turn make the senses of the

described experience more available" (Girogi, 2009, p. 133). The researcher's task was

then to communicate the core of what the participants experienced in such a way that it

resonated with the participants and it captured a deep understanding beyond even what

the participants were able to put directly into language. This transformation captured

psychological generality that was the essence of the experience. In order to complete this

step of data analysis, the researcher cross referenced the numbers with the text included

in the coding document in order to transform the participant's natural attitudes into

phenomenological psychologically sensitive expressions as the third step of data analysis

(Giorgi, 2009).

As the fourth step of data analysis (Giorgi, 2009), the researcher developed a

situated meaning structure for each participant. In order to contextualize every

participant's contributions to the study, the researcher wrote a 1-2 page description of

each interviewee's experiences. This allowed the researcher to fully consider each

participant's experiences. Seidman (2019) recommended a similar step, which he

described as crafting individual profiles. Individual profiles are a way for the researcher

to turn what each participant said into a story, although he noted that only one in three

interviews will provide enough content to create a complete profile. Vignettes can be

used when it is unrealistic to develop a complete individual profile. Seidman (2019) also

recommended using participant's own words to write individual profiles and vignettes. In

order to complete this step of data analysis, the researcher reviewed each participant's

phenomenological psychologically sensitive expressions and wove those into a narrative

that as accurately as possible captured the nature of the participant's interviews.

The last step was to create a thematic structure for each participant so common

themes could be identified between participants. Merriam and Tisdell (2016) described

this process as constructing categories. They recommend that categories should answer

the research questions and meet the following criteria:

be exhaustive (enough categories to encompass all relevant data); be mutually

exclusive (a relevant unit of data can be placed in only one category); be as

sensitive to the data as possible; and be conceptually congruent (all categories are

at the same level of abstraction)" (p. 213).

Each participant's phenomenological psychologically sensitive expressions were listed in

an excel sheet. Thematic structures were determined by reviewing the complete list of

phenomenological psychologically sensitive expressions for each participant in an

attempt to fully capture the essential themes for each participant. Once each thematic

structure was determined for each participant the full list of thematic structures for all of

the participants were listed in a new tab and organized to determine common themes.

There were several ways that the final themes could have been organized. The researcher

returned to the transcripts and situated meaning structures for each participant often in

order to ensure that the final themes fully captured the lived experiences of the

participants as accurately as possible. The final themes were determined once the

thematic structures were organized in a way that fit categorically while the researcher

discerned to the best of her ability when the themes also captured the essence of what

participants were sharing.

When developing the final themes for this study it was important to the researcher

that she acknowledged the many ways in which mothers have been oppressed by

"universal truths" about motherhood. The researcher approached the data analysis

process with an awareness and desire to resist contributing to the harmful ways in which

mothers have been told what motherhood should be like for all mothers. The

phenomenological essence of this study aimed to capture what it is that might connect

new mothers' mental health during their transition to motherhood. The essences were a high level interpretation that honored the understanding that each mother has a unique experience of motherhood while rejecting notions that motherhood should be any particular way in order to be credible or worthy.

Trustworthiness

Qualitative methods rely on the trustworthiness of the study as a way to ensure that the data was collected and analyzed in an informed and ethical manner. Merriam & Tisdell (2016) divided trustworthiness into four categories: internal validity or credibility, reliability or consistency, external validity or transferability; and ethical considerations.

Internal Validity

The internal validity of a study requires thoughtful, ethical, research design (Merriam & Tisdell, 2016). Internal validity is a matter of how credible the findings of a study are (Merriam & Tisdell, 2016, p. 242). For this study, the researcher presented initial findings to each participant and solicited their feedback on the findings. This process is known as "member checks" (Merriam & Tisdell, 2016, p. 246). Member checks were an attempt to make sure that data are not being misrepresented. The main purpose of this was to ask participants if they felt represented and understood by the preliminary findings. "Adequate engagement with data collection" (Merriam & Tisdell, 2016, p. 246) is another way to help increase internal validity. This required making sure that enough participants were interviewed to thoroughly capture the essence of postpartum mental health. The data were saturated when participants started to repeat similar information that had already been shared by other participants (Merriam & Tisdell, 2016).

Reliability

"Reliability refers to the extent to which research findings can be replicated" (Merriam & Tisdell, 2016, p. 250). Reliability becomes more complicated in qualitative research than it is in quantitative research because the nature of qualitative studies is socially constructed and dependent upon a multitude of variables (Merriam & Tisdell, 2016). With qualitative research "the question then is not whether findings will be found again but whether the results are consistent with the data collected? (Merriam & Tisdell, 2016, p. 251). The audit trail is an important tool to use to demonstrate reliability for a qualitative study (Merriam & Tisdell, 2016, p. 252). "An audit trail in a qualitative study describes in detail how data were collected, how categories were derived, and how decisions were made throughout the inquiry" (Merriam & Tisdell, 2016, p. 252). In order to promote reliability in this study, the data collection and data analysis processes were closely recorded and written about.

External Validity

External validity addresses how the results of one study can be used in another study (Merriam & Tisdell, 2016). External validity is also often thought of as generalizability, however, again, in qualitative research this becomes challenging because the nature of qualitative work is dynamic (Merriam & Tisdell, 2016). Qualitative researchers can demonstrate external validity by using, "rich, thick description" (Merriam & Tisdell, 2016, p. 256) of the research setting, participants and findings. Another strategy, which was attempted in this study, was maximum variation (Merriam & Tisdell, 2016). Maximum variation aspires to capture a diverse participant pool, which can allow

data to potentially connect with a wide-range of readers who can take the findings and integrate them into their own work or lives.

Ethical Considerations

The University of Missouri-St. Louis IRB approved this study before any data was collected. Any person who participated in this study was fully informed about the purpose of the study and about their right to stop participating at any point during the study. All identifying information of participants was protected in record-keeping, transcriptions and the final write-up.

Talking during the interview could have brought up mental health concerns that the participants might have had. Most of the participants were already connected to mental health professionals. Participants who were not connected to a therapist were offered a referral as a resource.

Lastly, it was of the utmost importance that the researcher fully embodied the role of researcher and not therapist while working on this study. The researcher acknowledges that although these separate roles of researcher and therapist are important to consciously tease apart, she also came into this research fully informed by her training and experiences as a counselor in addition to her education as a researcher. Phenomenological research is not therapy although it can be experienced as being therapeutic by participants. Healing, growth and insight can happen anytime that people have space to process meaningful experiences with someone who is attentively listening. Meeting with participants to conduct phenomenological research could have felt similar to therapy, however it was quite different. The task of a counselor is to enter the client's emotional, psychological, and relational worlds in order to empathically be with them while they

work towards their therapeutic goals, while the task for a phenomenological researcher is

to become intimately familiar with the client's lifeworld by asking questions and listening

deeply, without entering the participant's lifeworld themselves. In an attempt to approach

this research as a whole person, this feminist researcher understood and was protective of

the distinction between the ethical roles and responsibilities of researcher and therapist

and she relied upon her ability to help others feel heard, understood and connected in

order to strengthen her role as researcher.

Researcher's Perspective

Since the researcher is the primary tool for qualitative research (Merriam &

Tisdell, 2016, p. 16), who the researcher is as a person cannot be ignored. Data is

collected and analyzed through the relationships built between researcher and participants

so the researcher's own life experiences and biases might play a role in the study. The

greatest step that a researcher can take to minimize biases tainting the data is to be aware

of potential issues and to monitor their influence (Merriam & Tisdell, 2016, p. 16).

I developed the concept for this study while seven months postpartum with my

first child. As a first-time mom who was getting her Ph.D. in counseling, I was shocked

by how challenging it was to feel fully informed about postpartum mental health. While

pregnant, I worried about postpartum depression because it was something that I never

felt fully educated about. When I talked to my healthcare professionals and birth class

teacher about what support was available if I did get postpartum depression, the

responses were underwhelming.

Postpartum depression and maternal mental health never came up during my

training as a counselor and I couldn't find many resources within counseling literature

that gave me much additional insight into the postpartum period. I felt outrage at what I considered to be a major academic disinterest in motherhood. The feeling of having what appeared to be a serious mental health challenge looming in front of me without any preparation or adequate education on how to prepare for it or reduce its impact, left me feeling insecure about my ability to care for my mental health, despite being a mental health professional. I focused on the things I could control. I started seeing a therapist two weeks after I gave birth; I had friends I talked to about how I was really doing; I set boundaries with relationships that weren't supportive; I made a point to eat well and walk outside most days; and I sought new friendships with women who were already moms. Those steps helped in many ways but I still struggled with my mental health postpartum.

I experienced the transition to motherhood as a significant life event that changed who I am and how I engage with the world. Becoming a mom was a spiritual experience for me that elevated me to higher version of myself. It has also been a really difficult experience. It wasn't until actually going through my own postpartum experience that I started to consider the range of possible ways to conceptualize what happens for mothers' mental health postpartum beyond labeling the experience as "postpartum depression." I processed the heavy, gendered, social expectations that motherhood brought out. I noticed that my relationships provided a range of levels of support for me postpartum, from having absent support from some to feeling fully embraced and cared for by others. I noted how familiar experiences of anxiety and depression that I had at different points in my adult-life shaped the way that I experienced myself postpartum in more intense ways. I was confronted with the ways that I was or was not set me up to mother and suddenly, "postpartum depression," became much more complex and varied to me.

I came into this research with a personal interest in understanding the transition to motherhood better because despite having gone through it, I still didn't fully understand it. I had a hunch though that through thoughtful reflection with other new mothers, more wisdom could be gleaned. I believe that by providing space for new mothers to co-construct meaning about the transition to motherhood and how that transition impacts maternal mental health, that we were able gain greater awareness about what the experience is like on a deep-level. I also believe that allowing moms to be their own experts on their mental health was an empowering process that is not available in many other spaces.

In order to research this topic as someone who has recently lived this experience and as someone who was currently pregnant, I needed to actively bracket my own experience and knowledge about the transition to motherhood so that I could keep my focus and attention on participants' experience and their meaning-making process talking about their experiences. To do this, I maintained field notes where I could record any biases that I become consciously aware of during the data collection and data analysis processes. Findings for this study came directly from the transcribed interviews and not from my personal experience. I also consulted with my dissertation chair and methodological advisor to ensure that my potential biases were being checked.

Some strengths of being in a similar space as my participants was that I could pick up on nuances and ask more directed questions to collect rich data. My own recent experience as becoming a new mother helped me to connect with participants and build a level of trust which helped enable me to help participants feel comfortable enough to open up. The greatest strength of being closely connected to this subject was that I am

personally invested in this topic and am passionate about seeking greater understanding

as a way to better support new mothers. A challenge of having already experienced my

first year postpartum is that I had to resist finding results that simply fit my own

experience. I tried to resist making assumptions about other new mother's experiences,

which meant that I needed to ask participants to fully explain their own experiences.

Limitations

As an individual researcher writing a dissertation, one limitation was working as

an individual and not being part of a research team. This meant that I had to rely on

member checks to ensure that I was accurately understanding participants. It also

required me as a researcher to build intellectual community in other ways to help support

me through this process.

Another limitation was gaining access to participants with diverse economic,

racial, and ethnic backgrounds, which limited maximum variation in this study. I asked

interviewees to participate in my study for at least two hours over the course of one week.

This is a significant amount of time for mothers to be able to give, which limited my

participants to those who are in a stable enough place emotionally, psychologically, and

financially in order for them to feel like they could take the time to participate.

A final limitation was that data was collected while the COVID-19 pandemic was

a serious health concern in the United States and in the world. This was a time-period

when many people experienced depression and anxiety at some level. I anticipated that

psychological affects of the COVID-19 pandemic would appear in my interviews, which

I believe produced different findings than if I were to have collected data before March

2020, when the COVID-19 pandemic was not a concern in the United States. The current

public health crisis was in some ways a limitation of the study because it made the findings more particular to a time period when new mothers are also experiencing a global public health crisis. The beauty of phenomenology though is that I was not pursuing an absolute truth. I was interested in focusing on the lived experiences of the participants and how they made meaning of their experiences. This was certainly something that participants were able to provide. This was an important and historic moment in time to be able to understand what it is like for new mothers who also have to make sense of how they and their families are being impacted by the COVID-19 pandemic. New mothers have had to transition to motherhood under unstable social times and crises throughout history, so interviewing mothers at this moment in time provided additional insight into a very particular type of transition to motherhood, which is that of becoming a mother in a time of global crisis.

Conclusion

The purpose of this study was to better understand maternal mental health by seeking greater understanding about the ways that new mothers experience their postpartum mental health. Qualitative methods were the most useful approach to answer these questions. A descriptive phenomenology in particular was used to capture the essence of how new mothers experience their mental health after having a baby. Seidman's (2019) in-depth interviewing was an approach that excavated deep meaning-making from participants and Giorgi's (2016) descriptive phenomenological method in psychology guided the data analysis process.

Chapter Four

Results

This study investigated the phenomenon of postpartum mental health based on two research questions: *How do new mothers experience their postpartum mental health in comparison to how they experienced their mental health before having their baby? How do new mothers make sense of their postpartum mental health experiences?* Using Seidman (2019) three-stage interview process as a guide for data collection and Giorgi (2009) descriptive phenomenological method in psychology for data analysis, first-time mother's experiences of their postpartum mental health were studied and could be summarized as the experience of *postpartum processing*. *Postpartum processing* is the experience of first-time mothers making sense of their postpartum mental health. Four themes were identified as being essential components of first-time mothers' lived experiences of their postpartum mental health, or *postpartum processing*: What Just Happened?: Processing The Childbirth Experience; How Am I?: Processing Personal Well-Being; How Are We?: Processing Relational Health; and What Do I Have To Do?: Processing Tasks of Motherhood.

Seven, first-time moms with a baby under the age of one were interviewed twice for this study. The following demographic information is reflective of the mother's identities. Each participant agreed to share their demographic information and were informed that they did not need to share their information. Each mother identified as a woman. The average age of participants was 32.4 years old, with an age range from 28-38 years old. The age range of the baby's was 3 months to 10 months with an average age of 6.14 months old. The mothers in this study have been with their current partner, who is

also their baby's parent, on average for 6.4 years and the range of time that participants knew their partner was from 4.5-9 years. Each participant was married to their partner and has been married for an average of 3.2 years, ranging from being married for 1.5-5 years. Six of the participants were married to men and one participant was married to a woman. Six of the participants identified as White or Caucasian, while one participant identified as African American. Four participants identified as being heterosexual or straight. Two participants identified as being bisexual and one participant identified as queer. Three participants identified as being middle class. Three other participants identified as being upper middle class and one participant did not answer this question. Four participants lived in Missouri, two participants lived in Virginia, and one participant lived in California.

The credibility of this study relied on a detailed audit trail as recommended by Merriam and Tisdell (2016). Participants for this study were recruited using social media and word of mouth. One participant came from a birth month Reddit thread community. Two participants came from a general post on Facebook. Four participants were recruited from word of mouth. Most social media posts recruiting participants through large audiences did not yield participants for this study. Five participants who expressed interest in participating did not meet the criteria for the study and were not interviewed. Two participants met the criteria for the study at the time of inquiry and scheduled interviews but at the time of the interview no longer met the criteria of having a child under the age of the one because each of their baby's had just turned one the week before the scheduled interview. As the researcher scheduled interviews, she started to recruit more diverse participants as a method of purposeful sampling to help ensure maximum

variation within the participant population. She adjusted language in her advertising to recruit specific populations and experiences that were missing from the current data. This strategic advertising resulted in several participants with identities and experiences that were not already included in the study. In order to meet deadlines for this study, the researcher transitioned to convenience sampling so as to recruit the final participants that met a saturation point for the study. A saturation point was reached when no new themes came out of an interview (Merriam & Tisdell, 2016). To conduct member checks, each participant was emailed initial findings and were invited to share whether the findings resonates with their experiences.

Although a saturation point was reached, the individual experiences of each participant varied greatly. The phenomenon of *postpartum processing* is dynamic so there was no singular experience or sequential order to their experience, which made determining a saturation point challenging. There became familiarity in the themes that the participants brought up, but how they experienced each theme was unpredictable.

The first research question was slightly changed at the end of the interviews based on participants' shared experiences and perspectives on when they became mothers. Initially, the first research question was: *How do new mothers experience their mental health during the transition to motherhood in comparison to how they experienced their mental health before becoming pregnant?* That research question was adapted and became: *How do new mothers experience their postpartum mental health in comparison to how they experienced their mental health before having their baby?* It became clear that motherhood and the transition to motherhood is only one aspect of a larger phenomenon of postpartum mental health so including postpartum mental health in the

research question instead of the transition to motherhood more accurately captured what the study was actually about. Additionally, changing the part of the research question that focused on mental health before becoming pregnant to mental health before having the baby was based on participant's disclosure of when they felt like they became mothers and when there was the most defined articulation of a shift in mental health. Focusing on when the baby was born more closely aligned with participant's experiences. Agee (2009) explained that qualitative research is a reflexive process and that, "good qualitative questions are usually developed or refined in all stages of a reflexive and interactive inquiry journey" (p. 432). Agee (2009) offered to think of research questions as "navigation tools (p. 432)" to help the researcher map out potential ways to move forward. The researcher's decision to slightly alter the research questions after data was collected and before data was analyzed was based on her increased awareness of how the initial research questions would benefit from slight changes in order to better reflect the participant's experiences. She also decided to revise the research question before data analysis so that the data analysis process could be guided to more accurately investigate the phenomenon of interest.

<div align="center">**Individual Situation Meaning Structures**</div>

Participant One

Participant One (P1) always knew she wanted kids. She had a "rebellious phase" (P1A, 38) in high school when she wasn't sure if she wanted kids because she was worried about bringing them into the world with so many problems like climate change, but ultimately, she wanted kids. She remembered that when she was a kid she wanted to

be a mom, which she thought was typical of girls. It was never explicit but she grew up

with the idea that, "you're supposed to settle down and have a family" (P1A, 52).

In some ways, being a parent was easier than she thought it would be. It was more

practical than she expected. She tried to take parenting a day at a time in regards to

learning about childcare because it would be overwhelming to try to learn everything at

once. P1 had planned to be at home for three months and then return to work but the

COVID-19 pandemic hit at the end of her maternity leave. Because of the COVID-19

pandemic, P1 was home full-time caring for her baby and worked full-time from home.

Her husband worked outside of the home and continued to work outside of the home

throughout COVID. She and her husband cared for the baby together when they were

both home. Being a mom to her baby had been a meaningful experience. She shared:

> A couple months, a couple weeks in, I was home and I was just, I was just holding
>
> and I was just crying because I just felt like I just loved and I just love him so
>
> much. That just it's tears of joy, but it's just like such a deep, profound feeling
>
> (P1A, 364-368).

