*Psychology of Women Quarterly*, **33** (2009), 351–362. Wiley Periodicals, Inc. Printed in the USA.


# "AND YOU'RE TELLING ME NOT TO STRESS?" A GROUNDED THEORY STUDY OF POSTPARTUM DEPRESSION SYMPTOMS AMONG LOW-INCOME MOTHERS

Laura S. Abrams
*UCLA School of Public Affairs*

Laura Curran
*Rutgers University*

Low-income mothers in the U.S. are more likely to experience postpartum depression (PPD) and less likely to seek treatment than their middle-class counterparts. Despite this knowledge, prior research has not provided an in-depth understanding of PPD symptoms as they are experienced by low-income mothers. Through in-depth interviews, this study investigated low-income mothers' ($n = 19$) experiences and explanatory frameworks for their PPD symptoms. Grounded theory analysis uncovered five main categories that linked the participants' PPD symptoms to their lived experiences of mothering in poverty, including: (1) ambivalence, (2) caregiving overload, (3) juggling, (4) mothering alone, and (5) real-life worry. The analysis further located the core experience of PPD for low-income mothers as "feeling overwhelmed" due to mothering in materially and socially stressful conditions. These findings challenge the prevailing biomedical discourse surrounding PPD and situate mothers' symptoms in the context of the material hardships associated with living in poverty.

Researchers have estimated that postpartum depression (PPD) affects 13–16% of new mothers in the United States (Robertson, Grace, Wallington, & Stewart, 2004). This figure is, in all likelihood, quite conservative, because studies have shown that as many as 50% of PPD cases are undiagnosed (Chaudron et al., 2005; Murray, Woolgar, Murray, & Cooper, 2003; O'Hara & Swain, 1996). Despite substantial debate as to whether PPD constitutes a distinct type of depression, the American Psychiatric Association (2000) has categorized PPD as a specific type of Major Depressive Disorder (Boyd, Le, & Somberg, 2005; Riecher-Rossler & Hofecker Fallahpour, 2003; Whiffen, 1991).

Recent medical explanations for postpartum depression (PPD) have generally framed the phenomenon as a psychiatric disorder with hormonal and/or neuro-chemical underpinnings (Chrisler & Johnston-Robledo, 2002; Dalton & Holton, 2001; Epperson, 1999), and the mass media tends to frame PPD as a middle-class problem that can happen to "anyone" (Martinez, Johnston-Robledo, Ulsh, & Chrisler, 2000). Prior histories of depression, and particularly depression during pregnancy, constitute the most well-established risk factors for PPD (Le, Muñoz, Soto, Delucchi, & Ippen, 2004; Martinez-Schallmoser, Telleen, & MacMullen, 2003; Roberston et al., 2004; Rich-Edwards et al., 2006). Furthermore, epidemiological research has found that prevalence rates for PPD are higher among low-income women than middle- or upper-income women (O'Hara & Swain, 1996; Rich-Edwards et al., 2006). Research has also identified associations between low-income status and other risk factors for PPD, such as young maternal age, single parent status, and low levels of social support (Rich-Edwards et al., 2006). The prevailing biomedical and popular explanations of PPD do not explain why low-income mothers are at higher risk for the disorder or how the social environment factors into the etiology of PPD.

In addition to being at higher risk for PPD, research has found that low-income postpartum mothers are less likely than their middle-class counterparts to seek or receive mental health treatment (O'Hara & Swain, 1996; Song, Sands, & Wong, 2004). Consequently, the well documented negative consequences of untreated PPD, such as cognitive, emotional, and social developmental risks for children (Beck, 1995; Murray, Fiori-Cowley, Hooper, & Cooper, 1996), child abuse and neglect (Buist, 1998), and ongoing maternal depression, marital stress, divorce, and postpartum physical health problems (Brown & Lumley,

Laura S. Abrams, Department of Social Welfare, UCLA School of Public Affairs; Laura Curran, School of Social Work, Rutgers University.

Address correspondence and reprint requests to: Laura S. Abrams, Department of Social Welfare, UCLA School of Public Affairs, 3250 Public Affairs Building, Box 951656, Los Angeles, CA, 90095-1656. E-mail: Abrams@spa.ucla.edu

2000; O'Hara, 1994) disproportionately take their toll on low-income families. Despite knowledge that low-income mothers and their families face greater risks of suffering the negative consequences of untreated PPD, research previously conducted in the United States has not provided an adequate understanding of how these mothers subjectively experience, understand, or explain their PPD symptoms. This significant knowledge gap impedes the formulation of effective prevention and intervention strategies for this population (Abrams & Curran, 2007).

### *The Experience of PPD Symptoms*

Qualitative research has amassed rich descriptions of mothers' experiences of their PPD symptoms. Studies conducted primarily among White and middle-class samples in the United States, Canada, and Western Europe have found that common PPD symptoms such as sadness, anxiety, obsessive thinking, isolation, and the contemplation of self-harm are compounded by cycles of guilt and shame associated with mothers' perceptions of failing to meet the idealized expectations of blissful and self-sacrificing new motherhood (Beck, 1993; Mauthner, 1999; Nicholson, 1999). The grounded theory research of nursing researcher Dr. Cheryl Beck (1993) identified the core social psychological process of PPD as a "loss of control" over "emotions, thought processes, and actions" (p. 44). Feminist and other qualitative explorations of PPD have also posited a central construct of "pervasive loss of self," in which mothers tend to lose their core pre-partum identities, including their occupational, sexual, and autonomous selves, when they transition to a maternal identity (Mauthner, 1999; Nicholson, 1999; Edhborg, Friberg, Lundh, & Widstrom, 2005).

In the most comprehensive summary of qualitative research on mothers' experiences of PPD, Beck's (2002) "meta-synthesis" of 18 studies conducted both in the United States and internationally during the 1990s located the following cross-cutting PPD processes: (a) "incongruity between expectations and the reality of motherhood;" (b) "spiraling downward," a progression of distressing and debilitating emotions; (c) "pervasive loss," including loss of control over emotions and behaviors, autonomy, time, relationships and sense of self; and (d) "making gains," or women's process of acceptance and recovery (p. 453). In synthesizing and extracting these themes across multiple studies, Beck framed these symptoms as part of a basic social psychological process. The composition of the study samples were, with just three exceptions, White and middle class, and Beck did not offer an explicit socioeconomic or cultural analysis.

