The Lived Experiences of African American Women with Postpartum Depression: A Critical Hermeneutic Study

By

LaShawn L. Horton

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APPROVED:

Dena Hassouneh, PhD, R.N., A.N.P., P.M.H.N.P., A.P.R.N.-B.C., FAAN; Chair

Kristin Lutz, PhD, R.N.

Gail Houck, PhD, R.N. P.M.H.N.P.

Dedication

This dissertation is dedicated to the women who shared their stories of trial and triumph in bravery and honesty

Thank you for trusting me with your stories

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Abstract

TITLE: The Lived Experiences of African American Women with Postpartum Depression: A Critical Hermeneutic Study

AUTHOR: LaShawn L. Horton, MSN, RN, PhD Candidate

APPROVED: ___________________________________
Dr. Dena Hassouneh, PhD, R.N., A.N.P., P.M.H.N.P., A.P.R.N.-B.C., FAAN; Chair

The purpose of this critical hermeneutic study was to examine the lived experiences of African American women with postpartum depression (PPD). The specific aims of the study were to 1) describe the lived experiences of African American women with PPD in the context of society, 2) describe African American women's background meanings and concerns surrounding their experiences with PPD, and 3) examine the impact of familial and otherwise significant relationships in providing social support to African American women with PPD. The paucity of information surrounding African American women with PPD and lack of a critical theory framework supported the need for this study.

This study employed a phenomenological method with a Black Feminist Theory framework. Thirteen women participated. Data were collected during voice recorded semi-structured interviews lasting 60-90 minutes and a 5-minute EPDS screen was collected. Van Manen's (1990) approach to analysis was used; a system for establishing agreement was employed through member checking and through the dissertation committee. African American women share similar challenging experiences related to PPD. These challenges include: transitioning in the role of mothering, lack of knowledge about PPD, utilizing spiritual coping, lack of trust in healthcare providers, fear and secrecy, and the need for support. Additionally, African American women's PPD experience is uniquely defined within intersecting oppressions of race, gender, class, and religion. The findings of the study provide a greater understanding of the standpoint of African American women with PPD, and the need for better support. Moreover, they underscore the need for quality care to improve maternal mental health outcomes in this underrepresented group.

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CHAPTER 1

Introduction

Postpartum depression (PPD) is a devastating problem affecting 10-25% of women in the United States (Dolbier et al., 2013; Gaynes et al., 2005; Gjerdingen & Yawn, 2007; Gross, Wells, Radigan-Garcia, & Dietz, 2002). PPD is associated with negative outcomes for the individual, the family, and the child (Paulson & Bazemore, 2010). The symptoms of PPD include sleep and appetite disturbances, despondent mood, feelings of inadequacy as a parent, impaired concentration, anxiety, and thoughts of harming one's child, and suicide (Beck, 1998; Beck 2002; Verbeek, Bockting, Van Pampus, Ormel, Meijer, Hartman, & Burger, 2011). New mothers with PPD may be unable to properly care for themselves or their infants (Miller, 2002).

Depression is one of the more common complications that can occur in pregnancy and it places women at greater risk for postpartum depression (PPD) (Burton et al., 2011). Every year, 11-50% of perinatal women experience depressive symptoms, and 11-14% meet the diagnostic criteria for antepartum depression (APD), which experts define as major or minor depressive symptoms during pregnancy (Jesse & Swanson, 2007; Jesse et al., 2010; Molina & Kiely, 2011; & Sleath et al., 2005). If left untreated, women who experience depression during pregnancy are at a much greater risk for negative birth outcomes such as postpartum depression (PPD) and poor mother-child interaction (Abrams et al., 2009; Banti et al., 2011; Edge, 2010; Freed, Chan, Boger, & Tompson, 2012; Jesse, Dolbier, & Blanchard, 2010; Shen et al., 2010). The impact of PPD can be far-reaching, affecting fathers, children, and extended family members (Beestin, Hugh-Jones, & Gough, 2014; Letourneau et al., 2012). Although it is the mother who receives a diagnosis, PPD is a condition that may adversely affect the health of the entire family.

Negative outcomes for the mother may include anxiety disorders, substance use, tobacco and alcohol use, feelings of inadequacy, social withdrawal, anorexia, and somatic symptoms including fear and fatigue (Sterling, Fowles, Kim, Latimer, & Walker, 2011; Zuckerman, Amaro, Bauchner, & Cabral, 1989). Letorneau et al. (2012) suggested that depressed mothers are more likely to engage in unhealthy parenting practices and are less likely to form healthy sensitive interactions, such as engaging in cognitive developmental activities, with their infant. The depression these women experience can escalate if they feel they have failed in some way with themselves or in the care of the baby (Sterling et al.). The greater the severity of PPD, the greater the impact on the quality and quantity of interaction between mother and child (Beeber et al., 2013). Infants of these depressed mothers will often show less eye gaze during feedings, less playing, less positive affect, higher levels of withdrawal behavior, greater irritability, and more sleepiness (Goodman & Brand, 2008). Infants are not the only family members impacted by PPD (Goodman & Brand). When postpartum women experience PPD, the risk of depression in their husbands or partners may be as high 20% (Goodman, 2004). The depression fathers experience occurs later in the postpartum period and tends to increase throughout the first year (Kim & Swain, 2007). When fathers do not experience depression, they often step up and take on the role of both mother and father when the mother experiences PPD (Beestin et al., 2014). This, in turn, may lead to resentment and marital discord.

Additional risk factors associated with PPD include, but are not limited to, a poor marital relationship, breastfeeding status (McCoy, Beale, Shipman, Payton, Watson, 2006), stressful life events (Sampson, Duron, Maldonado Torres, Davidson, 2014), and poor social support (Knudson-Martin & Silberstein, 2009). These factors play a large role in PPD and should not be ignored when evaluating and assessing women during and after pregnancy. Social support during the postpartum phase directly impacts depressive symptomology (Amankwaa, 2003; Edwards et al., 2012; Logsdon, Birkimer & Usai, 2000; Ugarriza, 2006). Supportive relationships, such as that which the mother has with the father of the baby or with her primary parent, are particularly important (Edwards et al.). These relationships can be protective against depressive symptoms. Conversely, a lack of social support is a strong predictor for the development of PPD (Ugarriza).

Current literature defines PPD by two distinct sets of symptoms, or as major and minor. Major PPD is considered a more critical form of clinical depression. Minor PPD is a less severe but still impairing form of depression (Gaynes et al., 2005). Gavin et al. (2005) established a prevalence of 7.1% in women who experience major depressive symptomology in the first three months after birth. When minor depressive episodes are included, the prevalence increases to 19%. Evidence, nevertheless, suggests that PPD remains under-detected and under-treated (Abrams et al., 2009; Banti et al., 2011; O’Mahen & Flynn, 2008; Shen, Fang, & Jackson, 2010). Because PPD is directly related to the role of motherhood, women's risk for and experiences with PPD may be culturally and socially bound. The majority of PPD research has been conducted with White women or in mixed samples. Research on PPD has focused on under-diagnosis (Lui & Tronick, 2012), under-treatment (Kozhimmanil, Trinacty, Busch, Huskamp, & Adams, 2011), cultural and societal barriers to treatment (Abrams, Dornig, & Curran, 2009; Amankwaa, 2003), race and ethnicity prevalence (Kozhimmanil et al.; Segre, Losch, & O’Hara, 2006; Lui & Tronick, 2012; Howell, Mora, Horowitz, & Leventhal; Dolbier et al., 2012), a lack of help seeking (Abrams et al.; Edge, 2008) and family and social support (Amankwaa).

Race and ethnicity are risk factors that predispose women to PPD (Amankwaa, 2003). African American women are less likely than White women to see a mental health care provider (Abrams, Dornig, & Curran, 2009; Lui & Tronick, 2012; Ramos-Marcuse et al., 2010). In addition, women of lower socioeconomic status (SES) are more likely to experience symptoms of PPD (Dolbier et al., 2013; Kozhimannil et al., 2011; Lui & Tronick). The risk of perinatal depression in African American women is twice as great as in Hispanic and White women (Jesse & Swanson, 2007). PPD is more commonly under-diagnosed and under-treated in African American women relative to non-Hispanic White women (Kozhimannil, Trinacty, Busch, Huskamp, & Adams, 2011; Yonkers et al., 2001). Forty-four percent of non-Hispanic White women receive diagnosis and treatment compared to an estimated 23% of African American women (Kozhimannil et al.). The accumulation of stressful life events is known to cause chronic stress (Divney, et al., 2012). African American women who are of lower SES and who have children experience far more stressful life events and often lack social support compared to African American women without these risks (Divney et al.; Logsdon, Birkimer, & Usui, 2000; Ramos-Marcuse et al.; Ronzio & Mitchell, 2010; Segre, Losch, & O'Hara, 2006). Chronic stress can have detrimental effects on mother and baby during and after pregnancy. Chronic stress or stressful life events may include violence, death, illness of a relative or friend, loss of relationship, racial discrimination, and financial issues (Woods-Giscombé, 2010).

There are reported barriers related to ethnicity, socioeconomic status, and culture that cause African American women to seek treatment at lower rates than Caucasian women (Jesse, Dolbier, & Blanchard, 2008; Edge, 2010; Gary, 2005; Menke, & Flynn, 2009; O’Mahen, Henshaw, Jones, & Flynn 2011). African American women report concerns with healthcare provider trust, confidentiality, as well as access to providers and treatment (Abrams et al., 2009;

Brown et al., 2010; Jesse et al., 2008; Edge, 2008; Edge; O’Mahen et al.; Leis et al., 2011). Additionally, healthcare providers have reported a lack of cultural competence in treating Black women with perinatal depression (Edge, 2008; Edge, 2010; Leis et al.). However, prevention in PPD is equally as important as treatment. Effective utilization of screening and diagnostic tools in the primary care setting has been shown to improve the identification of depression during pregnancy and in the postpartum period (Siu, & the US Preventive Services Task Force (USPSTF), 2016). Policy favors screening with appropriate intervention during pregnancy and evidence suggests that screening be focused on the identification of potential support systems (Edwards et al., 2012). Accurate detection along with a capable support system has been shown to improve clinical outcomes (Siu & USPSTF).

Racial discrimination has been linked to poor maternal outcomes in African American women (Abrams et al., 2009). The racial discrimination perceived or real, that African American women experience leads to a lack of trust in health care providers and particularly in those who provide mental health services (Jesse et al., 2008). In addition to lack of treatment, many women lack information about the availability of treatment and services (Alvidrez, Snowden, & Patel, 2010; Ayalon & Alvidrez, 2007; Matthews, Corrigan, Smith & Aranda, 2006). 2011). However, prevention in PPD is equally as important as treatment. Effective utilization of screening and diagnostic tools in the primary care setting has been shown to improve the identification of depression during pregnancy and in the postpartum period (Siu, & the US Preventive Services Task Force (USPSTF), 2016). Policy favors screening with appropriate intervention during pregnancy and evidence suggests that screening be focused on the identification of potential support systems (Edwards et al., 2012). Accurate detection along with a capable support system has been shown to improve clinical outcomes (Siu & USPSTF). Prevention and intervention are both needed to help support women through depressive symptomology during pregnancy and the postpartum period. Research, for example, has shown that a four-session interpersonal group therapy-oriented intervention, carried out during pregnancy, was effective in reducing the risk of PPD (Zlotnick, Johnson, Miller, Pearlstein, & Howard, 2001). In addition, individual therapy, cognitive-behavioral therapy, and antidepressant therapy have been identified as effective forms of treatment in postpartum women (Appleby, Warner, Whitton, & Faragher, 1997; Misri, Reebye, Corral, & Mills, 2004).

Problem

A review of the literature reveals that African American women's experiences with PPD have been largely overlooked. It has been suggested that a woman's relationship with her health care provider may present an obstacle to help-seeking and, thus, to proper diagnosis. The limited evidence suggests that African American women may be at greater risk for PPD, and that clinicians and the health care system do not fully understand their culturally unique experiences with this disease (Abrams, 2004). Despite evidence highlighting the significance of social support during the postpartum period, women's support networks are often not assessed during the six-week postpartum visit (Corrigan, Kwasky, Groh, 2015). Postpartum social support is often left to family. However, when extended family members are busy working or caring for their own children, the mother of a new infant may feel a lack of support (Corrigan et al., 2015). It is not uncommon for mothers with PPD to become overwhelmed and experience a sense of loss of control or unfamiliarity as they navigate motherhood.

Despite important contributions to the knowledge base on PPD in African American women, an in-depth understanding of their lived experience and the role their families play in providing social support remains unexplored. It is not uncommon for mothers with PPD to become overwhelmed and experience a sense of loss of control or unfamiliarity as they navigate motherhood. Although much is known about PPD in the general population of women, African American women's life experiences are culturally and socially different from women belonging to the dominant culture.

Purpose of the Study

The purpose of the study was to understand the lived experiences of African American women with PPD within the context of society, and to examine the impact of the family or significant other in providing support. Research was conducted using a critical hermeneutic approach with a Black feminist framework.

This study addressed three significant aims:

1. Describe the lived experiences of African American women with PPD in the context of society.
2. Describe African American women’s background meanings and concerns surrounding their experiences with PPD.
3. Examine the impact of familial or otherwise significant relationships in providing social support to African American women with PPD.

Conceptual Framework

This study is the first critical hermeneutic study describing the lived experiences of African American women with PPD in the context of society and examining the impact of familial and other significant relationships in providing social support to African American women. Interpreted through a Black feminist theoretical framework, the results of this study provide an in-depth understanding of the lived experiences of African-American women with PPD and the roles played by their family in PPD care. A rich description of their identified experiences allowed for themes to emerge eliciting paradigm cases and exemplars that represented the women's experiences.

Definition of Terms

There are many terms associated with pregnancy and birth that can be used interchangeably and may cause confusion. Similarly, terms associated with race can also be confusing. To avoid any confusion, a list of definitions is presented below.

Perinatal period commences at 22 completed weeks (154 days) of gestation and ends seven completed days after birth (World Health Organization, 2015).

Antepartum is defined as the period before childbirth (Merriam-Webster, 2018).

Black or African American is defined as a person having origins in any of the Black racial groups of Africa (United States Census Bureau). The term Black is used when referring to women of African descent living outside of the United States or when referencing Black feminist theory. Otherwise, the term African American is used throughout the dissertation.

Significance of the Study to Health Sciences and Nursing

This study provides a significant contribution to the knowledge base on PPD in African American women. The work offers a foundation for the development of improved communication, assessments, interventions, and more effective care from healthcare providers in this underserved population. Nursing research that continues to examine the impact of PPD and provide culturally appropriate treatment options will improve mental health outcomes not only of African American women who suffer with PPD, but also for their children and their families.

This study also provides an understanding of the intersecting oppressions that African American women deal with on a regular basis that are often unseen by the dominant culture. Furthermore, it offers greater understanding of the nuances of African American family systems that are still influenced by ideologies established during slavery. This contributes to an in-depth understanding of the impact and dynamic of family and significant other support to African American women with PPD.

Chapter 2 will provide an exhaustive review of the literature to date on PPD, the impact of psychosocial support, and the influence of African American culture. Justification for the study through a critical analysis of the literature, along with a presentation of knowledge gaps will also be presented.

CHAPTER 2

Literature Review

Depression is the leading cause of non-obstetric hospitalization among women in the United States (O’Hara, 2009). A significant public health concern, the estimated annual cost of overall depression care, including PPD, is $44 billion (Gaynes et al., 2005). By 2020, it is projected that depression will be the second leading cause of disability in the world (Gjerdingen & Yawn, 2007). The peak period for the onset of depression in women is during the childbearing years. Postpartum depression affects between 7% and 20% of women in the United States (Gavin et al., 2005; O’Hara).

Societal norms inform women that giving birth should be a time of great joy and excitement. Despite optimistic expectations, childbirth and the postpartum period are a time of extraordinary physiologic change and psychologic adjustment. While many mothers experience joy and excitement, some report negative experiences after childbirth including depressive symptoms.

Defining Postpartum Depression

Postpartum depression is characterized by irritability, lack of energy, uncontrollable crying, loss of appetite or overeating, agitation, sleep disturbances, difficulty concentrating, and impaired decision making. It exists on a continuum which ranges from the baby blues to postpartum psychosis. Mothers with PPD may be less responsive to the needs of the newborn or to other children. They may experience a lack of relatedness to the infant or have feelings of inadequacy as a parent. Postpartum depression affects not only the mother, but the entire family, as it may impact relationships, attachment between mother and infant and child development (Beck, 1998). Researchers have concluded that PPD can occur up to 18 months after delivery (Beck, 2002).

Baby blues is by far the most common postpartum disorder, affecting up to 80% of women (Blum, 2007). It occurs within the first few days following delivery and is typically short-lived. Symptoms peak at around the fifth day after birth and are generally resolved within ten days (Blum). At the opposite end of the spectrum is postpartum psychosis, a condition characterized by major depressive symptoms accompanied by hallucinations and delusions. Although it occurs rarely, women with postpartum psychosis require emergency treatment including immediate hospitalization and antipsychotic medication (Blum).

The American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders* (5th ed; DSM-5) defines PPD as a subcategory of Major Depressive Disorder. Specifically, it is designated as Major Depressive Disorder with postpartum-onset (American Psychiatric Association, 2013).

Although a precise etiology remains unclear, there is a history of discussion and disagreement over whether the origins of PPD are biological or psychosocial. Currently there is consensus that the development of PPD is influenced by a combination of biological, psychological and social factors (Sword, Clark, Hegadoren, Brooks, & Kingston, 2012). The current understanding regarding risk factors is evolving, however, among the most significant are race, socioeconomic status, inadequate social support and associated stressful life events (Divney et al., 2012; Logsdon, Birkimer, & Usui, 2000; Ramos-Marcuse et al., 2010; Ronzio & Mitchell, 2010; Segre, Losch, & O'Hara, 2006).

The remaining chapter will provide a review of the literature that includes classic work that provides a background understanding of PPD within society. Additionally, literature that included African American women with PPD from 2000 to present was chosen to examine PPD in African American women.

The literature search met the following inclusion criteria: a) studies that were published in peer-reviewed journals between 2000 and 2018, b) English only, c) studies including Black women, d) studies including African American women with PPD. An extensive search was done using databases that included CINAHL (Cumulative Index to Nursing and Allied Health Literature), EBSCOHost databases, MEDLINE, and PsycINFO. Keywords that were used in the search were African American, postpartum depression, socioeconomic status, social support, impact on the family, detection, treatment, spirituality, mental health views.

Risk Factors that Influence the Development of PPD

Most women, even the most prepared, know that having a new baby is life altering and may be the most difficult job they will ever encounter. Nevertheless, because of ongoing household responsibilities, the need to care for other children, and pressure to return to work, women are expected to transition quickly in the postpartum period (Albright, 1993). Although it is not a risk factor per se, the transition to parenting is a source of significant stress for the new family (Epifanio, Genna, De Luca, Roccella, & La Grutta, 2015). Factors most commonly associated with an increased risk of PPD include a previous history of depression, complications during pregnancy, life stress, an unstable marital relationship, and lack of social support (O’Hara & Swain, 1996; Sejourne, Onorrus, Goutaudier, Chabrol, 2011; Tien et al., 2011). Other risk factors including low socioeconomic status, obstetric complications, and infant temperament have been less strongly associated with PPD (Beck, 2001). O’Hara (2009) notes that although published classic meta-analyses (see Beck, 2001; O’Hara & Swain, 1996) have not included race or ethnicity as risk factors, they are often associated with low socioeconomic status and require further inquiry.

Motherhood transitions. Mothers are expected to handle multiple roles throughout pregnancy and into the postpartum period. These roles may include but are not limited to cooking, housekeeping, caring for older children, caring for the newborn, providing transportation to traditional schooling or providing non-traditional schooling at home (Jevitt et al., 2012). The early transition phase for mothers and infants is a crucial time. Although most recovering mothers have not experienced complications during the birthing process, many mothers have survived challenging births. Difficulties associated with traumatic births may compound the challenges associated with transitioning to the role of mothering a newborn. It is a time when mothers, particularly new mothers, need extra support as they transition to their new role.

Mothers who experience PPD have difficulty transitioning in their mothering role (Logsdon, Wisner, Pinto-Foltz, 2006). Mothers are typically discharged within two days of delivery (Polduka, Stranges, Steiner, 2011). Prior to the 2018 recommendations by the American College of Obstetrics and Gynecology, mother and infant were discharged from the hospital and the mother was not seen again by her healthcare provider until the 6-week postpartum visit (American Academy of Pediatrics & American College of Obstetrics and Gynecology, 2012 as cited in Corrigan, Kwasky, & Groh, 2015), leaving new mothers to figure things out on their own. The current recommendation encourages mothers to make contact with their healthcare providers within the first three weeks of birth (American College of Obstetrics and Gynecology, 2018). Whereas the previous 6-week follow recommendation reflected a singular focus on the physical well-being of mothers (Fowles, Hsui-Rong, & Milles, 2012), the current recommendation stipulates a comprehensive assessment of mothers' physical and psychosocial well-being.

In a cross-sectional descriptive study (Corrigan, Kwasky, & Groh, 2015) including a diverse group of women in the midwestern United States, researchers found that assessments in the postpartum period should include broader areas of life's difficulties rather than focusing on childcare responsibilities alone. They also found that mothers were willing to contact professionals for help but lacked the knowledge to distinguish PPD symptoms. The women in this study wanted more help with household duties and care of older children as they transitioned after the birth of a new baby (Uggariza et al., 2007). In a large correlational study of White women in Ireland, researchers found a significant correlation between family support and maternal parental self-efficacy. New mothers in this study also experienced improved mental health within the 6-week time period after birth, but there was no correlation between professional support and depressive symptoms (Leahy-Warren, McCarthy, & Corcoran, 2011).

Blum (2007) identified three emotional conflicts common in women who develop PPD: dependency conflicts, anger conflicts, and motherhood conflicts. Dependency conflicts arose when a mother was reminded of her own need to be cared for. Having a baby was an exhausting and painful process and the postpartum period was a time when mothers often depended on the assistance of others (e.g., a nurse in the hospital or a spouse in the first few days or weeks adjusting at home). Although some women felt that they would be able to handle the competing demands of home, husband, and children, it was infinitely more difficult once the baby was born. New mothers sometimes became overwhelmed and recognized the need for someone else to help care for them.

Anger conflicts were typically the result of a conflict that had gone unresolved. This anger was compounded if the mother perceived that she was experiencing a lack of caring. Women become angry for having to provide total care for their newborns while not receiving any care for themselves. Unfortunately, this unresolved anger was often expressed towards babies. Some women reported murderous and suicidal thoughts toward their babies (Blum, 2007). Others suffered with guilt for having angry feelings and kept silent about their anger for fear of being judged or ridiculed harshly.

Motherhood conflicts arose when the new mother felt as though her mother did not care for her properly as a child. Feelings of abuse or neglect (real or perceived) could resurface and cause the new mother to question her fitness for her role. The new mother vowed to be different but often failed in that desire if she lacked alternative role models.

These psychological conflicts are important to consider when looking at factors associated with PPD. Research has shown that women who do not have familial and social support during the postpartum period are at greater risk of developing PPD (Albright, 1993; Blum, 2007; Jevitt, Groer, Crist, Gonzalez, & Wagner, 2012). There are conflicting reports on the relationship between race and ethnicity and unresolved conflicts especially in the areas of relational and financial stress. These should be further evaluated as we expand this research to African American women (Liu & Tronick, 2012; Liu, Giallo, Doan, Seidman, & Tronick, 2016; Mukherjee, Fennie, Coxe, Madhivanan, & Trepka, 2018).

Prior history of depression. In the largest population-based study to have explored the risk factors of PPD, Silverton et al. (2017), evaluated the records of 707,701 first-time mothers in Sweden. They confirmed previous reports (Gaynes et al., 2005; Vesga-López et al., 2008) that the occurrence of PPD is significantly increased in women with a prior history of depression. The rate of PPD in women with a previous diagnosis was shown to increase by a factor of 20 compared to women with no previous diagnosis of depression.

Stressful life events. Having a baby is itself a stressful event. In a meta-analysis conducted by Beck (2001) notable risks and stressors contributing to PPD included: low self-esteem, unplanned pregnancy, unemployment or low income, and single marital status. Likewise, A recent population-based study (Mukherjee et al., 2018) found that having a lot of bills to pay and having an unusually high number of arguments with one's husband or partner were also risk factors for developing PPD regardless of race or ethnicity. Chronic stress related to intimate partner violence and living in an unsafe neighborhood were highly predictive of PPD in single women. Moreover, chronic parenting stress was highly predictive of PPD in both single and married women (Reid & Taylor, 2015).

Racism is another form of chronic stress that African American women face. The health outcomes of African Americans have been linked to the chronic stress of racism such as low-birth weight and infant mortality and depression. Data from the National Study of Black Americans (NSBA) reported African Americans that were discriminated against experienced lower levels of happiness and life satisfaction, as well as poorer physical health (Williams & Chung, 1996). Internalized racism was also related to emotional distress. Internalized simply means believing what you've been told about something or someone (Taylor & Jackson, 1991;

Taylor, Henderson, Jackson, 1991; Williams and Williams-Morris, 2000). Internalizing racism was also related to low self-esteem, depression, and poor ego identity (McKorle, 1991; Tomes, Brown, Semenya, Simpson, 1990). Racism creates chronic stress for African American women that perpetuates pregnancy related mortality and morbidity in African American mothers and their children (Weitz, 2001 as cited in Abrums, 2004).

Social Support as a Protective Factor

Social support has been defined in the literature in many ways. For example, emotional support in the form of encouragement and concern, tangible support like money and time, and the education and professional support that may come from medical providers (Chojenta, Loxton, Lucke, 2012; Evans, Donnell, Hume-Loveland, 2012; Leahy-Warren, McCarthy, Corcoran, 2011). Despite inconsistencies in the definition of social support, it is clear that society and community both play a major role in what social support looks like for many postpartum women (Corrigan, Kwasky, & Groh, 2015; Cheng, Fowles, Walker, 2012; Evans, Donnell, Hume-Loveland).

In a cross-sectional study, Corrigan et al. (2015) asked women to assess their social support, depressive symptomology and receipt of professional assistance in the postpartum period. While White women reported having more social support than minorities, all women reported that they were overwhelmed with their lives and needed more professional assistance during the postpartum period than they realized. Indeed, 72% contacted a professional for assistance during the postpartum period. More than half of the women in this study attended prenatal childbirth classes but only two attended the postpartum classes. In this study it was also noted that Whites reported having more social support than minorities.

Social support is highly inversely correlated with PPD (Corrigan et al., 2006). The higher levels of support women have during the postpartum period the lower their levels of PPD (Brown, Harris, Woods, Burman, Cox, 2012; Chien, Tai, Yeh, 2012; Edwards et al., 2012; Fowles, Hsiu-Rong, Milles, 2012). Social support can have a significant impact on the healthcare of both mother and baby during the postpartum period (Stapleton, et al. 2012). Experts have recommended that husbands and partners be introduced to postpartum care needs in the hospital prior to the family leaving to go home (Cheng, Fowles, Walker, 2006). With proper social support, including help with the care of the child, the transition for mother and baby can be a much smoother process (Ugarriza, Brown, Chang-Martinez, 2007).

In a quantitative descriptive study with first time mothers at six weeks postpartum, Leahy-Warren, McCarthy and Corcoran (2011) examined the relationship between social support, maternal self-efficacy, and PPD. There was a statistically significant relationship between women’s self-efficacy and adequate informal social support from family and friends. Self-efficacy was shown to enhance a woman’s transition to motherhood and was associated with improved mental health outcomes. Additionally, Leahy-Warren et al. showed that women who received moderate and low levels of support were two and four times more likely to experience depression, respectively. Support from health care providers was not significantly related to outcomes in this study. However, in a population-based study, Mukherjee et al. (2018) found that provider communication was inversely proportionate to the development of PPD. Others have theorized that women who are at-risk for depression would benefit from follow-up care from a social worker or case manager once at home (Leahy-Warren et al.).

Systemic social support. Research suggests that it is essential for health care providers to evaluate a woman's social support system during pregnancy and in the postpartum period (Logsdon, Tomasulo, Eckert, Beck, Lee, 2012), nevertheless it is often overlooked. When social support is lacking for postpartum women social workers can assist in providing the necessary resources (Cheng et al. 2006). Social workers are an important community resource for the postpartum mother after she has been discharged from the hospital. Women should receive instruction and be able to demonstrate competency in the care of self and child in the hospital before leaving for home. If more education is needed, a social worker or case manager may provide additional instruction (Logsdon, et al. 2012; Fowles et al 2012).

Professional support is a valuable educational tool for women. New mothers should not be left to wonder about their self-care and the care of their new baby. Nurses should be assessing and providing the necessary support for mothers before they leave the hospital to improve maternal mental health outcomes. While professional support is important in the hospital, emotional support is important once the mother goes home.

Social support at home. Postpartum women desire positive interaction and affection from their spouse or significant other (Chojenta, Loxton, Lucke, 2012). The depressive symptoms of postpartum women have been shown to be mediated by the quality and quantity of support provided by their significant other, with support being directly related to the relationship between the two (Chojenta et al.; Stapleton, et al. 2012).

In a literature review examining the impact of perinatal stress on mothers' medium and long-term mental health and the efficacy of coping strategies, Razurel et al. (2013) noted that the type of support is equally as important as the support itself. Emotional support is valued most highly and appears to be directly related to how the mother perceives the interaction (Razurel et al.; Stapleton et al., 2012). In a large longitudinal study conducted with Australian women, Chojenta et al. (2012), found that women with PPD reported receiving positive interaction and affection less often than women without PPD. Overall, if a woman feels that a type of support is not valuable, then she may perceive it as no support (Razurel et al.).