P1 has a history of anxiety. She started counseling in college to treat her anxiety,

which she developed when she was in high school. Therapy was very helpful for P1. She

learned coping skills to manage her anxiety and had years when she wasn't in therapy

because her mental health felt stable and well cared for. P1 was surprised she did not

experience anxiety during pregnancy. She thought a major reason she didn't feel anxious

during pregnancy was because she felt well cared for by her OB/midwife team and

trusted that she had professionals she could turn to if she had questions or concerns.

This mother experienced postpartum anxiety and depression due to her anxiety, which was diagnosed by a psychiatrist. She was grateful for her therapy experiences because they served as a form of education that she felt equipped her to recognize when she wasn't okay postpartum. She believed strongly that postpartum mental health anxiety would be very easy to miss if you are a mom who had never experienced anxiety. Unlike her anxiety before having a baby, she experienced anxiety postpartum in a more intense way. Before having her baby, she could identify triggers for her anxiety but postpartum, she felt the anxiety first and then searched for what might be causing her anxiety. She shared:

> Like there's, maybe it's just there's too much like right now that a lot of things are causing me stress. And so there's just no way to just like deal with that one thing. It's just too many things and it's just kind of taking over so (P1B, 174-177).

She wondered if there are just too many stressors at once all contributing to her anxiety. For the first time in her life, she felt like therapy and the coping skills that worked for her before were no longer enough. She just recently got prescribed anti-anxiety medication because she felt like her anxiety was out of control.

P1 had postpartum preeclampsia immediately after delivering her baby, which resulted in high blood pressure that has yet to resolve. Her high blood pressure and the impacts of the COVID-19 pandemic, mostly not being able to see family, are causing her the most anxiety in her life. She felt like without her serious postpartum health issues and COVID she would be able to manage the more typical stress of her newborn because she doesn't feel overly anxious about her baby.

P1's interview was unique in that she had a deep desire for postpartum care to improve and she had a strong advocacy voice that named injustices about postpartum care. P1 wanted moms to be better cared for postpartum and had benefited from consciousness raising with other moms.

She said:

Yeah, I just feel the need to. I feel like I want to be that person in case they needed it. I wanted to say something in case it did happen to them or they something came up, or they struggle because I didn't have anyone I was able to reach out and get the help or support, you know, from my mom friends, but nobody offered it to me. It's like. It's harder to have to ask. It is… I messaged them. I said, just so you know, I didn't, I'm not breastfeeding. And if you decide that it doesn't work for you and need someone to talk to, or you're struggling with it talk to me because I will tell you, I don't want to guilt you about it and I was if you feel like you need to talk to me about it. I want to be that mom because people don't openly admit that they formula feed like as the way that they do (P1A, 658-667).

It is important to her that she help make other moms' transition to motherhood easier by destigmatizing formula feeding and by reaching out to new moms proactively because she believed asking for help can be hard, especially when you are struggling.

Participant Two

Participant 2 (P2) always wanted to be a mom. She came from a long line of very nurturing, loving mothers in her family. Her grandmother in particular was, "a powerful force" (P2A, 78), and a community figure who taught in a preschool. She was adored by

those who knew her. "She made everyone feel so loved and seen and she was able to pick out all the good things about someone" (P2A, 181-182), which are qualities that P2 aspired to as a mother. Retrospectively, P2 realized that she made all of her major life decisions based on her goal and desire to be a mom.

She experienced being a mom as "so gratifying" (P2A, 362) and "so rewarding" (P2A, 362). She felt like her baby was her, "*little prize*" (P2A, 363). At the time of this interview, P2 was still on maternity leave and was planning to return to work once her maternity leave was up. She enjoyed caring for her baby and spending time with him.

P2 had a traumatic birth experience. She had a severe reaction to the epidural that she got during labor, which caused her blood pressure to drop. Her blood pressure was eventually managed during labor but she had a C-Section, which was deeply disappointing to her. She felt like she missed out on a rite of passage that comes with delivering a baby vaginally. She also developed postpartum preeclampsia after her son was born. Her preeclampsia resolved itself before she left the hospital but it was a very scary experience.

P2 has a history of anxiety, which was triggered by a difficult breakup in her 20's. She spent about a year in therapy processing her relationship and even more so, she explored her lost sense of control about her future, which her breakup represented. She wanted to learn how to let go of her life plan and the importance of not staying with the wrong person in order to keep her life timeline. She learned to trust her gut. She learned that "when it doesn't feel right. It's not right" (P2A, 293).

Her immediate experiences postpartum were difficult and intense and made worse by being sleep deprived and stressed out from COVID. She felt robbed of two important

experiences that she had anticipated having with the birth of her baby: delivering her

baby vaginally and breastfeeding. Not being able to have the experience of childbirth that

she wanted and not being able to breastfeed her baby were challenging for P2 to process

and make meaning of. She expressed being in the process still of grieving both of these

losses and was trying to get to a place of acceptance.

Participant 3

Participant 3 (P3) felt like she became a mom when she was pregnant because that

is when she started worrying about her baby. She grew up always wanting to be a mom

but thought that it wouldn't happen. She didn't have a reason to think she wouldn't be

able to have kids, it was just a feeling she had. Becoming a mom brought on some fear

for P3 because she felt the weight of being responsible for another human and she felt

like it is her duty as a mom to protect her baby from harm, which she expressed as feeling

like a daunting experience in the world today with overt racial injustice and the fact that

there is a global pandemic.

P3 grew up with a dad who was incarcerated so her mom was the main parent

figure in her life throughout childhood. Her mom and older sister had a combustive

relationship growing up, which made her anxious. She also had a strained relationship

with her sister. Her sister is a mom to seven kids whose model of mothering she does not

wish to emulate. Her main mothering role models are her own mother and an aunt who

served as an example of what family stability could look like.

P3 has a history of anxiety. She has a history of being in therapy and started

seeing a counselor in college. She felt like the height of her mental health was during

grad school when she felt a strong sense of belonging and connection with others. She

felt like she could be herself, which had a strong, positive impact on her mental health.

P3 felt like she became a new version of herself postpartum. Looking back, she

thought that there is no way she could have completely prepared herself emotionally for

becoming a mom because it's new so she had to go through the transformation knowing

that she would change. "It's not that I'm really a new person. It's that I have. I feel like I'm

having experiences that I'm having because of the entire process of becoming a mother"

(P3B, 83-84).

She experienced severe anxiety the first week postpartum. She worried about her

baby dying and whether her baby was eating enough or sleeping enough. She also had

anxiety several weeks postpartum from having a difficult experience trying to breastfeed

and pump. She eventually stopped breastfeeding and pumping which continued to make

her feel emotional about the disappointment she felt from not being able to give her baby

breast milk.

P3 was screened for postpartum depression at her baby's pediatrician visits, which

is when she realized how much she was actually struggling postpartum. She felt like her

mental health was easier to understand before she had her baby because she knew why

she felt a certain way when she was struggling. Postpartum felt like there was some

unknown factor impacting her mental health and made her seek confirmation that her

feelings were being felt by other moms. She felt less capable of understanding her

feelings postpartum than she was before having her baby and also has a desire to

understand them better within a community of other moms.

P3 was very attentive to her transition into motherhood. She experienced it as a transformative experience that she was still processing. She was able to maintain patience and grace while having an awareness of the transformation that she was currently experiencing. This allowed her to cope with some of the postpartum mental health challenges she had experienced because she understood that she was having new experiences and she was in the process of changing.

Participant 4 (P4)

Participant 4 (P4) was the only participant who was in a same-sex marriage. She wanted to highlight in her interview that identifying as queer hadn't really impacted her experience as a mother. She explained, "but I think in many ways because I had a same sex partner and we're both going through this motherhood experience together has really in some ways, like made the journey easier" (P4A, 869-870). P4 talked about her wife often during the interview. She and her wife did everything together related to childcare during their maternity leave. They had since learned more about their strengths as parents and started to divide more of the workload so that one of them could watch their baby while the other one did chores. Her wife was a major source of support for her. Both she and her wife took 10 weeks of maternity leave and then worked part-time for around six weeks. They both just recently started work again full-time from home. They had a nanny who helped with childcare and P4's mother-in-law also watched the baby a few days a week.

P4 has a history of anxiety, which first presented when she was 25 as a feeling that something was really wrong with her. Her anxiety manifested physically so it wasn't until her primary care doctor recommended that she see a therapist that she considered

her feeling as being anxiety. She now has years of experience with therapy and medication. She took time off of therapy when she felt like she was managing her mental health and doing really well. She returned to therapy at one point to work on a new issue but was not in therapy at the time of childbirth. P4 set up appointments with her therapist and psychiatrist right after she had her baby because she experienced intense anxiety postpartum.

P4 experienced a shift in her mental health postpartum. Even though she had anxiety in the second half of her twenties, she had not experienced anxiety during her pregnancy and had a really positive experience being pregnant. Because of this, she did not expect to feel anxious once the baby was born but she experienced a sudden switch in her mental health from feeling really good and secure to feeling like her emotions were out of control. She felt, "like a wreck" (P4A, 394), for the first month. She was still taking her anti-anxiety medication daily, but during the first month postpartum it felt like the medication wasn't working at all. She felt like her postpartum body was overpowering the medication. Now that she was four months postpartum she felt like she was in a much better place.

A lot of P4's motherhood journey was related to her relationship with her body, the strengths she felt from having a supportive wife, her desire to use attachment parenting, and then negotiating how to have ideals for parenting and balance those with the reality she found herself in. Ultimately, her mental health started improving when she developed more confident opinions about what felt right for her, her baby, and her family based on their experiences and values, which required letting go of some of her own and other's expectations.

P4 was most grateful for having a support system already in place postpartum with her therapist and psychiatrist. Even though she didn't anticipate needing them, she was able to take advantage of the support that she had already established for herself. She recognized that feeling the way that she was postpartum would have made navigating finding mental health support on her own very challenging if she did not already have a relationship with her mental health providers.

Participant 5 (P5)

Participant 5's (P5) greatest anxiety in life was that she would never get married and have a baby. Becoming a mother was a very important part of her identity and who she wanted to be. She got pregnant quickly after getting married and left her job shortly after the birth of her daughter so that she could take care of her baby full-time, which was what she envisioned for herself as a mother.

P5 started therapy in grad school because of her anxiety of never getting married and having a family, which felt so completely out of her control. From her perspective, plenty of people who wanted to have a family never got one. She is someone who felt like she had a lot of options and opportunities in other areas of her life, which made the uncertainty of marriage and kids distressing.

She had a traumatic start to becoming a mother after a long, and physically taxing labor. She couldn't sleep for days because of intrusive flashbacks to labor and how she felt stuck and utterly exhausted. Her OB connected her to a postpartum therapist who was able to help validate for her that her childbirth was a traumatic experience.

P5 expressed feeling extremes while with her baby. She either was so infatuated with her or she felt an intense desire to run away. She had been struggling with feelings

of anger, which were disappointing to her because she waited so long to become a mom and wanted to feel happy, but she also felt trapped. At the time of the interviews she was nine months postpartum so she thought that she was past the point of being able to use postpartum as an excuse for struggles because she associated postpartum stress with figuring out feeding and sleeping.

P5 started working part-time in addition to caring for her daughter. She got some help with childcare from her husband during the day because he was home due to the COVID-19 pandemic. She hated that she felt like she needed help and felt shame that she can't do her job as a mom, but she also recognized that her role as mom extended beyond just providing childcare to her baby. She was also responsible for taking care of their household and the needs of their family, which led her to develop a robust calendaring system to help her organize her many varied responsibilities. She felt a great inequity in mental and emotional labor, which was a weight that she carried that her husband didn't. Her marriage had more tension postpartum than it did before. A lot of their relationship now consisted of negotiating their time so that they can get enough space and time away from their daughter to get done what they needed to. She expressed an ambivalence about wanting help for her husband because it's too much for her to take on her own, but she also didn't feel like she could trust him to make responsible decisions about their daughter so it just felt easier to make all of the child care decisions on her own. P5 and her husband have been in couples counseling for a couple of years.

P5 brought a unique perspective about motherhood, which was a central element to why mothering was a meaningful pursuit for her. She shared a concept about mothering as a co-creative act, which she came across in a book. Motherhood has called

her to think deeply about humanity and marvel in the ways that her baby is learning to love and to share joy with those she loves.

Participant 6 (P6)

Participant 6 (P6) valued her sense of self and was intentional about preserving her sense of self even after becoming a mom. She felt like she was ultimately the same person after having a baby that she was before having a baby. Her marriage and partnership with her husband were a source of connection and support for her. She described being able to watch many of her friends become parents before her, which helped her see parenting close up in such a way that she could develop her own ideas and values based on realistic insight into what parenting was actually like. P6 loved research and used research as an important tool to help equip her and her partner with the knowledge they felt like they needed in order to make informed decisions about caring for their child. It was important to P6 and her husband that they agreed about childcare decisions and both participated actively in caring for their daughter. She described a strong sense of teamwork in her marriage where they each looked for ways to help the other one out. The impression that P6 gave was that she and her husband had ongoing conversations about parenthood that flowed through their relationship for years with ease, comfort, and patience for becoming parents at the right time for them.

P6's description of becoming a mother was less about a transformation and more about a thoughtful and timely welcome of their baby into her and her partner's life. She described:

I feel like I kind of outed myself as being a weirdo to some friends, where I was like it's really nice to have a project to work on. And that's not like really how

you're supposed to talk about your child, but I was like, it is just like a project that

my husband and I are doing together, we're like, we're figuring this all out. And

that part of it is kind of really fun for me (P6A, 289-292).

P6 has a history of depression with suicidal thoughts and some anxiety that started

in high school. She was on and off of medication which she got prescribed by her

primary care doctor since grad school and basically managed her medication on her own

since then. She saw a psychiatrist once and had never been to counseling. She

experienced her mental health as being starkly different when she was on medication

compared to when she was not on it. Being on antidepressants made her more confident

and less emotionally sensitive. She described having greater tolerance to roll with the

punches. Being on medication made P6 feel like her mental health was stable although

she went through phases of questioning if she was missing something by not being on

medication.

Before having her daughter, she had terminated a pregnancy and had a

miscarriage, so she didn't feel like she became a mom until her baby was born. P6 felt

"freaked out" (P6A, 81) by becoming a mom and she felt discomfort with mom culture,

which she actively resisted internally as a way to maintain her sense of self. She could

have gone either way with having children and was intentional to communicate that she

does not think that being a mom is the most fulfilling thing that a person can do, which

was how she heard some other moms talk about motherhood. She did find being a mom

to be fulfilling but she did not experience motherhood as a peak, aspirational experience.

P6 had a physically traumatic birth, which resulted in injuries that had long-term

impacts on her health. Postpartum was the first time since being on medication that she

had felt her mental health was challenged in a significant way. Most of her mental health stress postpartum was related to feeling like she didn't know enough about her physical postpartum injuries.

She attributed feeling stable for the majority of her postpartum experience to being on her medication. She expressed feeling like she was cheating because she was on medication and appeared to be self-conscious that she hadn't struggled more postpartum. She has considered whether she should try going off of her medication because she worried that her medication might be dulling her experiences and that maybe she's not as engaged as she might be if she weren't on medication. P6 suggested that she would like to be able to not be on medication, but that ultimately, she believed that she needed it because she didn't want to risk having a depressive episode while caring for and raising her daughter.

Participant 7

Participant 7 (P7) wanted to have kids but always thought of it as something that would just happen down the road. She thought that it was more important to find a partner and then they could figure out having a baby. P7 didn't get married until she was 33 and by then she felt a time pressure to have a baby. P7 explained:

> I'm 38 and had her when I was 37 but you know and then we started trying at 34
> so I know that that was a huge part of my motherhood journey was, I'm running
> out of time. Um, but before that, I don't know, I, it kind of was always in the back
> of my mind (P7A, 60-62).

P7 and her husband struggled with fertility issues and P7 eventually used IVF to get pregnant. P7's daughter was born three months early and was in the NICU for 86 days.

Despite the premature birth of her daughter, she described her daughter being in the NICU as an overall good experience. She appreciated the support she felt like she got from the nurses and the increased access to medical professionals that she had during this time. She felt like they were cared for and she never worried that something terrible would happen to her daughter. She trusted that her daughter would be okay.

P7 has a history of mild depression, which has never been diagnosed. Her depression has manifested at points in her life when she was looking for a job or felt like she wasn't living up to her potential and often was related to struggling with her sense of worth. She used exercise as a way to cope with her mental health lows and ultimately, the depressive times in her life were resolved once she got a job.

P7 experienced increased anxiety postpartum. She felt like her mental health had been most impacted by the change in how she spent her time now that she was home full-time. She planned to work after maternity leave but she lost most of her business due to the COVID-19 pandemic so she cared for her daughter full-time when she had planned to have childcare support. She experienced anger and mood swings now that she didn't experience before having a baby. She felt anger because her life had changed so much postpartum while her husband's life seemed to mostly go on as it always did. He had agency with his time that she did not because as long as the baby was awake, she was on the baby's schedule. She and her husband started couples counseling when she was pregnant and it had been helpful to them.

Being an autonomous person was an important part of her identity. She did worry more now that she was a mom but she didn't feel like she had drastically changed as a person. A big piece of how P7 managed her mental health was by feeling productive. She

was learning how to reaffirm to herself that how she spent her time with her baby was productive and had been beneficial to her postpartum mental health.

P7 felt like she was a naturally optimistic and hopeful person, which had been tremendously beneficial to her mental health. When looking back on her life she saw how her dad was an optimistic person and that he taught her how to be hopeful. She saw how she was intentionally teaching her daughter this perspective as well.

Themes Derived From Participants' Meaning Structures

Four themes were identified in this study: What Just Happened?: Processing The Childbirth Experience; How Am I?: Processing Personal Well-being; How Are We?: Processing Relational Health; and What Do I Have To Do?: Processing Tasks of Motherhood. Each theme's finding will be reviewed here. Each theme has subthemes, which further clarify the meaning that participants made of their experiences with *postpartum processing*.

What Just Happened?: Processing the Childbirth Experience

Six out of the seven participants described their birth experience as traumatic. The one participant who did not describe her childbirth experience as traumatic delivered a premature baby who was then in the NICU for 86 days. Childbirth is a significant life event. It impacted new mothers in different ways but the shared experience was that childbirth significantly affected their mental health. For many of the moms the physical aspect of childbirth was what caused the most emotional and mental distress. For the moms who delivered their baby's during the COVID-19 pandemic there was an additional stressor of feeling more isolated throughout the experience because they could not have the people they wanted with them during labor and delivery. P2 also described it

as just feeling scarier because people were in masks and their movement was limited in the hospital.