More recently, Beck (2007) modified her earlier grounded theory of PPD when she examined 10 studies conducted with minority populations internationally, including 1 in the United States. Integrating this cross-national data, she suggested that the basic social psychological process of PPD, "teetering on the edge," reflects a core experience of loss of control over emotions in four stages, including "encountering terror," "dying of self," "struggling to survive," and "regaining control." Beck (2007) argued that this modified theory captures cross-cultural experiences of PPD because the more recent studies were conducted worldwide and with various ethnic, racial, and cultural groups.

International qualitative studies on PPD have also offered multiple examples of how ethnically influenced cultural norms, particularly around mothering and gender roles, influence women's experiences and interpretations of their PPD symptoms (see Dennis & Chung-Lee, 2006, for a review). Less research has investigated cultural variations in PPD symptoms among mothers in the United States, although one study found that middle-class African American mothers' values of "strong womanhood" influenced their experience of their symptoms and their willingness to seek help (Amankwaa, 2003). Overall, qualitative work has looked at the influence of ethnic and cultural norms on mothers' experience of PPD symptoms, but has not explicitly considered the significance of material hardship or poverty.

### *Attribution of PPD Symptoms*

Empirical studies have provided relatively little insight into women's explanatory frameworks for symptoms of PPD. Kleinman's (1980) explanatory model suggests that individuals attach personal and social meanings to their illness that allow them to fit the illness and their symptoms into their prevailing belief systems. Using this framework, research conducted on depression as an illness in the United States and the United Kingdom has found that members of ethnic minority groups are more inclined than Whites to attribute depression to situational causes and to reject biomedical explanations of their symptoms (Jacob, Bhurga, Llyod, & Mann, 1998; Karasz, 2005; Ying, 1990). Researchers have used this situational attribution to partially explain lower rates of medical or formal mental health service use among ethnic minority groups compared to Whites. Although this body of research on attribution has included low-income populations, the analyses tended to center on the salience of ethnic culture, with less attention given to socioeconomic status.

Explanatory models focusing specifically on PPD are relatively limited, particularly in the United States. One study of 30 nonhospitalized mothers in Florida (predominantly White and middle class) found that mothers' explanatory frameworks were only partially hormonal or biochemical and they tended to endorse explanatory frameworks related to role changes, maternal and child health, sleep deprivation, and other nonphysiological circumstances (Ugarriza, 2002). In addition, a small body of international research has suggested that mothers who are members of ethnic minorities and lower-income social groups tended to reject a medical explanation of PPD,

instead grounding their understanding of symptoms in more contextual factors, such as stress (Edge & Rodgers, 2005) or economic hardship (Rodrigues, Patel, Jaswal, & de Souza, 2003). Pointing largely to material and circumstantial stressors, in addition to cultural variations, these international studies thus establish a basis to investigate the relevance of the social and material circumstances of poverty in shaping mothers' explanatory frameworks for their PPD symptoms.

In sum, the extant qualitative literature on PPD symptoms in the United States has been primarily limited to White and middle-class samples. To fill this research gap, we sought to examine low-income mothers' experiences and understandings of their PPD symptoms. In doing so, this study aimed to contribute to an overall grounded theory of PPD and to provide insight into low-income mothers' explanatory frameworks for their symptoms.

## METHOD

### *Design and Epistemology*

The guiding methodological approach of this study was grounded theory, a naturalistic fieldwork strategy that seeks to build theory inductively based on the careful study of lived experiences (Glaser & Strauss, 1967; Strauss & Corbin, 1998). Grounded theory has evolved significantly from its original form, which was largely built on an objectivist perspective. Recent developments, particularly the work of Kathy Charmaz (2006), have sought to reposition the methods of grounded theory in line with a constructivist epistemology, in which data are understood as constructions of experience, and the researcher actively interprets their meaning. Although debate continues about grounded theory's evolution and its epistemological and ontological underpinnings (Ponterotto, 2005), a constructionist stance guided this study because we examined how mothers understand and construct their experience of PPD in relation to their lived experiences.

Another epistemological consideration concerns extant knowledge. The original architects of grounded theory argued that theory should be generated purely through observational data (Glaser & Strauss, 1967). However, subsequent developments in the field suggest that new insights can be generated by elaborating and expanding existing theories and building on preconceived "sensitizing concepts" (Charmaz, 2006; Strauss, 1995; Strauss & Corbin, 1998). We used this latter approach in our study because we entered the field with ideas from the literature, particularly Beck's (1993) grounded theory work, and then compared our findings with prior theories of mothers' lived experiences and understandings of PPD symptoms.

### *Recruitment and Sampling*

A sample of 19 low-income mothers was recruited from Women, Infant, and Children (WIC) federal nutrition program sites located in the urban areas of Los Angeles, California and Newark, New Jersey. We used the same sampling and data collection techniques in the two cities. We purposively selected WIC as an ideal setting to locate mothers in the postpartum period who were already screened for low-income status. Recruitment tools included graphically designed cards and fliers placed in WIC offices and brief presentations about the study during WIC postpartum education groups. Mothers who indicated an interest in the study were screened either in person or by telephone according to several eligibility criteria, including: (a) having an infant under 12 months of age at the time of study enrollment, based on the temporal criteria for PPD versus other forms of depression[1]; (b) maternal age of 18 or over[2]; (c) being a current WIC recipient, meaning that household income was at or below 185% of the federal poverty level; (d) fluent in English or Spanish, reflecting the demographics of a large number of Hispanics residing in or near the recruitment areas as well as the language capacity of research staff; and (e) self-report of PPD symptoms occurring since the birth of the infant.

Two of our eligibility criteria merit further discussion. Our first criteria, having an infant under 12 months of age, reflects a larger debate about the temporal boundaries for PPD that delimit PPD's onset and termination (Boyd, Pearson, & Blehar, 2002). Researchers have used varying postpartum time criteria for defining PPD, with onsets often up to 6 months and even a year after delivery (Stowe, Hostetter, & Newport, 2005). Although by no means diagnostic, the self-report of depressive symptoms since the birth of the baby (and up to 1 year postpartum) provided some assurance that the depressive symptoms corresponded with the postpartum period.