Virtual relationships may also be a source of perceived support for women during the postpartum period. Evans et al (2012) conducted a content analysis of an online PPD support group. They examined 512 messages posted on a PPD discussion board over the course of a year and a half. The women provided emotional support through words of hope, honest revelations about their illness and feelings and by sending each other hugs and empathy. The women felt validated as “normal” through participating in discussions on the board. They were mutually supportive and shared advice and suggestions about how to cope with the effects of PPD. Instrumental support was not as evident in this study, but women did offer their peers advice about seeking the help of more hands at home, suggesting that they include their husbands and family members more. This study demonstrated that women were comfortable expressing their feelings in an online discussion group without fear of rejection or stigma. Support groups may be a means of providing support to new mothers by allowing them to share their experiences of what it means to be a new mother with women who may be experiencing the same transitions (Cheng, Fowles, Walker, 2006).

Impact of PPD on Mothers

Women suffering with PPD commonly perceive it as a robber that stole their love and devotion away from their new baby and other children; they say they were robbed through anger, resentment, and anxiety (Mauthner, 1998). In the first groundbreaking phenomenological study of PPD, Beck (1992) extracted 11 significant themes from the seven women whom she interviewed. Mothers experienced loneliness because of their depressive feelings. When mothers attempted to share their feelings with family members and friends they were often told to "snap out of it." Mothers subsequently began to isolate themselves from those who failed to understand their pain. The thought of death provided solace. The constant isolation and the barrage of overwhelming loneliness seemed unbearable and these women felt like death was their only hope. Constantly thinking about their depressive state made them feel like they were bad mothers. Their minds raced with the thoughts of what was going on with them, what was happening to their bodies, and these thoughts led them to believe others were judging them as bad mothers.

Mothers in this study (Beck, 1992) mourned the loss of self with the pervasive thought that even if they did get better that they would not return to the self they were before having PPD. Mothers could not enjoy the activities they once enjoyed. They felt tremendous guilt over the thought of harming their infant. They also experienced guilt for being unable to love their infants in the way they knew was needed. Mothers were engulfed in a fogginess that left them unable to concentrate making it difficult or impossible to complete tasks that had been easy before the onset of PPD. They were reduced to feeling like robots, carrying out tasks without feeling or emotion. Mothers often reported experiencing anxiety attacks that would sneak up on them, leaving them feeling as if they were about to lose their minds. They felt a loss of control of their emotions and felt that there was no way out of their depression. Mothers felt their illness was beyond their control and they were overtaken by insecurities of motherhood. They felt unable to manage the care of their babies. These mothers felt as if they needed to be cared for by their mothers. Beck's (1992) research was the first of its kind to elicit the lived experiences of women with PPD.

Through this work Beck discovered that the screening tool – the Beck Depression Inventory (BDI) (Beck, Ward, & Mendelson, 1961) which was commonly used to screen women for PPD at that time– was not adequate for this purpose. Items on the BDI addressed only three of the 11 themes that revealed themselves in this later work.

A grounded theory study conducted by Beck (1993) identified similar findings to the phenomenological investigation. These two qualitative studies provided important new information on mothers' experiences with PPD. Seven of the women from the phenomenological study (Beck, 1992) were included in the grounded theory study. These women were from the same support group and had a similar timeframe from diagnosis to entering the study (Beck, 1992; Beck, 1993).

Beck's (1993) grounded theory included four stages: 1) encountering terror, 2) dying of self, 3) struggling to survive, and 4) regaining control. These mothers faced overwhelming anxiety attacks that made them feel as if they were losing their minds. They suffered feelings of tremendous guilt. They were in a constant fog and unable to concentrate on daily tasks. Mothers experienced what felt like a dying of the old self with an uncertainty of its return. Mothers isolated themselves from family and friends because they felt as if no one could understand their plight. They lost interest in all the things they once enjoyed, including sex, and felt death might be a good option, though none attempted suicide (Beck).

In addition to what Beck found in her phenomenological study (1992), the mothers in the grounded theory study (1993) felt that they had to battle the medical system. Healthcare providers dismissed mothers' symptoms as minor, telling them that their symptoms "would pass" and that they should go home. Mothers also experienced somatic symptoms. To get relief, some took antidepressants and some sought support from their churches or support groups. When regaining control, mothers experienced more good days than bad and began to see their way out of a very difficult and trying time.

Although Beck's two qualitative studies lacked information about the experiences of mothers from diverse ethnic or racial backgrounds, a later meta-synthesis (Beck, 2002) included women from other countries and other parts of the United States. This study was the first of its kind. Beck (2002) reviewed 18 qualitative studies conducted between 1990 and 1999, with three being her own work. She examined six phenomenological studies, four descriptive studies, two grounded theory studies, two ethnographies, and one case study. Six of the studies were conducted in the United States, eight in the United Kingdom, three in Australia, and one in Canada. Three hundred and nine women were interviewed for the 18 studies. Three were reported as Black. The other women were from the above-mentioned countries, with the exception a group of Jordanian women (*n*= 22) and Middle Eastern women (*n*= 45) living in Australia, and Hmong (*n*=52) women in the United States.

Beck (2002) identified four overarching themes: (a) incongruence between expectations and reality of motherhood, (b) spiraling downward, (c) pervasive loss, and (d) making gains.

Within the congruence theme mothers had to deal with the fallacies and myths that can accompany motherhood (Nicolson, 1990; Berrgren-Clive, 1998 as cited in Beck). Societal expectations can be overwhelming for many new mothers, causing them to feel inadequate and ill-equipped for the multiple roles that accompany motherhood. Many of the mothers viewed themselves as bad mothers because they could not meet the expectations they placed on themselves to align with societal expectations (Mauthner, 1998). Within this theme emerged a cultural context because Jordanian women living in Australia felt overwhelmed with sadness about their failed expectations of motherhood but could not express it. Within their culture a mother who is sad is thought of as a “bad” mother, unable to cope in her new role (Nahas & Amasheh, 1999 as cited in Beck). Jordanian women also lacked the social support needed to cope with their expectations and fears (Nahas, Hilege, & Amasheh).

In the second theme, spiraling downward, there emerged women trying to cope with a myriad of emotions such as anxiety, anger, guilt, loneliness, obsessive thoughts, and memory recognition. Anxiety was the most prevailing emotion and was present in all 18 studies (Beck, 2002). Some women were so overwhelmed by the responsibilities of caring for their infant that they did not believe they could survive. Culture played a role in this theme as well, because while the Jordanian women felt an overwhelming sense of responsibility due to a lack of support (Nahas & Amasheh, 1999), the Hmong women (Stewart & Jambunathan, 1996) did not feel overwhelmed. As part of the Hmong culture women are encouraged to take a 30-day rest after childbirth and typically receive much support during this time. Likewise, culture was significant for women feeling lonely and isolated. The Jordanian women experienced more loneliness and isolation due to their perceived lack of social support (Nahas & Amasheh, 1999), and the Hmong women felt supported and did not report loneliness and isolation (Stewart & Jambunathan, 1996).

In the third theme of pervasive loss, mothers experienced a sense of loss that was far reaching in all areas of life. Particularly, not found in the previous studies was that women experienced a loss of identity surrounding their employment (Nicolson, 1999). These women had given up their employment to be full time mothers and were experiencing the challenges of not having to think in the same way on a job. These women reported experiencing a loss of their identity intellectually. Some women were appreciative of the friendship with colleagues and felt supported in their workplace, while others felt they isolated as stay at home mothers.

Finally, in the fourth theme, to make gains mothers had to come to grips with the thought that they were suffering with a mental illness and they needed help to make it through. They had to surrender their own ideals and expectations of what a “good” mother is. Mothers had to be willing to be vulnerable enough to open their mouths and talk with someone who could help them see their way through. Some battled with unsupportive health care providers that were not supportive and others had to overcome cultural taboos about not expressing sad feelings after birth (Nahas et al., 1999 as cited in Beck, 2002).

In this groundbreaking study, Beck found that many mothers experienced the heartache of trying to cope with societal expectations that are difficult to manage. Unfortunately, societal expectations do not align with the realities many mothers face after childbirth. These unmet expectations, in turn, cause mothers to experience feelings that are overwhelming, and which may be debilitating. Then new mother experiences many losses for which she feels guilt and shame. When mothers get help they can move forward and regain a sense of control and normalcy (Corrigan et al. 2015).

Impact of PPD on the Family

PPD contributes to poor attachment, limited interaction (Beeghly et al., 2003; Murray et al., 2011), poor breastfeeding outcomes (Dennis & McQueen, 2009; Gross, Wells, Radigan-Garcia, & Dietz, 2002), poor marital relationships (Letourneau et al., 2012), and poor child cognitive and emotional development (Beck, 1998). Parental relationships are strained or there may be feelings of despair for women who are no longer in a relationship with the father of the baby (Jevitt et al., 2012).

Impact on fathers. Fathers play an intricate role in assisting mothers through their navigation of the postpartum period (Marrs, Cossar, Wroblewska, 2014). Fathers of mothers with PPD seek to manage the family relationships (Marrs et al.). Women who experience PPD are often resentful and angry with the father or significant other for not having the ability to read their minds when experiencing depressive symptoms and for not providing the support needed to navigate through the postpartum period (Morgan, Matthey, Barnett, & Richardson, 1997). The anger and resentment build and may lead to feelings of dissatisfaction with the father. The intensity of emotion causes the mother to feel as if she is not normal and she may retreat from the relationship (Morgan, et al.). When women experience PPD 10% of the fathers will experience depression in the first year (Paulson & Bazemore, 2010), and will often experience their depression later in the postpartum period, increasing over the first year (Kim & Swain, 2007; Matthey, Barnett, Ungerre, Waters, 2000). Men are less likely to seek professional help than women for mental health care (Addis & Mahalik, 2003; O’Brien, Hunt, & Hart, 2005).

Beestin, et al. (2014) conducted a phenomenological study examining the impact of maternal PPD and fathers’ ways of fathering. Participants reported that PPD had taken away their partner’s ability to mother the newborn or the older children in the family both psychologically and physically. Some fathers perceived this time of depression for mothers as an opportunity for them to care for their children without ridicule or advice by the mother. Other fathers reported feeling burdened and alone. Many fathers experienced an unshared parenting load that caused resentment and anger towards the mother. The men reported that they kept quiet during the mother’s PPD and felt a sense of isolation from fear of stigmatization. Other fathers felt they were liberated in being the father they wanted to be without the maternal influence dictating their role. The fathers had varying experiences with their ways of fathering and their experiences with their significant others. While much of the research looks at the experiences of women only, the proposed study will also examine women’s perceptions of the impact of the family and social support.

Marrs et al. (2014) reported that new fathers took their cues on how to respond to the baby from the mother. These fathers reported they felt the mother-baby relationship was more vital than their own relationship with the baby, and often felt as though they did not respond to the baby’s needs as sensitively. Like participants reported by Beestin et al. (2014), the couples in Marrs et al. study experienced strain in the relationship when the mother experienced distressed emotions. Where partners were supportive, the relationships were maintained.

Impact on children. Feelings of emotional distress in mothers have significant impact on the outcome of an infant and older children (Atkinson, 2000). Negative birth outcomes, poor infant-mother attachment, and long-term consequences are a few effects of PPD (American

College of Obstetrics and Gynecology, 2013). The negative feelings mothers experience are so overwhelming that they may be paralyzing (Mauthner, 1998). In the groundbreaking meta-analysis conducted by Beck (1995), in which she interviewed the same women from her 1992, and 1993 studies, she examined the effects of PPD on maternal interactive behavior, infant interactive behavior and mother-infant interactive behavior within the first year after birth. The study revealed that PPD has a moderate to large effect on mother-infant interaction. When a mother fails to respond with a positive affect or when she is emotionally unavailable, the synchronized ability to visualize and pick up on cues between mother and infant do not develop (Beck, 1995).

In a longitudinal study conducted with 94 women and their first-born children, Cogill, Caplan, Alexandra, Robson, & Kumar (1986) assessed the cognitive function of 4-year-old children. Using the McCarthy scales (McCarthy, 1972 as cited in Cogill et al.), the researchers evaluated verbal, quantitative, memory, and motor skills. They reported that older children sufferred from delays in behavior, development, and cognitive ability.

In addition to cognitive delays, Beck (1996) reported that women describe older children as being left in the cold when it comes to a relationship with the mother they once knew. Mothers felt suffocated and resentful toward older children and often pushed them away when they desired attention. Mothers reported that children who were pushed away would often act out to receive attention (Beck). Other mothers in this study felt a strong desire to minimize the effects of PPD on their older children, making sure their needs were met to protect against the scarring they perceived would result from exposure to their PPD.

In a study assessing risk factors associated with PPD in working mothers Darcy et al. (2011) looked at the longitudinal effects of PPD on maternal health and quality of life, child health and development at 4, 8, 12, and 16 months of age. The researchers reported that children suffered from gastrointestinal problems such as diarrhea more often than those of non-depressed mothers. This study also found that depressive symptoms in mothers at four months-predicted poorer child health outcomes at 8, 12, and 16 months of age. In general, mothers reported greater concern for the health of their child, more pain or discomfort in their children, and increased use of health services when dealing with depressive symptomology (Darcy et al.; Gjerdingen & Yawn, 2007; Chung et al., 2004; Field, 2005; Posmontier, 2008). Researchers reported that even when mothers' PPD symptoms have subsided, maternal-infant interactions can remain impaired up to one year old (Hipwell, Goossens, Melhuish, Kumar, 2000).

Postpartum depression has a profound impact on the family. PPD negatively impacts mother's functioning, interactions with her infant, relationships, infant and older children cognitive development and fathers experience with depression (Beck, 1998; Beck, 2002; Beeghly et al., 2003; Letourneau et al., 2012; Marrs et al.,2014).

African Americans and Mental health stigma

Cultural conditioning affects patterns of behavior, emotional responses, and ways of dealing with stress (Matthews, Corrigan, Smith & Aranda, 2006). Culturally, African Americans believe depression is a personal weakness and not a health problem (Amankwaa, 2003; Menke & Flynn, 2009; Mishra, Lucksted, Gioia, Barnet, & Baquet, 2009; Ward & Heinrich, 2009).This belief is congruent with the stigma associated with mental illness treatment in African American communities (Alvidrez, Snowden, & Kaiser, 2008; Alvidrez, Snowden, Rao, & Boccellari, 2009;

Alvidrez, Snowden, & Patel, 2010; Gary, 2005; Matthews et al., 2006; Menke & Flynn, 2009; Mishra et al., 2009; Nadeem et al., 2007; O'Mahen, Henshaw, Jones & Flynn, 2011). Gary defines stigma as "a collection of negative attitudes, behaviors, beliefs, and thoughts that influence the individual, or the general public, to fear, reject, avoid, be prejudiced, and discriminate against people with mental disorders." (p. 980) This kind of stigma is associated with secrecy within the African American community, and it is this need for secrecy that is associated with shame and embarrassment regardless of the reaction of others (Alvidrez et al., 2008; Amankwaa, 2003; Ayalon & Alvidrez, 2007; Knifton et al., 2010; Matthews et al., 2006; Oakley et al., 2011; Mishra et al., 2009). Moreover, there is a persistent hiding from family members for fear of shame, embarrassment, and rejection (Knifton et al., 2010; Matthews et al., 2006; Mishra et al., 2009).

These are the prevailing thoughts about mental illness within the African American community and may have even greater impact during pregnancy and in the postpartum period. The existing research on African American women with PPD has not been done in over 10 years with much of the research utilizing diverse populations and not specifically focusing the mental health of African American women. Without current research that is primarily focused on the experiences of African American women's experiences with PPD, we fail in providing accurate, culturally-specific support and interventions for this underrepresented population in research.

African American and Black women with PPD

Controlling images. Messages of self-reliance are taught very early in the African American culture and communicated through families or community leaders (Amankwaa, 2003; Alvidrez et al., 2008; Matthew et al., 2006). African American women report that the image of their mothers being “strong women” made an impression on them, and that they were socialized to handle whatever came their way (Abrams et al., 2006; Amankwaa; Edge, 2008; Matthews et al.). However, this self-image of African American women being “strong black women” is also a barrier in seeking mental health treatment (Abrams et al.; Edge; Gary, 2005; Matthews et al.). There are three qualitative studies (Abrams et al.; Amankwaa; Edge) that focused specifically on African American women and PPD. Other studies using both qualitative (Matthews et al.) and quantitative (Alvidrez et al.) designs focused on what mental health attitudes and messages have been passed down within African American communities, whether spoken or witnessed. The Amankwaa (2003) qualitative study focused solely on African American women describing the nature of their postpartum experiences. Under the theme “seeking help” the women reported on strategies they used to try and help themselves; one mother reported she had to make herself stop crying, take a deep breath, and just calm down when she felt depressed. Another woman reported she felt depression was a personal affair and suggested she was responsible for seeking help for herself (Amankwaa, 2003).

Likewise, Edge (2008) reported the “strong Black women” image implies that African American women can deal with the toughest of life’s circumstances and that depression is just another challenge that should be overcome through self-reliance. In addition, women who fail to meet the challenge often believe they have failed in some way (Edge). “Be strong, get over it, tough it out, deal with it, or pray until you have a breakthrough” are some of the phrases passed down from generation to generation of African American women (Abrams et al.; Amankwaa, 2003; Alvidrez et al., 2008; Matthews et al., 2006). One participant in a study conducted by Abrams et al. reported that it is frowned upon in African American communities to pay for psychological services. These attitudes and beliefs perpetuate African American women’s image of self-reliance and contribute to hiding depressive symptoms (Oakley et al., 2011; O'Mahen et al., 2011) and maintaining secrecy about seeking treatment (Ayalon & Alvidrez, 2007).

Women describe themselves as weak and flawed because of depression (Alvidrez et al., 2008; Amankwaa, 2003; Edge, 2008), experiencing feelings of sadness and not being able to fulfill the roles their mothers had. They struggle between who they are (the real self) and who they thought they were supposed to be (the ideal self) (Amankwaa). Accordingly, women with a perceived sense of failed self-reliance also experience self-stigma and are least likely to seek formal treatment for depression (Amankwaa, 2003). This sense of personal failure or moral weakness may be further reinforced by women's religious beliefs (Edge).

Spirituality. For many women, spiritual beliefs and behaviors are part of the meaning and experiences that shape pregnancy and childbirth (Dailey & Stewart 2007; Jesse, Schoneboom, & Blanchard et al., 2007). A lack of religion and connectivity with God was the cause of depression for some African American women (Matthews et al., 2006). Reliance on religious beliefs and religious coping was a preferred form of treatment for African American women (Dailey & Stewart; Jesse, et al.; Matthews et al.; Mishra et al., 2009; Ward & Heinrich, 2009). In African American communities, mental illness is often viewed through the lens of spirituality, as a curse, sin, demon possession, or a lack of spirituality (Alvidrez et al., 2008; Matthews et al.; Mishra et al.). There were four qualitative studies specifically addressing African American women, spirituality and their experiences with perinatal mental health.

In a qualitative descriptive study of 130 pregnant African American and White women, participants were asked one open-ended question: How does your faith or spirituality affect your pregnancy, if at all (Jesse, Schoneboom, & Blanchard, 2007)? Researchers found that 47% of women reported being positively affected by their faith or spirituality. Six themes relevant to the meaning of spirituality in African American women during pregnancy emerged: a) guidance and support, b) protection, blessing or reward, c) communication with God through prayer and study, d) strength and confidence, e) help with difficult choices and accepting God's will for their lives, and, f) a generalized positive effect and feelings of happiness during the pregnancy. Others have reported that higher levels of spirituality are associated with decreased levels of depression and formal treatment (Abrams et al., 2006; Amankwaa, 2003; Edge, 2008; Jesse et al.; Jesse & Swanson, 2007). According to Abrams and colleagues, women used statements such as, "The Lord never gives us more than we can handle," or "the Lord puts whatever we need in our path." They also described helpful religious practices such as praying and reading the Bible (Abrams et al.).

Amankwaa (2003) has also reported that women drew on their spiritual strength to help them through depression by reading the Bible and praying. The self-image of "the strong Black woman" and spirituality are common themes in studies conducted with African American women. However, this image may be a double-edged sword. Strength and support rendered through spiritual and religious practices may be a source of strength, but may also reinforce a view of depression as a sign of moral weakness or failure (Amankwaa). Despite stated beliefs only three studies reported religious leaders as a resource for African American women struggling with depressive symptoms (Matthews et al., 2006; Mishra et al., 2009; O'Mahen & Flynn, 2008). Quantitative data from O'Mahen and Flynn (2008) found that African American women (who screened > 10 on the EPDS) were more likely to speak with their religious leader than their White peers. They expressed increased confidence in the treatment they received from a religious leader. Similarly, in a qualitative study with focus groups, Mishra et al. found Black women to be more inclined to use spiritual remedies if their ontological framework was defined by spiritual beliefs about depression. Likewise, community leaders reported that having a family member with mental illness was still a source of shame among African Americans and that seeking formal treatment for mental illness was frowned upon (Matthews et al.).

In a focus group study of African American community leaders, Matthews et al. (2006) found that religious leaders and ministers saw mental illness as “a disturbance to the mind” on a spiritual level, or as caused by a demon or spirit of some sort. They also reported that those who viewed mental illness as curable attributed it to a religious intervention. The only exceptions were community members who were mental health providers.

The belief was that the mentally ill person could be cured by the Lord. This community ideology and perceived form of treatment perpetuates the idea of keeping PPD a secret for African American women. Improving knowledge in the Black community about how to seek formal treatment is an area that needs further development.

Keeping secrets. In Amankwaa’s (2003) qualitative study, 12 African American women were interviewed for an hour on two separate occasions to describe their experiences with postpartum depression. Five themes emerged from the interviews: 1) stressing out, 2) feeling down, 3) losing it, 4) seeking help, and 5) feeling better. A sixth theme emerged and represented how culture affected the ways in which African American mothers managed their depression: Dealing with it. In a subtheme, *keeping secrets,* the women reported the historically situated learned behavior of wearing a mask to cover their true emotions, not letting anyone see them crying, not talking about it. These women reported keeping these feelings to themselves for fear of being labeled “crazy” (Amankwaa, 2003).

Interestingly, a large quantitative study including roughly equal numbers of African American (n=251) and White (n= 281) perinatal women, O’Mahen et al. (2011) found no significant racial difference in the perceived need to keep depression secret. Culturally there are beliefs and practices to which African American communities are predisposed, and which have contributed to mental health care barriers. With the literature citing conflicting results, further inquiry was needed to explore whether these historic cultural practices still serve as barriers for African American perinatal women in need of mental health treatment.

Health care providers. Healthcare providers have reported a lack of time, uncertainty in detecting perinatal depression, inappropriate use of screening devices, staff shortages, and a lack of cultural competence when caring for the Black perinatal mother (Edge, 2010). Concordantly, Black women perceive that providers have a lack of knowledge and a lack of cultural competence on the issue of perinatal depression. The studies in this section include depression during the perinatal period (including pregnancy) (Leis et al., 2011; O’Mahen et al., 2008) and Black Caribbean women from the United Kingdom (UK) (Edge, 2008, 2010) and England (Brown, 2010). During the health care provider section, the term Black will be used to encompass women from Western countries and the Caribbean.

Black women report concerns with healthcare provider trust, confidentiality, and a lack of access to care and treatment (Abrams et al., 2009; Jesse et al., 2008; Edge; O’Mahen et al.; Leis et al.). The multidimensional barriers that Black women experience in seeking formal help are intensified by the relationship between patient and healthcare provider. To-date there have been seven studies examining the structural barriers faced by Black women when contemplating seeking formal treatment for perinatal depression. This current study was needed to examine African American women's perceptions and meanings about PPD care.

Lack of provider knowledge: Mental health detection, treatment, and cultural competency. Health care providers acknowledged their lack of confidence at deciphering depressive symptoms from among a host of confounding life circumstances (Abrams et al., 2009; Edge, 2010) making it difficult to distinguish between ongoing depression and perinatal depression (Abrams et al; & Edge). Health care providers reported lacking the requisite knowledge, training, and skills to treat perinatal depression or other mental health conditions regardless of ethnic orientation (Edge). They report lacking adequate time to screen for depression, a lack of confidence in the use of screening tools, and they acknowledge not routinely screening for PPD (Abrams et al., 2009; Brown et al., 2010; Burton et al., 2011; & Edge).

In a qualitative study conducted in the UK, healthcare providers were asked their views about perinatal mental healthcare for Black and minority ethnic women (Edge, 2010). Data were collected from 42 healthcare providers via focus groups or interviews. Participants reported that they ignored screening for depression during pregnancy as a risk for postpartum depression, even when the women reported known histories of previous perinatal depression. The providers reasoned that it was because during the antepartum period care primarily focuses on physical symptoms such as diabetes or preeclampsia.

In contrast, in a quantitative cross-sectional, study of 293 perinatal women (Burton et al., 2011), 55 of whom were African American, participants were screened during the antepartum and postpartum period in effort to optimize access to mental health care for PPD. Women were screened, using a self-completed Edinburgh Postnatal Depression Scale (EPDS), at 36 weeks gestational age in the outpatient clinic, again after delivery in the hospital, and at the 6-week postpartum visit in the outpatient clinic. Five percent of the women screened positive for depression at 36 weeks, 16% screened positive for depression after delivery (14 of 90), and 14% were shown to be depressed at 6-week postpartum. All 14 of the women who reported being depressed at the postpartum screening had received an in-patient mental health care follow-up before discharge, and all patients who reported positive screens received referrals for treatment. Of the 23 women who were assessed in the outpatient clinic, only four mothers followed up with a mental health evaluation. The researchers concluded that the optimum time for postpartum screening to achieve maximal mental health follow-up care was after delivery, prior to discharge (Burton et al., 2011). Similarly, O'Mahen and Flynn (2008) reported that mental healthcare providers at on-site clinics serving perinatal African American women routinely screened their patients for depression. Women meeting the criteria for depression risk then met with an on-site social worker, who assessed them and provided mental health care referrals. In many settings, however, providers reported a lack of on-site mental health clinicians or therapy services, a lack of publicly funded mental health facilities, and mental health clinics that service low-income populations (Abrams et al., 2009).

Some healthcare providers reported feeling guilty about the lack of services for depressed Black women in the antepartum period (Edge, 2008). Others cited time constraints and staff shortages to account for the lack of treatment. Edge (2010) reported that Black mothers with postpartum depression were rarely screened by a provider, even those who had a history of depression and psychosocial risk factors. The provider reported that while they may have overlooked some women, the women were not killing themselves, so they must be managing.

This same provider reported a resistance to using validated depression scales in their practice, viewing them as poorly designed and obsolete (Edge).

Healthcare providers reported a lack of cultural competence in treating Black women with perinatal depression (Edge, 2008; Edge, 2010; Leis et al., 2011). Likewise, Black women also reported negative encounters with mental health providers due to a lack of perceived cultural competence (Edge; Leis et al.). In a qualitative study involving low-income, perinatal Black women (n=38) participants in five focus groups were asked to explore their perceptions of mental health services as a barrier to service use. The women reported not seeking formal treatment because they feared the provider might not be able to relate to them or vice versa (Leis et al.).

In a large mixed method study of 101 Black Caribbean women (Edge, 2008), participants were asked how their beliefs and attitudes about perinatal depression affected their ability or willingness to seek treatment. Only the qualitative data were reported, and a major theme that emerged was their perceptions of the care and support they received in the perinatal period. The women reported reservations about being able to access culturally sensitive or culturally appropriate services for mental health. Twelve women from the sample of 101were interviewed for theoretical sampling within 12 months of delivery; these women reported feeling that mental health providers outside of their ethnic or cultural group were unlikely to understand their background or needs, and unlikely to respond in a way that was acceptable or appropriate.

In other studies involving cultural competence, Black women reported a lack of confidence in the ability of a non-Black healthcare provider to relate to their needs (Abrams et al., 2009; Leis et al., 2011). Nevertheless, 14 Black women who participated in a qualitative study reported that they were encouraged to seek formal help from a healthcare provider for depression symptoms and did not express concerns about healthcare provider ethnicity or cultural competency, findings that are in contrast with previous qualitative data (Abrams et al.).

While the literature has shown healthcare providers may lack cultural competence, the results in the studies on skill and knowledge in detecting and treating perinatal depression are mixed and conflicting. The lack of consistency in study findings underscored the need for the current study

Lack of trust and maintenance of confidentiality. Perinatal Black women often lack trust in health care providers, and in the mental health services they offer (Jesse, Dolbier, & Blanchard, 2008). In a qualitative study conducted by Jesse et al., 21 pregnant African American women from a rural, low-income prenatal clinic participated in a semi-structured focus group exploring the trust between patient and healthcare provider. The focus group topics included participants' perceptions of a) potential barriers to sharing depressive symptoms with health care providers, b) how health care providers can help women with depressive symptoms overcome barriers to seeking care, and c) prenatal interventions that might be helpful for low-income women with depressive symptoms, or depression in pregnancy. One emerging theme was a lack of trust. In large part, the lack of trust was due to dissatisfaction with care (Abrams et al., 2009; Brown et al. 2010; Jesse et al.), discontinuity of care, and length of wait time for services (Abrams et al.; Edge, 2008). Jesse et al. found that African American women believed their distrust could be overcome if the provider would simply ask how they are doing when arriving for their visit. Another study, conducted in England (Brown et al.), reported that women perceived their general practitioners lacked a sympathetic attitude toward mental difficulties

(Brown et al). While Leis et al. (2011) reported findings from one participant who acknowledged a positive experience with a mental health provider, the evidence overall suggests that Black women perceive uncaring and detached attitudes from their providers (Edge; Leis et al.).