Physical Trauma

P1 and P2 both had postpartum preeclampsia. P2's postpartum preeclampsia was resolved while she was still in the hospital but she described herself as being, "incapacitated" (P4A, 652) during the first 24 hours when they were trying to manage her high blood pressure. She described:

> *"And I just, I just felt so miserable and, you know, this is the time like your baby has just been born like this is like the most sacred time like your baby is supposed to just like be sitting on your chest and you're supposed to just be like having that intense bonding time. And I couldn't because I'm like vomiting and like having shutter vision and like nurses are rushing around and it's just like crazy"* (P4A, 629-234).

P2 also had a severe negative reaction to her epidural that resulted in her blood pressure dropping dramatically during labor, which was difficult for doctors to stabilize. This was an additional stressor during labor that made her feel out of control.

P1's postpartum preeclampsia was still affecting her during the time of the interview, which was really concerning to her. She had high blood pressure and didn't know if it would ever go away. She wondered if she needed to seek care from a cardiologist who was more of a specialist. She has also considered seeking out a hormone specialist because she questioned whether a previous diagnosis that she got regarding a hormone imbalance could be causing her high blood pressure.

P4, P5, and P6 also had reactions to the physical birth experience. P4 felt like:

all of a sudden like I couldn't do anything. I couldn't like get up from the couch. I

couldn't carry things. So it was really I felt unproductive, and it like made me feel

depressed and made me feel like sad and useless in like several ways, but at the

same time like my job was to care for the baby (P4A, 437-440).

P4 described feeling upset to be so physically limited that she felt like she couldn't care

for her baby.

P5 was traumatized by the physical exhaustion of her childbirth experience to the

point where she couldn't sleep because she kept reliving the labor experience and kept

crying. P5 was in labor for 43 hours and pushed for four and a half hours. She

experienced flashbacks when she tried to sleep after she had her baby for almost a week.

She worried that she would go crazy from the lack of sleep so she contacted her OB who

quickly helped connect her to a therapist. She explained:

And I wanted so bad to be a good mom, but I also felt this just like like I could

not. I just would, like felt so shattered that I just felt overburdened with this little

life. You know, I just wanted to like be able to heal. So I loved her, but I also was

sort of like scared of her. (P5A, 376-379).

P5 experienced her physical state getting in the way of her ability to care for her baby and

that was really challenging for her to be aware of.

P6 had few postpartum mental health issues. The issues that she felt strongest

were from her childbirth experience. P6 described feeling like her body was so

traumatized from her childbirth experience that she felt like she couldn't care for her

daughter. She was initially overwhelmed trying to process her physical injuries from

labor. She said:

It was just like devastating. Just devastating. So I had, birth wise, just like a lot of

tearing. I had like a forceps delivery. So physically very traumatic. So like pelvic

area pelvic floor, all of that. And so just afterwards, I couldn't really walk very

well. I couldn't get up and just because of I had also big sciatic issues. I couldn't

stand up or sit down very easily. I was like, totally incontinent, I. Yeah, I was. It

was just really awful and then having a newborn on top of that to take care of. It. I

remember in the hospital. It was just devastating and we. And I felt like a little bit

in the dark about my injuries and things like that as well. And so that's something

that I'm still a little bit bitter about (P6A, 311-317).

At the same time that P6 became a mom who wanted to care for her baby, her body was

so physically altered and injured that she couldn't function the same way in her daily

life.

Loss Of Faith In The Healthcare System

One of P1's greatest challenges postpartum was trying to make sense of why her

health issues, which were the result of childbirth, and not being cared for in a significant

way. She shared:

so we're talking about like you're care drops off, you have all these new burdens,

including breastfeeding, or feeding and like you're not sleeping well and then hey,

like if you have any health problems postpartum it's like you have to figure it out

yourself (P1B, 377-379).

P1 had high blood pressure as a result of her postpartum preeclampsia and had to

navigate caring for her postpartum health issues effectively on her own because she felt

like there was no longer a medical professional working with her closely, which

contrasted with the safety she felt from being well cared for by her Ob/midwife team while she was pregnant. She described:

> I just feel like kind of alone and like okay stranded, figure it out yourself. That's a huge stressor. When I'm just trying to take care of my baby. And like all I want to worry about is him. That's all I want to worry about is him (P1B, 297-300).

She also had chronic pain that she felt like doctors dismissed. The lack of postpartum care that P1 received left her feeling abandoned by a medical system that she had so much trust in before.

P6 was never told what her injuries were from birth. She overheard nurses talking at different points in her recovery and tried to get information from them but a healthcare provider never had a direct or clear conversation with her about what happened to her body and how she could heal, which was still upsetting to her. As a result, she researched her injuries and ways to recover on her own by googling late at night when she was feeding her daughter. P6 recognized that she could have asked, "the right questions" (P6B, 169) but ultimately, a doctor should have told her what happened to her body.

Emotional Distress

P2 was still trying to make sense of her birth experience. It was something that she had been looking forward to her entire life and then the experience was so dramatically different than what she anticipated and wanted. She felt "robbed" (P2A, 699) and "cheated" (62A, 650), out of her birth experience and like she missed out on joining the ranks of other moms because she had a C-section instead of delivering her baby vaginally. She felt disappointed that her body didn't work the way it was "supposed to" and she felt like she "failed" (P2B, 40) the childbirth test. P2 wasn't fully aware of

how impacted she was by the birth experience until she experienced PTSD symptoms. P2

had to return to the hospital months after she had her baby for a minor injury. She

explained:

> I literally had a PTSD reaction when I pulled up the hospital. I just. It all came
>
> back and I was just like sobbing in the car, like, oh my god, I was like, not
>
> expecting that. Um you know I'm it's like almost four months later, so I'm, I'm
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> still I'm still figuring it out. I'm still processing it. It's still so much better than it
>
> was though so much better. Yeah, so I'm just, I'm just, I'm so I'm. So at the
>
> beginning my mental health was like I was traumatized. I was genuinely
>
> traumatized. So, coping with that, while also being very sleep deprived and
>
> dealing with all of the other stresses of having a newborn and and COVID and all
>
> of that, um, It was a lot (P2A, 682-689).

Even months after labor, P2 was triggered by returning to the hospital and was flooded

with a trauma response from being reminded of her childbirth experience.

Loneliness had a significant impact on P3's birth experience. She had planned to

have her mom, who lived in Trinidad, with her for the birth but because of COVID her

mom wasn't able to be with her. Her husband was with her but he wasn't much support to

her because she felt like he couldn't really offer the support she needed and wanted,

which was to have someone who she loves who had been through childbirth before to be

with her. Her husband simply couldn't replace having the support of her mom or aunt and

that made the childbirth experience hard for her. P2 was also sad that she wasn't able to

have her mom with her during childbirth, especially since her mom was a doctor. It made

having her health conditions during childbirth feel even worse because she knew she

would have been supported and felt more cared for if her mom had been able to be there with her.

P4 had a challenging emotional reaction to labor and delivery because she went into it feeling confident and happy. She described:

> I went into labor being like, this is great. I got this. I've had, I've got it for the past nine months. It's been wonderful. And then to come out on the other side and have like weeks of the total opposite like that was a really hard experience. I just wasn't prepared for it (P4A, 568-570).

P4 described a type of emotional whiplash that took her very suddenly from feeling stable to feeling overwhelmed. For P4, childbirth just started a cascade of things not working in rapid succession and her having to adjust, manage, and process them all happening at the same time.

P6 described how the worst of her mental health low postpartum came shortly after her baby was born. Being exhausted and in need of rest, P6 asked the nurses to care for her daughter for several hours. She described:

> I remember we asked the nurses to take care of our daughter for a couple of hours so that we could get some sleep. And I just cried the whole time like I didn't sleep at all. I just cried because I was like I don't feel like I can take care of her. I don't feel like anyone's told me what's wrong with me. I feel bad about asking them to take her away. I feel like I just like gave away my baby like it was just really awful. So that was like that was maybe the worst (P6, 327-331).

Emotionally, P6 was completely overwhelmed after the birth of her daughter. P6 felt unable to care for her baby because she was so physically injured and so neglected by her healthcare providers that she questioned her ability to take care of a baby in her state.

P7's daughter was born premature and was in the NICU for 86 days. She saw the positive in this experience by recognizing that delivering her baby was not as physically taxing as it would have been at nine months. She described the time that her daughter was in the NICU as an elongated pregnancy:

> My responsibility related to her was to go there every day, hold her for a little bit, but then I would go home and do everything else. Yeah yeah it's like I was pregnant still, but not pregnant, you know, it was a weird transition (P7B, 272-274).

P7's experience during this elongated pregnancy while her daughter was in the NICU leading up to her daughter coming home was to shut down negative emotions, focus on the positive and try to normalize the experience as much as she could.

How Am I?: Processing Personal Well-being

In the midst of the many stressors participants described the ways in which they watched over their own mental health postpartum. For many moms, they experienced a tension of emotions. They held a belief that they were okay but that they also needed help or wondered if something should have been different. Some moms struggled more than others but it also was apparent that mom's assessments of their well-being could change drastically in a short amount of time.

Monitoring Personal Well-being

P5 shared in her second interview that she thought she came off as a more stable mom than she actually was because she knew what to say to sound like she was okay. She explained:

> Well, I've had a pretty hard week so I feel like thinking back at the interview. It like makes me feel like I sounded more together than I am. Like, I, I can talk, I can like say the right things that I know I should act on or that I should remember and kind of like recite to myself, but but in actuality, like I'm not that like Zen about the whole thing. You know, so yeah it's it feels like I don't know I I sounded like a stabler mom than I am (P5B, 57-61).

Monitoring postpartum well-being was an ongoing process and was something that could change quickly.

When P2 checked in on her own well-being she described feeling mostly happy. She described that she loved being a mom and thought her son was amazing. She said she loved her life and that she had what she wanted now. She recognized that she was also struggling though. It's something that she didn't like to think about and it wasn't anything she was actively working on but she described ways in which her unresolved feelings about her childbirth experience confronted her.

P4 had a lot of changes postpartum that she had to navigate in order to ensure her own well-being. First of all, she had a really enjoyable pregnancy, which led her to believe that she was going to transition postpartum with the same sense of enjoyment and ease from having things work out. Instead, she expressed feeling like life switched to a disaster during labor, which shocked her because she didn't expect it to be as hard as it was and she didn't expect to be as anxious as she was. She had been on anti-anxiety

medication before and during pregnancy which had been helpful to her since she started

taking it and postpartum was the first time that it felt like her medication wasn't working.

It wasn't until she stopped breastfeeding and her son got a little older that she felt like she

had some time and space to actually start processing her postpartum experiences. It

started with being able to have conversations with friends and then returning to work that

she felt more capable of connecting to her own sense of well-being so that she could

better determine what her needs were and not just what her son's needs were. At the time

of the interview, P4 described feeling like she was near the end of a difficult experience

and believed that she was thriving.

P7 felt increased anxiety postpartum particularly around the "time-suck that is

motherhood" (P7B, 54). Adjusting to the demands of being a full-time mom was really

challenging for her and one of the hardest aspects postpartum, especially since she never

wanted to be at home full-time. She felt anger and resentment toward her husband

because her life is so different now that they have a baby due to her being the primary

caregiver for their baby while her husband's life has basically stayed the same. P7

processed her personal well-being by trying to identify what her new normal was so that

she could work towards accepting her new reality.

P5 felt like everything was off since having a baby. She said:

just because everything feels off somehow. Like my relationship with my

husband often feels off, my feeling about mothering feels off, my feeling about

my body and my brain and how well it functions. Now, like everything just feels

off (P5B, 649-651).

She was struggling because she didn't understand why she was having such a hard time now since she had everything that she wanted in life. She talked about having things that brought security like a husband, owning a house, having a baby, but not feeling any actual sense of security. She talked about feeling stuck and like she didn't have options. She was in the process of working to understand what she needed and how she could get it in order to feel a sense of well-being. Right now, P5 described a sense of wading through mud. It was like she was trying to make sense of how things could be so very different than what she had expected and yearned for for so long.

P6 would describe caring for her own well-being now as staying on her medication. She wondered if she was missing out on something about motherhood by being on her medication. She talked about wondering if she would be more engaged and if her emotions would be heightened if she weren't taking antidepressants. She described being aware that antidepressants could make emotions duller. Ultimately, P6 made the decision to stay on medication because she didn't want to risk any mental health crises. Interestingly, P6 also described thinking of her own well-being as it related to her daughter. She started by focusing on her postpartum mental health and talked about what struggling immediately after her baby was born was like. She processed:

> Because I feel like it is made much more difficult by the fact that you feel like you should. It shouldn't be happening. Like you shouldn't be having a mental health issue. Partially because like, oh, you have a baby now so you should be happy. And then partially just because you're not the most important thing in your life anymore. So, there's almost just not time for it, if that makes sense, especially now, like I can. I haven't had really a bad episode since right after having my

daughter and like, I'm sure it'll happen at some point. But I'm guessing one of the

harder things for me is going to be like the guilt of wasting time on being

depressed when I should be like doing things to take care, again, there's always

something to do when you have a kid. So I should be doing things like take care

of her (P6A, 450-458).

Taking care of her mental health was about more than her own mental health. To P6, one

of her most important tasks as a mom was to ensure her own mental and emotional

stability so that she was capable of doing everything that she needed to in order to care

for her daughter. In addition to medication, P6 described a supportive and engaging

marriage, a history of observing and learning from friends as they became parents which

allowed her to witness the realities of parenting, being able to work outside the home, and

having access to daycare. Each of these were positive supports in her postpartum life.

P1 was vigilant of her postpartum mental health because she had spent so much

time and energy in therapy learning how to care for and support her mental health before

having her baby. She struggled when she had anxiety previously and was attentive

postpartum to any signs that indicated to her that her mental health might be a problem

again. Her postpartum mental health rock bottom moment was when she and her parents

decided it was too risky for them to see each other because of the COVID-19 pandemic.

She felt isolated and hopeless because she felt like all of her supports were ripped away

due to COVID. She was deeply concerned about her postpartum health and did not feel

like she was getting sufficient care from her healthcare providers, which added to her

anxiety. P1 assessed her personal well-being by comparing her postpartum mental health

to her mental health before having her baby, which helped her conclude that she was

struggling with her anxiety beyond what she felt capable of managing. Overall P1 was surprised that she managed her mental health without medication for as long as did. She said:

> Yeah, and I feel like I already had like a full plate with the just having a baby like that is a full plate and let's just like pile everything else on. It's like, I cannot hold the weight. I'm surprised it took this long for me to get to this point and I'm surprised I'm not worse (P1B, 372-374).

She talked to her dad and sister about their experiences on medication to further explore if she thought that anti-anxiety medication was a good choice for her.

P3 described still being in the process of change. She started by explaining that she felt like a new person postpartum and then adjusted her belief that it's not that she's a new person but it's that she is experiencing the world in a new way. She described her experience by saying:

> I feel like I'm having experiences that I'm having because of the entire process of becoming a mother, like what happened to my brain, like what happened. Like I feel like there's things that I that I went through in the process that I don't necessarily know you know like when I was pregnant, and I was like, like there was a lot going on like I was really emotional and I was this and I was. And I was like, what is this, you know, and I looked it up because I was like this doesn't seem normal. So I guess it was like a difference in like feeling like there was something going on with me that I wasn't in control of (P3B, 83-89).

Beyond her mental health though, P3 described the process of feeling that her identity was in a process of transformation. She was aware that she was changing and discussed

how she had patience with this unique moment in life because it made sense to her that she felt different postpartum.

P3 admitted that she mostly processed her postpartum mental health experiences by herself. She hadn't realized that she was struggling as badly as she was until she was screened for depression at her baby's pediatrician visit. She was emotional about not breastfeeding or pumping and had appeared to be in the early stages of processing the sadness that she felt around that. At the time of the interview she felt like she was in a much better place than she was right after her baby was born. She was happy because even with the emotional distress she was navigating, she liked her life and felt like her life was what she had wanted for herself.

Being Informed By Previous Understanding Of Personal Mental Health

The understanding that these mothers had about their own mental health before they had a baby impacted their postpartum processing. The understanding that they had before having a baby either equipped them to process their mental health or became a barrier that they had to address before further processing their experiences. For some, previously understanding their mental health was helpful postpartum while for others it wasn't helpful because they didn't see clear connections that threaded their mental health before having a baby with the mental health postpartum.

Postpartum Mental Health Makes Sense. P4 could understand her mental health now better than she could before. She felt anxious before having her baby but there was never a good reason for it in her mind. Now that she had a baby there were tons of reasons that anxiety made sense so she felt some relief. She was still experiencing anxiety but because there were reasons that made sense to her so it was less distressing than it

was before. Additionally, her greatest mental health lesson before having her baby was to seek help from her therapist and psychiatrist when she was struggling with her mental health which was helpful to her postpartum.

P2 first started therapy in her 20s to process a breakup that represented a stressful detour from the plan she had to have a baby by the age of 30. She had to learn how to let go of the plan and to adjust to something that she hadn't expected or anticipated. At the beginning of her second interview she reported:

> I am having a similar experience in reconciling my birth experience because it really wasn't what I wanted it to be. And I'm, so it's a similar kind of like it did not go to plan. Did not meet my expectations… And so I'm just sort of really still working through that and trying to figure out how to kind of put that to rest still so um yeah so that that that was kind of an interesting like an arc (P2B, 17-22).

The interview process and being reflective about her previous mental health helped P2 connect the ways in which she was repeating a similar lesson that she thought she had already learned. It helped her gain insight into why she might be having such a hard time processing her childbirth experience, which helped her postpartum mental health make more sense to her.

P6 and P7 understood their mental health the same way now that they did before having a baby. P6 continued to take antidepressants because she believed they were what kept her mental health stable. She stressed that she was the same person that she was before having a baby and that she wasn't changed in any fundamental way. P7 also talked about her strong sense of self and how she felt like she was still the same person she was

before. She knew that her mental health issues centered on feelings of worth and making

the most of her potential, which was consistent for her postpartum mental health issues.

Postpartum Mental Health Is Confusing. Some moms experienced postpartum

mental health in different ways than they did before they had a baby. P1's strongest

message from her past was to not mess around with anxiety. The moment she started to

recognize anxiety in herself she did what she could to manage it. She felt like she

understood her mental health better before she had a baby because she could recognize

triggers. Now she described that she felt the anxiety first and then searched for reasons

that she was anxious.

P3 felt like her postpartum mental health was fundamentally different than it was

before having a baby. She no longer trusted her ability to understand her mental health

and felt a need to confirm that what she felt postpartum was normal and something that

other moms experienced. This was a new experience for P3 because she had felt

confident about her ability to assess her mental health previously and she did not seek out

validation from others to confirm that what she was experiencing was normal.

P5 was confused by her mental health now. Before having her baby, her main

identified source for anxiety was her fear of never getting married and having a baby. She

is both married and a mom now so it doesn't make sense to her why she is feeling the way

that she is. She would have expected her anxiety to be resolved postpartum since her

identified source of anxiety before having a baby was no longer an issue.

