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POSTPARTUM DEPRESSION IN ANISHINAABE AMERICAN INDIANS

by

Natalie M. Nicholson
Bachelor of Science, University of North Dakota, 2001

A Thesis

Submitted to the Graduate Faculty

of the

University of North Dakota

in partial fulfillment of the requirements

for the degree of

Master of Science

Grand Forks, North Dakota

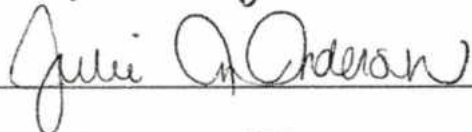
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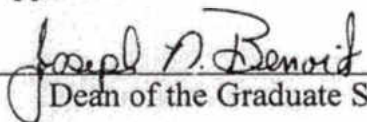
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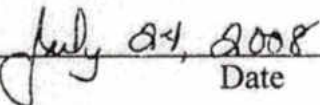




This thesis meets the standards for appearance, conforms to the style and format requirements of the Graduate School of the University of North Dakota, and is hereby approved.



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ABSTRACT

The purpose of this study is to better understand the personal experience of postpartum depression among Anishinaabe American Indian women and further examine how various resources such as family, friends, Traditional healing, local and healthcare options were utilized. In addition advice was sought from a Traditional leader as to how these women can care for themselves in the postnatal period and how providers can properly manage their care.

A descriptive qualitative analysis approach was used. Interviews were conducted in 1-1.5 hours in the home of the Anishinaabe American Indian women who are from Red Lake Band of Chippewa Indian Reservation. The inclusion criteria for this small pilot study is they have had a baby within the past two years, had a score of 12 or greater on the Edinburgh Postnatal Depression Scale and are residing on Red Lake. This reservation is located 30 miles north of Bemidji, MN in the northern counties of Beltrami and Clearwater County.

This study brought out many things that are not found in the literature. Namely the categories and themes identified, the significance of social, family, and community support, cultural practices and simply research conducted for the American Indian women population.

Recommendations to healthcare professionals by the Traditional leader suggest these professionals better educate themselves on American Indian culture, beliefs and

healthcare practices. Examples of how to accomplish this include community participation such as: pow-wows, healing circles and sweats. Furthermore, specific questions were established for healthcare providers to implement when inquiring about a patient's healthcare beliefs and practices.

It is essential for healthcare facilities and organizations to have regular cultural awareness training; this can be done by involving the community and encouraging staff to engage in cultural activities. Moreover, the need for hiring a Traditional healer to be staffed within the healthcare facility to provide Traditional healthcare is found to be imperative. It allows for collaboration with Western medicine and results in culturally holistic care. A potential goal for these organizations would be to work towards attaining Traditional healthcare as a billable service.

CHAPTER I

INTRODUCTION

Postpartum Depression and American Indian/Alaska Native

Postpartum depression (PPD) as a psychological disorder reportedly affects approximately 10 to 15% of women during the postpartum period (Baker et al., 2005). A history of depression and being treated for depression are well documented in the literature among American Indian people. Various differentiations of postpartum depression have been identified in the literature, specifically its prevalence in American Indians (Baker et al., 2005), the relationship to social status (Segre et al., 2007) using specific indices (income, education, and occupation/prestige), and differences among ethnicities in reporting depressive symptoms (Howell, Mora, Horowitz & Leventhal, 2005). Yet the Surgeon General's report, *Mental Health: Culture, Race and Ethnicity*, resulted in findings that failed to produce the "most basic information about the relative mental health burdens borne by American Indians" (Beals et al., 2005, p. 1723).

The necessity for screening of this population is supported by findings specific to postpartum depression and the prevalence of it in American Indian women, who are characterized by a young age at the time of pregnancy, low socioeconomic status and being single (Segre, O'Hara, Arndt & Stuart, 2007). Women with postpartum depression will show a significant change in their physical and emotional behavior such as a lack of motivation, sadness, tearfulness, inability to bond with their newborn, having difficulty

concentrating, decreased appetite or self-care. The literature tells us that 70% of women will experience postpartum blues or 'baby blues'. Baby blues is a time when women are having difficulty transitioning into motherhood. Postpartum blues do not last longer than two weeks, however the symptoms and feelings are similar to postpartum depression; this includes mood swings, feelings of sadness and tearfulness (Baker et al., 2005).

Postpartum depression is generally well documented in the literature; however there is minimal evidence on this topic in correlation with the American Indian population (Baker et al., 2005) and limited information regarding the prevalence of mental illness as a whole among American Indian and Alaska Native (AIAN) women (Duran et al., 2004).

The purpose of this study is to better understand the personal experience of postpartum depression in Anishinaabe American Indian women and further examine how they utilized various resources such as family, friends, Traditional healing, local and healthcare options. In addition advice was sought from a Traditional leader as to how these women can care for themselves in the postnatal period and how providers can properly manage their care.

With postpartum depression being a psychological disorder and Indigenous healing being sought for spiritual and well-being care, using both forms of healthcare practice should ultimately result in comprehensive and holistic care for American Indian patients.

CHAPTER II

REVIEW OF LITERATURE

The literature search I used included various databases such as Cochrane library, FirstConsult, PsychLit, PsychInfo, DynaMed, Bandolier, Scopus, Cinahl and PubMed with these last three providing me the most hits. Examples of phrases used in the search engines were: “American Indian and postpartum depression”; “Native American and depression”; “American Indian and mental health”; “minority and postpartum depression”; “Indigenous healing and American Indians”; “Indian health” and lastly using specific authors such as Roxanne Struthers and Valerie Eschiti.

The use of references listed in the articles guided me to other resources (Baker et al., 2005; Long & Curry, 1998; Marbella, Harris, Diehr, Ignace, & Ignace, 1998). I searched other links such as the National Alaska Native American Indian Nurses Association (NANAINA) and the University of Minnesota Native Nurses website that lists journal manuscripts published by the late Roxanne Struthers.

Postpartum Depression

Results from a number of the studies recommend screening for postpartum depression in ethnic populations due to the prevalence of early postpartum depressive symptoms (Howell et al., 2005). There are certain risk factors that put women of color at risk for postpartum depression: an annual income of less than \$20,000, less than a college

education, low occupational prestige, young age, single marital status, multiple children (Segre et al., 2007) and a history of depression and being treated for depression (Baker et al., 2005). Recognizable psychosocial risk factors linked to postpartum depression include: past history of psychopathology, experiencing psychological disorders during the antenatal period, poor bonding and attachment with parents during childhood, marital problems, low self confidence, low socioeconomic means, inadequate community support, stressful life events, unwanted pregnancy and a family history of depression (Verkerk, Pop, Van Son, & Van Heck, 2003).

Hobfoll, Ritter, Lavin, Hulsizer, and Cameron (1995) conducted a study on depression prevalence and incidence among inner-city pregnant and poverty-stricken postpartum women. The sample consisted of 192 inner-city women that were enlisted over a 2.5 year time frame from among the patient population at three obstetrics clinics for low-income, located in a mid-sized Midwestern city. Participation requirements were an age range between 17-40 years old, 16-24 weeks gestation, and free of serious medical complications at initial visit. Interviews conducted in the first and second trimester of pregnancy found 27.6% and 24.5% of the women depressed, with 23.4% of the women found to have postpartum depression; these results were compared to middle-class cases and found to be double their rates.

Risk factors for depression during pregnancy include being single and living alone. It was found that depression during the antepartum period is a serious risk factor for postpartum depression; the nature of this association is unclear as the rate of depression varied throughout the study, meaning women who initially had depression did

not report feeling depressed at the conclusion of the study (Hobfoll et al., 1995). This finding is crucial as these outcomes are similar to those of middle-class samples on this topic when compared to the lower case sample resulting in a hypothesis that this is a “general psychological principle, not a culture-bound principle” (p. 449). It was noted in the article that their findings specific to ethnic status be viewed with caution as “the historic openness of industry in this city to African Americans and the absence of strict ghettoization found in many U.S. cities may have limited the pervasive effect of ethnic status found in other studies of pregnancy” (p. 451). In addition, Hobfoll et al.,s (1995) findings detail that family and demographic factors such as ethnicity did not change the prevalence and incidence of depression but rather the fact that poverty is the sole denominator.

The Baker et al. (2005) study on postpartum depression involved 151 women, ages 16-40 years old; 60.9% of whom American Indian, 25.8% were African American and 13.3% were Caucasian. It found “76.8% scored within a normal range using the Postpartum Depression Screening Scale (PDSS) questionnaire. However a high number scored within the range for significant symptoms of postpartum depression (10.6%) and 12.6% scored positive for symptoms of major postpartum depression, yielding a combined prevalence rate of 23.2%” (Baker et al., 2005, p. 23). A different study performed by Segre et al. (2007) on the prevalence of postpartum depression of women with various social classes found that “25% of the American Indian/Native Alaskan population had a positive Inventory to Diagnose Depression (IDD) score” (p. 318). It is important to point out that there were 4,132 White participants, 25 African American

participants, 4 American Indian/Native Alaskan participants and 56 Asian/Pacific Islander participants in this latter study. Thus the population was primarily comprised of Non-Natives, leading one to interpret this elevated percentage of AIAN as exaggerated.