The final study eligibility criteria listed above (self-reported PPD symptoms) also warrants methodological and epistemological clarification. Methodologically, we chose to include both retrospective and current perspectives on the experience of PPD symptoms occurring within the parameter of the postpartum experience, or up to 1 year after the birth of the baby. Because there is no existing validated screen specifically suited to measure PPD symptoms occurring over the past several months or up to 1 year, the researchers loosely adapted key concepts from the Edinburgh Postnatal Depression Scale (EPDS: Cox, Holden, & Sagovsky, 1987), a widely used instrument in both research and clinical practice that measures PPD symptoms occurring over the last 2 weeks. Our adapted scale required mothers to self-report overall postpartum experiences with at least three of the major EPDS symptoms, such as feeling sad and hopeless, blaming the self unnecessarily, sleeplessness, and others. Although this adaption lacks empirical validation, the use of these criteria fit within the constructivist epistemology guiding this study, allowing mothers to define their own experience of "having PPD symptoms" while still establishing inclusion criteria to meet the study aims.

In all, 19 women were included in the study, 11 from Los Angeles and 8 from Newark. Respondents were ethnically diverse, including 10 African-American women, 5 Latina women (of varying cultural and nationality backgrounds), 2 Caribbean women, 1 African woman, and 1 woman who described herself as "multiracial." Twelve of the women were born in the United States and seven were immigrants. The average age of the mothers was 27 (range of 18 to 39). The mean age of the babies at the time of the interview was 5.5 months (range of 1.5–14 months), and the average number of children per mother was 2.4 children (range of 1 to 5). We discontinued recruitment when we reached a point of saturation—the point at which continued data collection did not yield substantive new insights or concepts (Charmaz, 2006).

### *Data Collection*

Data collection consisted of one-time, open-ended, qualitative interviews and a brief demographic questionnaire. The interviews were conducted either in mothers' homes or at WIC program sites. We, both former practicing social workers and now academic qualitative researchers, conducted all of the interviews ourselves, with the exception of one interview conducted in Spanish by a social work graduate student in Los Angeles in the presence of one of the authors. The interview schedule was loosely structured with a set of eight core questions asked in all of the interviews[3], along with several prompts attached to each question. The interview schedule was developed based on the study aims, reviews of existing literature, and feedback from several experts in the PPD field. The questions were geared to yield in-depth information about the experience of PPD symptoms that was grounded in mothers' day-to-day experiences. For example, one question asked mothers to describe what a down day was like for them, and then the interviewer guided them through a description of a "down day" from morning until bedtime. Additional questions gathered in-depth information about relationships with partners and significant others, understandings of PPD and mental illness, experiences of mothering, and help seeking. The interviews lasted between 45 and 120 minutes and were digitally recorded.

Mothers who participated in the interviews were compensated with a $25 (Newark) and $35 (Los Angeles) gift card for their time. This was the sole difference in data collection protocol between the two locations and was based solely on funding differentials. We found no evidence to indicate that the pay discrepancy led to any marked differences in recruitment or participation between the two sites.

### *Reflexivity*

As the primary interviewers and investigators, we spent significant time reflecting on our own positions in the research experience. We must first acknowledge that at the time the interviews were conducted, we were both relatively new mothers of two small children less than 4 years old. As such, we had empathy for these women and the challenges they faced as mothers. At the same time, we were keenly aware of the vast social differences between ourselves and the participants, both in terms of considerably greater material privilege and in regard to ethnicity/race, because both the authors are White. Moreover, as trained social workers, we felt compelled at times to help the mothers and grappled with curbing our own impulses to offer further assistance with their parenting and other difficulties that would take us beyond our research role. To protect against biases, we wrote memos that logged our feelings and responses after each interview. We also spent a considerable amount of time debriefing with each other after hearing these often very painful and emotionally provocative stories.

### *Protection of Human Subjects*

This study was approved by the Institutional Review Board for Human Subjects Protection at the participating academic institutions and the New Jersey State Department of Health and Senior Services, as well as by the WIC offices in both states. All participation was subject to standard informed consent protocols, including the identification of the researchers as mandated reporters. In two cases, we conducted brief suicide assessments, but there was no evidence of imminent risk of self-harm and thus no further reporting was indicated. The mothers did not share any information that indicated reportable child abuse or neglect. To minimize the potential risks associated with potentially difficult feelings associated with their participation, the researchers provided mothers with lists of local mental health resources and answered any questions about PPD and treatment at the conclusion of or during the interviews.

### *Data Analysis*

Data analysis followed the constant comparative method associated with grounded theory, consisting of ongoing comparisons of categories from one case to the next until theoretical saturation is achieved. Moving back and forth between data collection and analysis, we developed memos to record hunches, describe emergent categories and theoretical constructs, and address data collection issues (Strauss & Corbin, 1998). The interviews were first professionally transcribed verbatim and imported into Atlas ti (a qualitative software program) to assist with data management and retrieval. The one Spanish language interview (including interview protocol) was translated into English by our Spanish-speaking research assistant, and the English version of the transcript was coded and analyzed by us.

We first read all of the transcripts and conducted open coding, which refers to the development and application of codes that closely reflected the interviews (Charmaz, 2006). We then reviewed the open coding to create preliminary

clusters of similar and related codes, or focused codes, that we considered as broad emerging categories. We used these broader categories to construct data matrices that displayed each mothers' words, quotes, or codes around the category of interest. Next, looking within and across cases and categories, we extracted several overriding data patterns and themes, or axial codes, pertaining to the lived experience of PPD symptoms and the attributions of these symptoms. We then compared these axial codes and their properties with the initial codes and mothers' quotes to ensure that our abstracted group of categories captured the range of experiences contained in these rich data. At each stage of the analysis, we achieved higher levels of abstraction that continued to fit the observed data (Charmaz, 2006). The findings reported in the results section follow the general structure of how we organized the categories into an overall understanding of the phenomenon of interest.

### *Rigor and Trustworthiness*

In constructivist grounded theory, there are no rigid guidelines concerning the types of checks and balances on interpretation that should be integrated into any given analysis (Charmaz, 2006). In our study, we chose to use some established techniques to weigh our interpretations of the mothers' stories against other plausible explanations (Morrow, 2005). First, by having two primary researchers involved, we were able to increase the credibility and confirmability of our interpretations by building consensus with one another. For example, we frequently coded the same transcript simultaneously, and codes or passages that were subject to disagreement were revised until consensus was reached. Furthermore, although the interviews were conducted independently, we debriefed after each interview to discuss emergent themes, impressions of bias, and feelings (as mentioned above). We also implemented audit trails consisting of both code and theory memos, whereby our coding decision and levels of abstraction from these codes were explained in detail at each step of the process. As a final check, we considered elements of the data that did not support or appeared to contradict emerging patterns and explanations and used this technique to challenge and refine the developing grounded theory.