The lack of trust in healthcare providers also leads Black women to worry that confidentiality will not be maintained (Edge, 2008; Leis et al., 2011; Jesse et al., 2008; O'Mahen & Flynn, 2008). Many women are reluctant to share their depressive symptoms with healthcare providers, fearing their children might be taken away if they are diagnosed with depression or labeled crazy (Edge; Leis et al.). Leis et al. explored the perceptions of mental health services as a barrier to service use among low-income, perinatal African American women participating in a home visiting program. In addition to the 38 African American women interviewed, 26 staff paraprofessionals from the home visiting program took part in the five focus groups, which lasted 60-90 minutes. African American mothers reported fearing loss of confidentiality or their condition being reported to authorities; women admitted to feeling depressed but never following up with a mental health provider for this reason.

Women report that lack of rapport with healthcare providers contributes to fear of broken confidentiality (Jesse et al., 2008). They see the healthcare provider as an unsafe stranger instead of someone to be trusted (Abrams et al., 2009; Edge, 2008). In another study including African American and Latina women, community key informants, and service providers in focus groups and interviews, Abrams et al. investigated barriers to formal help seeking for postpartum depression symptoms. Six of the 14 women were African American and only two reported having prior contact with a warm, caring, and empathetic mental healthcare provider. These unfavorable results indicate that more work needs to be done to improve the relationship between Black women and mental healthcare providers.

Lack of PPD knowledge in African American and Black women. While research showed Black women appeared to lack knowledge about depressive symptoms or at times hid their depressive symptoms to normalize their perinatal depression, only four studies addressed the issue (Abrams, 2009; Amankwaa, 2003; Edge 2008, Matthews et al., 2006). Most notable were the focus groups and individual interviews of 12 African American and Latina women experiencing postpartum depression (Abrams). In this study, the women were individually interviewed about barriers to seeking formal treatment, and particularly their views of their depression symptoms. Study results indicated that while they felt that something was not right, the mothers were inclined to minimize, normalize, or hide their feelings from themselves and others due to the guilt of feeling like a failed mother.

Abrams et al (2009) reported that these thoughts inhibited their recognition of their postpartum depression. One participant reported that people told her “depression was normal and related to postpartum stress and hormones.” Another participant dismissed her depressive symptoms as normal after she was told that good mothers don’t get depressed. Others felt that postpartum depression meant they were “crazy.” Another African American mother reported that she thought she might have been suffering with postpartum depression, but felt she had to get herself together because she didn’t want anyone to think she couldn’t take care of her baby (Abrams et al.). These study results correlate with other findings noted in the section on controlling images of the African American woman.

Another exemplar among the studies was the Edge (2008) qualitative study in which White British women and Black Caribbean women living in the U.K. were interviewed. Study results indicated that some of the Black Caribbean women were unfamiliar with the concept of depression, and perinatal depression in particular. However, others indicated that while they had heard of perinatal depression they had no personal experience of it and were not able to identify the feelings or behaviors that might signify perinatal depression. Black Caribbean women reported they did not engage in conversations about perinatal depression. One of the women said that while she believed that some women do get depressed, they must always give a good impression and not let anyone "know [their] business" (Edge 2008). These findings corroborate the prevailing self-image and need for secrecy among African American women with perinatal depression.

The unwillingness to discuss depression within the communities of African American and Black Caribbean women makes it difficult to gain knowledge and awareness from within social networks (Edge, 2008). In addition, Black Caribbean women reported receiving most of their information about depression from talk shows, but the shows did not portray images of Blacks. One participant reported she had never met a Black person who said they were depressed. The lack of familiarity with perinatal depression makes it unlikely that Black Caribbean women will independently seek diagnosis and treatment or even recognize the condition. They may also have difficulty explaining their feelings to a healthcare provider (Edge). One participant reported a reliance on the healthcare provider to make diagnoses and give appropriate interventions when necessary, explaining that she had told her doctor that she "didn't feel right" and wanted him to tell her what to do. Like the Abrams et al. (2009) findings, women reported a social imperative to normalize and dismiss any type of distress. Researchers noted a reluctance to use the word depressed and reported women describing “feeling down” or “flat” (Edge).

What is known about barriers knowledge surrounding PPD symptoms and treatment in Black women have been correlated with other barriers in this population. Yet, because of the scarcity of literature and most studies focusing only on low-income women, it is difficult to determine if this barrier applies to Black women of other socioeconomic backgrounds. This underscored the need for the current study to examine African American women’s knowledge about PPD.

Fear of medication to treat depression. African American women are often fearful of and lack confidence in the use of medication to treat depression (Abrams et al., 2009; Brown et al., 2010; Edge, 2008; Leis et al., 2011; O’Mahen & Flynn 2008). Antidepressant medication is the least preferred form of treatment among pregnant African American women with depression (Abrams et al.; O’Mahen & Flynn). O’Mahen and Flynn found that pregnant African American women were least confident about the effectiveness of antidepressant treatment compared with Caucasian and Hispanic women. Quantitative data from Brown et al. also suggest that Black women are slightly more reluctant to take anti-depressant medication than White women (Brown et al.). Of the 12 participants considered by Abrams et al. (2009) none of the mothers said they considered psychotropic medication to be a viable option for them. One participant even reported she flushed medication down the toilet and lied to her doctor about it. Health care providers have confirmed that low-income ethnic minority mothers often hesitate to use psychotropic medication, especially if they are breastfeeding.

African American women who were studied not only doubt the efficacy of antidepressants, but also feared the side effects (Leis et al., 2011). In a qualitative study of low-income African American women, participants were asked their perceptions about psychotropic medication and reported feeling they were unnecessary, overprescribed, and associated with unwanted side effects (Leis et al.). Women with children reported fearing antidepressant medication would prevent them from caring for their children effectively and could ultimately cause them to lose their children (Leis et al.). One participant reported that antidepressants may be a good form of treatment for people without children. This mother reported that she could not take care of her children if she was sleeping. This kind of fear not only echoes in African American women who struggle with depression, but also among family members and leaders of the African American community (Matthews et al., 2006; Nadeem et al., 2007). These findings indicate that healthcare providers and health educators should be concerned with educating African American communities about the safety and efficacy of pharmacological interventions for PPD.

The family as a support system. Although many African American women are more likely to turn to family for support instead of consulting a mental healthcare provider, there is also a fear of social stigma that leads women toward secrecy and isolation (Abrams et al., 2009; Leis et al., 2011; Matthews et al., 2006; Oakley, Kanter, Taylor, & Duguid, 2011). In a quantitative study, Oakley et al. (2011) looked at self-stigma in a low-income mixed ethnic group of 49 women in which 18 self-identified as Black. More than half (55%) of the women in the entire study reported that they would choose their best friend as a support person and person with whom they would discuss their depression. Forty-seven percent reported they would trust their mother and 43% said they would express their feelings to their spouse or partner. Eighty percent of the women reported they would not communicate their depressed feelings to a healthcare provider. Despite saying that they would rely more heavily on friends and family for support, women reported experiencing loss of contact with people they cared about upon receiving a depression diagnosis. This led to feelings of social isolation, judgment and stigma.

Additionally, two qualitative studies also reported using family and friends as informal forms of support (Abrams et al., 2009; Edge, 2008). However, Abrams et al. reported conflicting results. They found that women revealed their feelings to spouses and family members immediately. Participants stated that most spouses or female family members were supportive and nonjudgmental. Moreover, the women also reported they were often encouraged by family members to additionally seek the advice and care of health care professionals. However, some women in Abrams et al. study also experienced family members that were insensitive, dismissive, judgmental, or ignored the problem completely. This attitude may have explained the need for secrecy expressed by some African American women.

Contrasting with studies that have reported favorable friend and family support are other studies that have found African American women experience lower relationship confidence and higher levels of stigma after sharing their PPD symptoms (Menke & Flynn, 2009, O'Mahen & Flynn, 2008; Pinto-Foltz & Logsdon, 2008). For example, O'Mahen and Flynn found African American women were significantly (0.08) less likely to report confidence in family and friend support than White women. One analysis, using case studies of postpartum women to assist in the construction of stigma as a concept, reported a model case of a postpartum woman confiding in her sister-in-law that she was experiencing feelings of sadness, having trouble getting out of bed, feeling little joy at being a mother, and that her doctor had recently put her on medication.

The woman’s sister-in-law informed her that she should be ashamed of the feelings she was experiencing and for using medication to escape responsibility (Pinto-Foltz & Logsdon). Given the conflicting evidence found in the literature, no conclusions can be made about the role of family and friends as a support system or as a barrier to formal treatment in perinatal African American women. This unclear picture points to the need for the current study to address informal treatment use of family and friends and how it impacts African American women with PPD.

Summary

There was no existing literature that looked at the lived experiences of African American women with PPD utilizing a critical hermeneutic lens and a Black feminist theoretical framework. This study will be the first study to do so. Most of the studies focused on mixed ethnic groups and perinatal mental health stigma, mental health treatment, spirituality and religion, and social support. The classic literature was primarily focused on White women, women from other countries, and mixed ethnic groups with a focus on African American women from lower-socioeconomic brackets. Only two studies (Amankwaa, 2003; Abrams, 2009) were conducted with African American women during the postpartum period and both notably used Black feminist theory to guide their designs. The experience of the African American woman is crucial in aiding healthcare providers with the necessary tools needed to educate, assess, and treat African American women with PPD. Most of the research that has been done in postpartum care is 10 years old or greater.

This critical hermeneutic study will be the first to describe the lived experiences of African American women with PPD, to examine their meanings within the societal context, and to explore the impact of family and significant other support to the African American woman with PPD. Results from this study will provide a foundation for future research to build a body of knowledge that is culturally appropriate for African American women with PPD and guide the development of interventions that may include the significant other, communities, and churches.

In Chapter Three I will provide an explanation of the methodology and framework used for this study.

CHAPTER 3

Research Design and Methods

Introduction

This chapter will include an overview of the aims of this study, a description of hermeneutic phenomenology and its methodological assumptions, and a description of Black feminist theory as it was used as the critical lens for this research. Additional information will include a description of data sampling, data collection, data analysis, methods used to ensure rigor and the protection of human subjects as it pertains to informed consent, risks, and confidentiality.

Study Aims

This study used a critical hermeneutic approach through the lens of Black feminist theory to explore the experiences of African American women with PPD. The specific aims were 1) to describe the lived experiences of African American women with PPD in the context of society, 2) to describe the background meanings and concerns surrounding their experiences with PPD, and 3) to examine the impact of familial or otherwise significant relationships in providing social support to African American women with PPD.

Hermeneutic Phenomenology

Phenomenology is the study of subjective human experience. The goal of this approach is to elicit understanding without measurement, taxonomy, or abstraction (Moran, 2000). Martin Heidegger, one of the most well-known phenomenologists, focused on ontological inquiry (the study of being) (as cited in Van Manen, 1990). He taught that one must recognize the “life-world” as a person’s being in the world and understand how the world influences being (as cited in Moran; Kafle, 2011). It is the phenomenology of Heidegger that most prominently influences hermeneutic phenomenology. Lived experience is the essence of phenomenological research. An understanding of the human experience is at the core of the art of nursing, thereby making phenomenology a fitting vehicle for research (Moran; Van Manen).

Employing hermeneutic phenomenology, the researcher seeks to describe subjective experiences using a co-constitutional approach. By this approach, researcher and participants fuse meanings based on their own understandings, assumptions, and experiences. Heidegger rejected the notion of one truth in favor of the idea of multiple interpretations of an experience. In hermeneutic phenomenology multiple meanings are extracted (Moran, 2000). Most often, hermeneutic phenomenology involves the collection of narratives from multiple open conversations with each participant. Multiple conversations allow for greater depth of interpretation by remaining close to the data through the writing and rewriting process (Moran).

Methodological Approach

In this study, narrative meanings of the everyday life experiences of African American women with PPD were examined (Moran, 2000). The essence of the African American women’s experience with PPD was captured using hermeneutic phenomenology in instrumental fashion. Essence is a term used to represent the basic nature of a phenomenon. It enables the reader to understand an experience in a way that would not have otherwise been known (Lopez & Willis, 2004; Moran). In hermeneutics the interpretation of meaning is brought to light through narrative (Lopez and Willis). Commonalities within participants' narratives provide a description of the phenomenon that is as broad as possible, capturing as many themes as can be identified (Lopez & Willis). Through their text, and the analysis and synthesis thereof, this study yielded a greater understanding of the lived experiences of African American women with PPD.

To position the experiences of African American women at the center of inquiry, the framework for this study was Black feminist theory (Tillman, 2004). This culturally sensitive research approach was essential to portraying an accurate account and to deepening our understanding of African American women with PPD (Tillman).

Theoretical Assumptions of Feminist and Black Feminist Theory

Feminist standpoint theory shifts the focus away from an exclusionary male perspective and illuminates the experiences of women (Hesse-Biber, 2012). It relays messages of empowerment while challenging those who inhabit positions of privilege. The feminist standpoint approach is helpful in capturing the full experience of women in their own voices (Collins, 1987). While Harding (1987) recognized the capability of men to conduct feminist research, she suggested that women participants are able to articulate information about themselves most accurately. In research guided by feminist standpoint theory, women's experiences are the major object of investigation. The goal of feminist standpoint research is to see the world from the standpoint of a group of women and to improve the lives of those women and other people (Campbell & Bunting, 1991).

In feminist standpoint research the focus is on women and the injustices that women face regarding social power. Feminist standpoint research provides a commitment to political activism and social justice and seeks to eliminate oppressive attitudes and behaviors within scientific research (Hesse-Biber, Leavy, & Yaiser, 2004). The feminist standpoint is derived from women dissatisfied with the lack of knowledge representative of them. Women felt marginalized and discriminated against in scientific research and felt that their stories could best be told in their own words (Harding, 2004). This standpoint originated in the late 1960s and 1970s from the views of Marxism. Women became acutely aware of the marginalization and disadvantages they experienced in natural and social science knowledge production (Harding, 1987). The research that was being presented about women was being conducted by those in power; specifically, a homogenous culture of heterosexual, middle–class White men. Recognizing their exclusion sparked the feminist standpoint movement – a theoretical belief that knowledge is driven by social status (Borland, 2015). Just as non-Hispanic White women were recognizing their unique standpoint, Black women were beginning to see the extent of their marginalization. Feminist research was primarily being conducted by White middle-class women, leaving African American women outside the production of scientific research (Zinn & Dill, 1996).

Patricia Collins (1986) examined what she termed the “outsider within” navigation process for African American women, operating within a White privilege society but never forgetting about their marginalization through race and gender. Collins additionally commented that when we explore the “matrix” of differences it is then that we truly understand a person’s lived experience. Black Feminist Theory brings to center those who have been marginalized by the dominant form of knowledge building and challenges who can be a knower and what can be known (Hesse-Biber, 2012).

There are some assumptions that underlie Black feminist theory. First, the development of Black feminist thought cannot be separated from the fabric and historical conditions that shaped the lives of Black feminists. Therefore, only Black women can shape Black Feminist Thought. Second, Black women have a unique social standpoint and because of their standpoint they will share some commonalities. Third, although there may be commonalities, the area of the country, socioeconomic status, age, and sexual orientation produces varied expressions. Finally, while the Black feminist standpoint is noted, its boundaries may not be well defined for every Black woman (Collins, 2000). The Black feminist standpoint enables the researcher to ask questions and choose methods that are relevant to the social location of Black women, historically and currently (Abrums, 2004). It allows the researcher to assess truths that are accepted among Black women. These truths are derived from Black women's experiences and worldviews (Abrums). This standpoint continually changes as the experiences of Black women change (Abrums). When non-Hispanic White women were recognizing their unique standpoint and thought it valuable to become contributors of their own stories, Black women saw that they were experiencing exclusion. They recognized that their exclusion was not simply bound by gender but also race.

African American feminist, Kimberle Crenshaw, first used the term "intersectionality" to describe the way in which African American women typically encounter oppression (Smith, 2013). She illustrated the interconnected nature of their experiences with racism and sexism using the analogy of driving through a busy traffic intersection. When vehicles are moving in several different directions simultaneously and an accident occurs, it may be difficult to determine which car caused the accident. It is the same way with an insult of oppression. African American women are sometimes unsure whether an offensive comment is motivated by racism or sexism or both (Smith). Likewise, Collins (1986) foreshadowed the concept of intersectionality by discussing the interaction of multiple systems of oppression, and their relationship to a concept she named “dichotomous oppositional difference.” This concept described the assigned differences between people, ideas, and things. However, instead of an augmentation of the differences, there is an opposition that occurs and produces an instability and an insubordination of one to the other in the interaction (Collins).

Collins (1986) described Black Feminist thought, and the need for African American women to reject the idea of societal stereotypes and to take hold of the meaning of self-definition and self-valuation. She stated that self-definition challenges the societal and political externally-defined stereotypes that have dehumanized African American women. African American women must define themselves, value themselves, and reject those stereotypes that have been assigned them. This act of self-definition removes the dehumanization that can accompany stereotypes and places power in the hands of African American women (Collins, 1986).

The discourse of African American feminism exploded in the 1960s with politicians, socialists, and African American media weighing in on the conversation of racism, sexism, and discrimination. It was during this time that societal stereotypes arose and were used to control African American women. These stereotypes include the mammy, the matriarch, and the welfare mother (Abrums, 2004). These ideologies of oppression came to dominate contemporary thought. The mammy was the African American domestic who cared for the children in the home of her non-Hispanic White employer. The matriarchal mother arose in the context of African American men's emasculation during slavery and subsequently their disproportionate exclusion from the employment market (Woods-Giscombe, 2010). These stereotypes were assigned to African American women not by their own choosing, but by a White male dominated society attempting to perpetuate oppressive ideologies (Collins, 1986). King (as cited in Collins) stated, "stereotypes represent externally-defined, controlling images of Afro-American womanhood that have been central to the dehumanization of Black women and the exploitation of Black women's labor." (pg. 178).

While self-definition challenges the societal and political externally-defined stereotypes that have dehumanized African American women, self-valuation examines the way African American women refute those defined stereotypes. African American women who were assertive or strong were labeled as matriarchs and were a challenge to the status quo. Black Feminist Thought challenges the negative connotations associated with the matriarch stereotype and redefines the assertive qualities that allowed women to survive and sustain their way of life and thought through the many challenges they faced. This self-valuation challenges externally-defined portrayals of African American women (Collins, 1986).

The role of the family matriarch, also termed the "strong black woman or superwoman" was reframed and taught African American women to rely on themselves when faced with difficult circumstances. It became a positive message for younger girls (Abrams et al., 2006; Amankwaa, 2003; Edge, 2008; Matthews et al., 2006). Messages of self-reliance are taught very early in the African American culture and are communicated through families or community leaders (Amankwaa; Alvidrez et al., 2008; Matthew et al.). African American women reported that the image of their mothers being “strong women” made an impression on them and that they were socialized to handle whatever came their way (Amankwaa). Hence, discriminatory and oppressive stereotypes were taken back by African American women and reassigned positive images and subsequently taught to future generations. But this reformulation was not without critics; Black feminists such as Morgan (1999) and Radford-Hill as cited in Wyatt (2008) called for a new movement that would reject the image of a strong Black woman and replace it with one of emotional vulnerability and humanity.

There is historical evidence of racism toward African Americans which has created mistrust within the community. This lack of trust in the healthcare system is rooted in unethical research among African Americans (Boulware, Cooper, Ratner, LaVeist, & Powe, 2003). The Tuskegee Syphilis Study is a grim reminder of how the federal government and the healthcare system can cause harm to a group of people through discrimination and racism (Gary, 2005). This study was conducted on African American men in 1932 and lasted for 40 years. The original objective was to examine the negative effects of syphilis. Three hundred and ninety-nine men with syphilis and 201 men without syphilis were enrolled. The men were not given an informed consent nor were they told that they could leave the study at any time. When penicillin became known as an effective treatment for syphilis, men who had the disease were not treated. They were left to suffer the effects of a horrible disease (Center for Disease Control, n.d.).

The Tuskegee Study speaks to the question of why there is fear and secrecy within the African American community surrounding mental illness (Alvidrez et al., 2008; Alvidrez et al., 2009; Alvidrez et al., 2010; Amankwaa, 2003; Gary, 2005; Matthews et al., 2006; Menke & Flynn, 2009; Mishra et al., 2009; Nadeem et al., 2007; O’Mahen et al., 2011) and any other health concern. There are other known disparities within the African American community that perpetuate this fear and secrecy. Infant mortality rates, for example, are 2.2 times higher than for non-Hispanic Whites (Matthews, MacDorman, Thoma, 2015). Maternal mortality is three to four times higher in African American mothers than that of non-Hispanic White mothers (Center for Disease Control, 2011). In addition, the Center for Disease Control reports that minority and ethnic groups suffer lower rates of life expectancy, higher rates of disability and preventable diseases (Center for Disease Control, 2011).

Study Design

Critical hermeneutic research requires the researcher to unfold and understand the common meanings of the practices, skills, and experiences of those with whom they participate (Benner, 1994; Creswell, 2007) and to understand how race and racism are ingrained in the society in which we live. Culturally sensitive research recognizes both race and culture through a qualitative method (Tillman, 2002). The data for this type of study is derived from participants in the form of inquiry, observation, and diaries, however, meaning can often be hidden in the everyday practices of human beings (Benner). The responsibility of the researcher is to unfold meanings of the experiences from participants in a naturalistic and co-created style (Benner).

Sample

Participants included two cohorts of self-identified English speaking African American women with PPD age 18 years of age or older. The first cohort had delivered a live birth within the last 18 months and had a diagnosis of PPD or self-reported symptoms of PPD. The second cohort also had a history of a formal diagnosis of PPD or self-reported symptoms of PPD, but their children were older than 18 months of age.

The goal in critical hermeneutic research is to provide a sample that elicits experiential exemplars that represent the phenomena studied. Depth of an experience from the narratives is preferred over a set number of participants (Van Manen, 2014). The number of participants is only approximated, as the final size of the sample depends, in part, on the amount of usable data collected from participants (Van Manen). As with other qualitative studies, the final size of the sample is linked with singular themes, not the notion of data saturation, as data saturation seeks sameness (Van Manen). Usable data and analytical singular findings contribute to deciding sample size. The recommendation for what constitutes an optimal sample in critical hermeneutic phenomenological research ranges from 4 to 20 participants (Abrums, 2004; Beck, 1992 & 1996; Hassouneh-Phillips, 2003; Nims, 1996; Semprevivo, 1996. The proposed study aimed to include between 5 and 20 participants experiencing the same phenomena, with the caveat that final numbers could be adjusted depending on the quality of data collected (Creswell, 2007; Van Manen, 1990).

Setting

Upon approval from the Oregon Health and Science University (OHSU) Institutional Review Board (IRB), an announcement was posted (see Appendix 2) and participants were recruited from Vance Stafford Pediatric Clinic (VSPC) and University of Tennessee Family Practice (UTFP) both facilities are affiliated with the Erlanger Medical Center (EMC), a tertiary teaching hospital, in Chattanooga, TN. VSPC is a teaching clinic that is a part of the pediatric rotation for residents and UTFP is a family medicine, residency training program with the

University of Tennessee College of Medicine. VSPC has 27 residents and UTFP has 18 residents in various stages of their three-year training. The EMC includes patients during the postpartum phase of pregnancy. An obstetric clinic was not chosen because moms are typically only seen at the six-week visit postpartum and may or may not be screened for postpartum depression. VSPC and UTFP both see moms throughout the first year of life for their newborn. VSPC residents screen postpartum mothers at the two-week, one month, and two month visit with their newborns. Debbie Johnson, MSW, assisted with recruitment at VSPC. She is a social worker at VSPC and was the referral source after the women had been screened by the residents. More specifically, she met with all patients who had been screened and scored $\geq$ 10 on the Edinburgh Postnatal Depression Scale (EPDS). She provided each patient with resource material and referral to counseling services for PPD care. UTFP does not routinely screen postpartum mothers for PPD, but the residents are trained in depression assessment and were able to recognize when a postpartum mother warranted an assessment (Dr. Robert Zylstra, EdD, LCSW, personal communication). Additionally, African American women who self-reported depressive symptomology were recruited from churches and on Facebook by snowball recruitment.

Recruitment Efforts

I met with Chattanooga Medical Center in Chattanooga Obstetrics (OB) and Pediatric Clinic's personnel to review the details of the study. When I was cleared to go into the OB clinic, it was difficult contacting the director of the clinic and recruitment efforts through the director were unsuccessful. Recruitment efforts continued through the Social Worker, but I had to employ other means of recruiting due to slow recruitment. That is the reason why recruitment criteria were broadened beyond the 18-month live birth time window and a second cohort of women was added to the study; these changes are reflected in the study recruitment materials in the appendix as described below.

An IRB approved flyer (See Appendix 3) describing the study in detail was sent via email and hard copy to VSPC and UTFP for recruitment purposes. Social media in the form of Facebook (See Appendix 4) was employed as a platform for recruitment. There were several likes on the Facebook page, although no participants were recruited via that mechanism. After going back to the research team for counseling on recruitment efforts and seeking additional IRB approval, a Craig's list account was created in the ten states with the highest percentage of African American residents. In addition, a social worker from Maternal Fetal Medicine at Loma Linda University Medical Center, with whom I had worked with previously, was brought in to provide assistance. Finally, I solicited a nurse practitioner administrator and officer in the United States Navy. She sent recruitment materials to minority health leaders within the Southeast region (Office of Minority Health).

The recruitment process was tedious and challenging. Therefore, I decided to reach out to an organization that was specifically dedicated to postpartum support: Postpartum Support International (PSI). The Executive Director for the organization was extremely excited about the research and immediately wanted to help. She posted the Facebook posting on their international website, and she also set up an email introduction with Perinatal Mental Health Alliance for Women of Color (PMHWOC). They posted the flyer to their Facebook page and on their website. Many women did not realize they were experiencing PPD because their associated meaning of PPD were extreme cases from the media. There is also societal stigma surrounding

PPD that the women described. It is possible that incomplete understanding and social stigma may have impacted recruitment efforts.

Through the iterative process of analysis, my committee chair and I decided to go back to recruitment efforts to see if we could attain more variation in participants and create more congruency in analysis. With IRB approval, we opened recruitment to include any woman who had ever experienced PPD within the age range of 18-50 years old. A local mosque was contacted in the area and a few social workers to see if other local organizations might be utilized for recruitment. An additional four participants contacted me. These women all met inclusion criteria and joined the study. Three more women initiated the process of participation but failed to complete the process. One woman was disqualified after learning that her baby had a stay in the Neonatal Intensive Care Unit (NICU), another woman failed to return phone calls and emails after our initial contact. The third woman opted out after our initial EPDS screening. She informed me that she did not have time to dedicate to two interviews.

The flyer had specific details about the purpose of the study, procedures, risks/benefits, cost, participation, and confidentiality. A phone number and email address were provided for potential participants to contact me if interested in the study. Each participant received a $25 gift card at the end of their interview to show appreciation for their participation in the study. Once potential participants made contact and confirmed their interest in the study, they were screened to inclusion criteria. Those who met the inclusion criteria were invited to participate in the study. Upon agreement, an appointment was scheduled to meet with the participant via phone and inform her of the purpose and details of the study and to obtain consent. After the prior listed steps were completed, an invitation was extended for them to join the study (See Appendix 5).

Data Collection

Data were collected from 13 African American women (Appendix 1). The participants contacted me either through a friend, text or email. Once initial contact was made, participants were asked inclusion criteria questions and were made aware of the study's purpose and all other relevant information. Women were asked again if they understood the study and if they wanted to participate. Interviews were conducted between February and November 2017. An interview guide (Appendix 6) was used to facilitate accessing participants' narratives about their experiences with PPD. The first interview was conducted and analyzed within two weeks; the second interviews followed within 4-6 weeks. All interviews were approximately 1-1 ½ hours in length. All participants were willing to answer any additional questions via telephone or text whenever needed, but no third interview was conducted.

Procedures and Interviews. At the first interview session, I reviewed the information sheet, verified the participant's understanding, and obtained verbal consent. Initial interviews were via telephone. All, but two participants were from other states. Those who were local preferred a telephone interview over meeting face-to-face. At the end of the first interview, a date and time for the subsequent interview was determined. After the second interview, I reminded each participant that I might contact them for follow-up questions for clarification and to ensure understanding. A copy of the information sheet was sent via email to all participants with contact information in the event they would have questions throughout the process.

A philosophical tenet of critical hermeneutic research is that the participant will recognize the influence of their interaction in the world and how their interpreted meanings make up their lived experience. Hence, the experiences that participants revealed provided knowledge and emancipation, as they described a freedom gained by sharing their story and a willingness to share their experience with others (Lopez & Willis, 2004; Tillman, 2002). Interviews were unstructured, allowing African American women to share their situated life experiences with PPD. The choices the participants made in their life-world around PPD were influenced by interactions in family, culture, politics, society, and history. These choices are subjective in nature and based on each participant's daily life (Lopez & Willis).

Participants were encouraged to include descriptions of interactions, experiences in the body, any significant relationships, and historical, social, cultural, and political influences (Lopez & Willis, 2004). Subsequent interviews were used to extract specific details that clarified experiences, enhanced emerging themes, and closed any gaps in assigned meanings. Probes and prompts from the interview guide (Appendix 6) were used as needed to assist participants with recall of their experiences.

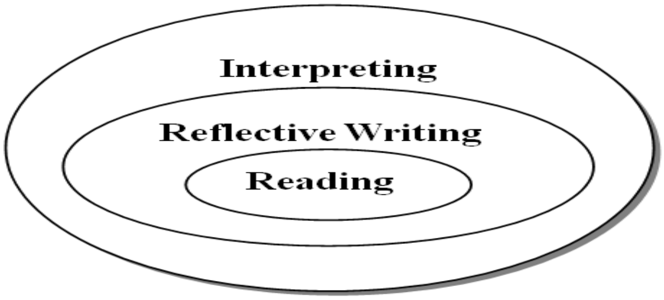
Recording and transcription. Interviews were recorded via a digital recording device and sent to a professional transcriptionist. Interviews were transcribed verbatim from each participant within 3-5 business days and sent back to me via email. Each interview was appointed an identifier for ease of retrieval and protection of confidentiality of participants (Van Manen, 1990). Transcripts were archived via the transcription company-GMR transcription and archived on an electronic device that was locked under password.