Current evidence regarding mental health, mental dysfunction, or self-destructive behaviors occurs in approximately 21% of the total AIAN population. This ultimately results in approximately \$1.07 billion in costs. It is critical to note that even with this cost estimation and the insurmountable suffering that occurs, the “overall mental health picture for AIAN is not fully documented” (Duran et al., 2004, p. 71) nor the prevalence of mental health disorders or the functional use of available resources in an area where AIAN primarily reside.

Coping Resources for Postpartum Depression

Of the studies reviewed in the literature, not one researcher documented the coping responses the women had experienced, the resources available to the women or what resources they utilized in dealing with their postpartum depression (Segre et al., 2007).

According to Duran et al. (2004), the Indian Health Service (IHS) offers mental health services; however the budget for this specialty accounts for less than 5% of the total costs, and funding for urban settings is even less. This issue exerts added pressure on IHS funding but also creates a rivalry between the IHS organization and tribal leaders for the same sources; current availability of healthcare dollars and other sources are inadequate to meet the needs of the AIAN people. To improve mental health funding and

resources, tribal and IHS leaders must work together to create opportunities for holistic and culturally competent services in primary and urban sites in the field of mental health.

The mental health issues AIAN endure are important for health care providers to pay particular attention to as “21.4% of primary care patients have seen a provider for a psychological problem” (Duran et al., 2004, p. 71). It is suggested that the AIAN women population also has a higher incidence rate of anxiety disorders, which may be concomitant with depression. In addition, these two disorders potentially put these women at a greater risk or risk maybe related to low socioeconomic conditions (Duran et al., 2004).

Disability caused by depression surpasses other morbid conditions such as hypertension, diabetes, arthritis and gastrointestinal problems. Furthermore, when depression occurs simultaneously with anxiety, this combination of disability is significantly greater than the disability effects of having depression or anxiety alone (Duran et al., 2004.) What is alarming is that postpartum depression continues to be considerably under-diagnosed and treated even though research has documented the substantial effects it has on the mother, infant and family relationships (Baker et al., 2005).

Effects on Infant and Family

Postpartum depression during a vital period of infant and family attachment can lead to other unfavorable outcomes, such as marital issues, problems with maternal-infant bonding, and poor behavioral and cognitive development in the child (Gjerdingen & Yawn, 2007). Children raised by depressed mothers have a higher chance of developing

psychological, cognitive, neurological and motor development delays. In addition these behaviors may present as avoidant and distressing. These issues could potentially have an impact on the child as early as 3 months old (Newport & Stowe, 2008) up to the ages of 4-8 years old. Gjerdingen and Yawn (2007) found that these children will utilize the healthcare system more often for various reasons as well. Newport and Stowe (2008) concur that this emotional instability, behavioral problems and increased risk of suicidal tendency requires psychiatric treatment. Fortunately, these cognitive and behavioral issues will typically resolve when maternal depression lifts (Gjerdingen & Yawn, 2007). When comparing the facts of “a depressed mother to non depressed mothers, the report shows a 3-fold greater risk of serious emotional problems in their children and a 10-fold greater risk of having poor mother-child relations” (p. 281).

Gjerdingen & Yawn (2007) note that when a mother is experiencing postpartum depression at an early stage of an infant’s life, and her demeanor is one of not forming infant attachment by acting withdrawn, and she has negative feelings about herself and baby, this lack of connection can lead to babies who fuss more, babble less and do not demonstrate appropriate positive facial expressions when compared to other infants of non-depressed mothers. The nature of this inconsistent pattern of maternal-infant relationship linked with postpartum depression is an unhealthy cycle that increases the incidence of long-term mental health, emotional and family dynamic crises.

Despite the fact that very little research exists regarding postpartum depression in the AIAN population, evidence suggests that traditional healing is critical in AIAN care in all aspects of health. An example is how indigenous healing, belief and practices are

incorporated into their participant's health and their use of Traditional healers (Marbella et al., 1998). Some of the approaches used were for health management, treatment of their imbalances, disease (Struthers & Eschiti, 2005), pregnancy, childbirth and use during prenatal care (Long & Curry, 1998). Therefore, a thorough discussion of traditional healing and its value with respect to PPD will follow in the next section.

Traditional Healing

Traditional healing, also known as Traditional medicine, practiced by American Indians is an ancient, multi-dynamic health care practice that is estimated by various theorists to have been around on this continent for more than 12,000 to 40,000 years ago (Struthers et al., 2004). Traditional healing encompasses four key elements for a healthy life and well being. These are spiritual, emotional, physical and mental, including everything surrounding the person and the universe. All things are thought to have life and considered to have an effect on one another. Disease and or illness are associated with an imbalance in one of these elements. It is believed that these four pieces are interrelated and connected and each one needs to be regularly taken care of and addressed to maintain a healthy life. If an imbalance occurs, it must be corrected for healing to take place (Struthers, 2003).

According to Dodgson and Struthers (2005) culturally in American Indian families other people are considered a priority versus taking care of themselves first. "They will do things for a loved one around them or somebody in the community" (p. 342). The view is not one of being they are "the center of the universe" (p. 342) traditionally.

Recent literature has found that when American Indians practice Traditional health and healing methods in their lives (Walters & Simoni, 2002), coupled with support from family members and their Native community, it makes a positive impact on their internal-spiritual well-being and their response to treatment (Long & Curry, 1998). The United States Public Health Services (USPHS) recognizes this very fact by establishing specific policies and procedures into the Healthy People 2010 goal of “eliminating health disparities among different segments of the population” (Healthy People 2010, 2003) pertaining to Traditional medicine by encouraging its use and implementation for goal attainment.

Multiple studies have concluded that the interruption of passing down Traditional beliefs from generation to generation has affected American Indian healthcare (Long & Curry, 1998). Being disconnected from Indigenous Traditions, community, cultural surroundings and teachings are viewed as the basis for the imbalances and diseases seen in the Native community (Dodgson & Struthers, 2005). The reason for this can be linked back to the United States government banning the rights of American Indians to practice their religion; including healing approaches and rituals from the 1880’s to 1978. The Secretary of the Interior set up courts of Indian Offenses which “forbade all public and private activities by Indians on their reservations, including ceremonies and so called practices of medicine men” (Struthers et al., 2005, p. 79). In 1978, the US government overturned this law and the American Indian Religious Freedom Act was put in to place. This Act states that Indigenous people are free to practice their religion however they wish.

The Long & Curry (1998) study found that the complete and total use of the Western Model of care for American Indian patients is not satisfactory. There is a need for culturally specific care and collaboration of both models to encompass comprehensive holistic care. Struthers and Eschiti (2005) found that the use of Traditional Indigenous healers and the interest in using Traditional healers are prominent in Indigenous people even if they have never been to one before. Marbella et al. (1998) found that American Indians would prefer to use both medical models for their care; however there is some dilemma when the healer and the physician make medicinal recommendations that differ from one another, so the patient has to make a decision on which advice to implement.

How patients view their health, culture and how they define illness and disease strongly influences how they will choose to take care of themselves and seek care. Patients will often request to see their Traditional healer for spiritual reasons, since western medicine does not focus specifically on Native American needs (Marbella et al., 1998).

It is necessary for providers to give holistic care that entails culturally specific treatment and management options (Marbella et al., 1998). "Simply asking the patient about their cultural belief practices or alternative therapy use is a way to integrate both healthcare practices and meet the continuum of spiritual and physical needs of the patient" (p. 185). Furthermore, Marbella et al. (1998) discussed that healthcare professionals that feel comfortable enough to inquire about their non-Native patients' interactions with their priests, ministers or pastors can simply ask similar questions to their Native patients regarding their involvement with their culture and Traditional

healers. This information can be obtained as part of a routine office visit during the medical history taking portion of the examination. In addition, to ensure upcoming healthcare professionals are well exposed to various ethnic settings it is recommended that academic settings include these multi-cultural issues into their curriculum so the students feel confident that they can properly address and manage diverse patient populations.

A qualitative study performed by Long and Curry (1998) on Native American women and prenatal care found a similar view from their participants, elders and young women. Both of these groups strongly expressed their point of view that it is critical for young mothers to take responsibility and be accountable for their pregnancies and their children. If these young women choose not to be responsible for their pregnancies and their babies, then they need to be mature enough to recognize this and take further appropriate action to address these circumstances. These parenting issues have not gone unnoticed, and perhaps are reflective of how these young parents were raised themselves. An elder in the Long and Curry (1998) study explained "If you raise your kids traditionally, it opens their eyes to their own self. I think that's what we've allowed our children to get away from; who they really are and this is what causes the disruption in our families" (p.213).

Struthers' Work on Traditional Healers

Struthers' research is not only a very useful resource and teaching guide but her studies are presented in a way in which the reader is able to connect with the participants and better understand the culture and its significance. She was able to establish trust with

the Native community so they felt comfortable sharing their traditions, beliefs and cultural practices for us to learn. For example, in the “Artistry and Ability of Traditional Women Healers” Struthers (2003) detailed the women’s individual gifts according to their tribal affiliation and how they came to develop these cultural values and health practices. Each healer is unique in how they mastered their talents and which gifts they possess. It is important to understand each healer offers different Traditional care. An example of this is where one healer uses Traditional medicinal plants and ceremonies to help guide her in deciding which plants and herbs are appropriate for her client. All of the women serve and work within the community and along side other healthcare professionals providing social, emotional and spiritual care. They may lead healing circles, conduct one-to-one healing sessions, and perform various ceremonies such as: naming, pipe, prayer, sweat lodge, and shake tent.