## RESULTS

Mothers in our sample described a variety of symptoms commonly associated with PPD, including feeling angry, irritable, stressed, tired, sad, and lonely. A few of the mothers described more extreme phenomena such as suicidal ideation, intrusive thoughts, or uncontrollable crying. To a large extent, these symptoms echoed prior qualitative research with White and middle-class samples (Beck, 2002). However, upon deeper analysis, we found that mothers' experiences and understandings of their depressive symptoms were largely situational, in that nearly all symptoms were described as stemming from the material and social circumstances associated with living in poverty. The five main grounded theory categories emerging from this analysis included: (1) ambivalence, (2) caregiving overload, (3) mothering alone, (4) juggling, and (5) real-life worry. Together, these categories formed a core experience of PPD symptoms as feeling overwhelmed by mothering under materially and socially stressful conditions. Table 1 displays the five core categories and their properties are presented below.

**Table 1**
Grounded Theory Analysis of Postpartum Depression (PPD) Symptoms

*Core experience of PPD symptoms: Mothering is overwhelming in the context of the material hardships associated with poverty.*

| *Category* | *Properties* |
|---|---|
| Ambivalence | "I wasn't prepared for this baby," "I didn't want any more children." |
| Caregiving overload | "Please stop crying." "I need a break," "I can't do this anymore." |
| Juggling | "No time to breathe," "Everyone depends on me," "Navigating the maze." |
| Mothering alone | "I really don't have any help," "My baby has no father." |
| Real-life worry | "I don't have money," "Will my baby be OK?," "It's not safe here." |

### *Ambivalence*

Several mothers located the origins of their postpartum depressive symptoms in the prenatal period, and more specifically, in their feelings of ambivalence about their pregnancies. For these mothers, their postpartum feelings of sadness, anxiety, and anger were experienced as a logical consequence of their initial ambivalence about adding a baby to their lives. This category of ambivalence had two properties: "I wasn't prepared for this baby" and "I didn't want another child."

*"I wasn't prepared for this baby."* It was common among this sample for pregnancies to be unplanned or unwanted and, consequently, for mothers to feel ill prepared for these new demands. The associated ambivalence was intimately connected with their material and other life circumstances, such as being single, young, and/or poor. Young women like Jenae,[4] a first-time African American mother who was 17 when she gave birth, worried about how she was "gonna do it," given that she hadn't finished high school and was unable to support herself financially. Imani, another first-time young mother, described how news of her pregnancy was "kinda heart breaking and how hard it would be for [her] to actually have to go through the whole process."

*"I didn't want any more children."* With similar ambivalence but dissimilar circumstances, some of the older mothers with multiple children worried about managing an additional child while struggling with being poor. Marta, an El Salvadorian mother of five children who lived in a small, two-bedroom apartment, attributed her pre- and postnatal depression to the fact that "I didn't want any more children." Similarly Bindu, an African immigrant and 34-year-old mother of three, reported that she did not want an additional child, but agreed to another pregnancy to appease her husband. Describing herself as "depressed and overwhelmed," she stated,

> I think one of my thing is a pregnancy is always good when you want to have it. When it's what you want and you'll do anything and everything that's possible to make it work. But if you're not deep down wanting it, you know, then it's like then every little thing bothers you. It's just me. Everything little thing just bothers me . . .

For many mothers in this sample, ambivalence about their pregnancies continued to play into their understandings of the causal origins of their PPD symptoms.

### *Caregiving Overload*

Mothers in our sample offered detailed descriptions of PPD symptoms such as anger, irritability, uncontrollable crying, and feelings of being out of control that they often attributed to the relentless and tiresome demands of providing care for their infants and small children. This category of caregiving overload encompassed a progression of experiences from feelings of being overtaxed on a day to day basis to mothers who questioned their ability and desire to parent in their current circumstances.

*"Please stop crying."* With very clear examples, mothers located their PPD symptoms in the context of their day to day and moment to moment interactions with their children. Claudia, a 21-year-old Latina mother of three children who were all reportedly unplanned and unwanted, offered a detailed narrative of what it is like to care for them:

> While I'm trying to be quiet for the other two, somehow the 4-year-old will wake up the other ones. Like he'll start crying, like, "Camry, Camry, Camry!" I'm like, "Please stop calling your brother." Then he'll start crying, like, "Mom, cup, cup, cup!" Like that means he wants juice. I'm like, "Okay, hold on a sec. I'm gonna get you a cup. One sec." And then when I turn around, bam, the refrigerator's already open and the 1-year-old is already pouring out juice, and he'll throw it all on the floor . . . . It's just me. It's like, oh, my god. Okay, hold on. So I'll just like a minute to myself, and I'm like, "Please stop crying!"

The interview data had many similar examples of mothers grounding their experience of postpartum emotions and sometimes extreme mood swings within the larger context of their overwhelming caregiving responsibilities.

*"I need a break."* As in Claudia's case, mothers' desire for a respite from the seemingly relentless demands of parenting was a prominent component in their accounts of feeling depressed. Within this dimension of their experience, our analysis located a mutually dependent relationship between children's needs and mothers' own emotional well-being. Referring to her responsibility to care for an infant with health issues, Shareese, an African American mother of four children, described her experience:

> Shareese: She [infant] was hospitalized, and they didn't know what was wrong with her, so that was like really aggravating, and then the other kids and having them go to the doctor and schools with them, and it's—well, it's because I be with my kids every day all day.
>
> Interviewer: Right, okay.
>
> Shareese: So, it be like sometimes it affects me like—like I need a break or something.

Here, Shareese's desire for "a break or something" is situationally specific, because she locates it within the context of caring for an ill child and older siblings, with little childcare support or opportunity for a reprieve.