Data Analysis

Critical hermeneutic analysis. Data analysis occurs using the hermeneutic cycle. Within this cycle there are three essential components: reading, reflective writing, and interpreting

(Figure 1) (Kafle, 2011). This cycle begins with data collection and is continuous throughout the data analysis process. This cycle is consistent with the analysis activities that are described in the literature for hermeneutic phenomenology: 1) reflecting on essential themes, 2) describing the phenomenon through writing and rewriting, 3) maintaining a strong pedagogical orientation to the phenomenon, and 4) maintaining balance between the parts and the whole (Van Manen, 1990).

Figure 1 - Hermeneutic Circle



Analysis. Data were originally coded as an iterative process through the writing of narratives from the interviews and lived experience descriptions (LED), transforming my LED to anecdotes. Anecdotes are a shorter, more simplified story of the lived experience inciting reflection and thought that is noteworthy (Van Manen, 2014). Anecdotes are meant to bring the experience close to the writer and reader by a vividness and an association with the experience described (Van Manen). Selective readings were used to guide back to the whole text and extract portions of the text that were significant to each woman’s PPD experience, the culture, or the interaction of the family system. This is where an examination of pieces of the whole (narrative) and the whole with pieces (smaller stories within the whole) developed. The writing of LEDs allowed the narratives to be broken down into more workable pieces that notable ideas could be extracted. It provided a more simplified means of looking at the pieces and comparing them to the whole. Then, the pieces of one narrative were put together with pieces of other narratives that made up themes. This process provided a road map and facilitated a smoother writing process.

Data were also put into tables and images were used to provide visual data. The data were separated into categories such as: Pregnancy, PPD emotions, PPD experience, social support, etc. to see segments of the participants’ narratives and to bring each participant’s individual experience together to create a collective experience. Upon completion of this iterative process, open coding was done of each transcript, collapsing codes that were similar and looking for overarching categories that provided a clear distinction of relationships or differences. Originally, the researcher wrote two paradigm cases, one of a positive experience and the other of a negative experience and from there thematic analysis. Thematic analysis led to themes that were derived from collapsing the codes. From the themes, subthemes were derived for some of the categories. Member checking and co-creation was established by sending the emerging themes and a copy of each participant’s transcript to them for validation of emerging themes and for editing of any part of their interviews they disagreed with. Participants were asked to verify whether the themes resonated with their lived experience. There were no participants who disagreed with the themes that had emerged, but there was one who wanted a portion of her transcript removed. The participant’s request have been respected and the redacted narrative segments do not appear in this dissertation.

To pursue the essence of their meanings, concerns, and lived experiences with PPD and to understand the impact of social support through PPD in these women, it was important to understand their entire experience from life before pregnancy through postpartum. Therefore, the researcher re-presented the life before pregnancy through the PPD journey for the African American women in this study through several paradigm cases. Second, themes and subthemes that emerged from the data were presented. These themes and subthemes extracted the essence of their lived experiences and the meanings and concerns associated with their lived experience with PPD. These methods yielded the results that are presented in Chapter 4.

Rigor

The most important variable in data analysis is maintaining quality and transparency of the research process (Kafle, 2011). There are four elements of rigor that are important to maintaining pedagogical significance in critical hermeneutics: orientation, strength, richness, and depth (van Manen, 1990). Orientation was consistent with openness in the interpretive process. Journaling provided accessibility into the process of decision-making and processes of thought made throughout the interpretive process (de Witt & Ploeg, 2005). Strength represents how well the text delivers and convinces the readers of the participants' experiences through their expressions of the text. Strength was validated by a committee member stating, "I think I may have had PPD after I had my baby." Richness refers to how the researcher can bring the participants' narratives to life. Richness was verified as the narratives were read by fellow PhD cohort members and dissertation committee members and they felt a deep sense of connection with the participants' stories. Depth is "what goes deep down in the text" to pull out the very intentions underlying the participants' experiences. Finally, the hermeneutic circle was an ongoing process of analysis that established the depth of the experiences of African American women with PPD (van Manen).

Additional steps to ensure rigor that supported the critical theory portion of this research was outlined by Lather (1986). They include: 1) triangulation, 2) construct validity, 3) face validity, and 4) catalytic validity. Triangulation was accomplished using multiple participants for data collection, the generation of multiple themes, and the ability to demonstrate comparisons and differences within those extracted themes. The latter was accomplished through the writing and rewriting process. Construct validity was maintained through the dissertation committee members providing detailed guidance on maintaining accurate methods in analysis. Face validity took the researcher back to participants after analysis for member checking of results and provided refinement of the written interpretations. Finally, catalytic validity provided a charge or surge of empowerment from an enlightened state of mind to participants that engaged in the research (Lather).

The aim of the study was to highlight the experiences of African American women with the purpose of eliciting rich and deep meanings of their experiences with discrimination, seeking to eliminate racial subjugation, and examining the inequalities that African American women face related to their race and gender. This research provided a greater understanding of the phenomena for African American women and elicited solutions that will provide change for African American women suffering with PPD that are directly linked to racism, sexism, and institutional structures of discrimination (Creswell, 2007).

Ethical Considerations

IRB policies, procedures, and protocols of Oregon Health and Science University (OHSU) and EMC were maintained throughout the research process. All participants were provided an informational sheet (Appendix 5) that detailed the purpose of the study, the right to withdraw at any time, an explanation of the benefits and risks of participating, and protection of confidentiality. This information was reviewed prior to conducting interviews.

Participants were informed that the research could produce adverse emotions. The participants were of a minority group and they were fearful about sharing their feelings about depression (Amankwaa, 2003). African American women are considered a vulnerable population and were provided with a resource list for referral (Appendix 7) if any emotionally distressing needs arose. In addition, immediate emotional support was provided for any participant who expressed distress or had a need for mental health services. A mental health referral was recommended for one participant, but she refused the referral. As a trained registered nurse with over 25 years' experience, I was able to recognize signs and symptoms of distress. When a participant demonstrated signs of emotional distress, the following protocol was implemented: 1) assess the participant, 2) if the participant was inconsolable, a call would have been made to either Debbie Johnson or Dr. Robert Zylstra, social workers, working at VSPC and UTFP respectively. There were no participants for whom the protocol was needed. Participants were informed, prior to the interviews and during the interview, that they could stop at any time if they were adversely emotionally affected. A few interviews enlisted this option and once participants were emotionally stable, interviews were resumed upon their request. No participant demonstrated a desire to commit suicide during the interviews. All ethical matters requiring nonemergent action were discussed with experts on the dissertation committee. The chair of the dissertation committee is a mental health care provider.

Protection of Human Subjects

All measures were taken to ensure anonymity and confidentiality throughout the research process and will be in any future publications. Pseudonyms were provided for each participant and non-descriptive markers were assigned for each transcript. These non-descriptive markers were pre-selected to protect the privacy and confidentiality of participants. As an African American woman, I was aware of the historical context and understanding of research in African American communities and was considerate of this during the process. All paper copies of data-based information were stored in a locked cabinet. Information loaded to an electronic device was maintained under a secure file with secure password access. The data will remain securely stored and locked until all associated manuscripts for publication are completed. Afterwards, data will be destroyed as outlined by OHSU IRB guidelines. All digitally recorded interviews were deleted after data analysis and all identifying information was removed during the transcription process. Only committee members were granted access to any of the research data collected from participants. If at any time a participant felt distress or discomfort during the interview process, they were free to stop the process of the interview. Some of the stories reflected on times and circumstances that evoked pain, angry, sadness, or feelings of oppression. A situation-appropriate response was provided. Risks involved during the interview process were minimal. Participation was voluntary, and participant could have discontinued their participation in the research at any time. Finally, the day-to-day activities of this research were handled in a manner that was safe and humane for each participant involved in the study. Decisions that were made were discussed with committee members and IRB analysts as was appropriate to maintain the highest ethical standards for research.

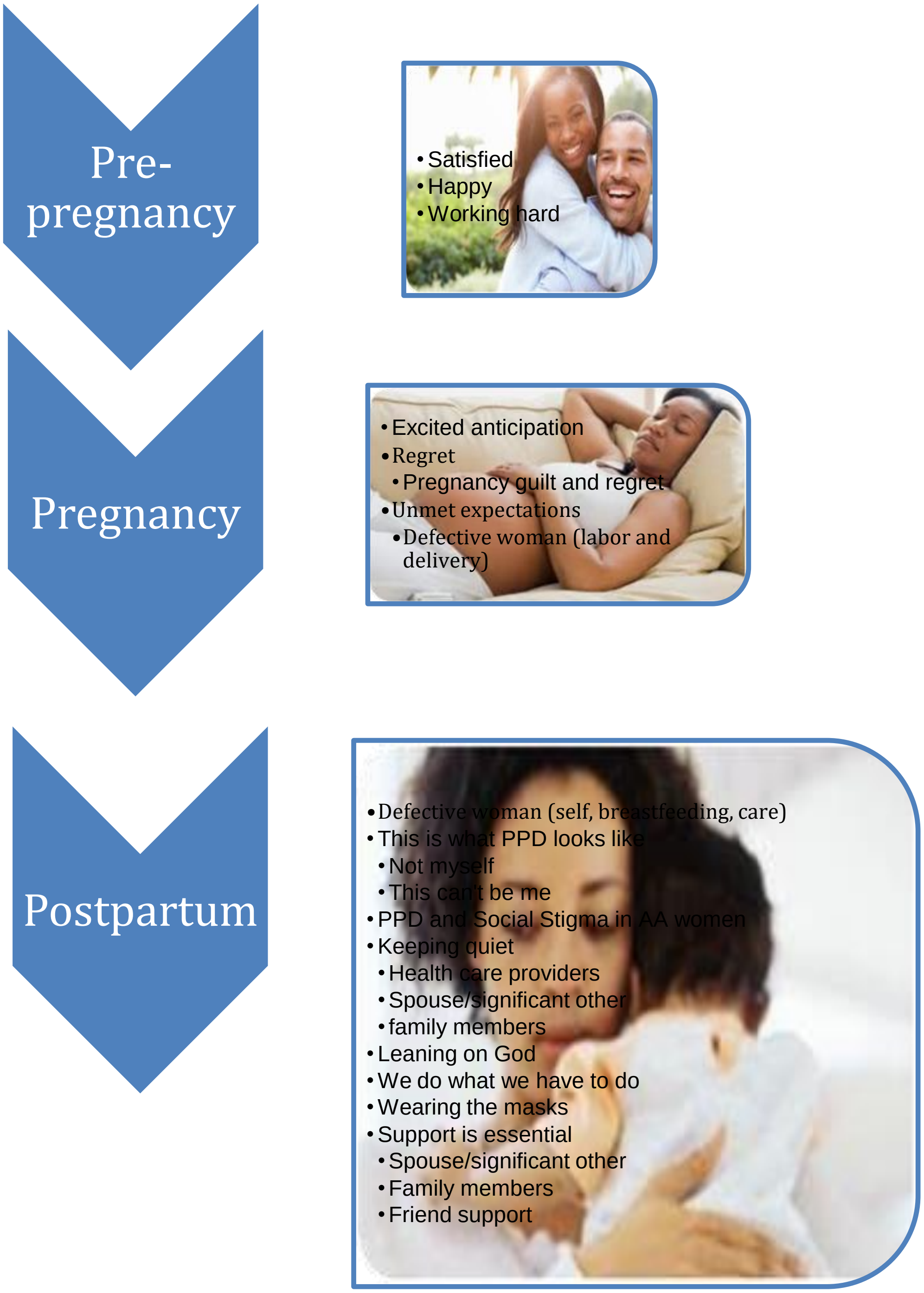
CHAPTER 4

Results

This study examined the lived experiences of African American women with PPD in the context of society, described their background meanings and concerns surrounding their experiences with PPD, and examined the impact of familial or otherwise significant relationships in providing social support to African American women with PPD. The purpose of this chapter is to present an interpretation of results using the critical hermeneutic approach described in Chapter 3.

To gain a holistic and comprehensive understanding of participants' lived experiences with PPD including the impact of social support, it was important to understand their journey from before pregnancy through the postpartum period. Paradigm cases and thematic analysis with exemplars are presented throughout the time periods: pre-pregnancy, pregnancy, and postpartum. The intent is to re-present these temporal aspects of the phenomenon, while providing data that reflects the strong influence and nature of common positive supports or negative outcomes experienced by participants. The results of the thematic analysis are presented throughout the telling of the story. Themes and subthemes are presented in the table below. These themes and subthemes reflect the essence of participants' lived experiences with PPD and their associated meanings and concerns.

Figure 2 - Themes and Subthemes



Pre-Pregnancy

Women frequently began the story of their PPD journey by describing the pre-pregnancy phase through their relationship with their spouse or significant other, their work life, and things they enjoyed doing. Some also shared their feelings about their family and future pregnancy. The themes that emerged from these stories were *satisfied*/*happy* and *working hard*.

Satisfied, Happy and Working Hard

The following is a paradigm case reflecting the themes that emerged for this period.

> We were so happy! We enjoyed each other to the fullest. We enjoyed our married life, we enjoyed our jobs, and we enjoyed the things we got to do without having to worry about anyone else but ourselves. I had a lot of time to myself, I guess you can say. I was in school for nursing anesthetist, so I studied a lot. And I didn't really have as much time with my husband because he was in dental school at the time. And at this point, we'd been married for seven and a half years. And once I graduated and started working, my time freed up. We went on vacation, and we started to enjoy life as we once had before going back to school for our advanced degrees and spending time with each other, being able to pick up and go whenever we wanted to or pick up and plan a vacation or a quick weekend away, or go to the movies or go to dinner or something like that. It was just kind of a time how you really didn't have to think about much. It was just living life and enjoying each other's company. I worked a full 40-hour week and did overtime if I wanted to. We just had freedom that we hadn’t had before and were happy, enjoying our time together. I didn’t have to worry about how I spent my money or worry about sharing

> it with anyone else. That is one of the reasons we waited to have kids because I didn't want to share my money with a child. So, I worked as often as I wanted and spent what I wanted. I was just focused on me and my husband during that time. I didn't have to think about anyone but my husband. We could sleep in and go out to eat whenever we wanted and not have to think about getting the baby ready or preparing for any extras. It was a quiet and happy time for us. We shared the same goals of wanting a family but decided to enjoy as much time together before embarking on the task of building a family right away. It was a time for us to enjoy the things we wanted to do and work as much as we wanted to do those things.

Pre-pregnancy Thematic Analysis

Felicia's pre-pregnancy experience centered on being able to focus on her career and the zealous attitude she exhibited for making sure that she and her husband had a solid financial foundation.

> Before I became pregnant, …I was working in the ER doing, you know, being a nurse. Well, let's see…I worked I think at least 40 hours a week. And my husband also worked night shifts – like five days – 12-hour shifts – and so, that was – we were busy during that time.

Like many of the other women in this study, Felicia's story reflects satisfaction in work life. Natasha reflected on how her life and job kept her busy. She stated she and her husband worked and enjoyed traveling together. Here are a few more exemplars reflecting on job and lifestyle.

> I was working at a phone company. I had just switched positions, co-parenting with my first child's dad. I had a very social life, very into church, and just happy all the way around. Independent.

Racquel described the freedom to spend her money the way she wanted before contemplating pregnancy and her reluctance to change that mindset if she were to have a child.

> I was working 40 hours a week and would do any type of overtime. We were still newlyweds so just the day to day, trying to make sure that we stayed working and hustling. I didn't want kids because I knew that I would have to share my money, and I didn't want to have to share my money. My lifestyle would have to change, and I would not be able to shop anymore.

Olivia described the pleasure she found in having only one child and being able to come and go as she pleased. This sense of being able to pick up and go was also echoed by Patricia. Patricia shared how she was able to go often with her significant other and her oldest child and reflected on how they shared responsibilities for the baby.

> I was going out a lot. I was working. I spent time with my baby, every chance that I got we took him out and stuff. It was okay because once you're out, it's not that bad. I did have his daddy. What I couldn't do, he could so it was okay and it worked well together. We worked well together as a team. It was good. It was okay.

Julie shared that she and her husband had some of the same passions such as their interest in working with children and enjoyed just hanging out together.

> We were, and we are, very close. We have a lot of the same, I guess, passions. We both really enjoy children. We enjoy being active in church. And so, you know, and there were – and we were both huge sports fans. And so, there were a lot of things that we enjoy doing together that we could when it was just the two of us.

Unlike the other women who talked primarily about the pre-pregnancy phase bringing only satisfaction, Ashley described a challenging time prior to her pregnancy and how an injury, lack of a job for her spouse, and poor body-image impacted her relationship. Yet, later, she described how a healed injury, the offer of a job, and the ability to work out again turned what was a stressful time for her into a happy time. The following is an exemplar of Ashley's experience.

> Before I became pregnant with my daughter I had my son, he was almost a year old before we got pregnant with her. My husband was not making much money and was trying to find a new job. He was very, very, very stressed out. I was happy at work. I was working out. I was not in a bad place mentally, but then I injured myself a few months before I became pregnant with my daughter, I hurt my knee. I started to feel a little down on myself because I was making strides towards losing my baby weight. I am very insecure about my body since I had my son. Around November or December of 2014, I started getting back to myself. My knee healed up, I started working out again. I got happy. My husband had a job offer.

Most of the women shared pleasant experiences of what life was like before becoming pregnant. They described their work life, home life, the ability to travel, and engage in things they enjoyed either as individuals or as a couple and it was satisfying for them. They also reflected on pre-pregnancy as a time that they were able to work hard and appreciate their ability to have a certain lifestyle or build a better a financial foundation for their family. The pre-pregnancy phase was a time of their own that reflected satisfaction, happiness, and hard work for their family.

Pregnancy

Given the satisfaction and happiness experienced during pre-pregnancy, the reality of pregnancy was vastly different for many of the women. For some it was met with excitement and joy as they looked forward to a planned pregnancy, and in some cases, a long-awaited pregnancy. For others the pregnancy experience was met with regret as the women contemplated an unplanned pregnancy, marital strife, lack of support, and single parenting. During the pregnancy time period the themes that were extracted are: *excited anticipation, regret*, and the sub-theme of regret *pregnancy guilt and regret*.

Excited Anticipation

In the following paradigm case, Natasha described her experience with a complex pregnancy history and a long-awaited pregnancy.

> For our journey in pregnancy, we started trying after our second year of marriage. And after a year and a half of trying, we decided to go see a doctor. And they suggested we see a fertility specialist… I was heavier then because of the stress. So, at that time, I started losing weight. The heaviest I've ever been was like 218… The fertility specialist said he didn't like the number, I guess, of eggs or whatever that I had… And he put me on Metformin because I was borderline diabetic and that was supposed to help with the

> fertility and everything. The doctor also put my husband on medication to try to get his numbers up. My husband's sperm count came up still low, what they considered low, but it was in a high enough where they felt like we could do IUI. So, we tried that twice. It didn't work… And so, then, 2012, the fertility doctor put me on fertility medication. I didn't do any shots or anything. It was just some oral medications. And then, we tried extracting my eggs and doing the actual in vitro. So, they did two embryos, but they didn't survive, so, that was one loss. And that was the end of 2012. …my left tube was so blocked and so inflamed that it was leaking fluid back into my uterus. …That surgery was in August of 2014… I was going to have to do all of the shots and injections and the progesterone and all of that. So, I went through, and I did all of that, and I got pregnant…And the day before Thanksgiving, I had to go in for my check-up. And the baby was not viable. For me, that was hard. And then, we were going to look into adoption. And so, December passed, and January came. And we said we'll go ahead and try, and I got pregnant…And so, I did the pregnancy test, washed my hands, and turned around to put it on the counter so, I could wait, and it read positive. I showed my husband, and he was like no, take another one. So, I took four more different kinds. And one was like the dipstick, one was the digital, four different kinds, and they all came back positive. So, …I went to my appointment, and she's like the nausea is a good sign. And so, they did the ultrasound. And it was like a little teddy bear, like a little gummy bear on the screen… And that was just so awesome.

The long journey of trying to conceive was a painful and difficult road for Natasha and her husband. The health challenges they faced were met with perseverance and a good team of health care providers until finally their dream of getting pregnant was realized.

Pregnancy Phase Thematic Analysis

Other women talked about the excitement of anticipating a planned pregnancy. Like Natasha, Felicia shared her sentiment of not being able to conceive right away, and the joy she felt when she finally did.

> We weren’t using birth control. We started off using birth control maybe like the first two years of being married, and then afterwards, I got off of birth control, so it was – we thought that maybe we couldn’t have a child, so – but I remember we took maybe – we took like a week off together – and that’s when I became pregnant, which was a total shock because we had been having unprotected sex for pretty much three years and nothing happened. And so, it was a big shock for us. We were very, very happy, you know, initially when we found out.

Rebecca did not experience problems trying to conceive as the other women did, yet, although she and her husband shared the excitement of a planned pregnancy as they eagerly anticipated their baby, they also confronted the challenge of not being able to experience the pregnancy in the same manner.

> I think because this was something that we both wanted and, I mean, when we found out we were pregnant, we had been married for eight years already, and so knowing that we had a solid foundation, and we, I mean, you know, he's my best friend.
>
> Well, I started to feel flutters and feel the baby first, and I would get really excited, and I would say, "Hey, come here, come feel the baby kick," or, “Come feel the baby move.” And at the time, I didn't realize that he couldn't feel what I felt. So it was a little

> frustrating for him because I'm experiencing everything, but he's not experiencing anything. And I wasn't really showing, so it wasn't really evident. Like, it was real, but it wasn't real for him yet.

Rebecca described this feeling of wanting to share her experience with her husband and then recognizing his frustration in not being able to join in the total experience that she had. Although four women in this study had planned pregnancies, the other 9 women described their pregnancy as unplanned. Two of the nine women shared the initial blow they felt with an unplanned pregnancy but described how the blow was softened by the excitement of finding out the fetus was a preferred gender. In this exemplar Julie described her thoughts about her unplanned pregnancy.

> We had our son in May of 2014. And when he was about 9-months old, we found out that we were pregnant with our daughter. And that was not planned. I was actually back on birth control, which, after we had our son, I had gotten back on birth control, because we said we would do maybe about a year and a half to two years – two and a half year spread between the two. We had no intentions of me being pregnant at Hayden’s first birthday... I think it took a toll more so on me than it did my husband, of course because I was the one going through the pregnancy. But it was a shock, and it took, I would say, maybe around a month to kind of get over that initial shock. And there were definitely feelings of anger, …So, I guess about 14 weeks into the pregnancy, we found out that we were having a girl. And that did help, knowing that we would have a boy and a girl…

Julie described feelings of anger when she found out she was pregnant so soon after her first child was born. She had no intentions of becoming pregnant at that time and had taken all the necessary precautions. She recounted the toll this unexpected pregnancy took on her, as well as how her negative feelings changed when she learned she was having a daughter. Similarly, Ashley shared her experience of being disappointed with an unplanned pregnancy and how that disappointment was turned to joy when she found out she was having a girl. Ultimately, by the end of her delivery, she gave a desperate plea for her baby girl.

> Around November or December of 2014, I started getting back to myself. My knee healed up, I started working out again. I got happy. My husband had a job offer. I told him that I missed being pregnant…Even though I said I wanted to be pregnant again, I was not very happy because that morning before I found out I was pregnant I actually stepped on the scale and I had met my first goal. I had lost 30 pounds and I knew I was on my way getting back to myself, to my body. When I got the positive pregnancy test I cried, and they were not tears of joy. I cried even harder because I felt bad for not being happy…When we found out it was a little girl everything just shifted and I was so excited through the entire pregnancy. I bought a little outfit and just doing everything – just so happy, just so happy… The doctor came in and broke my water and she was coming out. When I pushed her out – as I was pushing her out I was just crying hysterically, I want my baby! I want this baby so bad. So bad, so bad, so bad. I went from not wanting to be pregnant and being upset about the pregnancy, to, in the end, wanting her more than my own life. I got my little girl.

Ashley’s delivery was an overwhelming experience for her; as she recounted it she was filled with emotion and the tears flowed. She remembered the desperation she felt during the delivery and an overwhelming desire for her baby girl. Her desperation during the delivery was in total conflict with her feelings at the beginning of her pregnancy. The delivery experience for Ashley was a positive experience because she had finally delivered her longed-for daughter. However, almost all of the women had a negative experience either during the pregnancy or during the delivery of their baby. Their negative experiences led to feelings of *regret, disappointment, and unmet expectations.*

Regret

Of the women who experienced unplanned pregnancies, a few regretted becoming pregnant at the time of the interview. Women’s pregnancy regrets came from a variety of sources including feeling disconnected or isolated from their spouse or significant others, being pregnant out of wedlock or being a single mother, and unmet expectations during the delivery. Ashley expressed feelings of regret as she described not feeling as if she was ready to be pregnant:

> Even though I loved her more than anything, I felt like having her was a mistake. 1.) Because it wasn't planned, 2.) I just felt like I was not ready.

In Sonya’s exemplar, she only chose to become pregnant to please her husband in the context of an unsatisfying marriage. When she subsequently found out that her husband had been unfaithful to her Sonya felt disconnected from her baby and contemplated an abortion.

> When I told him I was pregnant, that was the day I found out he was cheating on me. It was quite confusing. It was quite confusing because, it's like, okay, this is what you asked

> for because I was done, but this is what you asked for and now you're not even there. There was no connection with the pregnancy. There was no connection even with the child, you know? So, it was frustrating. As a matter of fact, very early in the pregnancy, I remember calling him and I was on my way to an abortion clinic… He told my mother and she was like, don't do that. Don't do that, you know, kind of thing…

For Sonya, her husband's infidelity was *the straw that broke the camel's back*. She described herself as feeling "bamboozled" by her husband

> I think it was the point where I thought I knew him pretty well. I dated him for four years before we got married. I mean, we had gone through a lot together. And you know how you kind of build history with your partner, we went through some stuff together, where I felt like he had my back, and I felt like he knew that I was his girl all the way down to the bone.

Feeling as though she had been bamboozled, Sonya was left to care for a baby that she really did not want. She stated, "I was good with just one son." "I felt irritated to have the baby around. I wanted him to be cared for, but I just didn't want to do it because I felt bamboozled." Sonya described feeling as though she had been tricked into having a baby that she really didn't want in the first place. She felt blind-sided by a man that she thought she could trust. Her trust led her to giving him a child that he said he wanted, but when the pregnancy and delivery came, she was left holding a baby that she did not want and failed to bond with in the early years after delivery.

Olivia also shared how problems with her husband, including threats of abandonment, negatively influenced her pregnancy.

> I felt like here, now, I have a child, and I potentially don't have a father for this child. Because of how he was acting, I wasn't sure if things were gonna work out. Oh, and I want to say the day I brought her home he told me I'm going to leave you the place. I'm going to leave you with the baby. He said, "You can have it. I will take care of her financially, but this is not for me. And it makes me think man, maybe I shouldn't have had this baby, or I guess I don't really think like that. But I think if I didn't have the baby, I wouldn't be going through this right now.

Sonya and Olivia described regretting their pregnancies due to a shift in the relationship with their husbands. These feelings of regret about the pregnancy subsequently impacted their postpartum experiences. Although most of the women in this study experienced unplanned pregnancies, they did not experience failing marital relationships during their pregnancy like Sonya and Olivia did. Olivia continued to discuss her regret as she described the beginning of her pregnancy and feelings of remorse about becoming pregnant out of wedlock. It was evident during the interviews and subsequent member checks that it was extremely difficult for women to talk about regretting their pregnancies. After sharing their regret, the women would quickly add that they no longer had the same feelings as they reflected on their experience. During member checking one participant asked for a portion of her narrative where she shared her experience of regretting her pregnancy to be removed because she no longer felt the way she described her experience to be. Therefore, she no longer wanted it shared as part of her story.

The sub-theme *pregnancy guilt and regret* emerged from regrets women experienced when pregnancy occurred out of wedlock.

Pregnancy guilt and regret. All of the women in this study were affiliated with a major faith tradition and community. Their faith convictions were evident as they spoke through this lens, and notably when three women talked about their disappointment in themselves for becoming pregnant before marriage. This subtheme is reflected in the following. Olivia talked about feeling shame and embarrassment when she became pregnant, and the anger she had towards her significant other for not trying to spare her the embarrassment that she felt. This pain negatively influenced the trust that Olivia had in her significant other and caused her to question their relationship. Olivia was much like Sonya in that they both experienced strife in the relationship surrounding the pregnancy.

Olivia's exemplar shows her turmoil as she dealt with the feelings of this experience, and the strife that ensued in her family.

> Before I became pregnant, I was not married. And I had just one child. Once I became pregnant, I was, again, not married, and so that created just a lot of problems for me as well as for my now spouse and even our family members. And they didn't give me a hard time, but it was a big issue. It was kind of just unsaid. I guess that's what I'll say it'd be, the emotions, the feelings that everyone was having. And a lot of family arguments and that kind of thing came along at that time as well. I just kept thinking I don't want to be a single parent to this baby. And I didn't know how things were gonna turn out, and I guess that was a big issue for me. There was a lot of guilt and shame and embarrassment and, of course, anger. Anger being upset with myself and upset with him for not supporting me

> and wanting to move faster with marriage because we had talked about marriage before I found out I was pregnant. But it seemed like once I got pregnant, everything was like on hold. There was a trust issue, that kind of thing. So, yeah, it was all negative I felt like I couldn’t trust him because I felt like if I’m in this bad situation and you’re slowing down and you’re not gonna hurry along the wedding or marriage so that I don’t have to be embarrassed but take your time, I felt like I don’t know really how you really feel about me or what your real intentions are.