In summary, the healers discuss the connection they had with their elders, or grandmothers and simply participating and experiencing these Traditional cultural practices for themselves. Each person’s experience with Traditional medicine is unique and not everyone will interpret it the same. One has to participate and become involved to truly learn and understand it for themselves.

Struthers, Lauderdale, Nichols, Tom-Orme and Strickland’s (2005) work on “Respecting Tribal Traditions in Research and Publications: Voices of Five Native American Nurse Scholars” provides guidance by thoroughly explaining the process of incorporating principles, ethical considerations and their engagements with the participants. They remind us that Tribes require researchers to be respectful of their

culture, traditions, tribal and individual rights by seeking approval from tribal council and the institutional review boards and understand that they have the right to control how information is obtained and shared. An important point made in this article is that not all Indigenous people practice Traditional medicine. They state “it is not protocol to ask an Indian directly, unless you know him or her, about the traditional health practices” (p. 200).

In “Traditional indigenous healing: Part I,” Struthers, Eschiti and Patchell (2004) depict how one can locate a Traditional healer, explain the various Traditional healing techniques, the utilization of Traditional healing and compare Traditional medicine to Western medicine. They discuss that Traditional medicine also entails health promotion and prevention. Health promotion is encouraged in Traditional healing by continuously practicing Traditional ways and living a Traditional life. An example of health prevention in this article is the act of performing certain ceremonies or events to pray for the safe return of a soldier from war. Lastly, in their work on “Being Healed By An Indigenous Traditional Healer: Sacred Healing Stories of Native Americans: Part II”, Struthers and Eschiti (2005) share the experience of the participants being healed by a Traditional healer by giving detailed insight to the various ceremonies performed in a storytelling fashion, which is considered a “traditional Native method of instruction” (p. 79). They emphasize the importance of not altering the person’s experience, but telling it in a form of direct articulation to avoid miscommunication or misinterpretation by others.

Conceptual/Theoretical Framework

I chose the Medicine Wheel as my conceptual framework for this study. The medicine wheel is used by various Indigenous tribes unique to their traditions. Dapice (2006) discusses that the medicine wheel represents “a symbol of wholeness; including all races of life” (p. 251) and that “all are considered sacred and equal” (p. 251) including every animal and plant. The medicine wheel leads off with the four directions and is correlated with multiple essential facets, they are: aspect, color, animal and medicine all of these signifies and guides the way of living life. The following details each category under the specific ‘direction’. North: aspect-spiritual, color-white, animal-white buffalo and medicine-sweetgrass; East: aspect-mental, color-yellow, animal-eagle and medicine-tobacco; South: aspect-emotional, color-red, animal-red tail hawk and medicine-cedar; and West: aspect-physical, color-black, animal-bear and medicine-sage.

The philosophy of the medicine wheel includes Eastern and Western ideals, as Eastern views are cyclical with the notion that “what has been will be, where change is not possible” (Dapice, 2006, p. 251) and Western views projects “linear cause and effect and is interventionist” (p. 251). In turn, the wheel encompasses various cycles, seasons, and pathways but allows the need for change as anticipated. The circle design of the wheel links each section together showing us that everything is connected and whole. Connection to a person’s self, community, family, culture, and spirit are essential to being healthy in mind and body. The medicine wheel is evidence of this, not only as a guide in showing us how all things are connected and related, like the themes and

categories; but provides guidance for all people, regardless of their culture and profession.

Definitions

American Indian (Struthers, Eschiti & Patchell, 2004) and Alaska Native titles are accepted among tribes and organizations across the United States. These titles are federally recognized and they have a government-to-government relationship with the United States. It is important to note that there are some tribes that are only recognized by their state but not the federal government, and these terms are also different when one would describe Native/Indigenous people from other countries such as Canada, Central and South America. According to Beals et al. (2005), "The National Congress of American Indians and the National Tribal Chairmen's Association issued a joint resolution that the preferred term, in the absence of specific tribal designation, was American Indian rather than Native American when referring to indigenous population of the lower 48 states" (p. 1713).

Postpartum (Olds, London & Ladewig, 2000) is a time from birth of the child until the woman's body returns to her pre-pregnant state.

Traditional women healers "Have their arts, and gifts that are different from those of Western conventional medicine because of dissimilar world views related to health and illness. An increased awareness of health care providers related to the ancient art of traditional healing currently practiced in communities by gifted women who provide culturally specific holistic healing and health care is essential" (Struthers, 2003, p. 340).

Native American Traditional Leader is a term that means any “Native American who is recognized by an Indian tribe, Native Hawaiian organization, or Native American traditional organization as being responsible for performing cultural duties relating to the ceremonial or religious traditions of the tribe or traditional organization, or exercises a leadership role in an Indian tribe, Native Hawaiian organization or Native American traditional organization based upon its cultural, ceremonial, or religious practices” (Native American Free Exercise of Religion Act of 1993).

Support (Solchany, 2001) is essentially the people or support network in the mother’s life. Support resources or persons tend to be people already involved in the mother’s life, or rather a group that provides a positive environment. The mother may need to further explore how these factors will affect her and the baby.

Gatherings (Stone Woman, personal communication, March 14, 2008) pow-wows, healing circles, sweats, ceremonies, and a person’s community are some terms that encompass the action of the word “gatherings.” This is a way for people to come together to unify as a culture to celebrate, heal, pray and support one another.

Coping “People use a variety of ways to cope with life stressors, and a number of factors can act as mediators for stress in our lives, such as life satisfaction (work, family, hobbies, humor) and social supports. Four categories have been identified of coping styles that people use as buffers: (a) Health sustaining habits (e.g., medical compliance, proper diet, relaxation, pacing ones’s energy), (b) Life satisfactions (e.g., work, family, humor, spiritual, solace, arts, nature), (c) Social supports (d) Response to stress” (Varcarolis, 2002, p. 270).

Connection is defined as “the act or state of connecting, anything that connects; link, usually connections associates relatives, or friends especially considered as having influence or power” (Webster’s Dictionary, 1992, p. 288).

Emotion is defined as “an affective state of consciousness in which joy, sorrow, fear, etc. is experienced; a strong agitation of the feelings caused by experiencing love, hate, fear, etc” (Webster’s Dictionary, 1992, p. 437) or *emotional* which is defined as “pertaining to or involving emotions, showing or describing very strong emotions” (Webster’s Dictionary, 1992, p. 438).

CHAPTER III

METHODS

Overall Approach

A descriptive qualitative analysis approach was used. This method is designed to get the richest data possible entailing significant complexity and variety. This approach is not meant to predict, control the setting or the participants, but to gain knowledge and better understand “all that is knowing and contextual” (Macnee & McCabe, 2008, p. 203).

Qualitative designs offer three general purposes to: improve understanding, generate interaction or immersion and connect thoughts and concepts. This specific design strives to: (a) initiate more knowledge to answer descriptive design questions (b) initiate involvement or immersion that will answer questions associated with description and its relationships (c) connect thoughts and concepts that will answer questions aimed towards connection or relationship (Macnee & McCabe, 2008).

This type of design allowed me to better understand the participant’s point of view of what their experience entailed (Macnee & McCabe, 2008) resulting in a better holistic healthcare approach for all providers in future care of women with postpartum depression.

Qualitative descriptive studies as defined by Sandelowksi (2000) are a way to completely summarize an event in everyday language. The researcher carrying out the

study searches for descriptive validity or a precise clarification of the incident that most people (including researchers and participants) who witnessed the same event would agree is accurate, an interpretative validity. Struthers (2003) also cites Sandelowski in her own research by stating “validity, not reliability is defensible in qualitative studies. The test of validity is reached when the findings are recognized to be true by those who live the experience” (p. 344).

In today’s contemporary qualitative literature on methods, it does not depict an extensive explanation of what qualitative description entails. Sandelowski (2000) conveys her philosophy regarding qualitative description in three ways: (a) Qualitative description can be considered a “categorical, as opposed to non-categorical alternative for inquiry” (p. 335), this would mean that it is a method already established but not recognized when compared to “new distinctively nursing adaptation of grounded theory, phenomenology, and ethnography” (p. 335). (b) It is not considered mandatory for researchers who implement qualitative description to stray from or draw inferences from their obtained data, such as in ‘interpretive description.’ (c) “They do not require a conceptual or otherwise highly abstract rendering of data” (p. 335).

In addition Sandelowski views this method as a “complete and valued end-product in itself” (p.335) and considers it to be an ‘entry point’ to other qualitative modes. Researchers wishing to use this method should feel confident in its use without having to rely on ‘methodological acrobatics.’ To consider one method better than another is incorrect; comparing techniques should be used for “the purposes of

illumination, not ranking or denigration” (p. 335) as each method has its place in research when used accurately.