Coping

Despite the many challenges and experiences that these new mothers had to

process in a short amount of time the participants found a variety of ways to cope. From

connecting to mental health services to roller-skating, these mothers found ways to take care of themselves. Mothers allowed themselves to do things that brought them simple pleasure and learned to give themselves permission to name the things that they needed in order to function as a healthy human being.

Advocating For Other Moms And Self As A Way to Heal. P1 tapped into advocacy and found ways to use her experiences to help other moms. She said, *"*it's more of like a justice issue than an empathy thing, right, like it's just wrong that that people struggle. So, including myself. I feel wronged, a little bit" (P1B, 437-439). P1 talked about reaching out to friends who are becoming moms. She said:

> I just, you know, offered her to be that ear and support because I knew how isolated I felt so I just. Yeah, I just wanted to offer to be that because it's not easy to ask for that. So I volunteered myself. But it felt good. I was able, it was like a way to kind of also, you know, heal myself a little bit for feeling that way (P1A, 678-682).

A major theme throughout P1's interview was a feeling that things should be better for moms. She carried a sense of injustice with her that it's not right for moms to be left on their own to figure out their postpartum healthcare. She has found refuge and support in online mom communities where she has been able to learn from and with other moms as they collectively tried to understand their experiences.

Beyond advocating for other moms P1 considered the ways she needed to advocate for herself. Physically, P1 was worried about her high blood pressure and didn't think her primary care doctor was interested in helping her beyond managing her issue. P1 wanted to have more answers about what was going on for her and why. She had

developed her own potential theory for what was causing her high blood pressure based on previous health issues she had and was starting to explore that theory on her own by trying to connect to specialists who might be better informed about her postpartum health issue. Additionally, P2 was motivated by seeing other moms in the online communities that she was a part of take care of themselves. She recently felt encouraged to start exercising and doing yoga which was the first time that she started exercising postpartum.

Family And Friends Supporting Mental Well-being. P2 was supported by her mom as soon as she got home from the hospital. P2's mom lived with her and her family for the first several weeks to help P2 and her husband adjust to bringing their baby home. Even after those first few weeks P2's mom visited P2 at home daily to help with the baby. Having her mom's support was important for P2's postpartum experience. Additionally, P2 had benefited from spending time with mom friends outside.

P3 mostly coped postpartum by seeing family as often as she could. She explained:

> Yeah, because I would say it's a lot and I would say on my own I don't feel like, I don't know, I feel like I'd be struggling a lot. You know, so I do feel like because it's a lot I end up feeling like okay let me go and get some help and get some advice and be with other people (P3B, 167-169).

P3 really enjoyed talking to friends and feeling like she had connections. She also copied by feeling supported by her husband.

P4 noted a significant shift in her mental well-being once she had the emotional energy to reach out to friends and talk to them about her experiences and how she was

doing. Being connected to friends and sharing her experiences with them helped her further process what she had been through and it helped her feel less isolated. Her relationship with her partner was one of the strongest sources of support postpartum, which was also the case for P3 and P6.

Although P5 felt a lot of marital tension postpartum, she also coped through her challenges by getting childcare help from her husband. Ultimately, having breaks in childcare was something that she felt like she needed. Asking her husband for help also brought up complicated feelings around the shame of feeling like she needed breaks but ultimately, she had been coping by finding times when she was not responsible for childcare.

Honoring Her Own Needs. P4's self-care functioned by learning more about herself through her process of becoming more aware of her own needs. She described how initially she was in survival mode:

I had to figure out how to like operate as a mom and like do these things that nobody could help me with. And I didn't really have the space or the time to think about that. I was so much in like survival mode, like all I needed to do was like survive. I needed to eat, I needed to shower, I needed to like care for the baby and because I was nursing and trying really hard to keep nursing at that point, it felt like that was my and I wanted that to be my only job so I focus so much on being available for him to nurse whenever he needed to. But I didn't have any time or space to like look at myself and like how my life was changing and then all of a sudden it was just so different. (P4B, 95-102).

Once she got a little more time to think postpartum she asked herself, "what are my needs," and how do I balance those with my son's needs and my wife's needs? It was difficult for her to realize that she had different needs than her wife, which took some time to accept and honor. Returning to work helped P4 feel better able to cope because she had a break from childcare, which allowed her to feel like she could be more present with her baby when she did spend time with him. This made her feel like she could be a better mom.

   Creating Space to Reflect. P5 was excited to share a new dedicated time for self-care that she started. She had recently started spending 20 minutes in the morning and 20 minutes in the evening dedicated to reflection and planning. It was a time when she listened to podcasts, knitted, and worked on her calendar, which helped her organize the laundry list of tasks that she felt overwhelmed by. Additionally, her philosophy about motherhood, which valued the co-creative act of raising a human and basked in the joy of watching a person bloom, was something that appeared to anchor her to meaning when she was struggling.

   Patience With The Process Of Becoming A Mom. P7 described navigating her life postpartum ,which looked very different from what she had thought and planned for it to look like. She navigated her postpartum experiences by trying to accept that things were different and she spent time trying to adjust and adapt to her new normal. She was able to lean on her consistent sense of self to help her feel capable of weathering a time in life that was very different than anything she has experienced before. She hadn't really let any of her circumstances define her as a person or her potential. She had met the obstacles that she was encountering as things to overcome. P7 spent time and attention

noting when her mind was elsewhere when she was with her daughter and has focused on being more mindful with the time she does have with her daughter so that she could be more present. She also gained an increased sense of well-being as she was able to give greater dignity and value to her role as a mother. Finding ways to feel productive and valuable in her role as mother helped to support her mental health.

P7 would describe her greatest strength through her life and postpartum period as her optimistic and hopeful attitude and perspective. It was something that came naturally to her and something that was harder to have when life was challenging, which was the case in the first few months after her baby came home. Her optimism wasn't always easy postpartum but it was something that she prioritized rooting herself to. Her hopefulness was a big part of her identity so it was something that she strove to maintain. She was been able to return to optimism postpartum and that helped her cope through her stressful transition to becoming a mom. She also recently started roller skating a couple of times per week which is a way that she can be social and exercise, both of which have been important coping tools for her.

Accessing Medication and Therapy. Medication and/or therapy were helpful to most participants postpartum. P6 attributed her generally stable postpartum mental health to her antidepressant medication. She was open and curious about seeing a therapist but did not have any immediate plans to schedule any appointments. P1 described that her anxiety started to feel out of control postpartum and she believed, based on her previous experience in counseling, that talk therapy would not be enough to help her manage her current anxiety. She started anti-anxiety medication several weeks before her second interview. She started therapy with a counselor that she has seen before a couple of

months after her son was born and met with a psychiatrist to start her medication. P4 started to see a therapist and psychiatrists that she had an established relationship with as soon as her baby was born. She continued to take anti-anxiety medication through pregnancy and postpartum, which was something that she started around five years ago. She was grateful to have an existing support system that she could turn to postpartum despite having thought during pregnancy that she would not need to see a therapist and psychiatrists postpartum.

P7 and P5 were both in couples counseling which they had each started before they had their baby. P5 saw an individual therapist who specialized in postpartum mental health briefly, right after her daughter was born, but she felt like it was not a good time to start seeing a counselor regularly since it was so complicated to figure out getting out of the house for an hour each week. P7 was interested in finding an individual counselor but was not actively looking for anyone.

Three participants were currently not connected to mental health services. P2 was considering therapy to process the grief that she was feeling about her birth experience not being what she had imagined but was not seeking anyone out currently. P3 saw a therapist briefly postpartum, which was helpful but something that she didn't continue because she moved. P6 had never been to therapy before.

How Are We?: Processing Relational Health

Relationships played an important role in mothers' *postpartum processing*. Their relationships with their baby and with their partner were the two most significant relationships. The state of these relationships had the potential to create emotional stability or distress.

Understanding Her Relationship With Her Baby

Each mom talked about how they felt happiness or joy watching their baby grow and develop. Many of the participants talked about loving their baby and having a unique bond with their baby. Some of them also shared feelings of insecurity wondering if they were bonding as much as they could be with their baby. One mom spoke to the pressure she felt to manage her emotions when she was caring for her daughter. She actively tried to be a happy version of herself when she was with her baby and reserved negative or challenging feelings to times when she was not with her daughter.

Overwhelming Love For Her Baby. P1 shared how she felt a powerful relationship with her son that was a bond unlike anything else she has experienced in a relationship. She described:

> For me it's just overwhelming. I love him so, so much. And I can't even process it sometimes how much I love him. It's just part of me. I mean, it feels like this is what I was meant for. Not necessarily being a mom in general just being a mom to him. And my bond with him. It's, yeah, it doesn't. There's nothing like it. (P1A, 340-343).

P1 explained how the powerful feeling that she experienced through her relationship with her son was about more than just becoming a mom. She attributed the powerful feeling that she tried to describe to her specific relationship with her son.

P2 felt similarly. She said, "I'm just like so completely in love with him that, like, on the day to day. That's great. You know, that's really all I need" (P2A, 720-721).

Learning to Be Present With Her Baby. P4 and P7 both described learning to slow down and be present with their babies by giving them their full attention. This is

something that both of them had to work at but it's something they identified as being valuable to their relationship with their baby since becoming a mom. P4 focused on engaging her baby in more creative play and to push herself "to just use all of those things that I guess I always had in me, but I didn't ever like think about, like, I know how to creatively play" (P4B, 496-497). She had fun and felt proud of herself when she was able to teach her baby about the things around them and to engage him. Her relationship with her baby was challenging at first because he was so fussy and didn't sleep well. She thought that she must be doing something wrong and she has grown into being able to meet him where he is at and accepting him on his terms.

P7 noticed that she was getting distracted by the many other tasks that she felt like she had to do as a mother and so she became careful to notice when she could give her daughter more "face attention. That's what I call it. Doing these little things with her because she is at that level. And just like trying trying to think of where her brain is and its development is helpful" (P7B, 481-483). For both P4 and P7 being able to focus on nurturing their relationship with their baby was important to them.

Fear of Not Being Enough For Her Baby. P2 expressed being worried that maybe she wasn't special to her son because she couldn't breastfeed. She thought that breastfeeding provided such a special bonding time for moms and babies and worried that they were missing out on that because they were using formula. Her own mom had reassured her as she was able to point out instances where her baby was attached to her and looking for her, which seemed to put P2 at ease some.

P3 felt scared about becoming a mom because she viewed her role as a mother as being a protector. It felt like a big responsibility to her, that she would now be the one

responsible for watching out for this baby and making sure that she is okay. Unlike the moms who were overwhelmed by the unique bond they felt they had with their baby, P3 described a generational transition from her mom being her protector to her now being the one to watch out for her baby. She described:

> You know you're, you become an adult and you're like worried about yourself. But then you have a kid and you're like, I'm the person who has to protect this baby. You know, like as much as I might feel afraid for myself when things are happening, you know, the virus or things politically or whatever, you know, this baby can't protect herself from those things. I have to be there. So it's a little scary (P3A, 25-29).

Pride And Joy From Watching Her Baby Develop. P3 shared the happiness she felt when she watched her daughter learn new skills and how she wanted others to observe and take joy in her daughter's development. Most of the other participants shared that watching their baby grow and develop was the thing that most consistently made them happy postpartum. They expressed feeling pride and were in awe of their baby's growth.

P5 shared a memory of a special connection with her baby where her baby kept sharing with her a clump of dirt that was clearly very interesting to her baby. She said:

> And yeah, like things like that are starting to happen more often and are just really cool and make you just think about, like, you know, humanity and the things that you love being shared by someone that you love, which is like the greatest joy, I think, when someone you love is also loving something you love. I think it's just so great. And that's kind of what she was trying to do with me in the clump of

dirt. I think you know, like I've been sharing this poster with her and she's like

sharing this dirt with me, like, isn't this like the greatest thing, Mom? Yeah, and

that's something you found. And you want to gift it, gift that experience to me.

And yeah, those are moments I really like (P5B, 555-562).

For P5, seeing her daughter discover how to share joy was a profound experience for both

of them. She was able to recognize that her daughter had learned independently how to

find something she enjoyed and took interest in. For P5 she experienced a reciprocal

bonding where her daughter now started to enrich her mom's life by pointing out

something beautiful that P5 might not have taken note of otherwise.

Expressing Love Through Care. P6 spoke about her relationship with her baby

in terms of care. She had been building her relationship with her baby by making sure

that her baby's needs were met and that she was educated about how to best meet those

needs. P6 also described her and her husband being a united parenting unit so two major

ways that she was interacting with her baby was through the intentionality that she and

her husband were sharing about caring for their baby and by investing in her marriage to

maintain a relationship that was capable of caring for their baby. P6 described that:

having a baby was like a very intentional decision that we made like we planned

the timing of it very intentionally and like it's something we were like working up

towards like she was a very planned, baby. So in the lead in and and all of that we

had the kind of discussions of being like, what's this going to be like? What are

we going to do with regards to like daycare? What are we going to do for regards

to care? What are we going to do for middle of the night feedings? And that kind

of like, everything's kind of a conversation. Which I think is really good. And we

try not to make decisions without having the other person weigh in (P6B, 402-

408).

P6 described how her relationship with her partner was primary and that their relationship

was what helped to facilitate the bond between them and their baby.

Feeling Pressure To Be A Happy Mom Around Baby. P5 described feeling like

she had to manage her emotions in such a way as a mother that limited all negative or

challenging emotions to time when she was not with her baby. There were times when P5

described needing a break from her daughter. She talked about how she felt pressure to be

a happy mom with her baby, which resulted in her shielding parts of herself from her

interactions with her baby. She described:

sometimes I just feel like it's not me really being myself. Like I'm being the the

mom, the happy mom that is like telling her all these words and helping her play

and stuff and I'm being like a version of me but I am I don't want to always live in

that version of me and so that's, that's what gets exhausting (P5A, 338-341).

She went on to further explain:

I feel like the part of myself that knows, you know, not everything is so great and

wants to feel sad and wants to feel angry or frustrated. I can't, I can't feel those

ways around her when I'm on duty, and so I feel like I just need to have a break

and like go feel them somewhere (P5A, 354-357).

P5 described here the amount of emotional energy that she put into being the kind of

mom she thought she should be for her daughter which meant that she needed time away

from her daughter in order to feel all of her own emotions.

Understanding Relationship With Her Partner

Marriage and the way that these moms related to their partners dramatically changed for some participants and not for others. Determining how their relationship was and assessing its functionality and health appeared to be a component of *postpartum processing.* Participants described a spectrum of feelings about their partner from being grateful for having their partner through the transition to caring for a baby to feeling anger and resentment towards their partner postpartum.

Relationship With Partner As A Source of Strength. P6 felt like she and her husband enjoyed their time together before they had their baby. She shared, "we really did have a good time together as a couple beforehand" (P6B, 524). After getting pregnant unexpectedly several years ago, she and her husband decided to terminate the pregnancy because they weren't ready to give up their ability to spend quality time together as a couple at that point. As parents, their relationship was as strong as it was before having their baby. They approached taking care of their daughter together and made efforts to help one another and engage one another. They made decisions together and functioned as a cohesive couple. Learning how to parent together allowed them to recognize new strengths in each other as well that they could use as parents. P6 described being grateful for her husband and that she could fathom how challenging it would be to parent if they were in a "bad communication time" (P6A, 476).

P3's husband has been there for her. He was the only one at the hospital with her and he was with her at home during the first postpartum weeks. When describing the first few weeks she said, "We were a team. We are still a team, but we were such a team then" (P3A, 456). She also discussed how much she struggled with her mental health the first few weeks and she explained, "as much as my mental health was trashed. At that point I

would have been I have no idea where or how I would have been if he wasn't there"
(P3A, 461-463). There were limits to her husband's ability to relate to her experiences
fully because he didn't have the same experience as her, but ultimately her relationship
with her partner was a source of strength and support for her. They became closer as a
result of having their baby and going through postpartum together.

      P4's relationship with her wife was one of the most important supports for her
postpartum. She and her wife did everything together regarding childcare for the first few
months and went through the experience of becoming moms together. She shared:

> Like we were very much like together in all of the parent duties and I think there's
> a lot of interesting things there that like we are a same sex couple and we, you
> know, have this type of relationship like I don't know how the experience is
> different for people who have a male partner that are maybe not as historically
> connected to those like motherhood duties, but for all those factors like we really
> go through our whole day with our son like together (P4A, 374-378).

She talked about how they are committed to talking through tension. She also described
that their relationship is also different now because it went from being just them to them
becoming a family and that they have had to navigate how to take care of everyone's
needs which was a new challenge for them to take on.

      Relationship With Partner As A Source of Stress. P1 expressed having more
tension in her marriage because of how stressed both she and her husband were. They had
no support outside of each other, which meant that they were exhausted and anytime one
of them got a break it was because the other one was watching the baby. She explained:

we have bad days where we hate each other, but we know that it's like, literally,

this is a pandemic, like we don't have help like we'd have to accept that we're

going to hate each other at times like just fight and it… neither of us is like

running for like a divorce or anything like we just accept that it's going to be

tough at times, so we're not going to always get along because of this, and we've

had that talk (P1A, 555-559).

There is enough support in their relationship where they both helped with childcare when

her husband was home from work and they spent time together in the evening after the

baby had gone to sleep. There is limited connection though because they were both just

so tired when they reunited at the end of the day.

P2 described that it was hard to go through parenting in such a different way than

her husband. She felt like she had an instant connection and bond with her baby while her

husband did not, at least initially. This made her feel sad and more distant from her

husband. He had few previous experiences with babies so he didn't know the basics of

how to care for a baby while P2 felt like the basic child care was innate to her because

she already had practice with it from being around a lot of babies in her life. It got easier

once she could see the bond getting stronger between her husband and baby and now that

her husband is more comfortable with childcare. This in turn made her feel more

comfortable in her relationship with her husband because their baby is something that

they related to each other about.

Anger and Resentment Towards Husbands. P5 and P7 experienced their

relationships with their partners similarly to one another. They felt distance between

themselves and their husbands. They both expressed feeling anger and resentment

towards their husbands because their husbands were able to live their lives essentially the same way they did before the baby was born while their own lives were so dramatically different. P5 felt like her marriage was largely made up of each of them negotiating time away from each other and from the baby in order to get things done that they needed to get done. She felt alone with the bulk of childcare and household responsibilities and she also felt like she couldn't fully trust her husband if he were to take on more responsibilities because he had shown poor decision making in the past. P5 described feeling alone.