*"I can't do it anymore."* Feelings of irritability and extreme stress were highly characteristic of these mothers' lived experiences of PPD symptoms, and in just a few cases, caused them to question their ability and their desire to be a mother. LaKeysha, an African American mother of four, described her cognitive and emotional processes when she felt overwhelmed by parenting demands:

> . . . you have to wake up, do the feedings, change the diapers, wash the clothes. You know, cook, and it becomes a lot. I think sometimes I'm actually doing so much, and sometimes I couldn't explain how I manage to get through it all . . . . But I do have moments where after everything is done, I just go and I sit, and I think about it. "Why? Why is it so hard? Can I really still do this?" 'Cause it's four of them now, "can you really still do this?" I think on the hardest day, sometimes I almost say, "just give em up, it's the right thing, somebody needs to take them from me." 'Cause I can't do it anymore. . . .

Although only a few mothers questioned their ability or desire to parent, these examples were still significant for building a grounded theory of low-income mothers' PPD along a continuum of experiences.

### *Juggling*

In addition to experiencing caregiving overload, mothers' understandings of PPD symptoms were also shaped by their attempts to navigate and fulfill the variety of other responsibilities in their lives. In this sense, mothers described the presence of anxiety, irritability, and fatigue in the context of juggling multiple responsibilities while still trying to care for their infants and other children.

*"No time to breathe."* In ways similar to studies of middle-class working mothers (Hochschild, 2003), mothers in this sample consistently spoke about the stress they encountered in trying to balance and manage responsibilities of employment, education, vocational training, and housework in addition to childcare. Kendra, a 25-year-old African American mother of two who was trying to obtain her paralegal degree, described how she managed her demanding schedule:

> I only work [at a chain restaurant] on the weekends, but I have like school Monday through Thursday or Monday through Friday. So, I'll get done with my homework maybe 2 o'clock in the morning, and then take my shower and then go to bed like maybe 3:30–4:00—you know, just actually going to sleep, getting to sleep and then wake up with my kids up in the morning.

Grounded in the realities of low-wage labor markets and mandatory participation in welfare-to-work programs, the arduous balance of work and home responsibilities played into mothers' causal frames for their depression. Whether alone or with a spouse, mothers described being extremely burdened by numerous work and childcare demands that led to constraints on sleep, self-care, or "time for me."

*"Everybody depends on me."* Although low-income mothers' juggling acts were in some ways similar to those middle-class women have described (Hochschild, 2003), mothers in our sample often faced additional demands more unique to their materially deprived social contexts. For example, in addition to caring for their own children, mothers also found themselves engaged in caretaking for other members of their extended families, even including homeless relatives. After the birth of her child, Tiffany resided with her father and her stepmother, who had a substance abuse problem. After leaving her father's home, the state's child protective services requested that Tiffany return to supervise the care of her half-brother, who was just a few weeks older than her own child. In the following quote, Tiffany located the source of her depression and anxiety in having to juggle these multiple responsibilities:

> I was feeling depressed because I didn't have nothin' else to do but sit around and think about everything that was going on. And plus, everybody depended on me. . . . Everybody was bringing their issues to me—my brother, sisters and my dad. . . . And I was responsible for my son, my little brother, and sister, who's five—I made sure she had to get to school every day. And then my sister whose 18—she's not responsible—I had to make sure she got up to go to school. . . . You know, it's like too many responsibilities for me.

*"Navigating the maze."* Juggling for these low-income mothers also included navigating the maze of bureaucratic social service and welfare systems that are largely associated with the social circumstances of poverty. Destiny, an African-American mother of two, described her interactions with various public welfare systems:

> Well, just recently my apartment was broken into and the fact that his Medicaid for some reason was cancelled so a lot of things was happening within the last 2 weeks all at one time. So that in itself I don't want to say almost drove me mad but it put me in a funk . . . . Like I really was depressed.

Like Destiny, who clearly linked her depression to her attempts to manage multiple stressors, mothers described how their attempts to navigate welfare, health, and insurance systems undermined their emotional well-being and contributed to their ongoing symptoms of frustration, anger, and irritability in the postpartum period.

### *Mothering Alone*

Mothers in our sample typically described a deep sense of loneliness and emotional isolation intermingled with intense sadness, and they often grounded these feelings in lived experiences of literally performing multiple duties of parenting by themselves, or "mothering alone." For example, mothers lacked social support networks, especially immigrant women who were separated from their extended families. Others had experienced recent losses of close family members that contributed to this sense of isolation. Most consistently, mothers related their sense of being alone to the fact that the fathers were absent, only marginally present, or uninvolved in the daily tasks of child care.

*"I really don't have any help."* Mothers described their experience of emotional and social isolation in mothering as connected to their perceived lack of assistance with childcare and parenting demands. In particular, mothers focused on the lack of childcare support they received from their children's fathers. Claudia expressed resentment while discussing how her child's father would rarely help out: "Well, he's like, 'I don't know what to do with the baby.'" Although LaKeysha lived with her baby's father, she noted, "there's some times when I feel like, I'm still doing the bulk of the work so I still feel like a single mom even though he is here." Exhibiting the intersection of women's emotional and material lives, mothers related the lack of material assistance with child care to their depressive symptoms. When

asked to describe "what a down day is like for you," Mary said:

> A down day for me, probably, probably like in these last few days. It's been harder because umm, his dad has been working a lot, a lot of overtime, so I don't even get his help or when I need him get the baby, or his bottle, or all that.

As Mary clearly articulated, the absence of child care assistance constituted a major dimension of mothers' explanatory frameworks for their depressive symptoms.

*"My baby has no father."* Significantly, in families where the baby's father was either entirely absent or only marginally present, mothers directly attributed their depression to the circumstance that their child would be raised without a father. In describing the onset of her depressive symptoms at 3 months postpartum, Jenae spoke about her realization that her son's father was not a stable figure in her child's life:

> The sadness came around knowing that the father can just come in and out when he wants to . . . it wasn't nothing about being in a relationship 'cause he has his significant other, I got mines, you know . . . it's sad 'cause everyone wants a father like in their life you know and he's a boy so he should have a father.

Jenae further connected her sadness to her own upbringing by a single mother who passed away during her childhood. In this sense, she not only located her PPD symptoms within her current realities, but also connected to her own life history.

The category of "mothering alone" thus captured the connections between the circumstances of these women's lives in either the realities of parenting as single mothers, or, in the case of having a spouse or partner, still feeling emotionally isolated and unsupported. Here, women's lived experiences of social isolation in their parenting paralleled and fed the emotional isolation they experienced as symptoms of depression.