Sample and Sampling Procedure

There were four participants. Interviews were conducted in 1-1.5 hours in the home of the Anishinaabe American Indian women who are from the Red Lake Band of the Chippewa Indian Reservation. The inclusion criteria for this small pilot study is they have had a baby within the past two years, had a score of 12 or greater on the Edinburgh Postnatal Depression Scale (EPDS) (Cox, Holden & Sagovsky, 1987), and are residing on Red Lake. Red Lake Band of Chippewa Indians is a reservation that is located 30 miles north of Bemidji, MN in the northern counties of Beltrami and Clearwater County. There are four villages within the reservation; they are Red Lake, Redby, Little Rock and Ponemah. There are approximately 10,000 enrolled members and about half currently live on the reservation.

In addition advice was sought from an Anishinaabe American Indian woman who is identified as a Traditional leader from Red Lake. She was given tobacco and asked by the researcher prior to the interview if she would be willing to participate in the conducted pilot study. She agreed to share her wisdom for these women as to how they can care for themselves in the postnatal period and how providers can properly manage their care.

Research Question

The research question is to better understand the personal experience of postpartum depression among Anishinaabe American Indian women and further examine

how various resources such as family, friends, Traditional healing, local and healthcare options were utilized. Additional guiding questions that differed from subject to subject include: How did you feel emotionally after your baby was born? What concerns do or did you have about caring for your baby? Tell me about the help that was given to you from your family, friends, healthcare providers, Traditional women and/or grandmothers. Was their help, support helpful to you?

Furthermore, advice was sought from a Traditional leader as to how these women can care for themselves in the postnatal period and how providers can properly manage their care.

Data Producing Instruments

The Edinburgh Postnatal Depression Scale (EPDS) was utilized to screen the women for postpartum depression and its use for this study was a way to help determine if the women qualify for this study by meeting the standards of this valid and reliable tool. Verkerk et al. (2003) concur by stating the EPDS “has good psychometric properties and has been validated in the Netherlands” (p. 160). The EDPS is a 10-item questionnaire with each response correlating with a number based on its severity of symptoms from 0 to 3, zero representing the lowest severity of symptoms and three rating the highest level of symptoms being felt and experienced by the women. If a person’s total score is 12 or greater, it constitutes they are at risk for postpartum depression and should be evaluated by a healthcare professional. Verkerk, et al. (2003) explain the significance of 12 as a cut-off for “high depressive symptomatology, representing an adequate level of specificity” (p. 160).

Data Collection

The women completed the EPDS screening tool that was given to them by the Community Health Nurse from the Maternal Child Health Tribal program. This was scored by the researcher; a score of 12 or greater qualified the women to participate in the study. After scoring was completed, the women made a verbal agreement with the Community Health Nurse agreeing to allow me to make a home visit to talk with them about their PPD experience.

I interviewed three women on their postpartum depression experience and how they utilized the resources available to them. In addition, I interviewed one community Traditional leader from the same tribe about Traditional beliefs and recommendations for these mothers and the local healthcare providers on the reservation as to how to properly manage postpartum depression from a holistic Traditional standpoint.

Protection of Human Subjects

Permission for this study was obtained from Red Lake Tribal Chairman and the University of North Dakota Institutional Review Board prior to initiating the study. At the initial visit I reviewed the consent form that I developed detailing their rights, assured them of their confidentiality and how the information will be used. They were also notified at this time that they could withdraw from the study at anytime without consequences. At the time of the visit it was made known that they could ask questions or address any concerns they had throughout the process.

The participants were all given pseudonyms to protect their identity; cassette tapes were labeled according to the interview order and their pseudonyms. The

participants were informed that the tapes and transcripts will be stored in a locked cabinet at the UND College of Nursing and available to the researcher only and her instructor as it helps guide the researcher through this process. Consent forms will be stored separately from transcripts, and audiotapes and consent forms will be shredded after 3 years.

Analysis Plan

The information obtained was audio-recorded, detailed field notes were made after the interview outlining my observations of the interview. Field notes reflected the general feeling of the interview, the demeanor of the participant such as nervousness, body language, tone of voice and their willingness to share their story.

The audio-tapes were given to a hired contract transcriptionist, the transcripts were immediately sent to two of the researcher's instructors via e-mail for review. The instructors provided guidance to the researcher by giving step-by-step instructions on coding transcriptions as well as published literature for reference. I used a manual method of organizing my data; the transcripts were numbered continuously throughout the document creating a system of reference for efficiency of analysis. After initially reading through the transcripts, key words were listed and were later put into categories and themes. The use of colored markers that correlated with the themes was used throughout the second review of the transcripts, highlighting specific statements linked to the categories and themes. The color coded transcripts were ultimately cut up and separated into the colored themes. I focused on each category and theme and further analyzed the participants' interviews while incorporating the Traditional leaders thoughts

and Traditional healing recommendations. This information was also sent to the researcher's instructors for further evaluation and recommendations.

Limitations

One recognizable limitation would be the limited time frame in which I conducted the research. In addition, the results from this research are difficult to generalize beyond the sample studied as this reservation is sovereign.

To ensure rigor throughout this process, analyses of the women's experience were summarized according to their interviews, staying as close to possible using their own words as well as direct quotes. The researcher's personal opinions were not included in the analysis portion and this is evident if compared to the transcripts. In the case of Stone Woman who gave Traditional healing guidance, she reviewed her particular transcript for validity; she gave her permission to use the information as transcribed without correction or clarification.

In addition, professional academic references such as textbooks, dissertations and journal articles guided the researcher to ensure proper adherence to the selected method.

CHAPTER IV

RESULTS

The research question is to better understand the personal experience of postpartum depression among Anishinaabe American Indian women and further examine how various resources such as family, friends, Traditional healing, local and healthcare options were utilized. Additional guiding questions that differed from subject to subject include: How did you feel emotionally after your baby was born? What concerns do or did you have about caring for your baby? Tell me about the help that was given to you from your family, friends, healthcare providers, Traditional women and/or grandmothers. Was their help, support helpful to you?

Furthermore, advice was sought from a Traditional leader as to how these women can care for themselves in the postnatal period and how providers can properly manage their care.

You will find themes and categories outlined with the responses from all the participants in each appropriate section, with the Traditional leader's response of her guidance and recommendations incorporated throughout the various sections.

Results from Analysis of Research Question

Themes

Theme One

Anishinaabe women report a variety of emotions and experiences in the postpartum period.

Category 1

The women expressed feeling unprepared for childcare.

The women expressed feeling unprepared by having to learn how to care for an infant all over again with no way of turning back; feeling embarrassed because they have other children so they should know how to care for their newborn and should not have to ask for help. As one participant stated, "I should be able to handle all of this, but I didn't. I wasn't sleeping a lot and I wasn't prepared to get up every two hours to feed the baby in the middle of the night."

Two participants recount their experience of feeling unprepared, Nancy shared:

It didn't hit me as hard, I just felt really tired and I just felt like I was really lonely too, because I wasn't really talking to anybody. I was just going to work and being very standoffish with everybody, like everything is fine, just in and out everywhere so I didn't really talk to people. I didn't expect to feel this way.

Margaret shared:

It was kind of difficult. It was hard. Even though I have three other kids besides her, I really never experienced anything. It kind of got harder faster having three others. For one, I thought I was done having babies. Now I have a little one and I've got to go through all of this stuff again. I

wasn't prepared for it. I wasn't ready for another baby because all my kids are four years apart. I didn't know how to deal with it.

Anger, guilt, stress, feelings of loneliness and being unprepared are emotions that the participants reported experiencing. When the women shared their emotional experiences they were very open to telling their story but also appeared to be in awe of how terrible they felt at the time. Here the women recount these various expressions they were feeling. Crying was a common expression the women had whether it was because they had an unplanned pregnancy and didn't want to stay home to care for the baby, or they were so fatigued and emotional "from their hormones" and simply cried "for no reason" but knew they just felt "down and bummed."

Category 2

The women felt guilty for having negative emotions.

Feelings of guilt were expressed by two women. As Nancy explained:

It just felt like I was having a really big pity party, like oh, this isn't working, I don't know what to do. I felt kind of bad because I was complaining because I was like, I know you're right but I still feel this way. But it is important that I get away from everybody for a while. But then I feel guilty for leaving them because they go to day care all day and I don't see them, but I have them on the weekends too. In the summertime I only have my daughter because my son goes to visit his grandparents for the summer and he's gone all summer.

Barb shared:

It makes me feel guilty after I go take a break and come back. Then it makes me feel guilty that I felt that way that I needed to get away. It seems like I shouldn't be feeling like that, but it's like I need to be away from him, but then I shouldn't be feeling like I need to be away from him.

Category 3

The women expressed anger towards themselves and others.

Often the women felt angry and expressed a lack of support from their spouses in terms of “pitching in” with household chores and taking care of the other children as being a contributing factor to their anger, to simply not understanding how they were feeling themselves and the frustration that accompanied this uncertainty.