P7 similarly felt isolated in her role as mom. She desperately wanted her husband to understand just how much her life has changed since the baby was born. In order to help increase his awareness she left the house for two weekends and left him to care for the baby while she went to her parents house and did her taxes and work for her business. She thought he understood a little more than he did and she hoped that eventually by understanding more he would share more of the emotional labor with her. Both P5 and P7 stressed how the inequity in emotional labor was a burden for them to carry and was largely based on their assumed responsibility for taking on caring for the family and house in addition to caring for the baby since they are responsible for childcare full-time.

What Do I Have To Do?: Processing Tasks Of Motherhood

Four main tasks of motherhood were found in this study. Mothers had to process their emotions and experiences with providing breast milk, working as a mom, navigating existing definitions of motherhood and how they fit or did not fit into those definitions, and they had to make sense of how the COVID-19 pandemic changed things for them.

When mothers focused on these tasks they experienced a range of emotions from pride to despair.

Process And Pressure To Provide Breast Milk

Breastfeeding was one of the major sources of stress for moms, especially during the beginning of their postpartum experience. All seven moms tried to breastfeed. P6 was the only mom who reported, "we had a really easy time feeding her" (P6A, 278). P6 and her husband gave their baby both breastmilk and formula from the beginning. Each participant at the time of the interview gave their baby formula in some amount, except for P7 who used donor breast milk to feed her baby. P7 was able to pump while her baby was in the NICU but then stopped when she got home because it was just too much to manage. The moms who were using formula each reported that their baby was fine and healthy on formula. Five of the seven participants spoke about the physical and emotional toll that trying to breastfeed and not being able to took on them. Six of the seven participants identified that there was too much pressure to breastfeed.

The process and pressure to breastfeed and pumping were detrimental to the mental health of many of the mothers. Each of these mothers wanted to do what was best for their baby, which they were told was to breastfeed. After they took great efforts and exerted concerted energy to try to figure out how to make breastfeeding work, they came to realize that breastfeeding was negatively impacting them and becoming an issue that took a toll on their mental health.

P1 started off by breastfeeding but recognized that it was causing her anxiety, which was something that she was attentive to and protective of herself over because she knew how bad it could get if she couldn't manage her anxiety. She explained:

I wasn't able to successfully breastfeed because of my anxiety. It was starting to

cause me anxiety. And I realized it and I shut it down. Like I knew. I'm sure

there's women who don't understand what anxiety is or don't know when they're

feeling it. They just know they feel they don't feel good. And they continue to try

to breastfeed because they feel that they need to. And I felt that mom guilt, too,

but I knew that anxiety was creeping in. I just couldn't. I knew better, like I knew

not to do that to myself (P1A, 598-603).

P1 believed that because she was familiar with her anxiety she was better equipped to

notice it and care for it than other moms who might not be as familiar with anxiety.

P1 explained:

I have a huge problem. This is another soapbox for me. But like, I have a huge

problem with the way breastfeeding is pushed- the way. Not that, I get promoting

it but like the way it is pushed is at the detriment of maternal mental health. And I

feel like a lot of women suffer needlessly. Because of that, that there is no middle

ground there that it's like you're either a bad mom or, you know, breastfeed. It's

like that to me is so toxic, but I even like was starting to fall victim to that. I had

to stop because I was feeling that anxiety creep in, like, pretty much instantly and

you're basically like they're kind of forcing some women to starve their child. It's

like, how much endurance do you have for starving your child so that they can

figure out how to breastfeed (P1B, 446-454).

P1 specifically called out the pressure put on moms to breastfeed and how she sees an

issue with it because she thinks moms are suffering trying to meet the expectations that

others have for moms to breastfeed.

P2, P3, and P4 had really personal reactions to struggling to breastfeed. They experienced a lot of emotional turmoil, stress, and disappointment in themselves that it was something that didn't work for them. P2 described:

> and not everything is intuitive. It's hard. Like breastfeeding. That was just torturous for us. Like it just did not work for us. That was really, really disappointing. I like really, really wanted to be able to breastfeed and it was just so unbelievably painful like excruciatingly painful and um, you know, I was going to the lactation consultant, like every week and things weren't getting better (P2A, 477-481).

P2 talked about still feeling sad about it and feeling cheated out of the experience of breastfeeding her baby. She still felt like, "I wish that was something that we could do together" (P2A, 495-496). Not being able to breastfeed further contributed to her feeling like her body wasn't able to do what it was "supposed" to be able to do as a woman and as a mom. Additionally, P2 found that once she started talking to other moms about her difficulty breastfeeding they opened up about their own challenges breastfeeding or shared the hard experiences of friends who also struggled to breastfeed. When asked what it was like to find out that other moms had similar experiences to her she shared:

> Oh, it was kind of relief. It was like, oh, okay, like I'm not the only one. And there was like several other people to where it was like, oh, this one had a tongue tie and oh, that one had a tongue tie and um it was just, it was also a little, like, why didn't people tell me this? Like I felt sort of like what the heck. Why didn't I know about this? Um, yeah yeah that was. So it was a mix of both both like relief, like, okay, I'm not the only one like there are all these other babies that have had this

problem and they're perfectly fine. Um, But also kind of like frustration, like, well, I really wish that I had known about this ahead of time so that it could have been prepared in some way (P2B, 290-296).

In reflection on this P2 talked about how she wasn't sure if it's that mothers aren't talking about the challenges of being a mom and breastfeeding or if people who aren't mothers are just trained to tune out moms who talk about breastfeeding.

One of the few moments that made P3 emotional during her interview was when she talked about how she was still sad and disappointed that she wasn't breastfeeding her baby. She was worried that her baby was missing out on really important things because she wasn't getting breast milk. P3 had done research and saved pins on her Pinterest board because she wanted to be educated and prepared to breastfeed her baby. It was really important to her. She explained:

I wanted to breastfeed. This makes me feel kind of sad to talk about. I don't know why. But I couldn't get her to latch properly. So we just couldn't. I felt so like inadequate. I felt like I wasn't doing the best thing for her. It was like, what am I doing wrong? I didn't know what to do. Um, And I felt like I had nowhere to turn to. Because, you know, they, I had to leave the hospital early because of the virus, like I couldn't spend as much time talking to a lactation consultant, as I would have liked to. I couldn't just go to one (P3A, 267-273).

P3's postpartum anxiety was really rough during the first few weeks and a lot of her worry was about her daughter's health. P3 worried that she was starving her baby or that her baby was dehydrated because she wasn't getting enough breast milk. It was challenging to try to breastfeed since it was important to her and something she felt like

was best for her daughter but also to worry that her daughter wasn't healthy because she wasn't eating enough. She started giving her daughter formula and immediately her daughter had enough wet and dirty diapers which was a relief in one sense but was still distressing because giving her daughter formula conflicted with her valuing breast milk so much. P3 pumped to try to keep giving her baby breast milk but the demand of keeping a pumping schedule while doing everything else that she needed to in order to care for her daughter was rough. She reflected:

and I was already so anxious, you know, and so afraid and so worried that like trying to pump and trying to breastfeed made it worse. I was like, this isn't working (P3A, 334-335).

She eventually decided to stop pumping which was a hard decision that was still difficult for her but it helped her mental health.

P4 felt like she had every resource available to her to make breastfeeding work and she still wasn't successful breastfeeding. She went into having her baby thinking that breastfeeding would be hard but was told by a friend who is a lactation consultant that only 5% of mothers can't breastfeed because of medical reasons which reassured P4 that she would be able to breastfeed with the right support. P4 assessed her breastfeeding experience as being impacted by her anxiety. She thinks her milk wasn't coming in because of her anxiety, which caused her greater anxiety. She kept trying to breastfeed while also supplementing for several weeks and described what her lactation consultant friend told her, which was when she decided to stop breastfeeding entirely. She said:

She was like cut out the formula immediately. Nurse constantly and he will essentially go into like survival mode because he's gonna starve and figure out

that he needs to start working harder at your breast to get what he needs. And I

literally looked at my wife and I was like, not doing that. I'm not starving my

baby into being able to nurse. That is, to me felt like the worst, most terrible thing

to do to like make him suffer for like my shortfall. So I was like, I can't do it.

We're not doing that (P4A, 333-338).

Continuing to try to breastfeed by essentially starving her son, even if temporarily, felt

cruel to P4 and is where she drew the line about what she was willing to sacrifice in order

to try to make breastfeeding work.

P4 eventually got connected to supportive and nonjudgmental lactation

consultants who were able to help her navigate feeding her baby with formula. Bottle

feeding her baby was something that P4 had not anticipated but ultimately she described

learning how to adjust on the go so that she could do what she thought was actually best

for her baby instead of what she wanted to be best for her baby.

P5 felt like the most challenging times for her postpartum were related to

breastfeeding. She explained:

I feel like the really challenging times I mean, a lot of them had to do with

breastfeeding. I like I did not like breastfeeding. I never really you know, felt that

yeah, that thing that people who love it feel, I guess. And I was just kind of doing

it because I thought I was supposed to (P5A, 570-572).

She went on to talk about how she didn't feel comfortable breastfeeding in public, which

meant that there was a very limited amount of time when she could get out of the house

with her baby between her baby napping and nursing at home. P5 described feeling

trapped during the time when she was breastfeeding her baby because it meant she was

stuck at home so much of the time, even before COVID.

P1 wished she had been more educated about a middle ground approach to

breastfeeding, like breastfeeding and supplementing with formula. She understood that

there is a biological aspect to breastfeeding and if you don't breastfeed or pump then your

supply goes down, but she thinks that, "there's gotta be a better way" (P1A, 469) P4

described how she wished there was more education about what breastfeeding is like

realistically and what bottle feeding is like realistically, and then what it is like or what

you can do if you need to switch or supplement.

Working As A Mom

Being a mom is work. Pretty much every participant noted their exhaustion at

some point during the interview. It was something often noted off-handedly, like it was

something they were so used to that it wasn't worth elaborating on. Most of the moms

who participated in this study were employed in some capacity. P6 was the only mom

who physically left her home for a job. P1 and P4 were employed but worked from home

due to the COVID-19 pandemic. P5 worked part-time from home. P7 owned a business

but worked few hours because her workload shrank because of the pandemic. P2 was on

maternity leave and was planning to return to work. P3 did not have employment outside

of the home but planned to find a job at some point in the near future because she was

stressed about finances.

Finding Dignity In The Work of Mothering. Four participants changed their

ideas about productivity as a way to adjust to motherhood. This was a huge challenge

because the nature of the baby's schedule was cyclical and repeated around every three

hours. The cycle consisted of eating, playing and sleeping. These moms described how difficult it was to get used to their baby's routine. P4 shared:

> Feeling productive, it's always been something that like for my mental health like really like centers me like when I'm feeling anxious and out of control. I need to like accomplish a task and being productive and it makes me feel better and I think there were times when I didn't quite embrace or know how to like deal with him as a baby and like what to do with him. I felt that sort of like out of control feeling of like, oh my God, what do I do for the next 30 minutes like he's awake and he ate and like not gonna go to sleep and like what am I going to do, just like stare at you like, I don't know. And I think now finding moments of what I can do, and how to change it has like made me feel productive (P4B, 524-532).

Finding ways to feel productive caring for her baby instilled in P4 a greater sense of importance in the work that she was doing as a mother, especially in the moments where she simply connected with her baby.

P5 started keeping track of everything in a calendar so that she could see that she was actually accomplishing things. She described how hard it was not to be evaluated on her work and to have to run on her own, "self satisfaction" (P5B, 260). That is one way in which caring for her child felt very different than being employed from her perspective.

P7 noted that the specific language of "job*"* (P7B, 492) when referring to her work as a mother helped her find purpose in her childcare responsibilities. She said, "yeah, so, calling it a job and calling it work helps me mentally be better, be okay with the fact that that is my job" (P7B, 492). The transition from working full-time to being a

mom full-time was a challenging transition so she found ways to bridge her experiences

by making her work as a mother more professional to herself.

P2 shared how she had to train her brain to consider childcare as being a valuable

way to spend her time. She shared:

So I felt like, um, when he was like wake up from a nap. I'd be like dang it, you

know like, why? There's nothing else that I'm supposed to be doing, like, that was

the thing I really had to learn was like this is how the time is supposed to be. Like

this is how I'm supposed to be spending my time, there's not something else that

I'm like supposed to be doing right now um. Like this is just how this part is, but I

was like, I don't know if it was just, I don't know if it's like being in like our

American culture of like such a focus on productivity. But like letting go of like

feeling like I needed to be doing something or like feeling I need to be getting

stuff done when the thing that I'm supposed to be getting done is caring for my

child. So that took a while to really like let go of. And now, now it's much more

comfortable that like my entire day revolves around his schedule. Um, it's much

more comfortable for me and like now I'm like, I don't want to go back to work

(P2A, 526-537).

It took time for P2 to shift her expectations of what productivity looked like. She was at a

point now where she has transitioned to being more comfortable on her baby's schedule.

P6 also talked about ways in which they enjoyed the nature of caring for her baby.

She enjoyed being organized and planning for her baby. She talked about how she liked

to do research so she found pleasure in the task of researching different approaches to

taking care of their baby. She liked the process of having conversations with her husband

to make decisions about caring for their baby. These conversations were fulfilling because they brought her and her husband together close because they approached childcare as a project that they got to work on together utilizing each other's strengths.

Managing A Household Burdened Full-Time Mothers. P5 and P7 both talked about the stress of managing a household in addition to caring for their child full time. Because of these responsibilities both moms talked about a strange experience of time, how they were "bored" (P5B, 365) or "very calmly tending" (P7B, 325-326) to their baby while their baby was awake and then as soon as the baby was asleep they had to switch gears and become highly productive to get chores done. In order to be successful managing childcare and their households they both kept lists of things they needed to do. P5 had moved beyond lists to creating an organized calendar that had a place for each task that she wanted to accomplish. Tasks that she shared from her calendar included:

> when to get flu shots. What we want or need in a new printer and how much we're willing to pay, all the things I have to do for my job this week. And then things like buy my brother in law's birthday present, research child care options, work on family finances for the month of September, complete a list of activities we can do for baby inside, order more bras. That's just for me. Order a family recipe book and a book of baby sign language. And then under home, it's like sweep floors, steam broccoli and cook sweet potatoes for baby, wash bedsheets, and then one and a half hours of intentional tidying, which is when I time myself, for my tidying, like meals, meals I will cook and then date specific to do and appointments (P5B, 173-181).

P7 confirmed that:

I do think [my mind] was constantly racing and thinking of what, what do I need

to get done. And these are things that don't necessarily need to get done. But like

when I have the time, what am I going to do and like making little lists constantly

(P7B, 255-258).

Being in charge of childcare full time and the responsibilities of running a home and

family put a lot of pressure on these moms and made a lot of demands for their time that

were overwhelming to them. P7 talked about how being a mom alone is more than a full-

time job because it is 24/7 on demand. They both expressed feeling alone and isolated

with the workload that they were responsible for.

Employment Bringing Relief From The Demands of Motherhood. P5 had

recently started to work part-time as a way to make money for her family and to have a

break from childcare. She struggled because she felt like she shouldn't need breaks from

childcare since it's her job and her husband was able to do his job. Despite the guilt, she

also recognized that she needed breaks. Caring for her baby full-time was not what she

had expected it to feel like. Taking time to work part-time was a comfortable way that

she was able to negotiate getting increased childcare help from her husband. In order to

care for her daughter full-time and work part-time, she and her husband scheduled times

during the workweek when he watched the baby. It was an evolution of sorts to get to the

point where she had scheduled child-free time during the day to get her work done.

Typically, something worked for a while and then she got overwhelmed and had a

breakdown and then she and her husband evaluated what needed to change.

P6 was the only mom who physically left her home for work. Her baby was in

childcare outside of the home and work had been a helpful outlet for her. It helped her

maintain her sense of identity because she had a space where she could interact with people as an individual person and not as a mom. It also was something that she was doing before the baby was born so it added continuity to her life and lifestyle. She did better when her existence was about more than just her baby. It felt healthy to her that she had space from her baby while she was at work.

P4 worked full-time from home. Her mother-in-law took care of the baby a few days a week and then a nanny took care of the baby in their home the other days. Going back to work had a very positive effect on P4. She further reflected:

> I feel like I can build like I can pull strength from other areas of my life to bring them back to him like I can go and like recharge at work or by calling a friend or like taking a walk by myself. And then I can like bring that back to his space to like be more present with him and give him more of myself. Whereas before, I felt like he was literally just like draining me like emotionally, physically, like it was so draining and it was hard to feel filled up or lifted, just because I was giving so much. And so I think that for me I found this balance in like going elsewhere to kind of take what I need. (P4B, 125-131)

She spent most of her maternity leave in physical contact with her baby, which she described as being emotionally draining. Starting to work again gave her space from her baby in a way that she really enjoyed. She felt like she was able to be a part of something that filled her up so that she had more to return home with and share with her son and wife, whereas before, she felt like she wasn't able to fill herself back up again after she poured so much into her baby.

Navigating Existing Definitions Of Motherhood

P6's perspective on motherhood was shaped by the moms that she saw around her but also the social constructs of what motherhood should be. She was aware of what she described as "mom culture" (P6A, 534) mostly by observing the ways in which some mothers talked and presented themselves on social media in particular. P6 described that in mom culture:

> just basically everything revolves around your child and not in a way that necessarily like highlights your child as a person, but in a way that highlights you, does that make sense? Um, And then there's also like a judgmental, judginess that goes with it and like having the right stuff for your kid, have doing the right milestones doing like I feel like there is a little bit of like a secret script for like all the stuff you're supposed to do (P6A, 128-132).

P6 internally resisted mom culture because it was important to her to maintain her sense of self even after becoming a mom. Also, because P6, had two previous pregnancies, she was hesitant to think about herself as a mom until her baby was actually born and even then it took time for her to think of herself as a mom casually because it was a title that she felt didn't fit her. She preferred to think of starting a family as her husband, herself and her baby as being, "each other's people" (P6A,93).

Being autonomous and having her own sense of self were also important to P7 and the way she went into motherhood. P7 struggled in pregnancy because she was suddenly confronted with the ways in which others felt entitled to have and voice opinions about the way she used her body as a pregnant woman. P7 described a disagreement that she had with her husband and his family of origin about her decision to play softball when she was pregnant.

Oh, it was awful. Yeah, it was like, What did I sign up for? You know, it got

pretty pretty heavy, pretty quick. Because I was like, ultimately, I'm doing what I

think is best. You know, I think I and at the time I was using the argument that

softball was good for my mental health, and that was important. Because it's a

release and whatnot. And I was like, I'm doing the best I you know I'm putting

myself in positions that are less harmful, you know, less less likely for the ball to

hit me in the stomach or whatever it is you guys are worried about and ultimately

I think exercising is good for me. So that's what I want to do. And eventually I

mean I did play, but it was you know, sort of a shitty feeling, knowing that they

were like you're doing this thing that could harm the baby and like finger pointing

if something happens that they were going to blame me for it. You know, so

certainly, certainly was not a good time and then during the pregnancy or in my

life (P7A, 205-214).