### *Real-Life Worry*

Although "unfounded" or "excessive worry" is a dimension of PPD found in diagnostic screening tools such as the widely used EPDS (Cox et al., 1987), in this sample, mothers by and large grounded their anxiety symptoms in the realities of their circumstances, such as significant economic problems and realistic concerns about child health and safety. As such, "real-life worry" is another category linking mothers' PPD symptoms to their larger social and material contexts.

*"I don't have money."* Mothers' worries were primarily related to their financial stress and material hardships of welfare, unemployment, and absent or marginally employed fathers. Sheryl related her PPD symptoms to her ongoing financial problems. She described her response to her physician who told her "not to stress" and to take antidepressant medication, stating, ". . . they tell me not to stress when I have rent due and electricity, DWP (Department of Water and Power) and a car note and insurance and a baby behind me and you're telling me not to stress?"

On the basis of very real and pressing economic concerns, some mothers even more directly attributed their depression to their poverty and material deprivation. When asked what caused her depression, Kimberly, an African American first-time mother, replied:

> I guess it depends on the level of depression you have 'cause with me, my depression is, I think, totally different. That's me from not working, from not havin' a car, not havin'—you know, money just to go out and have a good time, go out to eat, shop . . . . You know, and *I'm poor* (emphasis added).

Kimberly's strong statement explicitly explained PPD as a consequence of mothering in poverty: often alone and without the financial resources to provide a safety net. Here, these mothers' explanatory frameworks for PPD directly implicated their worries about financially supporting themselves and their children.

*"Is my baby OK?"* Another dimension of mothers' real-life worries related to their children's health and well-being. These worries were not unfounded or abstract; rather, they were grounded in the significant and specific issues faced by these mothers and their children. Several women in the sample had children with health and developmental issues, including some whose children were born prematurely, a phenomenon that is disproportionately prevalent among low-income mothers (Kramer, 2003). LaKeysha, herself HIV positive, described her anxiety about her premature infant, who remained hospitalized in the Neonatal Intensive Care Unit: "It was hard going every day and having to leave her, it was the anxiousness and the anxiety; when can I take her home, when can I take her home?" Allergies, breastfeeding problems, asthma, and other health problems similarly troubled these mothers and provided them with concrete and tangible explanations for why they felt depressed.

*"It's not safe here."* In addition to health concerns, mothers worried about the safety of their children in what they described as dangerous living environments. Women also expressed concern about the safety of their children in low quality day care. Others, like Jenae, the young single mother living in a crowded apartment with her sisters, described her fears about raising her son in the inner-city, gang-laden environment of South Los Angeles:

> So it's like when you live in these types of areas you have to worry about a lot of stuff 'cause its got gangs

> and all that type of stuff. . . . A boy, wear the wrong colors, he could get shot walking down the street so its like you don't really want to grow your kids around here, but if you have no choice, you know being a low-income family, its not like a lot of choices where to move.

The social context of resource deprived and unsafe neighborhoods provided a real source of worry for these mothers, a problem that they interpreted as a cause of their depressive symptoms.

### *Core Experience of PPD Symptoms: Mothering Is Overwhelming*

Abstracting from these five main categories, we found that "mothering is overwhelming" is the core experience of PPD symptoms for low-income women. The demands of parenting small children, along with mothers' ambivalence, isolation, juggling, and real-life worries, converged to produce an understanding of PPD as feeling overwhelmed by both the material and emotional demands of mothering in the context of the hardships associated with living in poverty. As our presentation of the results suggests, the PPD symptoms that mothers described did not "stand alone" as arbitrary or abstract feelings. Rather, mothers attributed their PPD symptoms to their day-to-day realities of mothering under materially difficult and stressful conditions. These circumstances, and mothers' subjective experiences, together produced a core experience for low-income women with PPD symptoms of feeling overwhelmed, and literally being overwhelmed, by the multiple responsibilities that they were managing largely alone.

## DISCUSSION

Mothers in this study described a variety of symptoms commonly known to be related to PPD, including feeling anger, irritability, tiredness, sadness, loneliness, and for a few, suicidal and/or irrational thoughts. To a large extent, the symptoms described by these low-income mothers echoed prior qualitative and grounded theory research with White and middle-class samples. Yet, in contrast to extant qualitative work that located the primary psychosocial experience of PPD as an internal "loss of control" over emotions (Beck, 2002; 2007), our analysis found that the mothers' core experience of their symptoms was one of "feeling overwhelmed." Mothers did not interpret this experience of "feeling overwhelmed" as an internal psychological state that was divorced or alien from its larger context. Rather, these feelings of being overwhelmed were deeply grounded in the daily context of the strains of financial hardships, reliance on public benefits, a marginal relationship to the labor market, lack of social and child care support, the demands of parenting multiple children and ill children, dangerous inner city environments, and often tenuous or completely nonexistent relationships with the children's fathers. Given the low-income status of our sample, it was not surprising that our findings would diverge to some extent from prior U.S.-based qualitative research on the lived experiences of PPD.

Prior research has suggested that the gap between the expectations and realities of motherhood underscores women's experiences of PPD. This concept is related to feminist research and theory that posits the "loss of self," meaning the loss of autonomy, body image, sexuality, time, career opportunity, and independent identity, as a central component of women's experience of PPD symptoms (Edborgh et al., 2005; Nicholson, 1999, Mauthner, 1999). Although mothers in our study felt overwhelmed by the emotional and material demands of mothering, neither the gap between expectation and realities nor the loss of an independent identity emerged as central experiences. This divergence from prior research may be attributed in part to the predominance of mothers of multiple children in our sample (13 out of 19) who had already experienced their initial role transition to motherhood. Perhaps more salient, the low-income women in our sample may not have shared the experience of an autonomous self as described by middle-class women in other studies, given their circumscribed material circumstances and limited opportunities for independence even before the birth of their infants.

Our findings clearly speak to the relationship between low-income status and PPD. A large body of evidence supports a correlation between social adversity, economic deprivation, and higher rates of depression (Belle & Doucet, 2003; Dohrenwend, 1998; Stansfeld, 2006), including PPD (O'Hara & Swain, 1996; Rich-Edwards et al., 2006). Our study builds on this research by providing insight into how depression is experienced by mothers who are living in poverty and the interrelationship between women's emotional and material lives. Mothers' concerns about their finances, the juggling of multiple responsibilities, children's ill health, lack of child care support, and father absence were real causes of distress. In other words, mothers' PPD symptoms could not be disentangled from the reality of their difficult life circumstances. These findings force a questioning of the dominant biomedical discourse of PPD.