Olivia was not the only participant that shared the sentiment of shame and feeling as though she had not done the right thing by getting pregnant before marriage. Marla shared her desire to do the right thing this time around after having had two children with another man while unmarried as a younger woman. She too talked about the shame she felt about being “in the same place” she had been with earlier pregnancies

> When I met my husband was kind of at the peak of when I had jumped back into doing kinda like trying to be me again. So, after a year of knowing my husband I allowed him to meet the kids and all – meet my boys, my two kids, and then almost four months after that, I found out I was pregnant. So, my pregnancy started out very low, this is not what I wanted nor was it what I expected. I – of course, if you – we’re all adults, you expect what your – what you expect but I think it was my pregnancy started out more so of, I didn’t want to – to do this again, this way. I was really focused on finding a husband and I was really focused on doing it the right way because I am a Christian woman, I – I wanted to not have a child out of wedlock…like just kind of shameful and very, you know, I didn’t show anyone this, I just – I just felt that way and I felt ashamed because,

> you said you weren’t gonna do this again and you got life together…this is not what I planned.

Likewise, Karen shares her story of “trying to do it the right way”, according to her religion, by marrying before becoming pregnant and then learning she was pregnant.

> We were trying but we weren’t successful and then when we stopped trying, it came up. We’re both religious and our parents both say, “make sure you get married first before you have this baby. Do it the right way this next time.” We stopped after we kept getting those lectures and it was like, “Yeah, we better do it the right way.” Then, before we could do it the right way, I was pregnant.

Karen described a desire to stop having unmarried sexual intercourse out of a sense of conviction but by the time she had come to this conviction she had already become pregnant. As she talked about her experience, there was a shift in her tone that reflected disappointment in her perceived failure to “try and do it the right way.” On the other hand, Sonya felt disappointment in herself for being single and needing help from other family members to care for her children. She also talked about how she felt a sense of pride for not getting pregnant before marriage combined with feeling of discontent from being alone in the end after her husband decided he wanted to leave their marriage.

> I mean some people, it doesn’t matter to them, but I take pride that I didn’t grow up being a teenage pregnant mother. You know what I’m saying? I waited – even my first child, I was like 27 with my first child, so it wasn’t as if I was just loosey goosey, so to find somebody and think that they are a responsible type person that, you know, and then, to

> come to find out, they’re not, and you’re still stuck. You’re still looking like the teenage pregnant mom, because you’re by yourself. That’s how I felt. My mom was on her own my whole life because we were always moving. So she didn't have that luxury, and now here I come, and I need help. It's one of those, "Hey, if you need help, then don’t have a child," kinda thing. I felt like I disappointed others, so it felt like I was disappointing myself as well because I didn't fulfill that promise of being able to show people that it could be done and be done successfully.

Several of women described these feelings of self-blame during pregnancy. They experienced embarrassment and shame as they contemplated their unwed pregnancies. Two of the women eventually married their significant other and ultimately did not experience single parenting. However, for Sonya, her source of pride turned into her worst nightmare as she became a single mother to a child that she had desired only to satisfy her significant other. Sonya and Olivia both were baffled at their significant others as they experienced distrust in them and disappointment in themselves for being in the position they found themselves in.

For many of the women in this study, the delivery experience was equally challenging. Many women experienced high risk pregnancies, cesarean sections, and breastfeeding issues. Eight of the 13 women had a cesarean birth, three of which were emergencies. Six women experienced issues with breastfeeding. Five women had high-risk pregnancies (preeclampsia, gestational diabetes, advanced maternal age, and preterm labor). One woman received a devastating diagnosis for her newborn, another had a horrible hospital experience, and one more had a traumatic birth experience (postpartum hemorrhage and near death). These difficulties left them feeling as though they had no clue as to what to expect during this time.

Labor and Delivery

Despite the challenges many of the women faced during labor and delivery, most reported feeling happiness and peace immediately after delivery. Rebecca stated, “I felt happy…my son was a little rock star…I remember feeling peace.” Marla said, “I felt really, really, happy…I felt different from my boys, like I was young with them…I felt proud it was like I knew what I was doing.” But others experienced the delivery of their babies as traumatic, exhausting and sad. The theme *unmet expectations* started in the delivery period and continues into postpartum as women experienced perceived failure. A subtheme of *unmet expectations, defective woman,* emerges in three areas of the lives of the women: self, breastfeeding, and caring for their family and spans pregnancy and postpartum time periods.

This section reflects women’s experience of feeling unprepared for the challenges that ensued during or after the birth of their children. Although most of the mothers had children, they faced unexpected challenges in this birth experience and during their stay in the hospital. Feelings of unmet expectations were compounded for those who had experienced regret and disappointment during pregnancy and the sense of failure was exacerbated. Women who did not experience regret or disappointment during pregnancy still faced unmet expectations which in turn increased their risk for PPD.

Unmet Expectations - Delivery

Nearly all (11 of 13) the women in the study experienced unmet expectations during labor and delivery and into the postpartum period. In this paradigm case Natasha shared her traumatic, near death delivery experience as through tears she reflected on the difficult time.

> So, they did a C-section. And when they pulled her out, she was covered in meconium, so, they had to clean her up real quick and all of that. And then, everything was good again…And my husband noticed her blood on my blanket. And so, a nurse came over to look. So, my husband says that, from his angle, when they pulled the covers back, he said blood was just flowing out. Yeah. And I remember them coming with towels to clean up the blood and whatnot. I didn’t realize, at that point, how much it was. But the next thing I know, I wasn’t feeling good. I got nauseous, but I wasn’t really throwing up anything. It was dry heaves. My vision went from normal to just what was right in front of me. Everything else was kind of like blacked out. And then, I remember the nurse coming in again and reaching over me with the blood pressure medication. And she was doing that several times. And a lot more nurses kept coming in and asking me questions. I started getting ringing in my ear. I wasn’t feeling well. More nurses were coming in. And then, the doctor came in. He explained to my husband that they would probably try to see if they could put a balloon in to see if it would stop the bleeding…And so, they told me they were going to put a balloon in, and they described that. And they prayed over me again... And they ended up having to give me 1,500 cc of blood. And so, it was hard. And I made it, she made it. The balloon worked. I didn’t have to get a hysterectomy. And so, after, it was just hard the whole thing of I could have died.

Although Natasha had longed for a child for over two years, this near-death experience was traumatic. Having difficulty conceiving a child, and then subsequently a traumatic birth experience left her feeling as though something was wrong with her. She recounted feeling as though she was broken in some way, first by not being able to get pregnant right away and then by having a traumatic birth experience.

Felicia did not experience a traumatic delivery, but she did have a difficult postpartum experience. She experienced a great deal of pain after her C-section that left her sedated and hallucinating from the medication.

> I was medicated, and I'm not used to taking any pills at all, and so, I was really sedated and hallucinating at times in the hospital. The pain was – it was really unbearable for me. It was really painful having a C-section. Some people say that it's easy. I didn't find that it was easy at all. It was very painful. I just knew that I was completely pretty much out of my mind.

Then, there were women like Olivia and Racquel who experienced conflicting emotions. Olivia, who was experiencing relationship problems with her significant other reflected on her delivery and shared conflicting emotions of happiness and sadness as she remembered her experience

> I thought she looks just like him, and I was very sad only because of how he treated me the whole time…I didn't think he deserved to have her look like him...But I felt so happy because I got to see her knowing that she was healthy after everything that happened during the pregnancy.

Racquel also experienced conflicting emotions. “I didn’t think he was mine because he was white. I was expecting to see a chocolate baby.” She also described this immediate bond that she was told she would experience when she saw her baby for the first time and, when she did not experience this she was disappointed.

> I still just didn’t really feel a connection with my baby like everyone said you would at your shower or during the pregnancy like when you see your baby, you will feel this instantaneous love and affection for them. I did not feel that at all. It was totally the opposite for me.

Like Racquel, Sonya also described feeling disconnected from her baby. Sonya was overwhelmed by her son’s unexpected illness and her husband’s abandonment at the same time.

> It was a planned cesarean this time, so I was in there, and 15 minutes later I had a baby, so that was great... It was three days later, the first baby check is when we found out my son had G6PD. It’s dealing with anemia and it attacks the white blood cells, so he was very sickly, very, very sickly, and that was the day my husband actually left, the day we found out that he had G6PD. That’s when he left the home, so I was dealing with that by myself and trying to figure out how to take care of him, so I guess it kind of compounded from a person who asked for something, then, when they got it, they treated me badly for giving it to them, and then, totally leaving me when they saw that it was too hard or they thought it was too hard, so that, probably, helped drive me even deeper into depression, because I’m not really a depressive type of person. There was, now that I look back at it…there was no time for bonding really at that time. There was still quiet moments that it’s just you and the baby and you are like paying attention to their little quarks and, you

> know, it doesn’t have to be a long time, but just playing together, talking to the baby, things like that. Probably, the first six months, I really didn’t do that.

Sonya had to deal with multiple emotional wounds. She was overwhelmed with a diagnosis of a sick baby, the reminder of not wanting another child, the pain of a failed marriage, and the lack of connectivity with her child. She had to fight depression as she faced these devastating circumstances. After the birth of their babies, emotions were mixed for these women.

Some of the women in the study did not experience regrets, disappointment in self, or experience unmet expectations but nevertheless developed PPD. This group of women will be discussed further in the postpartum phase. Happy emotions soon turned to sadness and the sad and mixed emotions soon became dark for all the women in this study. Many of the women faced challenges and saw themselves as inadequate and failing as mothers as they navigated into the postpartum period.

Postpartum

The following is a paradigm case of what the women experienced after child birth.

> I didn't realize that I had it with her until I started to have feelings of harming her. Not even feelings, thoughts. We have a catwalk... a balcony in our house – she didn't really breastfeed for long, I couldn't produce that much milk for her. She had a lot of sensitivities…She would scream and cry and scream and cry. One night I was holding her and I walked past the balcony and my thought was to throw her over. I've never told that to anybody. Why? Just why? At that moment I understood why women – people in general that suffer from depression or anxiety, they react off of that initial thought. I felt

like I was doing her a disservice because I couldn't be the best mother for her because of all the things I was going through emotionally and psychologically. I truly believe it was because I wasn't getting any sleep. The first six to eight weeks I don't think I slept an hour each night. Without sleep your body and your mind can't recharge so you start having hallucinations, you start having insane thoughts and feelings. I would just cry for no reason. At first, I was like oh, it's because I'm not getting any sleep. I was like oh no, I have postpartum depression because I was just going through so many things, so many emotions. I would be happy one moment, I'd be sad the next. I never had the feeling of wanting to harm my child or myself – I just couldn't go through it – but the thoughts had come into my mind. The thoughts crossed my mind and it was very scary. After a few months, it dissipated. I don't know if it's because I got more rest or because I was praying and crying and praying and crying. Crying so bad I actually believed I had demons on me. It was a very scary time during those first couple of months. I was always frustrated. I always felt helpless. I felt like I could not do anything right, even when things were right. I felt isolated. I felt alone. I felt inadequate. Even though I loved her more than anything, felt like I was doing her a disservice because I couldn't be the best mother for her because of all the things I was going through emotionally and psychologically. I felt like I didn't deserve her. I felt like I didn't deserve my life. I felt like I didn't deserve my husband. Overall, just very undeserving. I felt worthless a lot of times. I doubted myself. I wasn't so much afraid anymore, I was more worried. I was always worrying and anxious. I had several anxiety attacks and a lot of times for no reason. I would sit and think about the what-ifs and then I would just – it would just happen. There were times

> where I thought I was having a heart attack, my chest would tighten up, I couldn't breathe. I felt helpless.

Postpartum Phase Thematic Analysis

Defective woman- self-blame. In Karen’s exemplar, she discussed her struggle with changes to her body and an inability to work after her surgery.

> During the pregnancy, I was having pains, so I thought it was something to do with the baby, but it so happened, I had a tumor growing inside... So, I had to have emergency surgery the next day. After the surgery, I had to learn how to walk again. I had to go through physical therapy. I couldn’t function on my right side, for whatever reason, they don’t know why. I lost my job and couldn’t go back to work. I felt like I was a failure. I had worked since I was 16. It’s been almost a year now that I haven’t had a job. So, it’s just like my independency has been stripped away.

Ashley described the harsh self-judgment she constantly engaged in after the birth of her baby. “I felt like I could not do anything right, even when things were right. I felt inadequate.” Similarly, Sonya questioned her desire to become a mother after being left holding the bag as a single parent. These doubts, her sense of disconnection from her son, and abandonment by her husband left Sonya to question her worth as a mother.

> I was not worthy of being a good mother. And that's probably what came through it too because you have this man that says, “Hey, let's have a child. We can do this and do it well. We could do it right," because my last relationship, I didn't do it right with my son. And then to have the son and then he's gone is the same thing.

Natasha’s experience with feeling defective was somewhat similar to Shannon’s but compounded. She experienced what she described as “a brokenness” for not being able to do what she thought was natural for a woman to do.

> I was really feeling broken like I’ve lost babies. My delivery went wrong. My baby won’t latch. As her mom, what’s wrong with me? Why can’t I… I kind of felt like I blamed myself for that. Like something has to be wrong with me that I can’t get this right.

Defective woman- breastfeeding. Although most participants were well-educated and successful in their careers, their perceived themselves as failed mothers which gave rise to depressive symptoms. Many participants were shocked to find themselves having trouble with breastfeeding. A few of them shared that they had never been informed that breastfeeding could be a difficult experience. Believing that breastfeeding is a natural experience, while at the same time having difficulty doing so, led many women to feel defective. As evidenced by what Raquel said, “I had this extra additional stress, and desperation and disappointment at this time because I didn’t feel adequate enough to even feed my child.”

In the following exemplars, Rebecca, Shelly, Olivia, and Natasha all described feeling as though they failed at breastfeeding their babies. Rebecca stated she had to go to the doctor’s office twice for breastfeeding assistance, and then when breastfeeding was going well she said, “I felt guilty for not feeding him directly from my breast when family members came to stay with me, but I needed to rest.” Shelly similarly described her struggle with breastfeeding and the way that struggle made her feel about herself:

> I felt like I failed my son because I couldn’t breastfeed him. It was kind of a hard pill to swallow because I think that was part of my sadness during the first pregnancy because I couldn’t breastfeed my son like I know I was supposed to, and it came right back up again with my second child.

Shelly described breastfeeding as a must when she used the term “supposed to” and the frustration of not being able to meet the expectation tormented her. She did not perceive alternative feeding methods to be as valuable as was breastfeeding and, because she did not breastfeed her first son, she felt that sadness all over again. Olivia described her painful experience with multiple trips to the hospital while attempting to breastfeed and saw her inability to breastfeed as failing at a “job”

> It felt like I was doing a job at first. I guess that’s what I’ll say, I was doing a job, and I wasn’t doing a good job at my job. Breastfeeding was very, very painful and I went and saw a lactation specialist several times. That didn’t help. I felt inadequate because it just wasn’t working out for me this time. So, I felt like I couldn’t feed this baby, and I was concerned that she wasn’t getting enough. So, we were back and forth to the doctor. I just felt inadequate as far as the breastfeeding.

It was evident that Olivia was determined to breastfeed her baby as she suffered persistently through the pain.

Natasha also shared her struggle with breastfeeding.

> It was hard just hard coming home because we didn’t have a consistent latching, sometimes, she would latch, and sometimes, she wouldn’t. So, I had to give her the

> bottle. So, that was disappointing. That made me feel low. I was really feeling broken like I've lost babies. My delivery went wrong. My baby won't latch. As her mom, what's wrong with me?

Natasha begin to question if there wasn't something wrong with her as she related multiple complications and unexpected outcomes during her pregnancy, delivery, and postpartum experience. She described this questioning as a feeling of not being a normal person- questioning if there was something wrong with her accompanied by a strong a sense of self-blame.

Raquel also expressed feelings of self-blame and judgment, "I just remember feeling disappointed in myself because everyone stresses the same, this love you will have and the importance of breastfeeding. But no one ever tells a mom that it is difficult, breastfeeding. It's not easy." She elaborated about her experience:

> Not only do I have this kid that I feel no connection with that everyone says I'm supposed to have and I'm expecting, but now I have to nurse a child that is not latching. I just wish someone had told me that it was going to be difficult and then I wouldn't have had this high expectation for myself and maybe I would not have been so depressed.

Natasha also blamed herself for not being able to breastfeed her baby after delivery stating, "I kind of felt like I blamed myself for that…like something has to be wrong with me."

Five of the women struggled with the unmet "expected" labor and birth experience- vaginal birth, the "expected" postpartum experience- without complications, and the "expected" means of feeding their newborns- breastfeeding with ease. It is no surprise that they subsequently perceived themselves as failures when their expectations were not met. Participants' expectations along with what they perceived as societal expectations, caused them to experience a feeling of failure, self-blame and guilt.

Defective woman- caring for the family. Feeling defective or like they had failed was perceived in other areas of their lives as a few women, including Julie described an inability to manage the care of their families. Feelings of ineptitude, guilt, shame, anxiety, judgment, and sadness ensued. Julie, the mother of multiple children, to saw herself as a failure because she faced challenges balancing the time, effort, and energy required to care for her children.

> I think mainly because we were going through this whole journey again a lot faster than we anticipated. And I think it would have been a little bit different if our son was older, and a little bit more independent. But he was still a baby at that point, and so there was definitely, I guess, a challenge in keeping the balance between giving him the attention that he needed, giving my husband the attention that he needed, and still taking care of myself and the baby that I was pregnant with.

Shelly shared her thoughts about failure but related her failure to her inability to maintain her household apart from caring for her baby. Shelly described this extra struggle of trying to care for her husband and all the household duties.

> I think by failing I felt like failing as a wife and not being able to take care of home. I like to be very organized and I like to keep things clean, so not being able to clean up my house or not being able to cook dinner or not being able to take care of the boys like I wanted to; there were times where I was in so much pain to where I couldn't do anything.

Although other participants expected a transition after giving birth, Shannon felt as though her life should have remained the same after childbirth.

> I felt like nothing in me should have changed. Even though I had an infant at home, I felt like I still have two more kids. They still need to eat. They still need help with their homework. They still need baths. I was still needed. Like, my family needed me just like the infant needed me. I would just sit there, maybe just sit on the couch and nurse the baby and that's all I would do. I just made sure the baby was fed and changed. My husband would come home, and I was still in the same spot. I still had on the same clothes. I felt like I couldn't take care of myself. I couldn't take care of my other kids. I had to get over it!

Shannon felt robbed by this inability to maintain a sense of normalcy. She knew she had other responsibilities within the home but, because of PPD, she could not care for anyone else but her baby.

Failure was primarily centered around self-blame, challenges with breastfeeding issues, care for the family. This sense of failure left the women feeling vulnerable and questioning their abilities as mothers. Most of the women in the study felt this sense of failure in some way or another.

This is What PPD Looks Like

As the mothers transitioned in their new role as mothers, the emotions they began to experience become overwhelming and all-encompassing. The emotional descriptors ranged from "indescribable to "hearing the devil's voice." The theme that emerged from this portion of the interviews is *this is what PPD looks like* and the associated subthemes *not myself and this can't be me*. This theme described the language, emotions, experiences, and meanings surrounding PPD. Rebecca said her emotions were indescribable. "You can't really put your finger on one thing…there were times where I would just start crying and couldn't really explain why." Almost all the women included an inability to control their tears in their PPD journey story. Many of them began their description of emotions with "uncontrollable crying at any time." Julie described a gamut of emotions, reporting "I was angry, had cutting responses, uncontrollable crying, overwhelmed, frustrated, very irritable, tense, and paranoid." She gave an example of a paranoid experience she had with her in-laws. "When my father-in-law offered to take my son outside to play, I questioned him and said, 'he is fine right here with me. He doesn't need to go outside." She also described her PPD as a weighty visor causing her to feel a physical exhaustion that was not attributed to lack of sleep, but related to the weight of her PPD.

> The best way to describe what I was feeling, I felt like somebody had a visor on the top of my eyebrows all the time. And it was a weighted visor, so I felt like weight on top of my eyebrows, and it was dark, and that's how I felt. I mean that's the best way to describe what I felt. And the only time I didn't feel that was when I was sleeping. And I remember there would be mornings where I would wake up and be annoyed that I was awake, because I knew that I was gonna have to deal with that through the day.

Ashley's description of a weighted visor over her eyebrows and clearly conveys the PPD experience as weighty and dark. A weight is heavy and burdensome. It is especially difficult to carry something heavy in the darkness. Historically, African American mothers have had to shoulder heavy loads and we continue to do so through a society laden with racism, sexism, and classism.

No other women in this study described their experience in this way, but they did describe feelings of inadequacy and an inability to fulfill their responsibilities as wives and mothers in the way they were used to doing.

Most of the women's descriptions were equated with darkness, as they talked about their overwhelming sadness, loneliness, helplessness, and abandonment. Similar to Julie, Ashley described her PPD emotions as helpless and crippling. She stated, "I could not move." "I could not speak." Shannon concurred with feeling helpless. She described herself as having lots of different emotions. "I felt overwhelmed, just a ton of different feelings." Sometimes I felt happy, and then the next time I would be sad again." Patricia said she would be sad, mad, or angry for no reason and she felt like she wanted to give up on life. "Like give up on life, like I just don't want to be here no more. If I could take my kids and leave without harming them or harming myself, I would leave." Patricia was the only woman in the study to discuss the idea of wanting to end her own life during that time. Her suicidal thoughts were in the context of her situation with the father of her children who was incarcerated during the time of our interview. She had little social support.

Another emotion the women experienced was anger. Karen and other women described feeling anger that could not be explained by their life circumstances. It was often directed toward the father of the baby. Julie reported that her anger started within two weeks of returning home from the hospital. She described her behavior as follows.

I would snap at him. Or maybe just ignore him, and not say a whole lot to him. I know

> that I felt resentment towards my husband, because he was able to just get up and leave, take care of himself and leave in the morning, and I didn't have that opportunity. So, yeah, I definitely felt resentment towards him for that. I would snap at him. Or maybe just ignore him, and not say a whole lot to him.

Likewise, Karen shared her story.

> I notice I've been angry, just mad, upset. My mood swings can go from 0 to 100 in a matter of seconds. I guess the madness or being angry is really geared towards him, even though he really hasn't done anything. But I feel like anything he does, it just makes me angry. He's one of my triggers.

> She shared: He works 11 hours and he works almost 67 days straight. This day, he was getting off of work and he didn't have to go in for the weekend. He's off on weekends, but he'll go in for overtime. So, he was getting off of work, later on in the day, my oldest daughter, he picks up my oldest daughter from school and he came home and he was just relaxing. I know he had just got off work, he just woke up, but he was playing the video game on his phone and he was watching T.V. At this time, I was dealing with the baby, trying to help the oldest one with homework, and trying to cook and I just got so angry because I'm like okay, at this moment, you see I'm trying to do multiple things, and I was in pain that day.

Although the women described anger that could not be explained, they were clear that it was most often directed toward the father of the baby. Many of the women described this emotion as being outside of themselves. The subtheme *"not myself"* emerged from these reports of their experiences.

Not myself. Several women described that they were a different person, distinct from what they thought of as their "normal self." Shannon described herself as being aggressive and brave, which she says she never experienced prior to her PPD. She was able to say things that she normally would not have said.

> I've never felt this way before ever. I'm pretty much easy going, always a happy person... I had like this urge to say, "no that's not how you will talk to me." For example, I needed a day off, I planned the day off because I was thinking I knew I had the hours. And you can get days. So, my supervisor denied me just because. I went to her office and…I normally don't speak my opinion and normally don't say much but it just gave me this bravery to speak my mind.

Shannon felt as though this bravery was derived from her PPD given that she was not assertive prior to this experience. Julie said that her friends called her a different person during her PPD experience. "I was kind of a different person." Natasha described the feeling of going crazy: "It felt like whispers…I just felt like I was going crazy. Like I was losing my mind…" Felicia also remembered this awareness of thoughts that were not her own as she described, "I was afraid to take her into the grocery store…I had unusual thoughts…fantasizing about abandonment." Marla also described her experience as "the enemy" using her thoughts against her. She described her experience in the following exemplar.

> I was just – I had negative thoughts in my mind, very – not – in the beginning, not so, like suicidal, but, it was more so of, like, do I need – do they need me, like, do I need to

> be here, am I – am I worth what – am I being a good mom? Am I doing anything for them am I – or am I just sitting here needing help, like, what it was – the thoughts were very negative, they were very like, are you really useful in this world? And I never thought things like that before.

Their thoughts were different from what these women had ever experienced before. They felt these thoughts were not who they were outside of their PPD experience. Marla continued to describe herself as "short fused" and how that led to violence towards her husband, ultimately ending in jail time, medication, and counseling. Marla provided the following description of this experience.

> I was short fused like crazy, I would just snap at everything, anything was just – I just had an attitude. I spent six days in jail because I lost it on my husband, I completely flipped and all – it was on his birthday, it was so crazy. It was his birthday and we were in Walmart…And he was like, "you choose, you're great at it you just choose." And I was so short fused because I'm like, "this is your birthday party, don't hit me with demands, you choose, don't hit me with the I don't feel like doing it, so you do it." And I said, "no, you choose," and he noticed...So, I – as he usually does, he walks away, and instead of it being a calming moment it frustrated me. And I didn't – I couldn't – in those times of the postpartum and when it was major, I could not see…like, I didn't have a great judgment, I was so – like, my fuse just came whenever. So, I decided to just add fuel to the fire…and I'm so angry, and he just yells, "stop!" To me and then I just – it – I flip in my head. And my husband is the softest-spoken man in the world, I think, and I think I met my match at that moment with the depression, I met – you cannot hide this,

> you cannot save him, because you are depressed, and you don’t have control over your feelings anymore. And I just closed fist punched him in the back of his head while we were driving in the car with my daughter in the back-seat. And he stopped the car and he got out the car and he walked up a couple of blocks,…and I could not control myself, it was – it was – it was – as people say it got real, real to me, the – the fact that I – that the depression is real got amazingly real because at that point in time it just escalated, and I tried to run him over with the car, his sister came, and I rammed into the back of her car, mind you, we are outside, my daughter is in the back-seat. This is not okay, this is – this is beyond okay. So, the cops were called, and I went to jail.

Marla’s case is an extreme one and was an outlier in this study. She was the only mother who described a violent act resulting from her PPD symptomology. Four of the 13 mothers described intense anger, but none described it to the degree that Marla experienced. This awareness of the old self versus the new/PPD self was a source of conflict for the women as they were not familiar with the person they became during their PPD.

As a further illustration of this conflict, Sonya described an experience she had with her baby crawling when she felt her absolute lowest. This experience made her seek help with her PPD.

> I had just bought a new blender and my baby had gotten a hold of the blades and cut himself, and when I found him, I was just sitting on the kitchen floor in the middle of the blood just holding him, not saying anything, just staring...my oldest son called the nanny to come over and she carried me to the bed.

This was the darkest feeling Sonya experienced during her PPD; she described almost a paralyzing feeling that was immobilizing.

The women experienced many emotions reflecting a broad continuum of PPD symptoms. The women who experienced the most extreme emotions were Patricia, who had suicidal thoughts and Marla who became violent toward her husband. All the women experienced a host of feelings and emotions that they distinguished as uncharacteristic of who they were before PPD.

The women in this study described various symptoms related to PPD that were associated with relationship issues, unmet expectations, feelings of failure and others; these experiences were somewhat different for each woman. However, they often did not know what they were experiencing until they talked to someone else about what they were experiencing, or until someone noticed a difference in them and pointed it out. Many had little knowledge of PPD and what it meant. Most of their ideas and thoughts about PPD came from the media. When the women were asked what they thought about PPD, the theme that emerged was *this can't be me*.

This can't be me. Nine women believed that they were not suffering with PPD. Not knowing the actual signs and symptoms, they assumed they did not have the disease because their experiences and behaviors did not match the extreme examples they saw portrayed in the media. The subtheme of *this can't be me*- reflects this disconnect. There were a few women that admitted they knew right away that they were experiencing PPD either based on a previous history or based on what someone else told them. Nonetheless, the majority did not see themselves as affected at the time.

Rebecca stated she did not think her symptoms were severe enough that she needed help. Julie said, “I will be honest and say that I thought that PPD only looked like what you saw on TV…the car drowning. I thought that it was always extreme…” “It was hard to differentiate.” Patricia stated, “I know a lot of people have committed suicide due to PPD…” Olivia and Sonya corroborated what Julie and Patricia had said. Olivia shared the following.

> I didn’t think this was me. I didn’t really feel like I was having PPD. I guess I’ll say, you see on TV the mother that killed her babies, things like that. It’s like those are outliers. So, you don’t think about like anyone could have it. It could happen to me. None of that. It’s like only these far-fetched stories, these things that are so far away from reality. That’s what was in my head when it came to that.

Shelly, like Olivia, didn’t think she was experiencing PPD when she compared herself to the extreme cases in the media. She stated, “At first I was like no, that is not me. That can’t be me.” Sonya also stated, “I knew about the extreme cases. I knew about mothers harming their children…” Shannon agreed with these women and said, “I didn’t associate myself with it.” Ashley described a story about a lady in Washington D.C. who was driving reckless and attempted to drive up to the White House but was shot, and the news media outlets shared that the woman had been suffering a first encounter with PPD. Racquel similarly shared that she did not identify herself as having PPD given the examples in media.

> I didn’t associate myself with it. When I think of PPD, I think of mothers who throw their hands up in the air and say whatever and leave their baby to cry for hours or women who want to harm their baby.