One woman, Barb, stated: “I remember looking in the mirror. It was like I was looking at a whole different person, and I never, ever felt like that before.” She further detailed how her primary emotion was anger but she could not explain how or why she felt that way. She stated:

There's not even a reason to be angry, because my relationship is perfectly happy; nothing I could be angry at him about. But it seems like that's who the anger is at is towards his dad. It's not toward anybody else. It's not toward the baby; it's not toward myself, it's just toward the dad and I don't know why.

Another woman, Nancy, stated:

I was really angry with him. There were a few times where I was like, well why don't you just leave? There's nothing you're doing for me and I really don't need you here if you're not going to help. I'd tell him, you're just like having another kid. I've got too many already. I just got really angry with him.

Margaret stated: "I was so angry, I would be lashing out. I would be hollering at my kids for no reason, and I know they didn't do anything."

Category 4

Difficult emotions cultivated in an overall sense of stress in the women.

Feelings of stress were felt by the women, which they believed contributed to their postpartum depression. For example; balancing work, experiencing illness themselves and having anxiety about "getting the baby sick" by interaction or having to take the baby outside in the winter so she could go to the doctor for care; home life responsibilities such as cooking, cleaning, laundry, grocery shopping and the baby. The women shared that they felt that these activities were the only thing they had time for in their day, which left no personal time for themselves. Another factor of stress for one woman was a death in the family three weeks before her baby was born. She explained that her grandmother passed away from cancer and how she had hoped she would have held on until after the baby was born.

Theme Two

Cultural knowledge is imparted through rituals and ceremonies among the Anishinaabe.

Category 1

Gatherings are significant means of Traditional support among the Anishinaabe.

Pow-wows, healing circles, sweats, ceremonies, and a person's community are some terms that encompass the action of the word "gatherings." It's a way for people to come together to unify as a culture to celebrate, heal, pray and support one another, yet it's not closed to other ethnicities if they wish to participate or are invited to partake (Stone Woman, personal communication, March 14, 2008).

Often times grandparents, elders or a family member participate in the gatherings and it can be reflective of how the culture is passed along to other family members. However in today's culture, Stone Woman feels that the people are not looking for guidance and healing in their communities to "just go and talk to the elders." She does advise that an elder should be someone who is not judgmental, shy, does not raise their voice or violate confidentiality, and a person that is honest and one you can sit and visit with and feel comfortable around. She also recommended that people need to pay attention and listen to their inner intuition when they have that feeling when they suspect an elder is not honest.

She explained that "you do get a lot of healing just through talking about whatever it is that's bothering you, and now I just think that we lost that connection." This appeared to be evident in the instance of these women and their lack of using Traditional ways in their lives. Nancy stated: "I don't have any grandparents; they all died. It's just my mother. My father died. No, in my own family there really isn't anybody really old."

Barb stated:

There's no elders or anybody Traditional in the family. There's very few people that I know of that go to any kind of Traditional healing and I don't know of anybody, like some people would say like 'maybe you should see a medicine man.' I wouldn't even know where to begin or where to go. I'm not really into Traditional healing and things like that. I really don't know what it is. We don't really have much left of it on the reservation, so not many people use it anymore.

Even though these women do not have the cultural knowledge to feel like they can participate in some of the gatherings such as ceremonies, healing circles or sweats, they discussed their willingness to participate if the opportunity presented itself.

Barb stated:

At first I would probably think no. Then I would have to put some thought into it. Then I think eventually I would because there isn't really anything like that around here so it would be kind of shocking for somebody to offer that. It would be different because it's not very often anybody offers that to you.

Margaret stated:

Yes, if they offered it to me I'd go. Probably the first one in line. I would love to go to one of those. I have talked to a spiritual leader and he suggested I go to a sweat. He said it would help cleanse the soul, relieve some of the stress because it all gets out in the open.

Stone Woman explained the type of questions she would initially ask when visiting with a woman who comes to her for guidance:

Do you have an Indian name? Have you ever been to a sweat? Do you ever take medicine other than the European medicine? Do you ever talk to an elder? Do you ever go and pray? Do you pray? Do you use tobacco? Do you understand why we have tobacco? Do you understand about the smudging, the foreign medicines that we have?

Category 2

Traditional childbearing experiences in Anishinaabe practices did not include postpartum depression.

Stone Woman shared that she never knew what postpartum depression was, that if it ever existed, it did not have a name. She reflected back to the old ways:

They used to make teas for women so they wouldn't hemorrhage when they had their babies. They made tea. You know there are all kinds of different herbs out there. There are stimulants; there are things that can calm you down. There's all kinds of things out there that you can use.

After reviewing what postpartum depression is and how it affects the mother, the family and the infant, Stone Woman had a better understanding of how dynamic postpartum depression is and stated:

I think that would be a really good thing for the young women who have that depression, to go to a healing ceremony, go to a sweat, go to a pow-wow, go to a gathering, go speak to an elder, go and get a medicine. I'd

probably tell them there are pow-wows. Go and listen to the drums. Maybe go to a ceremony. Go ask somebody to make you some herbal medicine. Go back to your community, your mom, your grandmother and whoever is in your family and ask the questions that you need.

Category 3

Healing circles is a beneficial method of dealing with health problems.

Stone Woman further described the healing circle she used to lead and the openness of the people of all different ages and gender. There were notable differences in how they interacted and carried themselves even after two weeks of being a part of the healing circle.

She detailed the atmosphere and attitude of the healing circle in that people were relating to others and encouraging them to participate:

It was people telling the other people 'Go, go, go, you're going to feel really good. This person can get you some medicine, you'll feel really good.' On the other side over here, you have the sweet grass and the sage and the medicines burning, when you introduce yourself to the people, you let them know that's available to them. You don't try to push people to that, but you always have to use the feather so the feather can go around because a lot of times, a lot of Native Americans that I worked with were kind of afraid of that because of the negative things that went on in their lives because of them being Native Americans. But they wouldn't stay away from that too long.

They would go and face themselves. Our groups that I used to put up had no name to it; it was just a healing circle. It wasn't specifically for cancer or for alcoholics or drug use. We don't put ourselves in those categories. If you go to a healing ceremony, there will be people there that will give you that guidance and that support that you need. They'll help you recognize those little things. Sometimes those problems are so big to us, but to another person it's just a little thing. Until that person starts healing they felt like it was such a big problem. They feel safe when they come to these little circles. They can talk about the hurt that they carry. When you talk about that depression, that's a lot of invisible hurt that person is carrying when they go into that depression.

Theme Three

People cope in many different ways whether they go to the doctor, use medication, rely on family and friends, or use various community resources.

Category 1

The healthcare providers the women went to reportedly offered patient education on the signs and symptoms of postpartum depression; assessed them for the potential of self-harm or to others, counseling in person or over the phone, and reiterating the counseling options available to them on the reservation. They also reportedly encouraged the women to talk to anyone they felt comfortable with and trusted even if they are not a mental health or healthcare provider, but someone that will listen to them. They also gave

additional strategies to cope by taking naps when the baby sleeps and the importance of taking breaks for themselves when they start to feel frustrated or overwhelmed.

The women did realize there were other services to them on the reservation for postpartum depression and found help outside hospital grounds such as the Women's Shelter which was noted specifically by Margaret. Nancy works in the healthcare field and knew of the counseling options not only at the hospital but other programs on and off the reservation. She also explained:

There's a lot of places up here that offer counseling for different areas of depression, drug and alcohol. If you just call them and talk to them and they're not qualified to deal with that, they will find somebody to talk to right away. They are very helpful.

Barb admitted to not knowing the available resources for postpartum depression "I thought you just go to the doctor and they will prescribe you something and that's it, because it's like a temporary depression, so I didn't know there were any resources."

Margaret found her provider helpful by simply asking her how she was doing and assessing what were the top three things that made her feel depressed. She stated, "They sit there and listen to what I have to say. Some people think it's selfish or whatever, but from my point of view, it feels good to have somebody listen instead of being the listener. It made me feel good."

She also utilized the nurses at the hospital:

I talked to that nurse there, and it made me cry because somebody asked if they could listen to me. Usually I'm the one sitting and listening to

everybody's problems so it was good to have somebody listen to what I had to say. At the time, too, I didn't feel safe from myself. I liked having people around because it would distract me from thinking about hurting myself or my baby.

Category 2

Counseling and medication are a common mainstream treatment for postpartum depression.

Nancy reportedly felt more comfortable visiting with her provider who in turn referred her to a counselor. She expressed that the counselor was helpful:

He just gave me different suggestions on how to deal with things better and that I should feel more comfortable with taking off from my kids instead of getting up so early to be alone for a while. But it is important that I get away from everybody for a while. He suggested keeping a journal to write down how I feel. He said 'maybe it will even give you a better perspective on what you're feeling and what it takes to get you back on track.'

Not all of the women felt like they were offered appropriate services by their healthcare provider, Barb stated:

Ya, my doctor really didn't have any resources and didn't refer me to any counseling or anything. He just prescribed medication and that was it. I find a little more support, like referred me to counseling or a therapist, because doctors really don't provide therapy, just your

symptoms and your medication. But he didn't provide any counseling or anything. Now that I look back on it, it probably would have helped me.