P7 found herself suddenly thrown into new ways that others felt comfortable interacting

with her because she was pregnant and becoming a mom. Her husband and his family

suddenly felt like they could voice their opinions about the way she chose to use her body

because she was becoming a mother, which gave P7 some insight into how others view

the role of mother. Ultimately, P7 prioritized her own beliefs and trusted her ability to

decide what was best for her and her baby but the friction she experienced with her in-

laws made her feel bad and took a toll on her emotionally. It became something that she

navigated carefully and it required emotional energy to manage doing what she wanted to

do while knowing that family disagreed with her decision.

P2 held a duality of her postpartum experience. On the one hand, her love for her baby and joy of finally being a mom was bright and palpable. On the other hand, she was trying to make sense of some very challenging feelings that she seemed to experience as a darker, more private side of motherhood. P2 appeared to struggle to fully access her more complicated feelings about motherhood that were not positive because they were distressing to her. She described feeling ease and pleasure by feeling what she thought she was "supposed" to be feeling as a new mother and she harbored guilt, shame, anxiety, and rage about the disparity she felt between her actually experiences as a mother and what she imagined becoming a mother to be like. Since P2 had a cesarean section and was not able to breastfeed she was in an existential crisis about what that meant about her as a mother. In regards to her cesarean section he explained:

> But like there is like a part that kind of feels like I like I feel like I didn't like give birth. You know, I like I, I had to have my baby cut out of me, you know it's it's really different. It's really, really different. I didn't get to have that like sense of accomplishment (P2B, 42-45).

She felt like she missed out on defining experiences and that has been challenging for her to reconcile. She described trying to remind herself that being a mom is about more than childbirth and she hoped that with time, it would be easier to feel more steady in her identity as a mother despite not having an idealized childbirth experience.

P4 didn't have much time to consider if she wanted children when she was younger because she was told she could never have a child due to a medical condition that she was diagnosed with as a teenager. So she grew up thinking that something was wrong with her body and was shocked when her OB recently told her that there was no

reason that she knew of that she couldn't conceive a baby. This information shocked her

and allowed her to shatter old messages about her body. She explained:

> Being able to like trust my body and then I had, I got pregnant, super easy and
>
> had a fantastic pregnancy. I was like, oh my god, like this is this is not what I
>
> expected. And this is really kind of incredible. It kind of like challenges,
>
> everything that I thought I knew about myself growing up to like experience
>
> something different in pregnancy (P4A, 208-211).

P4 had to process the shift in her thoughts about herself based on a previous

understanding of her body that simply was not accurate. Through pregnancy she learned

that should could trust her body, which required letting go of old truths she believed

about herself previously.

P4 was very inspired by the theory of attachment parenting. She went into being a

mother with the expectation that she would prioritize her baby's needs over her own and

that she would provide continuous physical and emotional support to her baby around the

clock which included breastfeeding and bed sharing. P4 stopped breastfeeding because

her milk production was low and she stopped bed sharing because her baby fell out of

bed. She also started to question parts of attachment parenting theory as well once she

realized that she did better when she had some space from her baby and also prioritized

some of her own needs. P4 had to let go of some visions of what parenting should look

like. She reflected:

> And all of a sudden, I'm like oh my god this is everything we did not expect to do
>
> as a parent. We have a bottle fed, pacifying baby, which was so not the plan. And

I think it just took time for like my mind and my body to catch up with like, that's

okay. Like, it's okay (P4A, 543-546).

Part of P4's task as a mother was to readjust her expectations of what a "good" mother

looked like so that she could best meet the needs of herself and her baby.

The COVID-19 Pandemic Changed Things.

The COVID-19 pandemic put mothers in a unique historical situation where they

had to make sense of an ever-evolving global pandemic while also learning how to care

for an infant. The pandemic mostly made mothers feel more isolated as a direct result of

being impacted by the social limitations of the time. Many of the mothers experienced the

COVID-19 pandemic as making their transition to motherhood more challenging.

However, one participant described some ways in which the social implications of the

pandemic made her lifestyle more relatable to other people around her who didn't have

an infant.

P1 worked from home so she cared for her daughter full-time and worked full-

time, which was an adjustment that she felt like she handled well. She focused her day on

her baby's needs and got work done when she could. Caring for her baby was definitely

her priority during the day. She had planned to use daycare and return to work after her

maternity leave but the COVID-19 pandemic changed all of that. She described:

I feel like I went into a cave and never came out like I went into the cave for my

maternity [leave] and never came out. I'm still living in that cave and it feels like

the world's never going to be the same (P1A, 405-407).

The arrival of the COVID-19 pandemic was shocking. P1 described how intensely she

experienced the collision of the COVID-19 pandemic with becoming a mom. That was a

sentiment that others touched on as well. So much changed for P1 due to the COVID-19 pandemic's impact. P1 found herself in an alternative reality that shaped her daily life so that it looked very different from what she had imagined before having her baby.

Another way that the COVID-19 pandemic impacted P1 is that she and her parents decided that it was too risky for them to see each other. This meant that P1 did not get the support from her parents that she had expected. She felt alone, isolated and hopeless. P1 thought that if it weren't for the COVID-19 pandemic she would have been able to manage her mental health without medication but the additional stress of the COVID-19 pandemic made her anxiety more intense and felt out of control to her.

P7 was also impacted by the COVID-19 pandemic and expected to have her business and work full-time which would have allowed her to use childcare for her baby. She never wanted to be at home full-time with her baby and was someone who enjoyed the fast-pace of her work. She found worth and value through her job. Her business was effectively shut down due to the COVID-19 pandemic, which meant she had to adjust to being with her daughter all day and not having employment. Being forced to stay home full-time because she essentially lost her business was distressing to P7 but she also worked towards accepting her situation without grieving it too much. She focused on trying to re-acclimate and adjust to her new reality.

P5 quit her job because she wanted to be at home with her daughter full-time but the COVID-19 pandemic altered the vision that she had for what being a stay-at-home would be like, and made it more isolating. Because of the COVID-19 pandemic she wasn't able to take advantage of free childcare options through gyms and community centers. She felt more isolated since she couldn't be a part of mom groups in person. She

expressed that because of the COVID-19 pandemic there was just a lot less support than she had counted on as a stay-at-home mom.

P2 was able to get support from her parents as soon as she got home from the hospital but she was aware of a deep longing in her to be with other new moms going through similar experiences. The COVID-19 pandemic made it so that she wasn't able to be in community with other moms the way that she had hoped she might be able to. She described:

> I do think in general like and I do think that it's because of COVID like I definitely even while I was pregnant. I like really had this intense like desire to like be with other people going through pregnancy and like going through this experience like I've, I definitely felt a bit isolated um. Yeah, I had this like strong like sense and like feeling that like I'm supposed to be doing this, like a, like in a tribe. Like I feel like this is a life experience you are supposed to be like doing it like with your peers. And we don't necessarily get that (P2B, 239-244).

This feeling that becoming a mother should be more of a community event with other moms was shared by P3. She shared:

> when I was in college, I took this class and we learned like about anthropology of reproduction. Right. And we talked about a culture where they have like a sitting or something. And like all the mothers of the tribe or whatever, come to the house when you give birth. Like, do that. Get all the mothers of your tribe. Don't be alone. What a horrible time to be like just alone, and the only and be the be the only mother there by yourself going through something like that. (P3B, 381-385).

P3 felt more alone because the COVID-19 pandemic limited her contact with the important mothers in her life. She found ways to visit her aunt who was an important mothering role model to her but her own mother hadn't met her baby because she couldn't travel from Trinidad to the United States because of the COVID-19 pandemic. P3 also felt like she wasn't able to access lactation support as easily which contributed to her struggling to breastfeed even though she wanted to breastfeed.

P4 recognized that it would have been helpful to her to have friends around after they came home from the hospital so that they could have shared their baby with others. She thought there would have been a lot of joy in that experience that would have been helpful to her when things were challenging that first month postpartum. Her parents hadn't met her baby yet because none of them were comfortable with them taking a plane to visit. Not having her parents around after the baby was born was a source of stress.

P6 was the only one to share the positive ways in which she felt the COVID-19 pandemic impacted her life with a baby. She thought that because of the COVID-19 pandemic, the pace of the world was more aligned with the lifestyle of having an infant. Everyone was spending more time at home. She thought that she might have experienced a sense of loss during the transition to having a baby if she saw friends doing things that she could no longer do or if she missed out on parties or events, but none of those things were happening. Furthermore, she thought that having a baby was helping her and her husband potentially cope better during the COVID-19 pandemic because their baby was an entertaining distraction and kept them busy, while she thought people who didn't have a baby or kids might struggle more because they had more free time filled with idleness.

Conclusion

This chapter presented findings from the qualitative study of first-time mothers' postpartum mental health experiences. Four essential themes were identified: What Just Happened?: Processing The Childbirth Experience; How Am I?: Processing Personal Well-being; How Are We?: Processing Relational Health; and What Do I Have To Do?: Processing Tasks of Motherhood. The findings within each theme were reviewed in detail so as to map out the postpartum mental health experiences of first-time mothers.

Chapter Five

Discussion

The purpose of this study was to better understand first-time mothers' postpartum mental health experiences and was guided by two research questions: *How do new mothers experience their postpartum mental health in comparison to how they experienced their mental health before having their baby? How do new mothers make sense of their postpartum mental health experiences?* Seven first-time mothers with a baby under the age of one were interviewed twice over the span of 4 to 7 days, using an adaptation of Seidman (2019) "in-depth interviewing." The researcher then mapped out the essential elements that appeared to shape the postpartum mental health experiences of the participants using Giorgi (2009) descriptive phenomenological method in psychology. This chapter will cover the findings of this study, limitations, recommendations for future research, implications and a conclusion.

Findings

Postpartum was found to be a time that consisted of processing mental health experiences within four essential themes. Each mother in this study experienced postpartum processing differently and had a unique experience making sense of her own postpartum mental health. What united the mothers in this study was that there were four key themes that each mother had to process. The four essential themes that made up first-time mothers' postpartum mental health experience were the following: What Just Happened?: Processing The Childbirth Experience; How Am I? Processing Personal Well-being; How Are We?: Processing Relational Health; and What Do I Need To Do?: Processing Tasks of Motherhood.

The processing at times was short and definitive. Other times, processing was ongoing or something that a mother returned to at different times throughout her postpartum mental health journey. Processing each theme led mothers to experience a range of mental health reactions from being positive/supportive to being stressful/challenging. The themes were not experienced in any particular order. The ways in which mothers experienced their mental health in each area contributed to her overall mental health, although some areas were more impactful than others and the level of impact varied for each mother.

Mothers' mental health was impacted by a range of postpartum experiences. This study suggested that postpartum mental health is about more than a list of symptoms to mothers. Participants in this study described experiencing their mental health in dynamic and fluid ways. Each of them described moments of joy, happiness, and connection as well as moments of despair, isolation, and confusion. Their mental health was affected by their relationships, their responsibilities, their existing ideas about motherhood, and the degree to which they felt they could access supportive relationships and systems.

Overall, mothers who felt capable of caring for their mental health and those who felt like they had choices and support were able to navigate postpartum processing with greater ease than those who felt stuck and unsupported. This study suggested that childbirth is an intense experience that requires meaning making, while there was limited time for recovery and processing. Many mothers expressed not being emotionally and mentally prepared for the experience. Childbirth was generally experienced as a jarring separation between a former stable life and a chaotic life filled with high-demands that

needed to be figured out quickly, all while being physically injured from childbirth and having an emotional reaction to the demands of *postpartum processing*.

What Just Happened: Processing the Childbirth Experience

Childbirth is a significant health and life event. The experience of having a baby and becoming familiar with how to care for a baby and how to manage life with a baby was filled with the need to process new experiences. There is limited data on the association between a mother's mode of delivery and postpartum well-being (Dekel, Ein-Dor, Berman, Barsoumian, Agarwal, & Pitman, 2019). Dekel et al. (2019) found in a quantitative study with 685 women that one out of three mothers who had an unplanned cesarean section experienced PTSD symptoms postpartum. Several other studies have found that mode of delivery does not have a significant impact on postpartum depression (Sword, Landy, Thabane, Watt, Krueger, Farine, & Foster, 2011) or postpartum emotional distress (Adams, Eberhard-Gran, Sandvik, & Esklid, 2012). Czarnocka and Slade (2000) found that specific aspects of labour and delivery such as duration and mode of delivery had no significant association with PTSD symptoms, although the "perceptions of support from partner and staff, perceptions of control and patterns of blaming, together with factors such as trait anxiety and past mental health problems do appear to act as predictors (p.49)".

The mothers involved in this study had to process the physical and emotional aspects of childbirth. Physically, mothers' bodies were injured during childbirth and they did not receive sufficient postpartum healthcare. They felt in the dark and abandoned about how to best care for their bodies postpartum and had to navigate healing on their own. Some mothers came out of their childbirth experience with a loss of faith in the

healthcare system. Mothers experienced health issues during labor that they had not anticipated, which caused them emotional distress fearing for their own and their baby's well-being. Mothers felt unable to care for their baby right after labor because they were so physically exhausted, injured, and emotionally traumatized which brought up sadness and disappointment in themselves that now that their baby was there they felt like they were not in a position to care for them.

The childbirth experience was disorienting for mothers because of the physical and emotional reactions that they had not expected to have. Long-term health issues and changes in the way their bodies functioned as a result of childbirth appeared to be particularly distressing to mothers. A major barrier to processing the impact of their childbirth experience on their mental health was the rapid speed in which mothers had to adjust to caring for their newborn and the co-occurrence of other experiences demanding their mental, emotional and physical energy such as trying to breastfeed and becoming accustomed to the cycle of baby needs throughout the day.

How Am I? Processing Personal Well-being

When asked explicitly about their postpartum mental health, mothers conceptualized their mental health as diagnoses such as anxiety or depression, even if they had never formally been diagnosed. It was evident that mothers thought about their mental health from organic-medical and psychological paradigms aligned with diagnostic language from the *DSM-V*. This finding aligned with the literature review for this study, which found that generally, postpartum mental health scholarship conceptualized mental health from organic-medical and psychological paradigms.

By limiting their conception of mental health to diagnoses using a psychological paradigm or an organic-medical paradigm some mothers missed opportunities to intentionally support their mental health beyond tending to their depression or anxiety. Research that used a systemic-relational paradigm showed that social support impacts maternal mental health (Leahy-Warren, McCarthy & Corcoran, 2011; Darvill, Skirton, & Farrand, 2010) including the support of a partner (Taubman-Ben-Ari, Shlomo, Sivan, and Dolizki, 2009; Dennis & Ross, 2006). Additionally, mothers could have assessed how capable they felt of accessing supportive relationships as a way to have conceptualized their mental health (Mauthner, 1999).

Using a social constructivist paradigm, mothers could have thought about their mental health as it related to socially constructed concepts of motherhood. O'Reilly (2004) promoted the idea of empowered mothering, which encouraged mothers to question patriarchal perspectives on motherhood by affirming their own agency and authenticity. Using the idea of empowered mothering, mothers could have assessed their mental well-being based on how empowered they felt in their role as a mother. Similarly they could have thought about their mental health as how capable they felt of embracing "good enough mothering" (Pedersen, 2016; Silva, 1996; Winnicott, 1953) instead of the expectations of intensive mothering (Hays, 1996).

By limiting their perspective of mental health to assessing their anxiety and depression, mothers missed out on thinking about their mental health from different relational and social perspectives. Since mothers didn't have knowledge beyond diagnostic language, they weren't able to process some other ways in which they were thriving. Additionally, some mothers were distressed because they couldn't understand

why they struggled with anxiety or depression due to being unaware of how their

relationships and social expectations impacted their mental health.

Despite the challenges that these mothers experienced postpartum, they found

ways to cope and actively tried to identify ways that they could increase their personal

well-being. Each mother had a unique approach to coping that was personalized to

herself. Many of the ways that mothers coped further support existing postpartum

literature. Social support was one of the most prominent ways that moms have coped

postpartum (Emmanuel, Creedy, St. John, & Brown, 2011; Negron, Martin, Almog,

Balbierz, & Howell, 2012; Reid & Taylor, 2015; Surkan, Peterson, Hughes, & Gottleib,

2006; Webster, Nicholas, Velacott, Cridland, Fawcett, 2011; Xie, He, Koszycki, Walker,

Wen, 2009). Mothers in this study also used reframing and acceptance, which Gutiérrez-

Zotes, et al. (2016) identified as a successful method to help mothers cope postpartum.

Currie (2009) found that moms who tried to integrate wellness into their everyday life

had an easier time coping postpartum which several moms were able to do in the study.

Several mothers used exercise as a way to cope postpartum which was supported by

(Blum, Beaudoin, & Caton-Lemos, 2004).

Mothers benefited from mental health support through counseling, medication, or

both. Those who had established systems of mental health support were grateful that they

had places to turn to when they were struggling. It was beneficial to them to have

somewhere to go without having to research how to access support systems postpartum.

How Are We Doing?: Processing Relational Health

Relationships played an important role in navigating postpartum mental health.

Mothers described a process of becoming more relational in their worldview. There was

an unspoken shift in identity from thinking individually to thinking more relationally and at a family system level. They had to balance their own needs with the needs of their baby and their partner and were no longer the single priority in their lives.

The mothers in this study suggested that there was something powerful happening for many of them by being in relationship with their baby. It was also distressing to the mothers not to experience joy and closeness with their baby. Taken in context of each of the other themes that are a part of the maternal postpartum mental health experience phenomenon, it appeared that these mother's relationship with their baby served to be one of the greatest sources of positive emotions postpartum and was even a driving force and motivator to work through their mental health challenges.

One way to think about mothers assessing their relationship with their baby is that mothers were assessing the nature of their attachment to their baby. Mothers themselves were ultimately asking, 'do I feel safe and secure in my relationship with my baby?' Attachment is one of the most researched areas related to maternal mental health. Most of the research on mother-infant attachment focused on the impact of attachment on the baby. Less is known about the impact of the mother-infant attachment on mothers, which is one way to interpret mother's assessing their relationship with their baby. Ainsworth and Bell (1969) acknowledged the "interacting spiral" which captures the ways in which both the mother and baby play a role in the mother-infant relationship. This supports the acknowledgement that mothers are impacted by their babies. Bretherton (2013) highlighted this overlooked aspect of Ainsworth's work on mother-infant relationships that is still currently under-researched. The potential here for increased research on this topic is discussed in more detail in the future research section.