Shannon stated,

> When I think about postpartum, I always think about harming somebody or harming something. So, because I didn't feel like really killing myself or killing anyone else… I felt like it wasn't that serious for one; it wasn't something that I need to seek attention for.

Natasha was one of the few women that knew she had PPD because she had heard about it from one of her girlfriends. Yet she also stated that she did not know exactly what it was. Felicia and Marla had very different views about PPD. Felicia described what she thought PPD was in these words, "Being the victim…I think it's a collection of negative thoughts…being self-centered and thinking mainly about yourself." Marla thought that PPD was "just a word that White people throw around to get medication... I'm half White so this is not a racist thing. My dad is full blooded White, this is just what I thought." Karen was the only woman who admitted to never having heard of the diagnosis at all.

Patricia stated that she had heard of people with PPD committing suicide with PPD, but did not seek help when she felt suicidal. Marla did not seek help because she thought PPD was a disease only for White people.

In addition to not believing that they had PPD, Rebecca and Julie felt that PPD was invasive and made them feel vulnerable and uncomfortable. The women's lack of knowledge about PPD symptomology, along with feeling vulnerable and uncomfortable created a fear about sharing what they were experiencing. Many of the women expressed an inability to share their symptoms with family members and healthcare providers for fear of being labeled. Participants discussed stereotypical ideology and societal perceptions about PPD being “taboo” and anticipated a negative or judgmental response when sharing their PPD experience with others. It was from these ideas that the theme *people don’t know what to do with us* emerged.

PPD and Social Stigma in African American Women

The women discussed societal perceptions that inhibited or served as a barrier to reaching out to others for information or help. This theme *PPD and social stigma in African American women* represents the women’s views about societal perceptions of PPD. The lack of an understanding of PPD was evidenced by Natasha who said that her health care provider had not informed her that it was a possibility. This reinforced her feelings that care for African American women is inadequate.

Most of the women feared they would be labeled as “crazy” if they sought help. The women perceived that society-at-large labels, judges, and disregards African American women who suffer with PPD. As Rebecca shared, “people are going to think I’m crazy or just can’t handle motherhood, not that you’re crazy but that you have the potential to be crazy. People’s eyebrows raise, and they get a judgmental look on their face.” Natasha extended the concern to the consequential loss of her child to the foster care system: “What if someone thinks I’m crazy…They will try to come get my kid.” Ashley also feared having her child taken by Child Protective Services if she shared her symptoms with her health care provider. “I was afraid my OB would get CPS involved and take my child…”

Karen elaborated the concern about being labelled.

> **W**hen you hear “depressed,” people think something is wrong with you because you’re

> depressed. Or, any mental illness, you don't think, "Oh, well, you crazy then. You crazy," or, "You ain't depressed," or, "You just going through this and you'll be alright." So, people's reactions to me probably in saying, kind of hinting to I think something's wrong.

Felicia feared similar perceptions and responses.

> Society sees African American women as aggressors, anyway. So, they already see us in a negative light, they frown upon you and think like something is really wrong with you. How can you feel that way about your child?…but as a mother, you don't want to feel that way.

In contrast, Shannon's perspective was that PPD is something that is ignored by society.

> I think it is ignored a lot. I think that society just don't say anything because they don't understand. They don't understand something if they're not educated on it.

In her narrative, Julie described how her understanding of PPD as an African American woman was influenced by race.

> I didn't necessarily have I guess a predisposed notion of what postpartum looked like with African-Americans. I had more with what it looked like with White women, because of the news. You know, you always saw those stories where the mom, and more often than not it was a White mom, put her kids in the oven or she drove them into a lake or she left them in the car and she just walked away. I don't know if that was, you know, the media's way of trying to gain empathy for these mothers or if those were the stories that were just being reported but Black women were also suffering as well and we just weren't being talked about. I don't know, but I never really – I mean, I knew that Black

> women suffer from PPD, but I just didn't know anybody who did. And you never saw it on TV because it was always, you know, White women.

In summary, most women feared discussing their experiences and symptoms of PPD. They feared being labeled crazy, and feared their children being removed from the home. Women voiced a lack of information about PPD, particularly from their health care provider and extreme media portrayals. One woman highlighted the observation that African American mothers with PPD are not reported on the news; there is no one with whom to identify. It is not surprising then that three of the women believed that PPD was a diagnosis only for White women. These fears and apprehensions all contributed to the women's lack of knowledge about PPD and may have furthered their silence about their experience.

Keeping quiet characterizes women's experience of having PPD and choosing not to disclose to others at the time they were experiencing it. They were inhibited by their concerns about the impact of their PPD on their marital relationships, the potential for burdening others, and being judged negatively. The theme *keeping quiet* and subthemes *health care providers, spouse/significant other and family members* emerged from this portion of the women's narratives.

Keeping quiet: Health care providers. Women largely chose not to share their PPD journey with health care providers. Patricia shared that she just did not want to be judged by how she felt and, believing she would be so judged, she did not feel comfortable disclosing her PPD experience with her health care provider. Shelly recalled no information being provided by her health care provider about PPD and she expressed a reluctance to ask.

> We really didn't cover it. She just asked me, like before I had the baby, "This is what happens." She never went over postpartum, like she never told me the odds that, "You could experience this, but it's okay if you're just going through postpartum." Like none of that ever came up at all. I had questions, like what would be the signs and symptoms, to figure out if it was truly postpartum. But there was no in-depth inquiry about it. I felt like I was in denial at first.

Shannon also was not provided information about PPD, attributing her reluctance to ask about it to not having a primary provider.

> I don't have a personal relationship with my health care provider It's my first time getting Kaiser insurance and I've seen about eight different doctors-none of whom probably know who I am. Neither of them came to the delivery room. I have no idea who delivered my child. So, me having a conversation with them was like that's something I wouldn't want to do because I wouldn't know who I'm talking to.

Natasha perceived her healthcare providers just didn't care about her.

> I just felt like they didn't care. I think it's more of a lack of knowledge. Like myself- you don't feel like your healthcare provider, or you don't feel like people care enough. And then, some people feel like, "Well, why would I go talk to somebody else? What are they gonna do if I couldn't help myself?" As African Americans' we are less likely to want to go and sit and talk with someone, professionally.

Rebecca summarized her reasoning about why women do not want to disclose to or talk with health care providers.

> I think oftentimes they feel like ‘what are they gonna think of me?’, or ‘what are they gonna say?’, and are they gonna stereotype me or classify me as such and such if I divulge how I feel about certain things? And so, I think it’s more provider-specific and the type of trust that person has within the system.

Although these women related several different reasons for not seeking medical attention from a health care provider during their PPD journey, one of the most salient was a lack of trust in their health care provider. Additionally, due to incomplete understanding of PPD, they concluded their symptomology did not warrant disclosure. Combined, these factors were barriers to communicating their feelings and getting help.

Juxtaposed to women who chose not to disclose PPD symptoms with their health care providers were a few women who sought treatment either by mandate or by choice. Marla’s treatment was mandated by the court system after her violent episode toward her husband. In contrast, Julie chose to seek medical treatment, and described in this exemplar the social circumstances that made this possible.

> I have a lot of girlfriends who I’ve literally known since elementary school. We have a group chat, and we talk literally all day, every day. So, the girlfriend that lives in Houston is actually a physician, and she contacted me offline one night, and just asked me how I was doing. And I said, “I’m alright. I’m fine.” This was close – my daughter was maybe two and a half months old at this point. And she asked me how I was doing and was like, “I’m fine.” So she’s like, “No, really, how are you?” And I just burst into tears…she said that she noticed in the group chat that I had seemed very angry…she had noticed that I was kind of cutting in responses to people. She said it just wasn’t me. And she said as a

> physician – as a girlfriend, she was like what’s going on, but as a physician, she knew that something was off, and she said that chemically, my body probably never got a chance to recalibrate itself after Hunter… And so she said, “Just go to the doctor, see what they say. If they say that nothing’s wrong, then you just – we can go over coping mechanisms. But it’s better to know than to kind of deal with this…I did go to my physician, and they prescribed Zoloft for me. And I noticed a difference in almost three days.”

Julie’s situation was different from that of all the other women in this study. She had a close friend who was a physician and who helped her confront her feelings and recommended that she seek help with a specific plan for doing so. Julie trusted her girlfriend and trusted that she had her best interest in mind when she recommended seeing her health care provider. That is what made the difference for Julie; she had a friend who was educated enough not to normalize her symptoms and instead directed her towards help. This was not the case for any of the other women and this left them to suffer in silence.

In another exemplar, Julie described why she was not opposed to seeking treatment and attributed her willingness to the nature of her family.

> I think that I was fortunate enough to grow up in a house where mental health treatment was not frowned upon. It was discussed. I wouldn’t necessarily say in great detail, but it was discussed. You know, when I went to therapy for postpartum, that wasn’t the first time I had been to therapy. I had been to therapy as an adolescent and as a teenager, and I think maybe even a couple times in college. So it was something that was discussed. I knew of family members who had suffered with depression at points in their lives.

In contrast to Julie's acceptance, Ashley was adamantly against medication. The following is her story about when her health care provider offered her medication for treatment.

> My doctor tried to prescribe for me some Prozac and I've seen the effects of Prozac. My mother used to be on it to treat for depression. She's no longer on it, but it would make her worse. My nephew was on it because they diagnosed him with schizophrenia and paranoia and they diagnosed him after he had been on medication to calm him down. He didn't expect what medicine can do. I told her; I said look, I don't want your medication. I don't want Prozac and she laughed at me. She was like; okay, well you can get your feelings and you can get your bible and you can get a glass of red wine tonight and see if that helps. That's exactly what I did and that's what helped me. I never took a pill. I never medicated.

Julie and Marla were the only two women in the study who took medication to help them through their PPD experience and reported positive outcomes as a result. Four of the women in the study participated in counseling as part of their healing experience; three chose counseling and one was mandated to treatment. The low rate of participation in any form of treatment reflects the themes of inadequate knowledge about PPD and the women's reluctance to disclose the experience of PPD to their health care providers.

Keeping quiet: Spouse or significant other. Several women revealed they did not want to discuss their PPD experience with their spouse or significant other for fear of either burdening their spouse, causing unnecessary strain to the relationship, or for fear of their spouse not understanding. Neither Shelly nor Shannon shared their feelings with their spouses because they wanted to avoid adding to the burden of lost income during their maternity leave. They anticipated that sharing their PPD with their spouses would create more stress in the relationship.

Shelly described the barriers to sharing with her husband.

> I couldn't communicate with him. We were having a difficult time communicating. I thought it would be more of a hindrance on him versus me telling him. It would be like here we go with this now- we've already got bills and we have to do this and that and he's trying to do the best that he can to manage financially, so I just thought it would be more of a burden telling him how I felt.

Similarly, Shannon withheld her experience from her spouse for similar reasons.

> I didn't want to overwhelm him or make him feel like he wasn't doing all he could do. So, it was just easier for me not to talk about it and pray about it and get over it than to feel like I'm nagging him. I just didn't want to cause him stress. Hearing that I was overwhelmed and he's overwhelmed, I felt like it would-because I know that he would try to do something, and there wasn't anything he could do.

Both Shelly and Shannon were able to share with their respective spouses after they had come through their experiences and they felt supported.

Natasha stated she simply did not want to share her PPD experience with her partner because the PPD scared her. She did not want to say it out loud during that time as it would make it more real, more certain. Although invited to talk with her partner, Karen was unable to discuss her PPD experience because she could not find the words to explain it.

> I think he's become more aware of what's going on with me. He'll just say, "Can you talk to me," and like I tell them all the time, it's nothing that I can explain. To me, I feel like I can't explain it because I feel like they can't relate to anything I'm saying. So, it's like I'm speaking foreign to them. So, I don't want to tell them if I can't explain it.

Karen struggled with the idea that her significant other wanted to know what was happening with her, but she could not find the words to explain it in a way that she felt he would understand. Raquel was quite candid about her reason for not sharing her experiences of PPD with her husband, "I just didn't trust my husband enough to think that he would not be disappointed in me even though I already knew that he wouldn't be. I just kept it to myself." Felicia was unable to discuss her experience with anyone until years later.

This difficulty in sharing their feelings and experience with PPD existed not only for women in relation to their spouse or significant other, but similarly existed for some of those who relied on family members as their main source of support. The reasons they chose not to share with family members ranged from a fear of being judged to a fear they would not be understood.

Keeping quiet: Family members. Four of the 13 women shared their experience with PPD with family members during the illness. The other women chose other ways of coping. Patricia knew about mental health resources that she could tap into through the Women, Infant and Children (WIC) Services Program in her county but stated that she did not want to access them because she did not want to feel judged or experience being viewed differently based on how she felt. She recalled her mother as her role model and, although she identified her as the person to whom she would disclose her experience, at the time of the interview she had not done so.

> I’m actually giving it time. I am going to talk to my momma. I’ve just actually been trying to give it time. I don’t know how to approach her and talk to her about what’s going on and how I feel… I don’t want to be judged. I really don’t want to be judged. I don’t think she would judge me. She’s so strong. Strong people want you to be like them, like you gotta be strong. I am strong, but my mindset is so different. I can’t think how other people think. I can’t feel how other people feel. I don’t want nobody to judge me on how I’m feeling or nothing. It’s just hard.

Patricia’s struggle seemed to be two-fold. She did not know how to approach her mother with what she was feeling, and she was torn over whether or not she would be expressing some type of weakness by revealing her PPD struggle to her mother. This reflected her view of her mother as a strong presence.

Patricia was not the only woman who did not want to share her struggle with the person closest to her. Karen also said her mother was her main source of emotional support but then stated, “I would rather stay sad while everybody else stays happy because I don’t want to burden them with my problems.” Ashley also revealed that she did not tell anyone about her PPD until much later. When asked why she chose to do so, she responded with the following.

> Nobody in my family knows. My mother-in-law knows because she came in to town right after I went to the doctor and saw the bottle of red wine and I had to explain to her why it was there. I wouldn’t have told her. I would have told her I was suffering from something else, but I don’t think I would have said postpartum. I don’t want to be

> reminded of what I'm dealing with or what I've dealt with. The only reason I didn't tell her is because I knew she would be on the first thing out to Maryland and I didn't want to inconvenience her or worry her.

Julie talked about not sharing her PPD experience with her in-laws, particularly her father-in-law given his bias against counseling.

> My husband's grandfather, his father's father, was a psychiatrist and for whatever reason my father-in-law is against psychology. His brother's wife was diagnosed with cancer and they had three boys. She fought for several years in her battle with cancer, but she ended up dying when the boys were young. My husband said that my father-in-law expressly spoke out against them going to counseling after their mother died. And so for whatever reason my father-in-law was like, "They don't need counseling. They're boys. They'll be fine." I knew that he had that feeling. I think that was part of the reason I never said anything to him about it.

Although Julie was in counseling for her PPD, she did not share her experience for fear of bias, judgment, or discouragement.

By contrast, a few of the women were able to disclose their feelings with family members. Rebecca said that she would talk with her sister who had given birth a month before she did. Julie stated that, while she did not tell her in-laws, she did share her experience with her own family, including her parents, sister, grandmother and aunt. Marla informed her husband directly.

> I told my husband. I said I could get PPD, but it'll go away, I said, after a couple of months…When I got out of jail, I had to tell everybody…and they looked at me and said, 'okay, we're gonna help you'…"

Most of the women in this study, including those who shared with others, relied heavily on their relationship with God as a source of support. They used prayer and scripture as a source of treatment instead of talking with people.

Leaning on God

The theme *leaning on God* described a strong connection with God which was reinforced by their lack of connection with people during their PPD experience. Ashley stated that she just did not feel as though she was connecting with anyone who would help her through her experience. Felicia feared having others analyze her thoughts, but she felt comfort in her religious practice.

> I was reading the Bible and it was comforting me." "It was my main source that helped me through the depression, so I didn't feel sad that I didn't have resources.

Karen described her experience as, "I prayed my way through it and then that was it." Olivia said, "I just thought about it and thought about it and then started praying and things got better." Ashley further elaborated how she would audibly call on the name of Jesus when she had thoughts of harming her baby.

> Whenever I would get that feeling I would walk around the house and I would say, "Fix it, Jesus. Fix it, Jesus. Fix it, Jesus. Remove it, Jesus. Remove it, Jesus. Remove it,

> Jesus." I just felt like I had demons on my back. I would say, "Get them off, Jesus. Fix it, Jesus. Fix it, Jesus." Walk around the house screaming, "Fix it, Jesus! Fix it, Jesus!" If my husband was home I would whisper to myself, "Fix it, Jesus. Fix it, Jesus." That was the only way I feel like I was able to maintain a little bit of sanity and not hurt my child or myself.

Shelly, Shannon, and Rebecca spoke to the power of prayer with family and friends. Shelly said, "We would just pray with each other," as she described a girlfriend that was going through PPD at the same time she was. Shannon found that it was easier for her to talk about her PPD feelings with others and solicit their prayers. She stated, "It eased my mind and it helped me from getting so overwhelmed." Contrary to the other women Julie connected her relationship with God to her medical intervention. She described praying about taking her medication and God giving her peace about taking it. Julie described an assurance that she felt from God after receiving her diagnosis from her health care provider and how she used prayer to confirm her decision to seek medical care.

> I mean, God really worked it out. They gave me the diagnosis... So I left…went straight and got the medication…And my husband asked how I was feeling. I said I was fine because like I told you before, I felt happy that there was something – I was given a name for what I was feeling.

Marla talked about being raised to believe that the church was the place in the African American community where you dealt with all problems. She stated, "Depression was just a word that White people throw around…Nobody ever talked to me about depression. We had the church in our community…you can go to God for anything and you will be healed." Marla was taught that the church was the place of healing and solace, and any problem that you had, you dealt with it through the church.

They Don’t Have the Same Struggles

Almost all the women expressed that White women do not have the same struggles as African American women. They indicated that PPD is more widely talked about and accepted for White women, and therefore, they expressed that strength is a requirement for African American women in a way that differs from White women. It is from these thoughts that the theme *they don’t have the same struggles* emerged. This theme was commonly expressed within women’s descriptions of racism and discrimination in how African American women with PPD are perceived, versus how White women are perceived, and what this means daily.

Raquel discussed why she felt PPD may be more acceptable in White women.

> I think they are probably a little bit more open to talk about their feelings…I thought it was White person’s disease…because it wouldn’t be uncommon to hear a White woman say, “Oh, I experienced postpartum depression.” But for me to say- to hear a Black mom say that, I would be like, Huh? What do you mean?

Karen shared her thoughts about the racism that African American women face.

> They don’t have to deal with necessarily racism or things like that that may come at us, or the gangs…you necessarily might not be a single parent, a single mom raising children on your own, or the absent father. You may not have to deal with that. So, that’s what I see as a Black woman. We are built tough for it because that’s just how it is. That’s in our

> makeup. That’s in our genes. And, if you’re not built like that or not strong...

Similarly, Julie talked about her feelings of sadness as she described PPD being one more thing that African American women must add to their plate. She stated, “We have more to deal with on a consistent basis…” Ashley’s sentiments corresponded with those of Karen as she shared, “I feel like we are targeted across the board.” This targeting may be why Olivia and Felicia both described that PPD is perceived more negatively in African American women, and that White women would more than likely receive more empathy and understanding.

This theme seemed related to the earlier finding that the women did not see or hear about African American women with PPD in the media or in their communities. It follows that they would assume that early symptoms of PPD are not dealt with in the community or that PPD is a problem that only White women deal with. Olivia connected her ideas about this as she shared a story about how a White criminal was treated.

> So, an example would be you had the boy, Dylann Roof, who shot those people in the church a year ago or so. And when they finally caught him and found him, what did they do? They take him to a fast food restaurant to feed him because he needed to eat. But he was a young, White male who committed a terrible, terrible crime. But that’s how he was treated. He needs to eat. We need to feed him. So, for the White woman, we probably would see much more empathy and understanding.

Sonya perceived that White women are privileged in this regard.

> There's always this thing that, you know, even though – It's that privilege thing I guess you can say. White women always had somebody to take care of things for them, and it's

> usually a Black woman that’s taking care of things for them. There, the Black woman is taking care of their kids. Nursing their kids. Raising their kids while they're doing whatever. Historically, we don’t have that. We don’t have that. We are the help, I guess you could say. So, when it's time for you when that hand turns around and it's time for you to get something in your hand, that doesn’t happen. So, you have to keep it moving.

Because of this perceived disparity in garnishing empathy, understanding and help, whether it was help accessing treatment or help caring for her family, the African American women in the study felt as though they had to do what must be done to take care of their families primarily on their own. They clung to the idea of staying strong throughout their PPD experience.

We Do What We Must Do

Ten women expressed ideas characterized by the theme of a strong Black woman. In addition to their strong spiritual connection, the women believed that they had to be strong even in the toughest of times. Strength was what they saw in their mothers, grandmothers, and other women and it was taken as an example of what they were to follow. From this, the theme *we do what we must do* emerged along with subthemes *single parenting* and *putting yourself aside*. In the exemplar below, Patricia talked about the strength that she saw in her mother, her need to press forward notwithstanding her own pain, and her fear of being judged if she did not persist with strength the way her mother did.

> I’m still gonna be a momma to my babies. I don’t want them to ever feel like they’re the reason why I’m hurt... You can’t give up. You gotta keep going even though you don’t

> want to or it's hard…My momma. I never seen her cry. Even when she struggled, she never showed it… She's been on her own since she was 12-years-old. Everything she said she was gonna do, get her GED, and go to college, and try to perfect the stuff that's she's doing. I don't want to be judged. I really don't want to be judged… She's so strong. Strong people intent on you to be like them, like you gotta be strong. I am strong, but my mindset is so different. I can't think how other people think. I can't feel how other people feel. I don't know how to explain it. *She's just so powerful*.

This was very compelling. As Patricia talked about her mother, she conveyed the weight of her attempt to measure up to a woman, that in her eyes, was bigger than life and who she clearly felt as though she could not match. However, at the same time, she desperately wanted to rise to a level that was equal but in her own right. This was a powerful example of this strong woman ideology that is passed on from one generation to the next.

Likewise, Shelly described her strong role model in her grandmother and the desire to reproduce this strength.

> I know I wasn't no mirror image of her, but just her being strong, I felt as though, even though I did go through the postpartum, but there was points in times where I thought of myself as really, really strong because I was able to do it. Unlike some, maybe, I was able to cook and clean and make sure the house looked good…just things that I'm pretty sure my grandma probably would have been proud of, versus me calling and get help. I was able to do it pretty much on my own.

Karen also talked about learning about the strength of an African American woman from her mother, grandmother, and other women in her life and, like Patricia she described never seeing her mother ever cry as part of staying strong no matter what life throws at you. To share her PPD experience with others, would have been to reveal weakness.

Ashley also cautioned about the weakness reflected by PPD and why she kept it hidden.

> I didn’t want anyone doubting my abilities, my capabilities as a mother. I didn’t want to be stigmatized. I was at my weakest in my life during this time.

Single parenting. Sonya discussed the importance of being a strong African American woman from another perspective – as a single mother. She shared ideas about what shaped the African American family throughout history and why African American women must be strong.

> I guess you can say that it’s from the beginning of our American history, we've had to deal with not having that man there anyway because, for whatever reason, whether he tried to escape, whether he was sold or whatever, we never knew what was gonna happen. So we had to make sure that everybody else was taken care of. And it still goes on to this day where you don't know if he’s going to be there or not but you need to make sure that you have tied your camel and that everybody is not going to miss that absence. We find a way to overcome, regardless of the adversity, that’s what makes us, us…

Sonya’s experience with her husband’s infidelity and his leaving the marriage right after her son was born also shaped her ideology about being a strong woman who must care for her family. Ashley concurred with Sonya’s perspective that single women are left without options other than to be strong. “Single mothers out there have no other choice but to be a superwoman and take care of everything.”

Shelly, Karen, and Shannon described similar thoughts about PPD developing in the context of African American mothers being disproportionately single and of a lower socioeconomic status compared to White women. Shannon most clearly gave voice to questions about why African American women might be more susceptible to PPD.

> Maybe the finances may be different. Maybe they have an easier time at home they could stay home and not worry about finances…I guess, most Black women – maybe most of us not married. I don't know…Most White people are probably married and they have more spousal support. Maybe they have their parents co-provide – they help a little more. Our parents probably are still working, you know?

Putting yourself aside. The strong Black woman concept was elaborated as having to maintain strength to holding things together in the family. The women described the necessity of being strong for their newborns. Rebecca discussed always wanting to be sure that whenever she saw her son in the morning, she was happy. Patricia, Felicia, and Racquel shared the conviction that they had to be a mother no matter what they were going through; in other words, they felt that their responsibility as mothers was paramount. Respectively, Patricia and Felicia expressed this conviction.

> I know I still have to be a mother even though I'm going to through what I'm going through. I still have to give my best…

> Regardless of what I was thinking, I would still just make sure she was taken care of. It's kind of putting myself aside and making sure she's taken care of.

Racquel further elaborated about putting aside her feelings for the sake of the child.

> What you feel does not matter…what matters is your need to care for this baby no matter how you're feeling…I really need to suck it up and get through it…Okay, I don't have the luxury to dwell on that type of emotion.

The women in this study had learned how to be strong despite difficult circumstances by observing their mothers, aunts, and grandmothers. Indeed, most of the women were able to pull themselves together enough to care for their newborns and to do what needed to be done in their households during the time of their PPD experience. No one would ever know what they suffered, as many of the women described they had to wear a mask to keep up with their "expected lives" and "live a life of silence."

Wearing the Mask

Wearing the mask developed as a theme from the women's descriptions of this legacy of having to deal or cope with adversity in silence. Julie shared her thoughts about the expectations for the African American community in this regard.

> Traditionally in the Black community we kind of shy away from psychotherapy and psychoanalysis…Black women are not allowed to experience psychological trauma and therapy be okay…communities of color were forced to be so tough in so many aspects. You're kind of taught to wear a mask…they were conditioned not to talk about trauma…

Karen described her experience of learning never to reveal weakness which prevented her from knowing anyone who may have had PPD.

> As Black women we’ve always been told don’t show a sign of weakness. You gotta stay strong no matter what life throws at you…In the African American community if we have it (PPD) nobody would know…they have painted it as a negative…

Raquel corroborated this sentiment of not being able to show weakness and elaborated, as did Karen, about her silence around PPD.

> I need to put on a brave face and I need to be something that I think my husband wants and that my family expects of me and whatever I’m feeling right now at the moment just doesn’t count…my emotions were definitely on the bottom of the totem pole. PPD is very taboo in our community. I don’t know if it is shunned because it is considered a weakness as a mother or taboo, but you just don’t hear about it in our community.

Rebecca reiterated the conviction that African American women have to be strong and linked that to the necessity of silence around PPD and not revealing the inherent weakness.

> I think African-American women believe that they have to be strong, not just for themselves, but for their families or whatever else. And so, admitting that you are struggling with postpartum depression can make one feel like they're not as strong as they should be and that they're weak.

Shelly and Ashley both offered the perspective that African American women do not disclose about PPD because they feel fear of embarrassment. Shelly added that African American families do not really talk to each other about their emotional issues. Likewise, Natasha said, “There are so many secrets and things that come out after the fact that you won’t find out until later.”

In contrast, Sonya spoke from her perspective as a military officer and asserted that masking was no different for her in that environment.

> I was an officer and as an officer that (PPD) looks terrible because they are gonna put that in your records. So, I couldn't share what I was going through. I went to an outside counselor and went to therapy.

Sonya might have worn the mask into the military because of her cultural background, yet she shared that the military, at that time, denigrated officers who could not maintain control in all areas of their lives. She felt that because she was an officer, she needed to hold it together for those reporting to her, so instead of sharing with others in the military, she chose to seek outside counseling. The cultural legacy regarding secrecy and masking was a consistent point raised in the narratives of the women in this study. The expectations for African American women run counter to the common advice from mental health professionals to share feelings and seek treatment for PPD. Such advice assumes that an individual will be accepted and supported for doing so.

Support is Essential

Seven of the women in this study described having a supportive spouse or significant other during their PPD experience. As the women shared their thoughts about support and the impact of that support or lack thereof, the theme *support is essential* emerged. The support that was most central to their experience was the support from women's significant other.

Significant other. Rebecca and Julie both expressed ways that their respective spouses supported them with their PPD care. Julie talked about her husband's willingness to take care of the children when she went to her counseling sessions.

> I think he was very supportive. I went to counseling on my own, not long after that, and he always made sure that he could work his schedule around what was going on with counseling or whatever else. So, yeah, I think he was very supportive before, during, and after the diagnosis.

Rebecca shared how her husband made sure to say things that would make her smile or laugh, and lighten her mood. She also shared about how he was deliberate in creating opportunity for her to do something other than care for the baby.

> And so what he would do was − he was very deliberate – when he would come home, he would force me, and he would say, "Listen, take a shower. Get out of the house. I don't care what you do. Just go somewhere. Go have dinner with one of your friends, or go out to the mall... But he made me get out of the house and thank God he did because there were times where I didn't feel like it.

Likewise, Racquel described her husband's intentional support at a time when she was frustrated and sad about her son not latching on with breastfeeding.

> I cried in his arms one night…He was very supportive…I remember him after the conversation, when he saw my frustration trying to get the baby to nurse, he would ask, "Is there anything I can do for you?" "Do you want me to prop you up?" He was trying as

> best he could to get me situated and sitting up properly…He definitely heard what I said and was very supportive…He tried as best he could…

Felicia, Karen, Ashley, and Racquel also talked about their spouses consoling them when they were feeling low and experiencing PPD symptoms. Ashley described telling her husband about what she was experiencing and how he responded to her.