The doctors offered medication and drug patient education to all the women. Of the women that chose to take the medication they reported that they responded well to the pharmacotherapy. Barb detailed her experience with how she felt before and after taking the medication:

It seems like your mind doesn't stop running with things going through your mind. At first I didn't feel it was helpful because it takes a while for depression drugs to start working. Then I got on this one and it made me feel just fine. I was losing weight and everything for about a month. Then it seemed like after a month I was on it seemed like I just crashed and it got worse. My depression got worse all in one day.

Margaret recalled how she felt before and after taking the medication:

It helped out quite a bit. They kind of cleared the picture for me. Before it was like everything was chaos. It was like blurry and I couldn't grasp anything. I couldn't get a handle on things. By the end of the two weeks I was more upbeat, I was happy, I had no bad thoughts. My kids noticed it. My provider basically told me to 'stay on the medication'; she noticed that it was helping.

When discussing using provider prescribed medication, counseling or Traditional healing to treat postpartum depression, Stone Woman stated:

The difference there is that when you take a pill, you're still by yourself, but if you go to a healing ceremony, there will be people there that will give you that guidance and that support that you need. We all have that connection as to what a young woman would need at that time when they are going through that depression. She wouldn't be left out in the cold. I don't know how this illness has come to where you have to start taking all of this medication, like antidepressants you talked about. I wouldn't recommend that to anybody because that's not a good thing. I just think there are other ways that moms can get counseling. I think that there are places she could go to get counseling.

Category 3

The role of family and friends in providing support to a woman with postpartum depression can have positive and negative effects.

The role of families and their support to help a woman cope is an important one when dealing with postpartum depression. Barb in particular felt that she could manage her depression by leaning on her family and didn't need to visit with a counselor. She had other family members that had experienced postpartum depression and they talked with her about their occurrence. Her family offered support by inviting her along when they did errands, or asking her to go out for the evening or simply asking how she was feeling and doing daily. She stated "They

usually know when I'm feeling bad. It's really helpful. I'm glad I have a supportive family.”

Nancy's experience was different; she stated “I didn't have a lot of support. My family is a really close family, but everybody pretty much does their own thing and everybody is always really busy, and it was really hard to keep everything together.”

The impact of the women's friends plays a significant supporting role. Helpful acts of kindness from friends included visiting with the women, baby-sitting, going to Bingo, “getting them out of the house” or “taking a ride.” Sometimes it was tough love as in Nancy's case when her girlfriend told her “you've got to get it together” or “really what you need is a swift kick in the butt because life is pretty good and you shouldn't be complaining.”

Getting help with the baby or household chores was something all the women expressed as a need to help them better cope with postpartum depression. With constant feelings of guilt for not feeling that they can handle “being with the baby” or “not being able to keep up with the house” or spending less time with their other children was an emotional, stressful struggle. Nancy stated “I didn't have a lot of help. My boyfriend was home, but he didn't like to get up with the baby at night, so I was getting up every two hours for the first few months.” Once she recognized she had symptoms of postpartum depression, she took the initiative to ask him for more help. She stated:

He started helping with more of the house things, like doing the dishes, sweeping and mopping and doing the laundry, making that stuff easier for me. But he still won't cook. And when he started taking over more things at home, so I didn't have all that much to do.

While Barb's boyfriend is reportedly now comfortable taking care of the baby by himself and encourages her to go out or take time for herself, she stated:

This is his first baby and he is just learning. In the beginning it was just all me taking care of the baby by myself. He would just mainly watch, but now it's better because he has seen me take care of him and he's getting a little bigger now and he's not as scary to handle.

Everyone's scared of a newborn, you know, they might break.

Margaret's situation was different than the others in this aspect. When her provider recommended to "stay off her feet" and that she needed to delegate chores to others in her family, her 'significant other' felt like he contributed in this area and was not receptive to her request for more help around the house. She stated:

But he had to do more like everything that I had to do, like cleaning the house, getting the kids ready, getting them up for school and then cooking, cleaning, laundry. He didn't take to it too good. He started doing everything again, but only doing it half as good, not doing the chores completely. He would start the laundry. He would have them all sorted out and usually he would only do half of everything and he would leave the rest. I asked my oldest daughter if she would carry

some clothes down for me. I said I can at least stand there and throw them in the washer, but I said you have to go down and finish it, put them in the dryer, take them out, put them up and I said I can sit and fold them. So I was more or less getting involved in that when I wasn't supposed to be.

Theme Four

Connectedness is a strong Traditional value among Anishinaabe people.

The term connection can have different meanings, but is defined as “the act or state of connecting, anything that connects; link, usually connections associates relatives, or friends especially considered as having influence or power” (Webster’s Dictionary, 1992, p. 288). Connection can have different forms such as through communication, family, baby, community or culture, or a disconnection to these forms can occur as well.

Category 1

Postpartum depression affects how Anishinaabe women bond with their infants.

Postpartum depression affected two of the women and how they bonded with their babies. They expressed that it made them feel like they could not care for their babies, Nancy stated:

I still took my baby to daycare so I didn’t have to deal with the baby. It really bothered me and I didn't feel very close to my child. It was like the first few months I felt like I had to take care of her and I really felt like I didn't feel that much for her. I still took really good care of her, I just fed her and I really didn't pay that much attention to her.

Barb's feelings are parallel to Nancy's when discussing her depression and its effects on her ability to bond with her baby. She explained "I think it interferes with it, like sometimes he'll be crying and then I'm feeling down and it's like I wish somebody would come and take care of him for a little while. I wish I could go somewhere."

Category 2

Disconnection from Traditional ways creates instability in families.

Stone Woman suggests that women are not as connected to their babies. She stated:

They don't breast feed. They go out and buy milk. They give their babies powdered milk, and I think that's where that connection, they need to bond with that baby. I know when you breast feed your baby, you bond with that baby.

Stone Woman believes that the people are so disconnected from who they are from today and yesterday that this factors into their connection to their infants. She also alludes to the availability of cars, gambling and drinking which impacts the time spent with their children and infants. She stated, "There are just too many other things that people do. They don't want to give time to the baby, but they want to run and go and play now." In addition, she feels there is a lack of education for birth control, parenting and too many teenagers becoming pregnant.

She shared a personal story depicting this from when she was growing up:

That was really inappropriate for a person to do, even though when I was growing up I knew that started to happen with my brothers and

my sisters. That's when I came in to be a caretaker for those little ones. So, they were left behind and they were going out and doing what they needed to do. So they didn't have that stability. Even if you take a look at my nephews and nieces today, they still have that insecurity, and not really stable maybe in their work or they're not stabilized in their home.

Category 3

Disconnection from Traditional practices has a profound effect on self identity.

The women were disconnected from themselves in terms of not being able to get enough rest, missing work due to their depression, getting up at the early morning hours to have time for themselves, or feeling like they are the only ones caring for the baby. Margaret detailed how disconnected she felt from herself, she stated "I didn't feel safe from myself. I liked having people around because it would distract me from thinking about hurting myself or my baby."

Stone Woman offers direction for women feeling disconnected to themselves, she stated:

Ceremonies that we do have are very spiritual, and getting to know yourself and really connecting and trying to look at yourself in the mirror and like who you see. Because when somebody is unhealthy and they go injured or something missing in their life, there's something really missing in their life and there's a big hole there. Maybe there's not that love there so there's a big hole there, so what

do you want to put in that hole? Do you want to put European medicine in there, or do you want to learn how to love so you can fill that hole with love?

From Stone Woman's experience as a Traditional leader she realizes that these women who are disconnected from themselves may not understand their own background. She stated:

I think that's why a lot of young women have a hard time after childbirth, because they lost that connection; they don't know who they are, they don't know where they came from, and some of them don't even know how they got pregnant. Some of them don't even have husbands, so it's really hard for them to bond with their babies. They might have been raped, why they got pregnant and they're certainly not going to have anything to do with their baby. Then, maybe they grew up in a big city and lost that spiritual connection even more so.

Category 4

Decreased interactions in relationships hampers communication and trust.

Disconnection with a spouse or a family member resulted in more tension, worry and anxiety for the women. Nancy shared the dynamics of her current relationship with the father of her daughter:

He's gone a lot. We don't get along that well lately. So it's kind of a good thing that he's gone a lot. Now we work opposite hours, so by

I was like, don't do that, don't ever look at that and he's like I wanted to see what you wrote about me and I'm not really that bad. I said it's just my personal thoughts about things and nobody is supposed to read it. After that I didn't write in it.

For Margaret, she knows she “doesn’t want my kids without a dad.” However she contemplated the connection with her significant other and their children. She states:

The past eight years, maybe seven, our relationship got worse. I said, but we ended up having two other kids. I said I don't know if it was for our relationship or because we wanted to have them. He’s not taking responsibility. I said I kind of feel like in the old days when they want their women home, pregnant, barefoot. Or more or less a maid; that's the way I look at it. I'm not for that; I don't want that.

Mentioned earlier in the section on coping, the influence families have on the women experiencing postpartum depression is great; not only do they play a role in coping but the connection they have with that woman gives shape as to how the woman progresses through the depression. When Stone Woman evaluates the disconnection that the women experience with their families, she states “They're not getting it because they lost their culture way back. They lost their closeness in their families.