The findings of this theme support limited previous research that found that a mother's postpartum mental health could be impacted by her attachment with her partner and perceived support from her partner. Iles, Slade, & Spiby (2011) found that parents with high levels of attachment anxiety and avoidance and parents who were less satisfied with the level of support they perceived from their partner were potentially at greater risk of posttraumatic stress and depression after childbirth. Mazzeschi, Pazzagli, Radi, Raspa, and Buratta (2015) found that attachment security works as a protective factor against parenting stress and that attachment insecurity can act as a risk factor in predicting parenting stress. More generally, adult attachment styles impact adults' mental health (Johnson, 2018). The ways in which mothers formed attachment to other adults in their life including their partner impacted their well-being postpartum.

Additionally, the birth of a child can greatly change a couple's life by magnifying traditional gender roles. After the birth of a child, many couples tend to transition to a more traditional division of labor which can lead to greater marital stress (Gjerdingen & Center, 2005). The mothers who struggled the most with their partners described taking on more traditional gender expectations for mothers, especially as it relates to mothers being responsible for managing the household and family needs. Their anger and resentment, which was directed towards their husbands, could potentially be anger and resentment towards patriarchal values and notions of motherhood (O'Reilly, 2004).

What Do I Have To Do: Processing Tasks of Motherhood

Mothers described three main tasks of motherhood that impacted their postpartum mental health: the process and pressure to provide breast milk, working as a mom, and navigating conflict about existing definitions of motherhood. Processing tasks of

motherhood were generally experienced as initially overwhelming however, overtime, mothers started to make more sense of their experiences and many were able to reconcile differences between expectations and reality.

Providing breast milk for their baby was experienced by the majority of mothers as being a major stressor. Many mothers wanted to breastfeed and were unable to. Mothers described spending a lot of emotional, mental and physical energy trying to make breastfeeding work. When they ultimately made the decision that breastfeeding wasn't working, many moms tried to pump their breast milk. Pumping was a stressful experience for them and most mothers decided to stop pumping because it required so much time and it was time that they would rather spend with their baby.

The majority of mothers expressed how they felt like the medical world put too much pressure on mothers to breastfeed, which contributed to their mental health distress when they struggled to breastfeed their baby. Mothers worried that their babies were missing out on something very important because they weren't breastfeeding. Several mothers talked about wishing there was more education and conversations with medical professionals about alternative ways to feed their babies such as breastfeeding and supplementing with formula or more education about formula use in general.

The American Academy of Pediatrics (AAP) recommends that mothers breastfeed for one year and encourages pediatricians to, "communicate the benefits of breastfeeding and the risks of formula feeding" (AAP, 2020) to all patients. The AAP website, which recommends that mothers breastfeed for one year, does not address maternal mental health. There is limited research on the impact of breastfeeding on maternal mental health (Borra, Iacovou, & Sevilla, 2015; Wouk, Steube, & Meltzer-Brody, 2017). Borra,

Iacovou, and Sevilla (2015) observed that the impact of breastfeeding on postpartum depression is not well known and that there are conflicting findings in the existing literature. Borra et al. (2015) found that when looking at breastfeeding experiences, the highest risk of postpartum depression was for mothers who intended to breastfeed but were not breastfeeding their baby, which highlighted the need to provide accessible support for mothers who planned to breastfeed but didn't for whatever reason.

Mothers in this study elevated a marginalized perspective, which was that breastfeeding and pumping were detrimental to their postpartum mental health. This concept carries social stigma and challenges the medical narrative that mothers should absolutely breastfeed. Feminist critics have suggested that breastfeeding advocacy contributes to mothers feeling shame and guilt (Taylor and Wallace, 2012). Exclusively breastfeeding has been found to best meet infant's nutritional and health needs (AAP, 2020), but maternal mental health also impacts infant well-being (Kingston, Tough, & Whitfield, 2012). A mother struggling with her mental health can have negative implications for herself and for her baby making it is just as important to prioritize maternal mental health as it is to prioritize an infant's nutritional and health needs.

Mothers who were responsible for childcare full-time described having to find ways to demonstrate to themselves that they were being productive and that their work as a mother was important and valuable. Vejar, Madison-Colmore, and Maat (2006) found that there is limited data on mothers who care for their children full-time and that studies focused on motherhood tend to focus on child development and needs versus the mother. Schultheiss (2009) further noted the gap in knowledge about the work of mothering and how there is a lack of research on motherhood as a career.

The ways in which the mothers who participated in the study struggled to find inherent worth in the work of mothering is a reflection of the ways that American society takes mothers for granted (Rich, 1986) and trains workers to assess their value based on their production output. Mothering required a shift in perspective, which was no longer about a quantifiable output measure. The work of mothering instead required quality interaction, attention, and connection that a mother provided to her baby. The mothers didn't seem to be conscious of why the adjustment to the work of mothering was challenging for them and no one explained to them how to become more comfortable with their role. Many of the mothers discovered on their own that they felt like they were doing their job as a mother well when they measured their success on their ability to be present and attentive with their baby.

Existing definitions of motherhood shaped the experiences of the participants and their transition into motherhood. Part of their postpartum processing was focused on reconciling ideas about motherhood that didn't end up serving them once they actually became mothers. They also had to navigate the definitions and expectations of motherhood that others had for them. "The good mother" (Hays, 1996) was a consistent ideal, which they wrestled with, as was the concept of "masks of motherhood" (Maushart, 1997), which describes the ways in which mothers try to conceal the darker sides of motherhood. Participants described the pressure they felt to experience motherhood in a particular way. Mothers described a pressure of idealized expectations from themselves and others about how motherhood should be experienced such as having a vaginal birth, breastfeeding with ease, only being happy once their baby was born, and prioritizing the baby's needs above their own. Many mothers, however, were unable to articulate an

active, conscious awareness that they had to reconcile toxic messages about motherhood with the realities of mothering. The exception to this was that participants did consistently identify the pressure placed on mothers by medical professionals to breast feed, which was one definition of mothers that they could point to as being problematic for themselves and other mothers.

It appeared that most of the participants were in the process of making meaning about how their lived experience of motherhood conflicted with their expectations of what motherhood would be like and that many of them seemed to be stuck in their ability to process and understand the ways in which the discrepancy between the expectations and realities of motherhood was a source of emotional and psychological distress. For some mothers it was as if they sensed that there was something unjust happening postpartum or that they had been ill-prepared in some way but they didn't have the vocabulary or a working framework to guide their meaning making process beyond their own experiences. For other mothers, their lack of consciousness about the social pressures put on them through patriarchal ideas of motherhood led them to feel personal shame or like they were a failure. With or without an awareness of toxic cultural messaging about motherhood some participants coped through their distress by gaining increased confidence in their own ability to discern what was best for them, their baby and their family. O'Reilly (2004) describes this approach to motherhood as empowered motherhood.

Core to feminist thinking is the belief that the personal is political. Additionally, a foundational understanding within motherhood studies is that motherhood is both an identity and an institution (Rich, 1976), which is aligned with the concept of the personal

being political. Overall, it was evident that most of the mothers who participated in this

study understood motherhood as an identity and they were less aware of the ways in

which motherhood as an institution shaped what they felt and experienced. Mothers who

understood motherhood primarily as an identity described feelings of isolation and shame

from not meeting the social expectations of what a mother is supposed to be able to

achieve. The mother who was most aware of motherhood as an institution experienced

her awareness of the harmful patriarchal systems and beliefs about motherhood as healing

and it served as a coping resource for her as she worked to make sense of her mental

health struggles postpartum. She was able to understand her issues as being more than a

personal failure and could recognize the systemic failures that contributed to her stress

and lack of structural support. Furthermore, her increased consciousness about

motherhood as an institution helped her feel empowered and more connected to other

mothers.

The COVID-19 pandemic played a unique role in impacting these mothers'

mental health postpartum. Most of the mothers expressed having what they believed to be

more mental health issues postpartum because of the COVID-19 pandemic than they

thought they would have had if there wasn't a global pandemic going on. Most mothers

felt isolated because of the COVID-19 pandemic. Many mothers didn't get as much

support as they had planned on which was challenging both practically and emotionally.

It was challenging practically because they had less help with the baby and with chores.

The emotional challenge was experienced due to feeling disconnected and like they

missed out by having important people with them. Mothers also expressed that they felt

like they missed out on bonding with other new mothers who went through the same

experiences as them. They had a deep desire to be with other mothers, which they described as feeling an intuitive push to be in community while they became mothers. Davenport, Meyer, Mesh, Stryndka and Khurana (2020) found that there has been a substantial increase in pregnant women and mothers who were less than a year postpartum who self-reported depression and anxiety during COVID-19 compared to pre-pandemic rates.

Feminist Critique And Contextualization of Findings

It is useful and necessary to examine the findings of this study through a critical, feminist lens that is curious about the ways in which first-time mothers' postpartum mental health issues might be manifestations of social shortcomings and not just personal failures so as to further contribute to a growing feminist counter-narrative of motherhood. Mothers in this study expressed receiving inadequate postpartum healthcare that left them feeling like they had to figure out their postpartum injuries on their own. Mothers described inequity in emotional labor at home once they became mothers signaling the persistence of traditional gender roles which assume that a mother who cares for her child full-time should also be responsible for running a household and managing a family's affairs. Mothers named the ways in which they had to teach themselves how to view their mothering work as being valuable and productive because that is not a lesson they had already learned in a culture that takes mothers for granted. Mothers talked about the time-pressure of trying to get work done from home because they didn't have access to affordable childcare that would allow them time and space to complete tasks for their jobs. Mothers outlined the ways in which breastfeeding was promoted and how the use of formula is stigmatized and negatively impacted their well-being.

Mothers need increased access to quality postpartum care, they need greater shared emotional labor in their partnerships, they need to have society reinforce the belief that the work of raising children is indeed valuable and productive, they need increased access to affordable child care, and they need to be better educated on how to feed their babies without sacrificing their mental well-being or their infant's well-being. These are social issues and not just mother issues. A society that supports its mothers will be a more stable society that is capable of nurturing greater humanity.

Limitations

This study had several limitations. Being a qualitative study, the findings of this study are not generalizable. Phenomenological research explores individual experiences deeply, which is an important contribution to scholarship. This research approach also has limited findings of this study to the participants who were interviewed. Additional or different stressors might have emerged with different participants so it is important to contextualize these finding so that readers understand that the phenomenon studied here was both universal to the participants of this study and limited in that the phenomenon of first-time mothers' postpartum mental health experiences was studied through the experiences of these seven participants' experiences.

By the nature of this study, in order for a theme to be established, the theme must be experienced by each of the participants. A limit of this approach is that the researcher is unable to identify experiences that participants want to avoid. Since the existing themes exist on a continuum from fully processing an experience to being in the process of making meaning, experiences that are avoided cannot be captured. Perhaps there were other essential experiences of *postpartum processing* that simply did not appear across

the interviews because some mothers talked about it and others didn't or none of the

mothers talked about an experience because it was something that they were actively

avoiding.

When designing this study, the researcher weighed the merits and challenges of

including a diverse population of research participants in a phenomenological study. The

greatest benefit was being able to prioritize social justice as an important value within

this study and was a way to acknowledge the intersectional identities that mothers have.

A challenge proved to be gaining access to diverse participants on the limited timeline of

this dissertation. In reflection, the researcher understood that gaining access to diverse

participants most likely requires building the kinds of relationships needed to gain trust

from a group that might perceive an outside researcher with skepticism.

The participants included in this study shared many identities. The research would

have benefited from a more diverse group of participants. The women who participated in

this study had economic and educational privilege. Most of the mothers had racial

privilege as well, in that they identified as white women. The postpartum mental health

experiences of first-time mothers is a universal phenomenon that is experienced by all

mothers. Since this study had limited diversity, the study was only able to understand this

phenomenon as it was experienced by a select group of mothers. No qualitative study is

generalizable, but this study would have been strengthened by greater diversity in

identities so as to initially explore this phenomenon with a wider lens.

The COVID-19 worldwide pandemic contributed another limitation of this study.

Some of the mothers who participated in the study had their babies before the pandemic

started and some had their babies after it started. All of them experienced parts of their

time postpartum during the COVID-19 pandemic. Each mom articulated ways that they believed the COVID-19 pandemic had impacted their postpartum mental health and experience. There was no way to measure or tease apart in what ways the COVID-19 pandemic was impacting them specifically, which meant that there was an additional shared phenomenon occurring simultaneously while trying to study the phenomenon of postpartum mental health experiences. All phenomenological research is tethered to specific times and places based on the experiences of the participants. For this study, the contextual influence of time and place was heightened because of the unusual nature of experiencing the impact of the COVID-19 pandemic.

Due to the COVID-19 pandemic, these interviews were conducted virtually. There were certainly benefits to being able to conduct interviews remotely. Mostly, it made participating in the study more accessible for mothers with babies. However, there were also things that may have been missed because of the remote nature of the interviews. The researcher spent concerted effort trying to build rapport with participants and helping to make them feel comfortable through the process. Having interviews in person might have further contributed to feeling a sense of trust between the participants and researcher, which is an essential goal of phenomenological research. An increased sense of trust between the participant and researcher might have helped to yield greater depth in what participants shared in their interviews.

This study was done as a dissertation and by its nature was a mostly solitary research endeavor. Research is often strengthened through collaboration, especially qualitative research. This study was limited in that it was run by an individual and did not benefit from a research team. The solitary nature of this study made the findings more

vulnerable to researcher bias. While the researcher tried to manage the potential for bias, ultimately, working with a larger research team would have helped to check researcher bias more closely. The researcher also transcribed and analyzed the transcriptions alone which was a limitation of this study.

Lastly, a limitation of this study was my own proximity to the phenomenon, which was investigated. At the time of this writing, I am nearly two years postpartum after the birth of my first baby. Going through the experiences that I myself studied for this dissertation potentially made me more susceptible to researcher bias. To help manage this vulnerability, I returned to the participant's transcripts often during the data analysis process to ensure that my findings were rooted in the actual experiences of the participants and not based on my own preconceived ideas of what the findings might be. It was reassuring to me as a researcher that I was surprised by some of the findings which demonstrated to me that I was at least partially successful in basing the findings of this study on participants' experiences and not my own. I worked to bracket my own experiences throughout this research process by journaling my own reactions to participants interviews and the perspectives that they shared in an attempt to provide myself space to process my own personal reactions to what participants shared and so that I could be aware of biases that I brought into the research process. I also discussed initial findings with my advisor, a peer and my methodologist.

Recommendations For Further Research

Each of the themes analyzed in this study offered potential areas for future research. By better understanding the four themes identified in this study, researchers might be able to gain greater insight into specific ways that new mothers experience

stress and strength postpartum. Additional qualitative and quantitative research in these areas would be beneficial.

Studying maternal mental health through a mother's life stages has been suggested by others (Schultheiss, 2009) and continues to be an area that would benefit from further exploration. It would be helpful to better understand if *postpartum processing* is a phenomenon that moms also go through with subsequent births and if so how their experiences compare to first-time mothers. There is limited research on maternal mental health beyond the postpartum stage and studying the nature of maternal mental health as mothers themselves develop would yield valuable data that could further prepare mental health professionals to support mothers.

A quantitative exploration of similar research questions to this study would enhance knowledge about postpartum mental health that could be generalizable. This study has demonstrated that women are navigating a time in life filled with rapid change and processing, which impacts their postpartum mental health. Having generalizable data based on quantitative research questions similar to the research questions in this study can help researchers potentially develop a mental health scale that can assess maternal postpartum mental health beyond just a depression scale.

As mentioned in the findings section, it would be beneficial to better understand the impact that babies have on mothers while they form the infant-mother relationship and their style of attachment. It would also be useful to better understand attachment between mothers and their partners and what impact their attachment has on maternal, paternal and the infant's mental health. Mothers who felt safe and secure in their relationship with their partners appeared in this study to experience greater resilience and

flourishing postpartum. This observation is notable and worthy of further research. Additionally, mothers are aware that attachment matters so it would be helpful for research to focus on how to help mothers have a better understanding of how to form a secure attachment with their baby.

This study also highlighted a great need for more research on the ways in which breastfeeding and providing breast milk for babies impacts maternal mental health. Existing research on breastfeeding has neglected to address the impact that breastfeeding has on a mother's mental health. The findings of this study suggested that breastfeeding is challenging and that it takes a great deal of emotional, mental and physical energy right after the baby is born. The participants in this study named that they felt like there is too much pressure to breastfeed and that they wanted more options and to feel educated about all of their options so that they could make an informed decision based on what they believed was best for them and their family. Further research is needed in order to investigate this further so that mothers and medical providers are more fully aware of all of the ways that breastfeeding impacts babies and mothers including their mental health.

Using counseling paradigms (Cottone, 2012) would be a helpful way to explore maternal mental health from specific theoretical paradigm perspectives. This study investigated the experiences of first-time mothers' postpartum mental health from a broad perspective allowing mothers to fill in the details of how they understood their mental health postpartum. Counseling paradigms (Cottone, 2012) could lend a useful structure to further investigate postpartum mental health using specific paradigms so that more detailed information can be learned about the ways that mothers experience their mental

health using the organic-medical paradigm, the psychological paradigm, the systemic-relational paradigm, and the social constructivism paradigm.

Mothers exist within a family system. It would be illuminating to conduct a similar study focused on the mental health experiences of partners of first-time birth mothers. This study captured one side of married couples' transition to becoming a parent. Understanding the other perspective of what it is like to become a parent as the partner of the birth parent would illicit important data and expand understanding on this topic. By better understanding the mental health experiences of birth mothers' partners, perhaps greater insight can be gained into parts of the family system impacting the well-being of infants, mothers and partners.

A final area for future research is studying the experiences of more diverse mothers. This study only interviewed participants who were married even though being married was not a part of the selection criteria for the study. Understanding the postpartum mental health experiences of single mothers and mothers who adopt their children as infants would be helpful as would understanding postpartum mental health experiences of more diverse people including racial, socioeconomic, religious, ability status, gender, and political diversity. Studying postpartum mental health experiences globally using this study's approach would also enrich the field.

Implications

Counseling

This study illuminated several implications for counselors working with new mothers. The first is that having a strong emotional connection with a partner and communicating openly with that partner supports postpartum mental health. Emotion

Focused Therapy, which helps couples increase their emotional connection and attachment, might be a beneficial intervention for couples to use before having a baby so that they are well positioned as a couple to transition to parenthood together. Counselors can serve clients by taking the opportunity to teach attachment to individual parents and couples in a non-judgmental and supportive way so as to combat the social stigma associated with struggling to maintain secure attachments in relationships. Counselors can model empathy and compassion towards significant adult figures in clients' lives who were unable to provide them with secure attachments and should consider contextualizing attachment within a systems perspective. Counselors can reinforce the fact that it is not only a mother's responsibility to equip their child with attachment security but that it is the role of many significant adults surrounding each child. The purpose of attachment work is not to blame those who were unable to provide clients with secure attachments but to help clients learn the skills necessary to begin to form secure attachments as an adult, especially as a parent. Additionally, the work of John and Julie Gottman focuses on strengthening couple's relationships and has a resource specifically designed for first-time parents called *And Baby Makes Three*, which is a book meant to help parents care for their marriage after they have a baby.