This study leads to several implications for the treatment of PPD among low-income mothers. First, treatment should address women's material circumstances. The mothers in our sample clearly framed their experiences of PPD within their larger social contexts and attributed their depression to their social circumstances. As such, treatment of and services to this population should include material assistance that can help ameliorate some of these larger strains, such as appropriate referrals to and pro-active assistance with applications to income assistance programs, respite care, workforce reentry programs, and child care services. The provision of concrete assistance may help engage women, prevent treatment attrition, and make mental health services more meaningful to low-income mothers.

Relatedly, our findings suggest that clinicians should approach the topic of PPD without assuming a medical frame and should be cautious about prescribing psychotropic medication. The voices of these mothers tell us clearly that they do not understand their depressive symptoms as a medical condition or a psychiatric disorder, but rather as a psychosocial experience related to their material and social conditions. We are not attempting to make an argument about the etiology of PPD, nor are we suggesting that PPD does not have a biomedical component or that medication is not effective. Rather, we are encouraging service providers to take women's explanatory frameworks for their PPD symptoms into account as they engage them in a helping alliance, recognizing that many low-income mothers may reject a medical model, at least initially.

Future research should continue to build on these findings and, in particular, should look more closely at the ethnic and cultural dimensions of this experience as they intersect with poverty. Although we were not able to accomplish such a task in this particular study, we suggest a more intentional cultural analysis among U.S. populations. A study of the intersections of culture and class would contribute greatly to this discussion of the contextual aspects of the PPD experience and would help inform outreach and intervention strategies with diverse, at-risk populations.

There are several limitations associated with this study. First, human subjects' mandated reporting requirements, such as child abuse reporting, may have limited the depth or accuracy of the information that mothers shared during the interview process. Further, although the sample was composed exclusively of ethnic minority women, our analysis centered on the common experience of poverty among the participants, and we did not examine variations in women's experience of PPD symptoms based on potentially relevant factors such as culture, ethnicity, immigration history, acculturation, or regional differences. Finally, our own perspective as White, professional mothers may have limited some of the more nuanced understandings of these mothers' life circumstances.

## CONCLUSION

One of the major methodological benefits of grounded theory is that new accounts of lived experiences present the opportunity for continued modification and elaboration of existing theory. This study was the first to examine low-income mothers' experiences and understandings of their PPD symptoms in the United States. We suggest that the five major categories and the core experience of PPD symptoms that we found delineate an initial grounded theory framework for understanding low-income mothers' PPD experiences. These findings contribute to the prevailing qualitative work on this topic that has largely eclipsed income status or poverty as a major dimension of the PPD experience. Situating these mothers' symptoms of PPD also challenges prevailing biomedical discourses around depression and signals the importance of examining contextual variations in experiences and understandings of distress.

*Initial submission: February 22, 2008*
*Initial acceptance: September 12, 2008*
*Final acceptance: February 2, 2009*

## NOTES

1. In one case, by the time the interview was scheduled, the youngest child was 14 months old. However, our criteria for study enrollment was that the infant be 12 months of age or younger.
2. Our IRB protocol did not include the recruitment of subjects under 18 years without parental consent. Rather than pursue this option, which may have raised a host of recruitment issues in an already hard to reach population, we decided to focus on women 18 and over.
3. The eight core questions included (prompts are not listed): (1) Before you were pregnant with this child, what did you think or know about PPD? (2) With this pregnancy and baby, can you tell me how you realized you were not feeling yourself? (3) Can you describe what a particular "down/sad day" was like for you? Let's start with the morning . . . then afternoon . . . then evening? (4) When you had one of these days, how did it make you feel about yourself as a mother? (5) Did you tell other people, such as friends, family, or your spouse/partner about your feelings or experiences? Tell me about that experience. (6) When you realized that you felt depressed or sad, what did you think about getting help from a health or mental health provider? (7) How have your ideas about PPD changed from this experience? (8) What advice would you want to give to a new mother in your community who seemed sad or depressed?
4. All names are changed for confidentiality.

## REFERENCES

Abrams, L. S., & Curran, L. (2007). Not just a middle class affliction: Crafting a social work research agenda on postpartum depression. *Journal of Health and Social Work, 32,* 289–296.

Amankwaa, L. C. (2003). Postpartum depression among African-American women. *Issues in Mental Health Nursing, 24,* 297–316.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders text revision* (4th ed.). Washington, DC: Author.

Beck, C. T. (1993). Teetering on the edge: A substantive theory of postpartum depression. *Nursing Research, 42,* 42–48.

Beck, C. T. (1995). The effects of postpartum depression on maternal-infant interactions: A meta-analysis. *Nursing Research, 44,* 298–304.

Beck, C. T. (2002). Postpartum depression: A metasynthesis. *Qualitative Health Research, 12,* 453–472.

Beck, C. T. (2007). Exemplar: Teetering on the edge: a continually emerging theory of postpartum depression. In P. L. Munhall (Ed.), *Nursing research: A qualitative perspective* (4th ed.; pp. 273–292). Sudbury, MA: Jones and Bartlett.

Belle, D., & Doucet, J. (2003). Poverty, inequality, and discrimination as sources of depression among U.S. women. *Psychology of Women Quarterly, 27,* 101–113.

Boyd, R. C., Le, N. H., & Somberg, R. N. (2005). Review of screening instruments for postpartum depression. *Archives of Women's Mental Health, 8,* 141–153.

Boyd, R. C., Pearson, J. L., & Blehar, M. C. (2002). Prevention and treatment of depression in pregnancy and the postpartum period—Summary of a maternal depression roundtable: A U.S. perspective. *Archives of Women's Mental Health, 4,* 79–82.

Brown, S., & Lumley, J. (2000). Physical health problems after childbirth and maternal depression at 6 to 7 months postpartum. *British Journal of Obstetrics and Gynaecology, 107,* 1194–1201.

Buist, A. (1998). Childhood abuse, postpartum depression and parenting difficulties: A literature review of associations. *Australian & New Zealand Journal of Psychiatry, 32,* 370–378.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Thousand Oaks, CA: Sage.