Nancy stated her connection with her family is a close one, but she says that when she experienced postpartum depression, she stated:

I didn't see them very often, and when I did see them I was pretty distant. I would just say, yep, everything is fine, don't worry, I'll see you later. I didn't want to talk about it, so I was kind of very standoffish about it.

When Nancy's counselor advised that she communicate with her family more about what she is going through, she stated:

I said, no, my mom's got her own issues and my brother, I wouldn't talk to him about anything. My sister would be really good to talk to, she's really helpful if you let her, but she's also really bossy. She's the oldest one, so she thinks I don't know anything. We get along great now, but all the time we were growing up, I don't think we liked each other until after I was 18. Before that we growled at each other, I hate you. We fought a lot, that's about it.

The ability for the women to communicate with others was imperative to their recovery. Barb's past experience with postpartum depression allowed her to communicate with her family and boyfriend and "warn" them of what to potentially expect.

Stone Woman blames instability in the home for lack of communication and trust. Whether it is communicating with an elder, the ability to trust the person whom a person seeks help from (i.e., healthcare professional, Traditional healer, family or friends) or the method of properly disciplining children, she stated:

Nobody is communicating. Nobody is really talking anymore. When I grew up, we had to help. Nowadays you almost have to scream at a child before they help, but back then you knew what the routine was and everybody just helped. Back then everybody was around, everybody helped. What do you need to hear? Everybody was there.

Category 5

When people rely on their community they are able to cope with their problems in a more effective manner rather than dealing with it on their own.

Opening up to a community can often times make people feel too vulnerable.

Nancy gives an example of this; she stated:

I don't know; I just really didn't want to. Because it's a lot of people that I work with, too, and it's like, no, I don't want to. No. I knew a lot of them personally since I do counseling and all that, and I just thought no, I don't want to work with them. If I had reached out faster and to more people, I know it would have been easier, but I chose not to, but I don't know why.

Barb has a similar reaction to leaning on her community, she shared:

At the time, no, I didn't really even want to talk to anybody at the time. Now that I look back on it, it probably would have helped me. Just talking with people and telling people actually how you feel about it, because if you don't it makes it a lot worse. Keeping it to yourself it gets a lot worse. After I started opening up, it got better.

When Barb shared her postpartum depression with others, someone gave the response of “It’ll pass, you have to get over it,” which she felt was not beneficial. She stated, “But if you don’t get help, then you can’t get over it.” She further gave specific examples of hurtful statements from her community, she stated:

I can't remember who said it, but probably the main thing that wasn't helpful was somebody saying that everybody goes through it, all the moms go through it and it will pass. Just deal with it and it will pass. Give it a couple of days, or by tonight you'll feel better, you'll get over it. That was probably the main thing that wasn't helpful.

Stone Woman can not stress enough the importance of a person being connected to their culture, spirituality and themselves. She mentioned this not only for American Indians but other cultures as well.

She emphasized that people are “only as strong as their spirituality, if you don’t have faith in nothing, you are going to fall apart.” She gave the example of having an Indian name, she stated:

Those spiritual names are so important, and if you don't have that, you don't have that good aura that we need. I don't know if that's the right word I should use; does that sound right? You don't have that and when something or somebody hurts us, it's like that low string of web breaks and trying to put that web together. How would you put that web together? There's not really much you can do with that web; it's going to stay broken until you start talking and doing what you're

supposed to do to get yourself spiritually strong. I've worked with many different types of people and they all come to the conclusion that if you're not spiritually strong or you don't know yourself, you're going to be unhealthy. You're going to be weak. You're going to get weepy. You're not going to make good choices if you're not spiritually strong, if you don't know your culture, because you're walking on aimlessly, trying to look for something all the time that can fill that hole that spirituality fills.

Summary

I have identified various themes and categories that attempt to encompass the content of these interviews, while summarizing similar or dissimilar views using among the women and the Traditional leader.

While each has its own distinct theme and category, there is a significant amount of overlap since they all interconnect with one another. This will be further discussed in Chapter 5.

CHAPTER V

DISCUSSION AND CONCLUSIONS

This chapter will address recommendations to healthcare professionals; summarize findings of the themes and categories identified from the interviews, special contributions to practice, future research opportunities and conclusion.

Recommendations to Healthcare Professionals

Healthcare professionals working with Indigenous people need to better understand their culture, health beliefs and practices. Providers can become familiar and educate themselves on the culture by participating and doing so without feeling they are intruding. Stone Woman shared her recommendations for healthcare providers, she stated:

The very first thing that would need to happen in any community is the health providers, like I said, have to educate themselves into the communities. They have to go participate, maybe a pow-wow is even a beginning. Why do they have pow-wows? Pow-wows are a place where a person goes, they dance, the dancers. The girl is beautiful. Nevertheless, they are out there dancing for the people that are sick everywhere. Not only in the community, but everywhere. And not excluding the white people, the black people, the yellow people. They're dancing for everybody and even the drums, when you hear

them say the drums vibrate out into the universe. It just doesn't stop there. When a person needs that healing and if they have that connection with a spirituality, they're going to get that healing from that drum 10,000 miles away. That's how it works. They dance for the nation and plead for the nation. They could hire a Native spiritual person, a medicine person, somebody that is not shy to talk about certain things about abuse, alcoholism, the sexual abuse, the incest. All of these things have to be talked about and we can't judge those people for whatever happened to them. In Minnesota they have treatment centers that have sweats and they have an elder that works there with the people. Not only one elder can do that. You need at least about four elders to fulfill that kind of job that those elders are doing right now.

Stone Woman further specified key questions healthcare professionals should ask their patients:

The best thing you can tell her is do you have an elder in your community? Do you know about your culture? We do have somebody on hand that you can talk to. You can give her a call if that's who you want to talk to.

Clarification is needed in respect to the appropriateness of inquiring about a patient's cultural beliefs or Traditional health practices. Struthers et al. (2005) commented that it is not respectful to ask an Indian directly without knowing them and what their views and beliefs are in Traditional medicine. Marbella et al (1998) discussed the fact that asking these key questions about patients' views on their health and what they practice is a great way to integrate both healthcare practices in order to adequately meet the spiritual and physical needs of the Indigenous patient. Ultimately both sources are correct and offer the notion that providers must establish trust and have a good, open patient-provider relationship in order to ask these personal questions to give holistic care.

In essence, patients prefer to have their health care provider address all the factors affecting their specific chief complaint during their visits, not just episodic visits solely. It is the providers' responsibility to address all aspects of a patients care in order to provide competent holistic care. More importantly, it is not the sole responsibility of the provider to initiate all the effort. Patients must take responsibility of their own health in terms of seeking care for their concerns by being receptive to the information given to them by their provider, participate and communicate their concerns, frustrations and successes. In addition, health care providers are simply one aspect to a person's well-being. Patients know themselves best when reflecting upon themselves honestly. Struthers and Eschiti (2005) echo this by adding that "working in Indigenous forms of healing, a lot of the answers, they feel that you have inside of yourself" (p. 86). While

this task is difficult and trying at times, patients can work through these challenges by utilizing other healthcare resources to help guide them through this process. The following section summarizes the findings to the categories and themes identified from the participant interviews.

Theme One

The women expressed multitudes of emotions, specifically anger, feelings of being unprepared, guilt and stress that they all felt were causative and reflective of postpartum depression. All of the women felt anger, namely for being the sole caretaker of their infants and other children as well as household responsibilities. Common responses from the participants were that their spouses were not helpful in these areas as well as not understanding what they were going through in terms of how they were feeling or postpartum depression in general.

Two of the participants felt unprepared; one woman detailed that she felt unprepared because she did not plan on having another child as her youngest at the time was 4 years old. So now she feels there is a gap and has to “remember” how to care for a newborn all over again. The other woman participant “forgot” how hard it was to adjust to late night feedings, feeling tired, lonely and her decrease in interaction with others. Both women were surprised by their own feelings and emotions and felt guilty for having them, a category which will be discussed next.

Two of the women felt guilty for needing to take time for themselves, and needing to get away from the baby. Not doing so seemed to add to the stress of experiencing postpartum depression. Stress was a feeling all the participants reported experiencing; the other categories within this theme are determinants that result in feelings of stress. Specific tasks that were overwhelming include balancing work, not enough personal time, experiencing illness themselves and worrying that they will get their infant sick as well, lack of spousal support in terms of being emotionally understanding of their feelings and taking on more responsibilities to help with the children. The women then had to juggle household responsibilities such as cooking, cleaning, laundry and grocery shopping in addition to primarily caring for the newborn all while battling postpartum depression.

Theme Two

Gatherings is a term defined by Stone Woman a Traditional leader as a way for people to come together to unify as a culture to celebrate, heal, pray and support one another. Specific examples of gatherings include pow-wows, sweats, ceremonies, and healing circles to name a few.

None of the women participated in gatherings, whether it was because they were not exposed to these traditions, because they do not have grandparents or elders in their family that actively practice Traditional ways of living; do not understand what it all means, simply do not know it's available or think people still practice. Two of the women

expressed interest in participating in Traditional healing if the opportunity presented itself.