> I remember feeling grateful for him... I just want you to understand what I'm going through. It has absolutely nothing to do with you, I'm suffering from postpartum depression and I didn't realize it until now." I broke down and I started crying and he consoled me. From that point on, he was like a new person, a new husband. He was still doing the same things that he was before with the kids, but he was more gentle and more thoughtful when it came to how he approached me and how he dealt with me.

Marla told about when she knew her husband was all in the marriage and how she felt fully supported by him during this time.

> I can say from the second time that I went to jail, I had my husband's support full-fledged, like he – I knew he was here for the long run, because he could tell there was a difference in me.

Whereas, these women felt supported and cared for by their husbands, others did not. Shelly and Shannon feared they would be a burden to their husbands if they shared their PPD symptoms with them, so they chose not to say anything. They both expressed that their husbands were the only ones working at the time and felt as though their feelings would cause extra strain to an already strained financial situation. They did not count on their husbands as their main source of support during that time, yet they both acknowledged that their husbands helped with caring for their children.

Seven of the women in this study counted their spouses as a support person for them during the time of their PPD experience. Many of the women shared how their husbands were supportive even when they as wives were not treating them well.

Lack of spousal support. Eight women described strain in their relationship either during the pregnancy or in the postpartum period. Among those who described strain in their relationships, three women described a total lack of support during their PPD experience. These women described painful experiences in their relationships that resulted in a lack of desired support from their significant other. In these cases, the significant others were not capable of or were unwilling to provide the support the women needed. Reasons ranged from incarceration to abandoning their family. The women were left feeling abandoned, lonely, isolated, and overwhelmed. Patricia described having to deal with the pressure of being the sole parent to her children while their father was incarcerated.

> My kid’s daddy is in custody so I’ve been going through it by myself. It was a high-risk pregnancy, in and out of jobs, hard to find somebody to watch my kids, and it’s hard to now that I have two, lack of money so I’ve been doing the best that I can to get what me and my kids need. I do have a car and a house, but it gets hard at times because I don’t make a lot at my job. It’s just really hard, but I try to keep my head up and I try to keep going because I do have kids that’s looking up to me.” “I feel alone and like I’m doing everything on my own.

Further, Patricia elaborated about sharing how she was feeling with the father of her children and how he made her feel worse.

> At times he needs supporting himself. His attitude would throw me off. It would make me feel worse than what I already feel because his attitude, like he don’t know how to – I don’t know it’s that he don’t know how to express himself or it’s that he don’t know how to word himself.

She also described their tumultuous relationship from the beginning.

> He done cheated the whole relationship since we first started going together. He did stuff the whole relationship. When I was pregnant, there was another girl also pregnant by him. He has hit me too. Well, I sent him to jail a couple of times for it and other people had called because it was so loud... But I think that’s what I was called, I want to say it was a restraining order. No, an order of protection.

Patricia described herself as a very forgiving person and this relationship as one that she did not want to lose. She perceived he needed her to make it through his jail time. Nonetheless, she did not rely on him for support, nor did she receive support from him during her PPD experience. Patricia’s experience was singular; none of the other women in the study had a spouse or significant other who was incarcerated or who had experienced domestic violence.

Olivia described her experience with her significant other as a very sad and dark time for her.

> I have a child, and I potentially don't have a father for this child. Because of how he was acting, I wasn't sure if things were gonna work out. Oh, and I want to say the day I brought her home he told me I'm going to leave you the place. I'm going to leave you with the baby. And that was the day we came home from the hospital. He said, "You can have it. I will take care of her financially, but this is not for me." And so what I ended up doing was I couldn't take care of myself after a C-section, and I didn't bounce back like I thought I would because the first one I had when I was a lot younger. So, I bounced back. This one I needed someone to take care of me, so I had to go to my family and stay with them for a week because he refused to take off of work although he had been at his job 20 years. He has lots and lots and lots of leave. He said he could not take off of work, so he drove me to my family's house and dropped us off.

She recounted telling her husband the day she came home from the hospital that she was experiencing PPD and that he simply said, "I can't help you. I don't know what to tell you." She talked about feeling completely alone and lonely, especially when she first arrived home from the hospital and he wanted to leave her and the baby. Sonya also described her husband leaving the day they found out their son had a disease while he was still in the hospital. Sonya recalled not understanding why her husband did not appear engaged in the pregnancy until later finding out that he had been unfaithful in the marriage. Olivia and Sonya's experiences represent the continuum of a strained relationship and lack of support that began in pregnancy and continued in the postpartum period. Sonya commented as follows.

> He never touched my belly. He never laughed and talked about it, like, the stuff that was going on during pregnancy. He didn't treat it well. It was quite confusing. It was quite

> confusing because, it's like, okay, this is what you asked for. Then he left when my son was 3 days old. It was stressful. Trying to figure out what was going on. That’s all I can say about it…

Both Olivia and Sonya feared being single mothers as they recounted their experience as single mothers to their older children. Olivia described it as follows.

> I just kept thinking I don’t want to be a single parent to this baby. And I didn’t know how things were gonna turn out, and I guess that was a big issue for me…It was just I didn’t know one day to the next what was gonna happen.

Sonya recounted a sense of pride as she reflected on not being a teen mom having waited until she was older. Nonetheless, she still described feeling as if she was a teen mom, now that she was left to raise her newborn son without his father.

I prided myself on not being a teen mom, but still ended up being a single mother anyway. … we planned to have a baby…well, I did it for him because this is what he said he wanted…and then you leave… I was dealing with it by myself…now that I know his character…it was probably his goal to push me to the edge…

The sense of loss that occurred with these two women was incredibly taxing. The joy they thought they would have experienced during their postpartum period was overshadowed, and the “darkness” they experienced was almost all consuming. Single parenthood was something both had known before and it was an experience they would do anything to avoid again. Although, one ended up as a single mother anyway, they both managed to come through the experience as stronger women.

Family members. While many of the women received support from their spouses, other women sought and received support from other family members. These included parents and siblings. The support from family members was significant for the women; in fact, some identified family members as their main source of support. Rebecca, Julie, and Olivia described their families as especially close knit. Rebecca and Julie lived away from their immediate family but reported frequent visits and frequent supportive phone conversations. Rebecca stated she confided to her sisters about her PPD symptoms and additionally had a family with a shared strong faith. Rebecca, Shannon, Natasha, Karen, Sonya, and Racquel all described their mothers as central support persons to them as they navigated the postpartum experience.

Karen described her mother as her “savior”. When Karen lost her job during her pregnancy, she and her significant other went to live with her mother. Karen credits her mother with being the one that pointed out that she had PPD.

> I’m the only child…She’s my savior for everything so I was just like I’m moving back with mom…So, I said, “Do you think I’m depressed? Why would you say that?” She said, Well, you are showing the symptoms of post-partum depression.” Then, that’s when I started researching and seeing like wow, I guess I do have it.

A lot of the women described their support from other family members as tangible, especially as they described feeling overwhelmed by the transition to motherhood. Mothers and sisters helped them navigate through certain circumstances. They were present to help them with childcare. Rebecca expressed appreciation for her mother, along with two of her sisters, coming to help her with the baby when returning home from the hospital. Racquel remembered her mother stopping by her house most days after work or her sister stopping by after school to help her care for her baby. Sonya’s mother lived with her and she found her mother’s help to care for her older son extremely valuable. Natasha described the joy of having her mother come to help her twice during that time.

Shannon described talking to her mother multiple times a day about everything that was going on in her life but did not disclose her PPD symptoms. Still, she described her mother as a support in her transition to motherhood. She also described the support that she received from her sisters throughout her PPD experience.

> I talked to my mom every day, maybe twice a day, maybe more, she knew I was sad, but she didn’t think it was postpartum. She knew I was sad…I didn’t want to overwhelm her because my mom doesn’t live in the same state. I have two sisters that I pray with every morning. So, I would talk to them about it, scream with them about it, cry with them about it, whatever the case it was. We would pray over it every morning.

Marla described her sister and her father as supportive in helping her follow through with PPD treatment.

> My sister paid for the session for me to go after I got out of jail…My dad and my sister paid for the medication they prescribed me, which the medication is not cheap…I needed their help and they game me full support.

Marla was not the only participant to include the support of a father. Similarly, Natasha talked about how her father supported her during her PPD experience.

> He would always say however many times you need to call me, call me. So, "If you pick up the phone," he said, "I'll sit here. Even if I have to sit here on the phone, if we don't say anything, you put the phone down, and just put it on speaker." And so, that helped a lot because I think it was loneliness. I really wanted my mom here.

Ashley and Shelly included the support of a mother-in-law and an aunt, respectively, as important support persons during their PPD experience. Ashley described her mother-in-law as an encourager. "She would tell me I was a great mother." "She would send me inspirational thoughts." Shelly stated, "I would reach out to my auntie and just tell her about it and she was very supportive."

While most of the women described support received from family members, a few of them described a lack of support. They talked about not being able to rely on family members at times when they were needed most or not feeling comfortable in sharing their PPD experience with family members.

Lack of family support. Felicia described her parents as workaholics who did not offer much support after her baby was born. This was contrary to what she had hoped, but also described a strained relationship with her parents during that time**.** Patricia described being the mature one and the advice-giver amongst her siblings; therefore, she did not consider them a support. Instead, her mother was her powerful role model, and she wanted to be a mother that could take care of children, despite what she was experiencing, in the same way she had seen her mother do. Thus, Patricia did not go to her mother for support during this time. She perceived that her mother was already stressed out and felt that she knew what her mother would have told her to do about her PPD.

> She would say what she always tells me, to put my feelings in my pocket. I can’t cry over spilled milk…

Rebecca described her mother-in-law as judgmental and lacking sympathy and empathy.

> I think I felt kind of judged by my mother-in-law because there were times where I literally, when the baby slept, I just wanted to sleep, but I felt guilty because I felt like I should be exercising. I know she's gonna say I should be exercising, or if there was something that I really wanted to eat… I don't know – chips or – I don't know – juice or a slice of pizza or something like that, I felt like she would judge me…

Natasha described feeling disappointed by the lack of support she received from her brother and sister-in-law when her sister-in-law offered to be her support person for the birth but failed to follow through.

> My brother and I were close growing up. It got a little distant once he got married. ..My sister-in-law and I were never like super, super tight. But when she offered to be my doula, she was here all of the time. She would come. She would see about me…So, when she didn’t come because what happened was, I guess, her friend or roommate was getting married. And it just so happened that her wedding was going to be, at that time. It was just her going and attending. And I was like, “you can’t do that.” So, she was like, “no, no, I’m going to do both,” blah, blah, blah…And she went anyway. And then, after I gave birth, I think my brother came by with the kids, and she sent me a text to say congratulations. She said, “Congrats. I have a cold, so, I won’t be coming by…So, that was disappointing, very disappointing.

Olivia also described not being able to depend on family for support. She feared sharing with her close-knit family all that she was enduring in her marriage as they would not have wanted her to return to him. She turned to friends for support as did some of the other women. Five of the women described a lack of family support in some way or another that was a disappointment for them. These women wanted to be able to receive support from family members but were unable to rely on that, during a time when they needed it most.

Friend support. Friend support was a valuable source of support for some of the women. Sonya and Felicia described their communities as major sources of support for them, whether it was their lived in community or their church community. Support from friends was essential to their surviving their PPD experience**.** Sonya described support from her neighborhood.

> My neighborhood, my home, have a support system at the time. So even though I wanted to say something, I knew that I could just go back home and call up one of my friends and just talk to them… And that was, let me tell you, I think I've said it already before, if it wasn't for them, I would not have survived. I would have – sorry – I would have probably been one of those statistics, you know.

Felicia described how it was helpful for her to be around her church family, "being around uplifting, positive people was very helpful. I had friends. My church family was very helpful during that time." Shannon and Shelly talked about friendship support and how they were able to call and pray with friends throughout the situation. Additionally, Julie talked about the support she received from women with whom she had been friends since childhood.

The support of community, friends, and family members was invaluable to the women in this study. Without this support during a very difficult and pivotal time in their lives, many of the women would have had a much greater struggle. Support is essential for African American women dealing with PPD.

Summary

In this chapter I presented findings from the study including paradigm cases and exemplars presented in participants' own words. Results include findings that are common to the lived experience of PPD of women across races as well as findings unique to African American women. I presented the lived experiences of African American women with PPD using a chronological approach starting with pre-pregnancy and ending with the postpartum period, demonstrating the fluidity of the African American women's experiences during the perinatal period.

In the pre-pregnancy period, the women were happy, satisfied, and working hard to enjoy their lives or to improve their financial situations. This was a period that many of the women described as a good time with their significant other or a time where they enjoyed having the freedom to do as they pleased. While there were a few women who had planned pregnancies and anticipated welcoming a child with excitement, most of the women experienced unplanned pregnancies. They were not originally excited, some even expressed regret in getting pregnant. It was during the postpartum period that all the women met challenges that appeared insurmountable as they faced PPD. Many of the women experienced feelings of powerlessness, failure, guilt, shame, perceived judgment, and a host of emotions that left them feeling as if they were operating outside of their "normal" self.

Many of the women shared their lack of knowledge about PPD and most did not seek help despite sometimes experiencing severe symptoms. There were a few women who received treatment as they were directed by someone outside of their family who recognized changes in them and encouraged them to seek treatment. All the women demonstrated resilience and strength as they continued to care for their families and themselves throughout their PPD experience. These women shared that this strength was something they had witnessed or had been taught to maintain regardless of what they were experiencing personally. Seeking to stand in this strength, most of the women chose to keep their PPD experience to themselves.

The women also expressed a uniqueness as they discussed the feeling of not being understood or empathized with in society or media. They talked about a lack of representation in media of stories about African American women with PPD contrasted against the perceived normalization found for White women with PPD. All the women relied on their Christian relationship to help them through their PPD experience. Support was considered crucial, particularly support received from their significant others. Extended family, friends, neighbors, and church friends were also important sources of support as the women navigated their PPD experience.

Chapter 5 will discuss the findings and their relationship to existing literature about African American women with PPD, the strengths and limitations of the study, the implications of the results, and future recommendations.

CHAPTER 5

Discussion of Findings

This study used a critical hermeneutic methodology grounded in Black feminist theory to examine African American women's lived experiences with PPD. The purpose of this study was to describe the lived experiences, meanings and concerns of African American women with PPD. In addition, the study examined the impact of family and significant other relationship support on African American women's experiences with PPD. In this chapter, I compare the findings with existing literature, and consider the strengths and limitations of the research. Finally, I summarize the overall conclusions of the study and consider implications for practice and future research.

Understanding PPD

Pregnancy guilt and regret. Most of the participants experienced unplanned pregnancies, and some even described feeling regret during pregnancy that may or may not have impacted their feelings in the postpartum period. Unplanned pregnancies were a predictor of PPD in a meta-analysis where the researcher examined predictors of PPD (Beck 2001), so the findings for unplanned pregnancies among African American women with PPD in this study are consistent with previous research. However, the experience of pregnancy regret adds to our understanding of the prenatal experience of women who subsequently experienced PPD. This feeling of regret for some participants was centered on participants feeling unprepared for a new baby or a lack of support in the home. Mothers had a difficult time sharing their feelings of regret and felt badly about even saying, “I felt like having her was a mistake.” “I felt irritated to have the baby around, I wanted him cared for, but I just didn’t want to care for him.”

The women were quick to remind me how much they loved their child, and some were sorry that they had shared their initial feelings of regret about their pregnancies. In fact, one woman asked that her words be removed from the transcript during the process of member-checking; this was the only theme that a participant asked me to remove original interview data from her transcript. The regret they felt was very difficult and painful for participants to recount. Thus, it may be that the regret that can accompany an unplanned pregnancy adds to the vulnerability to PPD during the postpartum period for African American women. This topic could be an opportunity for future research.

Eleven of the women in this study identified as Christian. Of these, three conceived out of wedlock and experienced pregnancy regret because they felt an unwed pregnancy was inconsistent with their religious beliefs. These participants believed that they had behaved in a manner that was morally wrong, worried about social stigma, and struggled when the fathers of their unborn children did not ask them to get married early on. Fear of the social stigma of being pregnant and unmarried caused great anguish for these participants, particularly for those who were already single parents. They felt shame and embarrassment about their situations, vowing to themselves not to get pregnant before marriage again. Later, when they had accepted the reality of their situations, they sought help through religious and spiritual coping.

The women in this study were similar to those in a study conducted by Mattis (2002) in which 23 African American women were asked to define and examine the ways in which they had used religion and spiritual coping during times of adversity. They shared that facing reality can be painful and difficult but that it is nonetheless necessary to grow stronger. Likewise, in Jesse, Schoneboom & Blanchard's (2007) study of 130 African American and White women where participants were asked to discuss how faith and spirituality affected their pregnancy, a theme that emerged for African American women revealed that accepting God's will for their lives helped them to make difficult choices. Overall, 43% of the women in Mattis's (2002) study indicated they lived within a set of religiously and/or spiritually informed principles. Similarly, although they had experienced pregnancy out of wedlock, participants still wanted to live by their religious principles. Participants in the current study discussed how they prayed about their situations and asked God to make a difference for them while accepting what they could not change. This is consistent with the published literature highlighting African American women's reliance on religious and spiritual coping as a means of dealing with challenging circumstances (Abrams, 2009; Abrums, 2011; Amankwaa, 2003).

Given their reliance on spirituality, it is possible that some segments of the African American female population may be less likely to seek outside help. The magnitude of religious and spiritual coping for African American women of faith with PPD points to an opportunity for future research in this area and the need to integrate, support, and build on these coping methods in the overall treatment of this group of women.

Defective woman. The women perceived that they were not meeting expectations which caused them to feel as though they had failed in some way. The sense of unmet expectations followed a variety of experiences including a perceived failed delivery experience, a traumatic birth experience, a failed relationship, a newborn diagnosed with a disease, problems breastfeeding, and difficulties caring for the family. Regardless of the nature of the unmet expectation(s), the women typically experienced feeling defective or like a failure when attempting to care for their family. This finding was distinct from that reported by Sterling et al. (2011) in which African American women were asked to examine altered perceptions of control after pregnancy. While the women in that study reported that the care of their children was a stressor, they did not, attribute the stress of caring for their children to their own performance. In the current study, participants believed that the feelings of failure deriving from perceived unmet expectations contributed to the development of PPD. For most of the women, the awareness of failure occurred very early in the postpartum period, many experienced a letdown while still in the hospital setting.

Several participants shared that they lacked a connection with their baby at the time of birth. This finding is congruent with Mauthner's (1999) study of (mainly White) women's experiences with PPD. Women in the current study described feeling disappointed about the lack of connectivity because "everyone" had told them about this instant connection mothers have with their newborns. When they did not experience this loving connection, the feeling of failure and inadequacy was compounded. Impaired maternal-infant attachment is often associated with PPD (Beeghly et al., 2003; Murray et al., 1996). The emotional experience during the immediate period after delivery for the women in this study was consistent with findings for African American women reported by Amankwaa (2003) who characterized this period of recovery as the time of "stressing out." Stressors included physical symptoms such as pain and recovery from cesarean section delivery, and mental stressors like birth plan failures and loneliness.

All the women in this study attempted breastfeeding after birth and a majority had difficulties. Many of the participants had to seek support from a lactation consultant. They reported that this made them feel inadequate and further elaborated that, in addition to their symptoms of PPD, they perceived they were failing at the "job" of breastfeeding. They felt broken when breastfeeding efforts were not successful. Although pain, and concerns about the adequacy of milk supply have been reported as common concerns among first time mothers (Ong et al., 2014) many of the first-time mothers reported that they had never been told that breastfeeding issues could arise, and they felt additional stress as a result of their breastfeeding difficulties. These women believed that since breastfeeding is a natural process they should not be experiencing any problems. These findings are consistent with a study of new mothers in Switzerland (Razurel et al., 2011) which reported that expectant mothers understood breastfeeding to be a natural process that doesn't require any special direction or coaching. The women did not know of potential difficulties with breastfeeding and they ultimately described their breastfeeding experience negatively (Razurel et al.).

Some research suggests that mothers who intend to breastfeed their children but do not do so are at greater risk for PPD compared to mothers who do breastfeed their children (Borra, Lacovu, and Sevilla, 2014). In contrast, other research has found that not being able to breastfeed is a consequence of and not a risk factor for PPD (Dennis & McQueen, 2009; Gross et al. 2002). In fact, women who reported being happy during their pregnancy and who experienced difficulty breastfeeding, did not experience depressive symptoms in the months after delivery (Gross et al.). Although conclusions cannot be drawn, most of the women in the present study did not report feeling unhappy throughout their pregnancy, still, many experienced breastfeeding issues and all experienced PPD symptomology. While these findings are congruent with the conclusion that breastfeeding difficulties increase women's risk for PPD, further research is indicated.

Many of the participants in this study reported a sense of failure in caring for their older children and maintaining their households. This sense of failure is much like the feelings of failed maternal role expectations other researchers have reported (Amankwaa, 2003; Beck, 2002; Mauthner, 1995; 1998; Nicholson, 1999; Berggren-Clive, 1998). In other words, the participants in this study held expectations for themselves, mirroring their perceived societal expectations and, when unable to meet them, they considered themselves failures. Like those reported in Amankwaa's study, women in the current study expressed that they were unable to fulfill their expected roles after the birth of their babies. The women did not allow themselves the liberty of having a different experience without judgment.

Along with societal expectations of mothering such as feelings of happiness and joy, breastfeeding without difficulty, and having support after leaving the hospital, African American postpartum women carry the burden of controlling images assigned to them from White patriarchal ideology such as the strong Black woman. These patriarchal groups in power sought to define African American women by assigning these controlling images derived from an ideology built in racist oppression; images such as the mammy, the matriarch, the welfare mother also known as the breeder woman from slavery, and the sexually aggressive. These controlling images classify all African American women as bad mothers and have not just been singular in their relationship to race but have included intersecting oppressions through race, gender, class, and sexuality (Collins, 2000). These images are rooted in this ideological justification of intersecting oppression by those in power through racial stereotyping of African American women; women are stereotyped as lazy because they collect a check from the government. Or, because they must work to provide for their families it is assumed that they don't know how to socialize their children (Collins, 1991).

When unable to live up to these ideological expectations, participants blamed themselves. They viewed themselves as failures, “broken vessels”, and bad mothers. Their negative thoughts of themselves were persistent and caused them to feel sorrow because they could not measure up to their own expectations. This finding underscores the unique experience of African American women in the postpartum period and marks it as distinct from that of White postpartum women (Mauthner, 1998). Unmet expectations engender a sense of failure in the postpartum period that may contribute to or exacerbate the symptoms of PPD. What was notably different in this study of African American women, was the self-imposed silence as participants compared themselves to their mothers and grandmothers who they perceived as strong Black women who “did it all” without breaking. Such findings demonstrate the continued relevance of examining how African American women perceive ways of knowing about motherhood transitions and the reality of those transitions.

PPD symptoms. In conjunction with feelings of failure, the women suffered a myriad of symptoms consistent with prior research (Amankwaa, 2003; Beck, 2002). These symptoms included uncontrollable crying, anxiety, irritability, anger and aggression, guilt, paranoia, insomnia, loneliness, helplessness, abandonment, mood swings, negative thoughts, thoughts of harm to self or baby and violence. Previous research characterized these symptoms thematically as “losing control” (Amankwaa) and “spiraling downward.” The women in the current study further described these feelings as being “outside” of themselves or “not me,” meaning these were not feelings that were not typical of their personality or character. They described themselves as feeling and acting in ways they had never previously experienced. The mothers further elaborated that they felt that coping with PPD symptoms “robbed” their older children of the time that would have been devoted to them. This dynamic was previously captured in Beck’s meta-analysis where the mothers reported a loss of relationship with their older children because they felt smothered by their needs and subsequently began to resent them. Rather than feeling overwhelmed by caring for their infant as did the mothers described by Beck, the mothers in the present study reported that care of their newborn was their only focus and all they could accomplish.

Social stigma and PPD. Feeling judged by outsiders is difficult; it is uncomfortable and challenging to navigate, particularly, when dealing with PPD. A participant echoed this sentiment, fearing judgment from outsiders. She did not want her mothering to come in to question so she felt it best to hide her PPD experience. She feared that others would judge her ability as a mother and did not want to experience the stigma associated with not being able to handle everything. She shared that she was at her weakest during that time of her life. Most participants expressed fear about the social stigma of PPD and feared being labeled “crazy.” These findings are consistent with the results of several other qualitative studies of PPD in African American women (Amankwaa, 2003; Abrams, 2009). Sterling et al. (2009) reported that women worry about the stigma of mental illness. They assumed would be labelled as crazy if they shared their experiences with PPD with others and they worried that people would conclude they were incompetent mothers. This fear was so significant that three of the women kept their PPD symptoms a secret. This finding echoes previous research (Edge 2008; Leis et al., 2011) reporting that African American women fear having their children taken away should they be diagnosed with depression or labeled as crazy.

In one study (Leis et al., 2011) African American women feared a loss of confidentiality, specifically, they feared that their mental illness might be reported to the authorities. The reported lack of confidence was in the ability of a non-Black healthcare provider to relate to their needs. Similarly, one participant in the current study spoke to this fear directly; she feared that if she disclosed her symptoms to her health care provider the clinician would contact child protective services and that her children would be removed from her care. As an African American woman, she lacked trust in social services and health care providers and she kept her PPD symptoms to herself.

Stigma is a term used to convey prejudice (Gary, 2005). Gary described barriers related to stigma in mental illness in four minority groups and discussed the double stigma that African Americans face in our society. Double stigma is the combined stigma of mental illness and discrimination that African Americans face when dealing with healthcare providers. The Tuskegee Syphilis Study is commonly used as an example to describe this intersecting oppression. Gary goes on to describe that when the dominant group develops stereotypes about a minority group, the stereotype becomes the foundation for discriminatory actions by the dominant group. The women in this study feared the stigma associated with PPD and because they did not have a relationship with their healthcare providers, they were not confident that any stigmatizing information they shared would not be used against them.

Keeping quiet. Healthcare was an area in which the participants uniformly did not have trust and they consistently shared that healthcare providers were not interested in discussing PPD with them. Few participants reported a relationship with their provider, and most participants felt their providers cared little about them These findings are congruent with those from previous studies (Brown et al., 2010; Edge et al., 2008) in which African and Caribbean women living in the UK felt as though they were not valued as patients, believed they did not receive the care that they should have, and held an overall distrust towards their healthcare providers. Findings from Jesse et al.'s (2008) qualitative study of trust between patients and providers in pregnant rural African American women echo this finding. Jesse et al. reported that these women lacked trust in clinicians due to dissatisfaction with health care and fear of breaches in confidentiality. Together, these findings support the urgent need for African American and Black doctors and nurses to address health inequities in treatment access and quality (Sullivan Commission Report, 2004).

It is not enough to train White doctors and nurses to provide culturally sensitive care to African American and black women because patients who are fearful and distrusting of Whites will not disclose sensitive health information. African American women are, therefore, precluded from accurate diagnoses and treatment of critical conditions like PPD. Failure to provide African American women access to clinicians who engender a sense of trust may result in poor outcomes, not only for the women but for their families. The negative outcomes may come to bear across generations (Morgan, 1999).

The current study's finding that participants did not feel cared for and did not trust their clinicians is consistent with findings from previous studies conducted with African, Caribbean, and Black and White British women living in the UK (Brown et al., 2010; Edge et al., 2008). Of note, data obtained from one participant in this study contrasts with this body of evidence. This participant sought medical treatment for PPD and worked closely with her healthcare provider to initiate and adjust pharmacologic therapy. This participant had previously experienced positive encounters with mental healthcare professionals and felt comfortable seeking them out again when faced with PPD. This was congruent with a participant in Leis et al.'s (2011) study where one participant also acknowledged a positive encounter with a healthcare provider and felt as though the healthcare provider took the time to uncover how she was feeling. Although these women were the exception, they underscore the importance of cultivating positive and caring health care clinician relationships with African American women as means of improving future access.

Most participants in this study did not disclose their PPD symptoms to their spouses or family members for fear of burdening, overwhelming, or discouraging them, or straining their relationships. They did not have a clear way of communicating what they were experiencing and, even if they could, they feared not being understood. Perhaps this was not surprising as the women consistently reported they did not know they were experiencing PPD and had concluded they had failed at mothering in some way. In their minds, they did not want to add another "failure" to their list of role failures, so they kept quiet. Participants further reported the sense that African American women were not allowed to experience psychological trauma and talk about it. To some of the participants, PPD represented weakness, leaving them to mask their true selves during their PPD experience. Amankwaa (2003) found that African Americans, generally, perceive depression as a weakness, so it was not surprising to have found this to be true in relation to PPD. It is notable that Amankwaa's research was published 15 years ago, yet these ideas persist. Some of the women expressed fear of stigma and judgment that they could not bear under the burden of not being able to admit to a "weakness."

Like older studies conducted by Abrams (2009) and Amankwaa (2003), where African American women chose to avoid stigmatization and judgment by allowing friends and family members to normalize their PPD experience, the women in this study chose not to share their experiences out of fear of judgment and burdening others. Abrams concluded from her study of the barriers to care faced by minority women with PPD, that African American women often minimized, normalized or hid their PPD symptoms. African American women in the current study shared a reminiscent experience of being uncomfortable with sharing their PPD symptoms with others.

Amankwaa's (2003) study of African American women with PPD described the essence of the phenomenon as keeping secrets. The women in Amankwaa's study did not share their PPD symptoms with others including spouses, family members and outsiders. Likewise, nine women in the present study said they did not feel they had PPD, therefore, they were not inclined to share their symptoms with anyone. One participant reported she thought PPD was a disease from which only White women suffered. She did not think she could be experiencing it. This is also reflective of Amankwaa's study in which participants reported that they did not know African American women could develop PPD.