Chaudron, L. H., Kitzman, H. J., Peifer, K. L., Morrow, S., Perez, L. M., & Newman, M. C. (2005). Self-recognition of and provider response to maternal depressive symptoms in low-income Hispanic women. *Journal of Women's Health, 14,* 331–338.

Chrisler, J. C., & Johnston-Robledo, I. (2002). Raging hormones? Feminist perspectives on premenstrual syndrome and postpartum depression. In M. Ballou & L. Brown (Eds.), *Rethinking mental health and disorder: Feminist perspectives* (pp. 174–197). New York: Guilford.

Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry, 150,* 782–786.

Dalton, K., & Holton, W. (2001). *Depression after childbirth: How to recognize, treat, and prevent postnatal depression* (4th ed.). New York: Oxford University Press.

Dennis, C., & Chung-Lee, L. (2006). Postpartum depression help-seeking barriers and maternal treatment preferences: A qualitative systematic review. *Birth, 33,* 323–331.

Dohrenwend, B. (Ed.). (1998). *Adversity, stress, and psychopathology*. New York: Oxford University Press.

Edge, D., & Rogers, A. (2005). Dealing with it: Black Carribean women's response to adversity and psychological distress associated with pregnancy, childbirth, and early motherhood. *Social Science and Medicine, 61,* 15–25.

Edhborg, M., Friberg, M., Lundh, W., & Widstrom, A.-M. (2005). "Struggling with life": Narratives from women with signs of postpartum depression. *Scandanavian Journal of Public Health, 33,* 261–267.

Epperson, C. N. (1999). Postpartum major depression: Detection and treatment. *American Family Physician, 59,* 2247–2254.

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago: Aldine.

Hochschild, A. (2003). *The second shift*. New York: Penguin.

Jacob, K. S., Bhurga, D., Llyod, K. R., & Mann, H. H. (1998). Common mental health disorders, explanatory models and consultation behavior among Indian women living in the U.K. *Journal of the Royal Society of Medicine, 91,* 66–71.

Karasz, A. (2005). Cultural differences in conceptual models of depression. *Social Science and Medicine, 60,* 1625–1635.

Kleinman, A. (1980). *Patients and healers in the context of culture*. Berkeley, CA: University of California Press.

Kramer, M. S. (2003). The epidemiology of adverse pregnancy outcomes: An overview. *Journal of Nutrition, 133,* 1592S–1596S.

Le, H. N., Muñoz, R., Soto, J., Delucchi, K., & Ippen, C. G. (2004). Identifying risk for onset of major depressive episodes in low-income Latinas during pregnancy and postpartum. *Hispanic Journal of Behavioral Sciences, 26,* 463–482.

Martinez, R., Johnston-Robledo, I., Ulsh, H. M., & Chrisler, J. C. (2000). Singing "the baby blues": A content analysis of popular press articles about postpartum affective disturbances. *Women and Health, 31*(2/3), 37–56.

Martinez-Schallmoser, L., Tellen, S., & MacMullen, N. J. (2003). The effect of social support and acculturation on postpartum depression in Mexican American women. *Journal of Transcultural Nursing, 14,* 329–338.

Mauthner, N. S. (1999). "Feeling low and feeling bad about feeling low": Women's experiences of motherhood and postpartum depression. *Canadian Psychology, 40,* 143–161.

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology, 52,* 250–260.

Murray, L., Fiori-Cowley, A., Hooper, R., & Cooper, P. (1996). The impact of postnatal depression and associated adversity on early mother-infant interactions and later infant outcome. *Child Development, 67,* 2512–2526.

Murray, L., Woolgar, M., Murray, J., & Cooper, P. (2003). Self-exclusion from health care in women at high risk for postpartum depression. *Journal of Public Health Medicine, 25,* 131–137.

Nicholson, P. (1999). Loss, happiness and postpartum depression: The ultimate paradox. *Canadian Psychology, 40,* 162–178.

O'Hara, M. W. (1994). *Postpartum depression: Causes and consequences*. New York: Springer.

O'Hara, M. W., & Swain, A. M. (1996). Rates and risk of postpartum depression: A meta-analysis. *International Review of Psychiatry, 8,* 37–54.

Ponterotto, J. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of Counseling Psychology, 52,* 126–136.

Rich-Edwards, J. W., Kleinman, K., Abrams, A., Harlow, B. L., McLaughlin, T. J., Joffe, H., et al. (2006). Sociodemographic predictors of antenatal and postpartum depressive symptoms among women in a medical group practice. *Journal of Epidemiology and Community Health, 60,* 221–227.

Riecher-Rossler, A., & Hofecker Fallahpour, M. (2003). Postpartum depression: Do we still need this diagnostic term? *Journal of Affective Disorders, 108,* 51–56.

Robertson, E., Grace, S., Wallington, T., & Stewart, D. E. (2004). Antenatal risk factors for postpartum depression: a synthesis of recent literature. *General Hospital Psychiatry, 26,* 289–295.

Rodrigues, M., Patel, V., Jaswal, S., & de Souza, N. (2003). Listening to mothers: Qualitative studies on motherhood and depression from Goa, India. *Social Science and Medicine, 57,* 1797–1806.

Song, D., Sands, R. G., & Wong, Y. L. I. (2004). Utilization of mental health services by low income pregnant and postpartum women on medical assistance. *Women & Health, 39,* 1–23.

Stansfeld, S. (2006). Social support and social cohesion. In M. Marmot & R. Wilkinson (Eds.), *Social determinants of health* (pp. 148–171). New York: Oxford University Press.

Stowe, Z., Hostetter, A. L., & Newport, J. D. (2005). The onset of postpartum depression: Implications for clinical screening in primary care. *American Journal of Obstetrics and Gynecology, 192,* 522–526.

Strauss, A. (1995). Notes on the nature and development of grounded theories. *Qualitative Inquiry, 1,* 7–18.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research*: *Techniques and procedures for developing grounded theory*. Thousand Oaks, CA: Sage.

Ugarriza, D. N. (2002). Postpartum depressed women's explanations of depression. *Journal of Nursing Scholarship, 34,* 227–233.

Whiffen, V. E. (1991). The comparison of postpartum with nonpostpartum depression: A rose by any other name. *Journal of Psychological Neuroscience, 16,* 160–165.

Ying, Y. W. (1990). Explanatory models of major depression and implications for help-seeking among immigrant Chinese-American women. *Culture, Medicine, and Psychiatry, 14,* 393–408.