Mothers need greater access to resources that will prepare them mentally and emotionally for postpartum. Many hospitals have birth classes, which educate women and partners on labor and delivery. Pregnant women and their partners would also benefit from a similar class focused on educating them about postpartum mental health and steps they can take to have as many important supports in place as possible before their baby arrives.

In regards to breastfeeding, The AAP is advocating for the physical health of infants. Mental health professionals need to advocate for the mental health of both mothers and infants. Mental health professionals know attachment matters and that attachment impacts infant well-being. A depressed and anxious mother will have more of a challenge time forming a secure attachment with her baby. Mental health professionals need to advocate for mothers by engaging in professional dialogue with medical professionals so as to educate them on the ways in which mothers' mental health is being negatively impacted by the pressure they are feeling to breastfeed.

It would be helpful to expand the conversion about depression and anxiety postpartum beyond a mother not being able to bond with her baby or a mom only feeling anxious about her baby. Mothers in this study expressed confusion over what's been communicated to them about postpartum depression and postpartum anxiety, which was limiting in scope. It is critical that moms who experience mental health distress seek help. Limiting the nature of postpartum mental health to being connected to the mother's relationship with her baby is keeping some mothers away from seeking help for their mental health either because they believe their issues aren't technically postpartum or because they want to avoid stigma associated with postpartum depression. The truth is that the terms postpartum depression and postpartum anxiety are not clinical diagnoses and that the ways in which they are described to moms is not substantiated by empirical evidence. Mental health providers would do mothers a great service by being intentional in the use of their language when talking to moms about postpartum mental health.

The counseling field should engage healthcare providers and other mental health providers in a professional conversation about postpartum mental health. The *DSM-V* is

the standard tool used to assess and diagnose mental health issues. There is a professional

issue that medical providers and mental health providers are using diagnostic language of

"postpartum depression" and "postpartum anxiety" without the accepted professional

standard of actually being a diagnosis in the *DSM-V*. The potentially harmful impact of

using diagnostic language without being a diagnosis is that there is in imprecision and

inaccuracy in the ways that postpartum mental health is being explained and presented to

mothers. This causes unnecessary confusion at a time when mothers are already

processing a great deal of new information. Counselors should advocate for mothers by

demanding that postpartum maternal mental health is talked about in a way that is

reflective of empirical evidence and expanded to be inclusive of a full spectrum of mental

health experiences, including thriving postpartum. The language of "postpartum mental

health" instead of "postpartum depression" or "postpartum anxiety" is a more accurate

way to talk about postpartum mental health in a way that is not deceptively diagnostic.

Counselors need to play a more active role in leading the public conversation on

postpartum mental health because as a field, counseling offers ways to conceptualize

maternal mental health beyond the medical model. This is a strength of counseling that

has underserved mothers because there is not an active dialogue in the counseling

community about maternal mental health or postpartum mental health. Beyond

"postpartum depression" and "postpartum anxiety" there are other ways to understand

postpartum mental health, which can be informative and empowering to mothers as they

try to make sense of their own postpartum mental health experiences. Counselors are

extremely well positioned to support mothers during this vulnerable time of transition and

should proactively offer mothers and society counter conceptualizations of maternal postpartum mental health.

Feminist therapists in particular can play a pivotal role in supporting maternal mental health by facilitating consciousness raising spaces for mothers to learn about and process toxic and unachievable patriarchal concepts of motherhood that can negatively impact postpartum mental health. By giving mothers a collective opportunity to access concepts and a vocabulary for the disparities they might feel between idealized visions of motherhood and the lived reality of being a mother, counselors can help mitigate and manage some of the shame and isolation mothers might feel postpartum when they are unable to live up the unrealistic social expectations of mothers. Naming oppressive assumptions about motherhood can be a deeply healing process postpartum and can help better prepare mothers who are pregnant.

Currently, mothers are more isolated as a result of the COVID-19 pandemic and would benefit from greater support and access to connecting with others mothers through support groups. It would be helpful if counselors could invite mothers to be in community with one another virtually throughout the COVID-19 pandemic so that they might not feel as alone during their transition to motherhood. Counselors who facilitate support groups for new mothers can play an important role in providing support that mothers are struggling to find outside of social media and their current support system of family and friends.. Groups focused on well-being and breastfeeding, pre-pregnancy, pre-delivery and postpartum periods would be especially helpful to care for maternal mental health.

Healthcare

Women need increased access to postpartum healthcare. This is already something that is being advocated for by the American College of Obstetricians and Gynecologists. Women need to be fully informed about their childbirth injuries and what steps they can take to heal their bodies. Additionally, mothers' healthcare providers are well positioned to talk to mothers about their mental health and connect them to resources. Additionally, medical professional and other breastfeeding advocated can better support mothers by using a mother-centered approach (Benoit, Goldberg, & Campbell-Yeo, 2016). Benoit et al., (2016) wrote, "emphasis of the care provider on the importance of women's experiences in infant feeding would support women's ability to conceptualize what being a good mother means to them, as opposed to idealist maternal behaviour being imposed by health care providers and the broader social context (p. 63)." Infants and mothers are both impacted by breastfeeding so conversations around breastfeeding should include consideration for both infant and maternal well-being.

Doctors should continue to or start screening moms for depression and anxiety and/or talk to moms about their mental health. At present, mothers are usually seeing their baby's pediatrician more often than a postpartum health care provider. A pediatrician played an important role for one of the moms interviewed in this study by screening for and identifying depression in this mother so that the pediatrician was able to connect the mom to mental health support. Pediatricians are well positioned to be on the frontlines assessing parents' mental health and can play an important role in getting parents the mental health support they might need but are unaware of.

Mothers

Many of the mothers in this study assumed that their experiences were unique and unlike the experiences of other mothers who might be having a smoother transition, were able to breastfeed with ease, had a happy childbirth experience, or weren't overwhelmed after the birth of their baby because they were so physically impacted from childbirth. The reality was that many mothers had shared experiences, which were more common than they thought. Due to this disparity between perception and reality, mothers would benefit from informative and honest conversations about postpartum experiences before having a baby and while going through the postpartum period.

Mothers in this study wanted more information about all of the ways that they could potentially feed their infant. Mothers would benefit from being fully educated about infant feeding methods before having their baby, including how to implement or transition from one feeding method to another. Mothers who are fully informed about the potential risks and benefits of all infant feeding methods would be better prepared to conduct their own risk assessments postpartum to determine the best method to feed their individual baby considering all relevant factors including their own state of mental health, which is a valid and important factor.

Mothers should consider asking the healthcare provider who delivers their baby what their own childbirth injuries are. It is their right to know what happened to their body during childbirth so that they can seek greater information about how to heal. Mothers can ask to be connected to specialists who can help them physically recover postpartum. Pelvic floor therapy can be a helpful first step in helping mothers become acquainted with their postpartum bodies.

The mothers in this study benefited from having pre-established support systems. Support systems included having assistance at home right after the baby was born so that mothers had help with chores and had more time to sleep; a sense of support and connection with their partner; other mothers they could talk to; ways that they could take breaks from childcare; and an established relationship with mental health professionals. Having a close and secure relationship with a partner seemed to be a potentially important resilience factor for mothers postpartum.

A mother who feels unsupported or insecure in her relationship with her partner would benefit from couples counseling before or after their baby is born. Additionally, a couple that struggles with communication would benefit from couples counseling before or after their baby is born. The relationships in this study that demonstrated the greatest stability approached parenting as a team, encouraged one another, and looked to learn and use one another's strengths. Mothers would benefit from having direct conversations before and after their baby is born about what her own and her partners expectations are of her role as a mother and her partner's role as a parent. More specifically, full-time mothers and their partners should discuss whether managing the household and family needs should also be their responsibility in addition to caring for their child full-time.

It became important to the mothers in this study to be able to feel present and in the moment with their baby. There were all kinds of distractions that made being present and mindful challenging for mothers. It would be beneficial for mothers to identify what barriers exist for them that might make giving their baby dedicated, focused attention difficult. It is important to note that being present did not require a certain or large amount of time for the mothers in this study. The feeling of mothering well came from

intentional moments where mothers could give their baby their full attention that seemed to require quality over quantity.

It would be valuable for mothers to understand the ways in which toxic patriarchal notions of motherhood impact their personal and relational well-being. This can be done through consciousness raising with other mothers so as to identify what toxic patriarchal notions of motherhood are and how those notions are impacting their lives. O'Reilly (2004) suggests that mothers work towards empowered mothering as a response to patriarchal influences over motherhood. The concept of empowered mothering encourages mothers to seek out ways that they can feel like they have agency and autonomy so that mothers are in the best position to care for themselves and others.

Taking care of an infant and learning to be a mother leaves a small margin of space for other emotional needs. It would be helpful for mothers to do all that they can to reduce the amount of stress in their postpartum life. Every stressor makes the postpartum period more challenging. Mothers who can reduce the amount of stress in their life to the best of their ability before their baby is born will be as well positioned as possible to care for the postpartum mental health.

Mothers should seek mental health support postpartum and could benefit from therapy during and after pregnancy, even without being in crisis. Becoming a mother is a major life transition and even if the experience is without any major complications it is still a time in life when mothers are required to process a lot of changes in a short amount of time. Therapy is a helpful resource to support mothers who are struggling with their mental health and to support mothers as they make meaning of their transition to motherhood.

Conclusion

The initial desire to complete this study was to demystify postpartum mental health, especially by better understanding the experiences of first-time mothers. By illuminating the specifics of what the mothers in this study experienced and how their experiences impacted the ways in which they understood their mental health it is the hope of the researcher that there is greater awareness of what being a first-time mother is like and how much they have to navigate. Becoming a mother and starting to care for a child is not an innate, easy process. It is at times scary, overwhelming, confusing and isolating. There are also times of happiness and joy, growth and connection despite the challenging tasks that mothers are confronted with after having a baby.

The postpartum period is filled with small and large reactions to new experiences and those reactions have to be processed. It is these experiences, and a mother's reactions to them, that make up first-time mothers' experiences of their postpartum mental health. Open and honest exposure to postpartum mental health is a way that others can become better educated and informed about the realities of having a baby, which is a counter narrative that challenges the assumed ease with which mothers are expected to become a mother and also normalizes experiencing a spectrum of emotions postpartum.

This chapter offered a discussion on the findings of this study. It also reviewed limitations, recommendations for future research and implications. The study of first-time mothers' postpartum mental health experiences provided important insight into the ways in which mothers processed their postpartum experiences referred to as *postpartum processing*.

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Appendix A: Recruiting Materials

Demystifying First-Time Mothers' Postpartum Mental Health:
A Phenomenological Study of the Transition to Becoming a Mother

Social Media Post

Are you a first-time mother with a child under the age of one? Your voice is needed! I am a counselor educator writing my dissertation on the mental health experiences of new moms to enhance our understanding of postpartum mental health during the transition to becoming a mother. If you would like more information about getting involved with this research please contact me at mdg47@mail.umsl.edu.

Email to organizations who can help recruit

Dear ___,

I am a counselor educator doctoral candidate at the University of Missouri-St. Louis and am writing to see if you would agree to forward my email below to anyone you think may be interested in participating in my study.

Hello!

I am a counselor educator doctoral candidate at the University of Missouri-St. Louis and am looking to interview first-time mothers with a child under the age of one. I am interested in hearing from new mothers themselves to learn more about their postpartum mental health experiences during the transition to becoming a mother. If you would like to learn more about the study and be interviewed for this research please contact me at mdg47@mail.umsl.edu.

 Sincerely,
Megan Dooley Hussmann

Appendix B: Informed Consent

UMSL│Education

**Department of Education Sciences and
Professional Programs**

College of Education

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St. Louis, Missouri 63121-4499
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Informed Consent for Participation in Research Activities
Demystifying First-Time Mothers' Postpartum Mental Health:
A Phenomenological Study of the Transition to Becoming a Mother

Participant _____

Principal Investigator: Megan Dooley   PI's Phone Number: ████████████

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You are invited to participate in a research study about first-time mothers' postpartum mental health. This research study is being led by Megan Dooley, doctoral candidate, and Dr. Emily Oliveira, faculty member in the Department of Education Sciences and Professional Programs at the University of Missouri-St. Louis. The purpose of this study is to better understand the experiences of first-time mothers as they transition into motherhood after the birth of a child or children. You will be asked questions about how you experienced your mental health before becoming a mother, how you are currently experiencing your mental health and what meaning you make of those experiences. You will also be asked to share the ways in which you thought and felt about motherhood before becoming a mother and what your typical day as a mom is like. The ultimate goal is to provide space for new mothers to provide insight into their experiences so that medical and mental health professionals might be better equipped to support mothers in addition to helping you make meaning of your transition to motherhood.

Your participation will involve being a part of two interviews, which will be conducted remotely online using a HIPPA compliant platform so as to protect your confidentiality. Your interview will be audio recorded. The audio recordings will be kept until the completion of this study and then they will be destroyed. Recordings will be kept confidential by saving them with a number that will be associated with your interview. Your name will not appear anywhere on any saved audio recording. Each interview will last between 60 and 90 minutes and will be spaced between three and seven days apart. You will be compensated with a $20 gift card for participating in the study. Approximately eight participants may be involved in this research at the University of Missouri-St. Louis.

Your participation is voluntary, and you may choose not to participate in this research study or to withdraw your participation at any time. You may choose not to answer any questions that you do not want to answer. You will NOT be penalized in any way should you choose not to participate or to withdraw. You will still be paid $20 for completing the interviews even if you choose not to answer specific questions.

Although unlikely, it is possible that some of the topics raised in the interviews may make you feel anxious or sad. If you feel like you need additional support following an interview, a list of resources will be provided to you.

We will do everything we can to protect your privacy. As part of this effort, you identity will not be revealed in any publication or presentation that may result from this study. In rare instances, a researcher's study must undergo an audit or program evaluation by an oversight agency (such as the Office of Human Research Protection). That agency would be required to maintain the confidentiality of your data. In addition, all data will be stored on a password-protected computer.

If you have any questions or concerns regarding this study, or if any problems arise, you may call the investigator, Megan Dooly at (314) 773-9559 or Dr. Emily Oliveira (314) 516-6099. You may also ask questions or state concerns regarding your rights as a research participant to the Office of Research Administration, at (314) 516-6759.

I have read this consent form and have been given the opportunity to ask questions. I will also be given a copy of this consent form for my records. I hereby consent to my participation in the research described above.

Participant's Signature   Date

Signature of Investigator or Designee   Date

Appendix C: Interview Guide

The following interview guide is for two 60-90 minutes interviews based on Seidman (2019) to conduct a phenomenological interview. The questions listed here are not in a particular order and will be used in response to the natural dialogue that takes place between the researcher and participant. Not all questions are required to be asked.

Interview One: Focused Life History and The Details of Lived Experiences

Focused Life History

Tell me about your life up until the point of becoming a mother.

When you think about your journey to becoming a mother, what/who has impacted you the most?

What did you think about motherhood before becoming a mother?

How did you feel about motherhood before becoming a mother?

Please tell me about how you experienced your mental health up until you became a mother.

> What has your relationship with your emotions been like?
>
> What has your relationship with others been like?
>
> What has your internal thinking been like?
>
> Were there times in your past when you felt like your mental health was strong?
>
> What were those experiences like?
>
> Were there times in your past when you struggled with your mental health?
>
> What were those experiences like?
>
> Are there ways that you have cared for your mental health in your life?
>
> Are there people you have talked to about your mental health in the past?

The Details of Lived Experiences

*Focus for the interviewer: This part of the interview is less about opinions and more about **details**. Ask the participant to express their thoughts, feelings, perception, and actions that they might take for granted in their everyday life.*

Will you walk me through your typical day as a mom?

> What is it like? (Sample follow ups: Who do you talk to, what is it like with your baby, what is it like with your partner if you have a partner, what is it like with others, what do you think about, how do you feel through out the day, where do you go, how do you spend your time, what are the things you find yourself caring about most or paying attention to, what worries you, what excited you/brings your joy…)

How have you experienced your mental health since becoming a mom?

> What have your emotions been like?

> What have your relationships with others been like?

> What has your internal thinking been like?

> Who are you talking to about your mental health?

Interview Two- Reflection on the Meaning

Researcher explains: This is the second and final interview. Thinking back to what you shared with me about your last interview:

What do your experiences as a mother mean to you?

How do you make sense of your postpartum mental health experiences?

> What does that mean to you?

What does it mean to you to think about your mental health before having your

> baby compared to your postpartum mental health.

Follow-up prompts/questions to gain more detail about their experiences:

Would you say more about. . .?

Please share some examples. . .

What else can you tell me about. . .?

What was your experience. . .?

Would you please clarify what . . . means?

Do you mind if I ask you more about . . .?

What happened then…?

Appendix D: Closing Email to Participants

Hello!

Thank you so much for being a part of my study! I am so grateful for you. I just sent you a giftcard to Amazon. Please let me know if you don't get it.

Like I mentioned, I will send you my initial findings to see if they resonate with you before I move forward with my final analysis and paper.

Here are some demographic questions that would be helpful as well if you feel comfortable answering them. They are by no means required.

Age:
Relationship status:
How long have you been with your partner?
How long have you been married to your partner, if you are married?
Race:
Sexual orientation:
Socioeconomic status:
State where you live:

Take care,
Megan

Appendix E: Member Check Email to Participants

Hello!

I hope you are well!

I wanted to share my initial findings with you from my study. My goal was to better understand the postpartum mental health experiences of first time moms. To do this I interviewed seven mothers who had a baby under the age of one. I mapped out the essential elements that appeared to shape their postpartum mental health experiences. Overall, I concluded that postpartum mental health is a time that consists of processing mental health experiences within eight essential areas. Each mother experienced postpartum processing differently and had a unique experience making sense of her own postpartum mental health. What united the mothers in this study was that there were eight key areas that each mother had to process. The processing at times was short and definitive. Other times, processing was ongoing or something that a mother returned to at different times throughout her postpartum mental health journey. Processing each area led mothers to experience a range of mental health reactions from being positive/supportive to being stressful/challenging The essential elements were not experienced in any particular order. The ways in which mothers experienced their mental health in each area contributed to her overall mental health although some areas were more impactful than others and the level of impact varied for each mother.

Here are the eight essential themes that I found that made up first-time mothers' postpartum mental health experience:

- Processing the childbirth experience

- Assessing relationship with baby

- Assessing relationship with partner

- Breastfeeding

- Working as a mom (work includes the work of being at home full-time)

- Being informed by previous understanding about mental health and motherhood

- Monitoring personal wellbeing

- Coping

I am so grateful that you were a part of my study! If you have feedback you would like to share I would love to hear it.

All my best,

Megan