Keeping secrets is a theme that has been used to characterize the dynamic in which women do not readily disclose their PPD symptoms to family and friends (Abrams, 2009). Abrams suggested that African American women may carry a subconscious agreement such that neither mothers or other family members should mention their PPD symptoms, reflecting a pattern of secrecy or masking that African Americans adopted while enslaved. By keeping their PPD experience quiet, participants in in the current study were seeking to maintain a façade that everything was fine even as they secretly felt that they were falling apart on the inside. The use of silence as a coping mechanism highlights the major significance of stigma and distrust as major contexts influencing African American women's experience of PPD and underscores the need for anti-stigma community interventions.

Strong Black woman: Myth or reality. Participants in this study shared that they possessed a strength that was unspoken and which they felt expanded beyond their spirituality. Since emancipation, White, patriarchal, powerful, elite groups have imposed inferior social positions on African Americans through societal stereotyping. The gender stereotype of the strong Black woman and weak Black man is a direct binary opposition to the ideology of the dominant White man and submissive White woman societal narrative (Wyatt, 2008). This ideology and stereotype of the African American family was thrust upon them not by desire but by design. The job market for African American men, post emancipation, was designed to keep them out of jobs that would bring a sustainable income into the home (Wyatt). This made it necessary for African American women to enter the workforce to help provide for their families. Women had to be strong, not because they wanted to be, but because of the racist oppression in society towards African Americans. As Wolfstein (1998) describes, “One of the built-in features of racist oppression is that it forces black women to bear unusual hardship to survive and care for others in the most difficult of circumstances.” (p.50) This ideology dates back as far as slavery as African women were beaten and raped and still expected to render service (Wyatt). Additionally, because the Black woman has had to provide for the family financially and emotionally, they have acknowledged their place of authority within the family system (Wyatt).

This controlling image of the strong Black woman has become a part of the fabric of African American communities that is silently passed from generation to generation. According to Black feminist, Morgan (1999), after racism and sexism cast a dark light on the image of the strong Black woman, the ideology of a “superhuman” woman was viewed as desirable for the African American community. To reclaim control of the image, the strong Black woman persona was placed in a position of respect and women were to be revered for their strength and ability to be resourceful. Although Morgan described this shift as an attempt to maintain women's dignity, she also described the negative effects of the strong Black woman image. Attempting to live up to this controlling façade, she described her experience of repressing her feelings to maintain a "rock" persona for others; she recalled the resulting misery including uncontrollable crying spells. Chambers (1996, as cited in Wyatt, 2008), echoed this critique, describing many years of silence to stay strong. These prior reports of uncontrollable crying and silencing from seemingly healthy African American women are remarkably like the patterns reported by participants in this study of PPD.

The women in the current study reported they had to be strong because many of them were witnesses to this pattern in their families; they had mothers, aunts, grandmothers, and other women in their lives who were strong. For example, one participant in this study gave voice to the complexity of this mandate. She referred to her mother as "powerful" and as a result felt that she could not share with her that she was suffering from PPD. She feared being judged by her mother as not able to handle the pressures of motherhood. She described her mother as a woman who had been on her own since the age of 16 while still managing to raise a family and go back to school to obtain a degree. She viewed her as superhuman and feared she could not measure up to that standard; and thus, she remained silent. This continued need to press on and be strong despite their emotional pain resounded in the African American women in this study. This finding is consistent with Amankwaa's (2003) study in which the African American and Black participants with PPD reported that they were socialized from a young age to be strong and handle whatever difficulties they had to face.

Doing what we must do. Most participants reported that they had to put their needs aside for the sake of their newborns. One participant said, “What you feel doesn’t matter…what matters is your need to care for this baby.” Another participant related her need to “press on” being a single parent and not having the support of a spouse to help care for her newborn. She shared her story in terms that were like the controlling image of a matriarch, but redefined it for herself, out of necessity, as she described a marriage that ended during her pregnancy. In her book, *Black Feminist Thought*, Collins (1990) said the idea that African American women should live sacrificial lives is the norm for Black motherhood. What resilience these women emanated, came at the expense of their own well-being and mental health.

Most of the women in the current study were willing to sacrifice their own well-being for the sake of their babies. While some may find this admirable, it begs the question how much care can really be given when in a state of emotional disarray or depletion? Participants continued to hold perceived cultural expectations for a “good” mother in high regard and maintained the mask of the strong black woman. They did whatever was necessary to hold themselves together on the outside while managing to care for their newborn with a strength that was challenging to maintain; this made it difficult for them to recognize a need for professional help. This finding suggests that consciousness raising to challenge the hegemonic image of the strong Black woman is needed. Encouraging and supporting help seeking in the African American population is critical to counter this oppressive social image. African American woman should not have to carry the burden of having to be strong in whatever difficulty they face. While being strong in and of itself is not a negative thing, not being able to express your true feelings out of fear of being perceived as weak can lead to poor outcomes for new mothers experiencing PPD.

Coping with PPD

Leaning on God. Most of the participants in the study drew on their spiritual faith for coping and “called upon God” to see them through their PPD experience. Historically, African Americans have used prayers and spiritual songs for comfort and emotional survival during tumultuous times. During slavery, spiritual songs were sung to grieve, to comfort, and to communicate among the slaves (Darden, 2014). As Christianity was introduced and slowly started to spread among slaves in the early nineteenth century, their faith was further expressed through singing spiritual songs that reminded them of a changed state or a better place (Darden).

The African American women in the current study reported a persistent resolve that was rooted in their spirituality. Most described prayer and reading the Bible as a source of comfort and healing. They relied heavily on their strong spiritual connections to get through their experiences of PPD. One participant characterized depression as being “a disease for White people.” She recalled how she was taught that the church was the place where you go so that God could heal you of anything. Most of the women recognized God as their source of strength when they were overwhelmed by their PPD symptoms. This finding is congruent with previous research. For example, Abrums’ (2000; 2004) studies of African American women’s use of religious coping to resist racism in healthcare, revealed that women often trusted in God and relied on the power of prayer to change their circumstances when facing oppression in healthcare.

In line with previous research showing that African American women relied on faith and prayer to help them through emotional pain (Amankwaa, 2003), participants in the current study drew on prayer a means of coping. Prayer eased one woman’s mind from her PPD symptoms, and another participant described calling on Jesus to interrupt her thoughts of wanting to harm her baby, walking around saying, “Fix it Jesus.” “Fix it Jesus.” “Remove it, Jesus.” The positioning of Jesus as the source or healer is also congruent with prior research. Abrums (2004) reported on women who described Jesus as the doctor. They believed that even if they went to the physician for help that God was in fact the one to heal.

Mattis (2002) found that African American women not only used religion and spirituality to cope in times of adversity, but they more specifically engaged in spiritual surrender when they were unsure about how to cope with adversity. Participants in the current study felt strengthened, supported, and encouraged in their Christian faith and practices. This faith-based strength and support contrasted with the disparities based on race, gender, and class that they experienced in society. This finding is congruent with previous studies (Mishra et al., 2009; Ward & Heinrich, 2009) which have found that African American women rely on and prefer religious coping as a form of medical treatment. This finding suggests that church-based outreach, education, and support programs would benefit African American women with PPD. In addition, this finding points to the opportunity to harness the strengths of women’s spirituality as part of an integrated approach to PPD management.

They don’t have the same struggles. The women in this study shared a perception that they did not have the same struggles as White women and therefore they did not believe that White women would be able to relate to their life experiences. The women reported that one of the reasons for their lack of knowledge about PPD is the way it is portrayed in the media. Participants described seeing White women talk freely about their experiences, but they did not see positive portrayals of African American women with PPD.

One participant recalled a media portrayal of an African American woman with PPD in which the woman drove through the White House gate and was shot by the guards because she would not stop. She remembered hearing the news anchor saying the woman had recently had a baby and that the incident was most likely related to the birth of her child. Another participant listed PPD as one more thing on a long list of things that African American women must deal with. She offered that many White women do not have to deal with racism, gang violence, police brutality, or raising kids in a single parent household. “We are targeted across the board,” said one participant as she described her thoughts about the difference between the experience of African American women and White women with PPD.

The intersecting oppressions of race, gender, and class were at play in how the women perceived they were viewed and valued when it comes to PPD. One participant concluded that White women would likely receive more empathy based on what the media portrays. This finding strongly suggests that there is a need for public information campaigns that introduce and normalize PPD in African American communities. Additionally, it underscores the harmful influence on women’s health of negative media portrayals of African American mothers.

Most of the women in the current study perceived that White women talk more openly about their PPD experience and are more likely to try pharmacological therapy than African American women. This finding for limited engagement in treatment is consistent with at least one study of racial and ethnic differences in mental health utilization which reported that 9% of White women seek treatment compared to only 4% of African American women (Kozhamannil et al., 2011). African American women were also less likely to refill prescribed medications (Kozhamannil et al.). Consistent with this finding, only three women int the current study sought counseling for PPD and only two took medication. Several participants indicated they never would have considered medication as a treatment choice, reporting they felt that healthcare providers want to put you on medication for everything.

According to Leis et al. (2011) African American women doubted the efficacy and feared negative side effects of antidepressants. They worried that medication would make them unable to care for their children. Of note is that each of the three participants in the current study who sought professional mental health services reported unique circumstances. The first woman came from a family of mental health professionals and she had accessed mental health care previously, suggesting that familiarity increases the likelihood of future use. A second woman was mandated by the court to take medication and see a counselor as part of her plan of care. Finally, the third woman who was seeing a counselor recognized that she needed help after an accident occurred with her son. The reluctance of most participants to consider pharmacologic therapy is not unique to African American women, but reinforces the need for healthcare providers to screen and educate patients about the various treatment options available for PPD. Considering the findings about clinician mistrust and the perception that many clinicians don’t really care about African American women with PPD, it is imperative that treatment conversations take place after steps to build trust have occurred.

Support is Essential

Significant other support. The literature consistently documents the importance of emotional support provided by significant others for postpartum mothers (Chojenta et al. 2012; Negron et al., 2013; Stapleton 2012; Razurel et al. 2013). Consistent with this information, 11 of the 13 participants in the current study looked for and appreciated support from their significant others while experiencing PPD. Although participants did not always share their symptoms of PPD with their significant others, they appreciated when their partners recognized that there was something wrong. A participant described the support she received after she finally shared what she was dealing with. “He was a new person...he was more gentle and kind in how he dealt with me.”

In contrast, eight of the mothers described some sort of strain to their relationships during this time. Likewise, among 34 couples who went through a group program for postpartum distressed mothers and fathers, many of the women also perceived strain in the relationship during their postpartum experience (Morgan, Matthey, Barnett, & Richardson, 1997). Some attributed these problems to a lack of support from their significant other. Women in this stdy looked for support in ways that were tangible - offering to care for the newborn or older children, for example. This is consistent with research in which women reported that not getting help with the baby was like setting yourself up for PPD (Negrons et al., 2013).

Some women in the current study described the sadness, loneliness, and abandonment they felt in their relationships with significant others. These women felt no sense of emotional or tangible support. A few disclosed that their perceived lack of support was related to their babies’ fathers’ sense of sadness or negative emotions during the postpartum period. Postpartum depression in fathers has been reported in 24-50% of men whose partners are experiencing PPD (Goodman, 2004). Indeed, maternal depression is the strongest predictor for paternal depression after childbirth (Goodman). Since men were not interviewed in the present study, future research examining African American fathers is needed to evaluate this important implication.

Fathers who were not supportive impacted the women's interactions with their babies as they felt less inclined to interact with the baby outside of feeding and changing diapers. This is consistent with Negron et. al. (2013) who reported that women who did not get the support they desired from their significant other were resentful and became angry, often lashing out to get support. Also consistent with Negron et al. was that participants in the current study felt as if their significant other should have known what to do without being asked. They wanted their significant others to read their cues when they were feeling overwhelmed or overtaxed.

Emotional and tangible support from their significant other was extremely important for the women in this study. In another study which included 128 racially mixed mother, father, and infant triads, Goodman (2008) examined the influence of maternal PPD on fathers. Father-infant interaction is negatively impacted by a depressed mother and the more severe the mother's depression, the less optimum the father-infant interaction. The quality of the father's interaction with the infant was more significantly influenced by maternal mood than by paternal mood. There was no support provided that an infant is buffered from the depressed parent when interacting with a non-depressed parent. Additionally, men whose partners were depressed reported higher levels of parenting stress than men whose partners were not depressed. These findings suggest the need for future studies examining both fathers and mothers and support the concept of PPD as a disorder affecting the entire family (Beestin et al., 2014)

Family and friend support. Many of the women talked about the value of family support particularly from mothers and sisters. The women looked for support from their mothers and sisters as they came and provided help with caring for the baby, cooking, cleaning, and being a shoulder to lean on. This finding mirrors the results of Negron et al.'s (2013) study in which an ethnically diverse sample of women reported needing help with chores and personal care needs. Family support was very instrumental to the women.

Five of the women in the current study described their mothers as their central support, one described her mother as “a savior.” Mothers as key supporters of African American women with PPD is consistent with existing knowledge. Forty-seven percent of women in one study (Oakley et al., 2011) reported that they would trust their mother to discuss PPD symptoms. In another study, however (Abrams et al., 2009) African American women described most members of the family as being supportive.

It may be difficult for family members to know what is helpful to new mothers (Knudson-Martin & Silverstein, 2009). A few of the participants in the current study indicated support that was not helpful. As in previous research (Abrams et al., 2009; Negron et al., 2013), women in the current study described family members specifically, mothers and mothers-in-law, who judged the care and upkeep of their homes, their abilities, dismissed feelings, ignored problems, and provided unsolicited help. Indeed, some of the participants in this study chose not to share their PPD symptoms with these family members for fear of further judgment or stigmatization. Consistent with previous study findings with African American women, some of the study participants lacked confidence in availability of family support (Ayalon & Alvidrez, 2007; O’Mahen & Flynn, 2008). It is notable, however, that all the women who shared their PPD experience with family members received positive support. They reported having close, trusting relationships with their family confidants.

Some of the women in this study relied more on friend support than the support of a significant other or family members. They relied on close knit ties, church groups, and neighbors. Some equated friends to family members. Many of those whose significant others were unsupportive relied on friends to provide material and emotional support including caring for the baby, talking when needed, praying together, and providing meals. This finding adds to our understanding of how social support may moderate symptoms of depression in postpartum mothers (Surkan et al., 2006). It points to the need to creatively incorporate sister networking in women's care. Furthermore, this finding highlights an area for future research in examining differences between the nature, quality, availability, and impact of friend and familial support networks for African American women with PPD.

Limitations of the Study

Due to time constraints and accessibility, participants were not interviewed face to face, therefore expressions and body language were not able to be observed. Because most of the participants in this study identified as Christian, findings from this study are transferrable to a select group of African American women. Research investigating the experience of African American women with PPD who are Muslim, Jewish, Bahai, atheist, or of other faith backgrounds continue to be urgently needed. Highly educated, middle and upper middle-class women were overrepresented in the study sample; it is likely had the sample been primarily comprised of African American women of lower educational and economic backgrounds the findings would differ. Hence, the transferability of these findings to poor African American women is limited. Similarly, because all participants disclosed current or past heterosexual relationships when sharing their PPD experiences, findings from this study are not transferrable to African American women with PPD in same sex relationships.

Implications and Recommendations

There is an urgent need to provide culturally competent, effective, and caring health services for African American women with PPD. The findings of this study have significant implications for African American women with PPD and provide the basis for future research and practice innovations. The unveiling of controlling ideologies, practices, motherhood, and role expectancies, lack of knowledge and secrecy about PPD symptoms, and the crucial need for support from significant others, family and friends can inform the specialty field of perinatal mental health to expand and improve the care provided to African American women in the postpartum period, especially those with PPD.

Future studies should include African American health communities as controlling images continue to pervade African American women's thoughts about silence, masking, and the strong Black woman. Informative campaigns that include visuals of African American women with PPD testimonials should be advocated for on all media platforms, increasing the awareness of PPD symptoms and, destigmatizing the PPD experiences that African American women encounter. Educational interventions within African American communities are needed to counter patriarchal stereotypes and establish a safe place for learning. Additionally, antiracism activism and training should be included for healthcare providers including mental health providers, to reduce the barriers to disclosure of PPD symptoms.

Ongoing improvement in mitigating perceived racism and the attendant stressfulness of patient-provider encounters in the healthcare setting is essential to improving African American women's mental health. Additionally, it is essential to adequately train obstetric and pediatric healthcare providers in screening and PPD recognition in African American women. The assessment of racism-related experiences would benefit both the healthcare provider and the African American woman. Improved cultural competency for providers will allow for improved care for African American women and raise women's overall confidence in their providers. Healthcare providers who offer counseling and psychotherapy could adapt coping skills to include women's empowerment related to barriers of stereotyped images of African American women that encourage help-seeking when dealing with PPD symptoms.

Given the propensity of African American women to rely on religious or spiritual beliefs as a means of coping, these outlets should be relied on more formally to assist women with PPD help-seeking. Such work should be consistent with the enlarging impact of social justice approaches in this country (Miller & Sendrowitz, 2011). Qualitative studies should also be done to examine the lived experiences of partners to African American women with PPD, as PPD includes the dynamics of the relationship between partners, and provide partners with education on how to deal with and support African American women with PPD. Moreover, descriptive comparison studies of African American women would be beneficial in evaluating friendship support versus family support, including evaluating differences in impact, nature, quality, and availability of supports.

Findings from this critical hermeneutic study reveal that African American women have some unique challenges in their experiences with PPD. Racism still impacts the health of individuals in this country and, specifically, the outcomes of African American women with PPD. The recommendations herein offer critical steps that should be taken to mitigate African American women's experiences with PPD.

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Appendix 1

Participants and Demographics

Participant Pseudonym	Age	Children /Ages	Marital Status	Household Income	Job Description	Location
Rebecca	35	7 m.o. ♂	M	135,000	Health care	PA
Julie	33	2 y.o. ♂, 17 m.o. ♀	M	75,000	Docit specialist	GA
Patricia	22	3 y.o. ♂, 3 m.o. ♀	S	15,000	Fast food chain worker	TN
Olivia	36	15 y.o. ♂, 12 m.o. ♀	M	131,000	Health care	CA
Shelly	33	2 y.o. ♂, 5 m.o. ♂	M	90,000	Office coordinator	GA
Ashley	33	3 y.o. ♂, 18 m.o. ♀	M	190,000	Computer	MD
Shannon	38	11 y.o. ♂ 5 y.o. ♀ 6 m.o. ♂	M	140,000	Health care	GA
Natasha	39	18 m.o. ♀	M	90,000	Business	AL
Karen	29	9 y.o. ♀, 2 m.o. ♀	S	50,000	Homemaker	TN
Sonya	44	17 y.o. ♂, 9 y.o. ♂	M	50,000	Homemaker	TN
Felicia	46	16 y.o. ♀	M	110,000	Health care	GA
Raquel	33	3 y.o. ♂, 6 m.o. ♀	M	60,000	Information Technology	CA
Marla	29	2 older ♂, 6 m.o. ♀	M	75,000	Server	GA

Appendix 2

Study Announcement

ATTENTION POSTPARTUM AFRICAN AMERICAN WOMEN
RESEARCH STUDY ANNOUNCEMENT: PARTICIPATION RECRUITMENT

Purpose of research study:

To understand the lived experiences of African American women with postpartum depression.

Type of study/Participant requirements:

This is a qualitative study, that will require participants to engage in 2 interviews with a focus on the experiences of their lives dealing with postpartum depression. Each interview is expected to last 60-120 minutes. Participate in interviews for 2 or 3 months; the timeframe of study may be up to 3 months. Upon completion of all interviews, participants will receive a $25 gift card as an appreciation for their participation in this study. **The anonymity and confidentiality of participants will be protected throughout the research process and in any future publications of this research.**

Participant criteria:

To meet the required criteria for participation in the study, you need to be a self-reported African American woman, 18 years old or older who speaks English, and delivered a baby in the last 6 months, self-report depressive symptoms and/or score $\geq$ 10 on the EPDS screening tool, and speaks English.

Contact Information:

If you meet the above criteria and are interested in volunteering for this research study, please contact LaShawn Horton, RN, PhD student @ **916-759-7954. Screening for eligibility is a confidential process and anonymity and confidentiality will be maintained.**

Contact Information:
Dena Hassouneh, PhD, RN, ANP, PMHNP, FAAN, Primary Investigator
Oregon Health & Science University
phillide@ohsu.edu
(503) 494-7887

LaShawn Horton, MSN, RN, PhD candidate, Investigator
Oregon Health & Science University
hortonl@ohsu.edu
(916)759-7954 (cell)

Appendix 3

Study Flyer

A RESEARCH STUDY OF AFRICAN AMERICAN WOMEN'S EXPERIENCES WITH POSTPARTUM DEPRESSION

Nurse researchers at Oregon Health & Science University want to better understand African American women's experiences with postpartum depression. This study is for mothers who have/had depression after childbirth **IRB#16420**

WHO CAN PARTICIPATE?

- Women who identify as African American
- Women who report depression symptoms
- Women who have delivered a baby within the last 18 months
- 18 years or older
- English speaking

WHAT DOES THE STUDY INVOLVE?

If you decide to take part in this research study, you would:

- Complete 2 interviews 60-90 minutes
- Answer a 10-item questionnaire

ALL PARTICIPANTS RECEIVE A $25 GIFT CARD and childcare upon request @ time of interview

For more information contact: LaShawn Horton, MSN, RN @ 916-759-7954 email: hortonl@ohsu.edu or Dena Hassouneh, PhD email:

Appendix 4

Facebook Page

Postpartum Depression Research Study

Page Title: Research Study- African American women's experiences with postpartum depression after childbirth

What: A Research Study: The lived experiences of African American women with depression after childbirth
When: Ongoing
Where: The United States
Who: African American women between the ages of 18 and 50 currently living in the United States who have experienced depression after childbirth.
Pinned Post: Oregon Health and Science University (OHSU) and an African American, OHSU, PhD student are seeking to interview African American women between the ages of 18 and 50 currently living in the United States who have experienced depression after childbirth. The purpose of this research study is to learn more about African American women's experiences with depression after childbirth. We are seeking women who would be willing to talk face to face or via telephone for 2 interviews and take a 5-minute depression questionnaire. Interviews will be audio recorded and your identity would be kept CONFIDENTIAL throughout the process. Interviews could last up to 90 minutes. There is no obligation to participate in the study and no obligation to answer any question that you don't wish to answer. You can withdraw from the study at any time. You will be compensated with a $25 gift card after the second interview. This study is being conducted in part for a doctoral dissertation at Oregon Health and Science University and has been

approved by the Institutional Review Board (IRB) as study #00016420.
Contact: Please contact LaShawn Horton @ hortonl@ohsu.edu or (916) 759-7954, if you are interested in learning more about the study and would qualify to participate in the study.

Appendix 5

Information Sheet

OREGON HEALTH & SCIENCE UNIVERSITY

IRB #00016420

TITLE: ***THE LIVED EXPERIENCE OF AFRICAN AMERICAN WOMEN WITH POSTPARTUM DEPRESSION***

PRINCIPAL INVESTIGATOR: Dena Hassouneh, PhD, ANP, PMHNP, FAAN (503) 494-7887

CO-INVESTIGATORS: LaShawn Horton, MSN, RN, PhD candidate. (916) 759-7954

FUNDED BY: Sigma Theta Tau (Rho Iota Chapter) and the OHSU School of Nursing

PURPOSE: You have been invited to be in this research study because you are an African American woman and have reported depression after giving birth. The purpose of this study is to learn more about African American women's experiences with depression after childbirth.

PROCEDURES:
Everyone who joins this study will complete a 10-item self-report depression questionnaire and be interviewed. The questionnaire should take 5-15 minutes to complete. You will be asked to participate in two interviews conducted face to face or by telephone depending on your location. The second interview will be conducted within 2 months of the first interview. Interviews will last approximately 60-90 minutes and be audio recorded for transcription. At the conclusion of the first interview, an appropriate time and/or place for the subsequent interview will be determined. If you agree to be contacted, the investigators may call you after all your interview data has been analyzed to ask clarifying questions.

If you have any questions, concerns, or complaints regarding this study now or in the future, or you think you may have been injured or harmed by the study, contact *LaShawn Horton, MSN, RN, PhD candidate, lhorton@ohsu.edu or cell 916-759-7954*.

RISKS:
Although we have made every effort to protect your identity, there is a minimal risk of loss of confidentiality. Some of the experiences you share may evoke pain, angry, sadness, or feelings of oppression. You may refuse to answer any of the questions that you do not wish to answer. You have the right to pause or stop the interview at any point during the interview process. The investigator will check with you to see how you are doing before restarting or ending the interview. Should you need additional support you will be provided with referrals to mental health providers in your community.

BENEFITS:

You may or may not personally benefit from being in this study. However, by serving as a subject, you may help us learn how to benefit women in the future.

CONFIDENTIALITY:

We will take steps to keep your personal information confidential, but we cannot guarantee total privacy. All identifiers will be removed from the transcribed interviews and your identity will not be revealed in published reports. Your name will not be linked to any data collected. We will provide pseudo names for participants and non-descriptive markers for each transcript.

We will create and collect health information about you as described in the Purpose and Procedures sections of this form. Health information is private and protected under the federal law of Oregon law. By agreeing to be in this study, you are giving permission (also called authorization) for us to use and disclose your health information as described in this form.

The investigators, study staff, and others at Oregon Health and Science University (OHSU) may use the information we collect and create about you in order to conduct and oversee this research study (and conduct future research, store in a repository, as applicable; state if any of these are optional).

We may release this information to others outside of OHSU who are involved in conducting or overseeing research including:

- The funders of this study, Sigma Theta Tau (Rho Iota Chapter) and OHSU School of Nursing, and the funders representatives
- The Office of Human Research Protections, a federal agency that oversees research involving humans
- Journals or other publications that are involved in publishing research

COSTS:

It will not cost you anything to participate in this study. Upon completion of all interviews, you will be paid a $25 gift card as a token of appreciation for your participation*.*

PARTICIPATION:

This research is being overseen by an Institutional Review Board ("IRB"). You may talk to the IRB at (503) 494-7887 or irb@ohsu.edu if:

- Your questions, concerns, or complaints are not being answered by the research team.
- You want to talk to someone besides the research team.
- You have questions about your rights as a research subject.
- You want to get more information or provide input about this research.

You may also submit a report to the OHSU Integrity Hotline online at https://secure.ethicspoint.com/domain/media/en/gui/18915/index.html or by calling toll-free (877) 733-8313 (anonymous and available 24 hours a day, 7 days a week).

You do not have to join this or any research study. If you do join, and later change your mind, you may quit at any time. If you refuse to join or withdraw early from the study, there will be no penalty or loss of any benefits to which you are otherwise entitled.

Contact Information:

Dena Hassouneh, PhD, RN, ANP, PMHNP, FAAN, Primary Investigator
Oregon Health & Science University

phillide@ohsu.edu
(503) 494-7887

LaShawn Horton, MSN, RN, PhD candidate, Investigator
Oregon Health & Science University
hortonl@ohsu.edu
(916)759-7954 (cell)

Appendix 6

Interview Guide

Sample: African American woman

1st Interviews, unstructured

Tell me about your experience before and during your pregnancy. Tell me the story of your pregnancy: I would like to know what your life was like before you became pregnant and what your pregnancy was like for you. You can include significant relationships and the impact of pregnancy on those relationships.

Now, I would like for you to share your experiences while feeling depressive symptoms. You can start with the beginning by sharing how you felt right after you delivered your baby. Have you ever heard the term PPD? When did you first hear the term PPD?

- What did you think about the term?
- How did it make you feel?
- What are some emotions that come to your mind?

2nd Interviews, semi-structured

Interview Guide for interviews 1 & 2:

1. Talk about what it was like for you to experience depression after you delivered your baby.
   - Can you elaborate on this point some more?
   - What feelings, emotions, or moods would you experience daily?
2. Describe a typical day for you during this time of PPD.
   - That is very interesting. Tell me a bit more about this point.
3. Describe the interaction with your family.
   - How would you describe your family dynamic?
   - Can you elaborate on your marital relationship, if you are married?
   - How did you tell your husband and family members?
   - Have they been supportive of you during this time?
   - Who provides you with the support you need?
   - Describe in more depth how this made you feel.
4. What are/were some of the emotions that you feel/felt do you experience?
   - What did those feelings and emotions mean to you?
5. Did you encounter any barriers related to you dealing with PPD?
   - How did these barriers impact you as a woman?
   - Can you elaborate on what that meant to you?
   - Can you describe your interactions with the health care system?
   - Are there any examples that come to your mind?
   - Were there any stereotypes that shaped your thoughts about PPD and African American women
   - Are there any societal or cultural examples that come to your mind?
   - How do you think society perceives PPD? Do you think it is different for different groups of people?

  - What is your perception about PPD in comparison to women of other cultures? Do you believe it was the same or different?

6. What was it like navigating the medical system?
   - Can you give an example of your experience?
   - What was that like for you as an African American woman?
   - What did that do for you?
   - How would you describe your socioeconomic status in relation to your navigation of the health care system?
7. What was it like for your family members?
   - Elaborate on that point some more for me.
8. Based on research, African American women are fearful and secretive when it comes to reporting PPD symptoms. Was there anything specific that helped change your mind about talking about it?

Appendix 7

List of resources for women with PPD

1. University of Tennessee Behavioral Health
   Jucinta Rome, LCSW (423) 778-2965

2. Sound Living Counseling Center
   April Taylor, LPC (423) 505-5474

3. Healing Waters Counseling Center
   Nancy Rose JD, LCSW (423) 698-5090

4. Crisis Response Team (If participant wants someone to come to their home) (888) 242-1340

5. Valley Respond (if participant wants to come to a facility for treatment) this number can be called (423) 499-2300