In meeting with Stone Woman, I had to explain what postpartum depression was and how it affects the mother, baby and the family as Stone Woman had never heard of postpartum depression prior and if it did exist, it did not have a name. After this discussion she gave specific examples of questions she would ask a woman experiencing postpartum depression who came to her for guidance. The questions are as follows: "Do you have an Indian name? Have you ever been to a sweat? Do you ever take medicine other than the European medicine? Do you ever talk to an elder? Do you ever go and pray? Do you use tobacco? Do you understand why we have tobacco? Do you understand about the smudging, the foreign medicines that we have?" Stone Woman further gives specific Traditional activities for the women to participate in such as powwows, healing circles, sweats, and visiting with a trusted elder. It is important to understand that these gatherings are for all people and is a place where people can go and trust, and as an example healing circles are for anyone experiencing difficult times whether it is depression, drug-alcohol dependency, battling cancer, it does not matter. Everyone is welcome to come and participate, even if you just go and listen. There are people there to help, guide and truly care about the participants' well being and that people do not need to go through life alone.

Theme Three

All of the women went to visit a health care practitioner to get help with their postpartum depression. Two of them took medications, while the other women chose not to. Two of the women knew of additional outside resources that were available to them, whether they decided to utilize them or not was not explored in this study. One woman did not realize the other services outside of the hospital “because postpartum depression is a temporary depression.”

All of the women felt that talking to someone was most helpful, whether it was a counselor, nurse, friends or family this seemed to be most beneficial in how they coped. Other strategies that worked for the women in how they coped were taking naps when the baby slept, getting out of the house with friends, journaling for a brief moment for one woman and taking prescribed anti-depressant medication. Stone Woman explains that the problem with taking medication is that you are still by yourself, however if the women participate in Traditional gatherings they will have unlimited support and guidance.

One woman felt that her provider did not offer or educate her on all the resources available for her to utilize and found this frustrating, other factors that were not helpful for another woman were comments from community members stating “everyone gets depressed; you’ll get over it by tonight”. In addition all of the women expressed the need for more help from their significant others to step up and help with the baby and household chores. It also appears that their significant others do not understand

postpartum depression and what responsibility they have and should contribute to the family. Furthermore, even after being told by these women how they can be more helpful, all of the men initially were not responsive and after several months only one man started to become accountable and responsible. The reasons for the lack of spousal support was not reviewed or explored in this study.

Theme Four

Two of the women felt that they were not able to care and bond properly with their babies because of their depression. Other forms of not being connected include disconnection from themselves by not getting enough rest, being the sole caretaker in all aspects of being a mother, household tasks and also missing work due to depression.

All of the women were disconnected from their spouses at one point in time; in two cases it seems to have stemmed from a lack of communication and mistrust, and another woman felt disconnected from her family as she details being in denial about her postpartum depression.

Communication appears to be a key factor in how the women progress through their depression. In one instance one woman was able to tackle her depression before it even occurred by warning her family and spouse of her prior experience with postpartum depression and what helps to get through it. So when she started to have the same feelings again with her newborn, her family was prepared.

Stone Woman blames instability in the home for the lack of communication and trust, and the loss of relying on community members for help and guidance.

None of the women discussed their connection or disconnection from their spirituality or faith as being a factor for their depression or in how they dealt with depression.

Furthermore, Stone Woman stressed the importance of a person being connected to their heritage, spirituality and themselves to living a good, healthy life. Each of these themes and categories all relate and has an effect on one another. Feelings of anger, being unprepared, and guilt all lead to potential stressors in a person's life. The ability to communicate makes a significant impact as well; addressing these feelings in an effective manner may or may not pose a different recovery experience.

Special Contributions to Practice

This study helps give health care professionals specific activities they can participate in to educate themselves on American Indian culture, beliefs and healthcare practices. In addition, specific questions a healthcare provider should ask their Indigenous patients were given to help guide the practitioner on giving culturally competent care. The provider should take the initiative to learn about the culture and meet with the Traditional leaders; this will help establish an open trusting relationship with the Native community and patients. In addition, the providers will have future references for patients who wish to implement Traditional healing into their care based upon first hand knowledge, not their own opinion.

In terms of policy development, healthcare facilities and organizations should strive to attain Traditional healthcare as a billable service. These facilities need to have regular cultural awareness training; this can be done by involving the community and encouraging staff to engage in gatherings. The literature review echoes this suggestion of cultural training. It is proposed that academic institutions need to start incorporating more culturally diverse classes into their curriculum for their medical students; this should be applied to all professions that interact with patients.

The need for hiring a Traditional healer to be staffed within the healthcare facility or where deemed needed is documented in the literature and Stone Woman validates this view as well. It makes sense to hire and staff the people that currently practice and believe in the cultural Traditional ways versus staff that are not as familiar and do not practice Traditionally and expect them to adequately address their patients holistically. This does not mean providers are not accountable to educate themselves on the matter, but they will not be and are not experts and patients deserve more than adequate care.

Recommendations for Future Research

Suggestions for future research may include a study focusing on an intervention with women before and after participating in a healing circle, or studying the healing circle ceremony itself. There needs to be further investigation of why women chose to use or not use available resources for support and exploration of the reasons why men lack in spousal support during the postpartum depression period.

Conclusions

The study brought out many things that are not found in the literature namely the themes and categories identified, the significance of social, family, and community support, cultural practices and simply research conducted for the American Indian women population. The literature touched more on emotions and feelings of tearfulness, sadness and mood swings and did not address coping mechanisms, resources utilized or the used of a cultural approach for any ethnic group.

While generalization is difficult beyond this sample studied, one potential prospect could be related to available coping resources from reservation to reservation. While these resources and funding options are unique to each Tribal Nation, Traditional healthcare practices are available without regard to these programs.

Stone Woman's wisdom and perceptions parallel what was detailed in the literature, such as in Dodgson & Struthers' (2005) study regarding being disconnected from Indigenous traditions and the association with illness and imbalance in a person's community and health. Stone Woman also proposed hiring qualified Traditional healers in various settings; this notion can be applied to the study conducted by Marbella et al., (1998) where cultural issues need to be addressed appropriately in an academic setting so students may learn properly how to interact with diverse patient populations.

This study reminds us that often times it is easy to become stagnant in one aspect of life, and not looking at and nurturing the whole picture can lead to unhealthy behaviors,

illness or disease. It is critical for people to come together and support one another whether it is in a time of need or to celebrate. All people have something to offer, and people should be given the opportunity to share their stories, and gifts to help others. It is therapeutic for both parties and the connection to each other will be strong and the community will thrive.

APPENDICES

CONSENT TO PARTICIPATE IN RESEARCH

PROJECT TITLE: Postpartum Depression in American Indians

PROJECT DIRECTOR: Natalie M. Nicholson

PHONE NUMBER: 218-333-3573

FACULTY SPONSOR: Dr. Bette Ide

Introduction:

You are being asked to take part in a research study being conducted by Natalie Nicholson for a thesis under the supervision of Dr. Bette Ide of the University Of North Dakota College of Nursing in Grand Forks ND.

You are being asked to participate because you have notified a community health home visiting nurse that you have experienced postpartum depression within the past two years and are an American Indian woman who resides on Red Lake Indian Reservation in Red Lake, MN. There will be three women total who will participate and one traditional community elder who will be interviewed for this study.

Please read this form carefully and ask any questions you may have before deciding whether to participate in the study.

Purpose:

The purpose of this study is to better understand the postpartum depression experience of American Indian women and further examine their personal experience as to how they coped utilizing various resources such as family, friends, local and healthcare options. In addition by seeking guidance from a Traditional Community Elder this will help guide American Indian women on how they can care for themselves in the postnatal period in addition to how providers can properly manage their care would ultimately provide a framework for the future.

Procedures:

If you agree to be in the study, you will be asked to:

- Have your words audio-taped
- Have the individual interview of about 1-1.5 hours about: your postpartum depression experience, how you felt, concerns you have/had about your baby, explain the help that was given to you from your family, friends, healthcare givers (western medicine), traditional women and/or grandmothers (Traditional medicine/healing)?

**University of North Dakota
Institutional Review Board**

Approved on MAR 14 2008

Expires on MAR 13 2009

Risks/Benefits:

There are no known risks in being part of the research besides those you experience in everyday life. There are no direct benefits to you as an individual but the results from this study may benefit other American Indian women who experience depression after the birth of a baby.

Compensation:

You will receive a \$15 gift card to Wal-Mart for participating.

Tribal Ownership:

- Typed transcripts without identification of the people who spoke will be returned to the tribe.

Researcher Ownership:

- When audiotapes are typed, names will be changed in the transcripts.
- Besides the researcher, her teachers may review the transcripts and notes as they help her learn the research process. The Institutional Review Board auditors may also have access to the data to ensure proper procedure and handling of items to protect subjects, participating facilities, the student and the university.
- Requirements for mandatory reporting of child abuse will be followed.
- Tapes and transcripts will be stored in a locked cabinet at the UND College of Nursing Center and available to the researcher only. Consent forms will be stored separately from transcripts. Audiotapes and consent forms will be shredded after 3 years.

Voluntary Participation:

Participation in this study is voluntary, you have the right to refuse or withdraw at any time throughout the process without penalty. The decision to not participate will not affect your current or future relationship with UND Nursing Center.

Contacts and Questions:

If you have any questions about this study, please feel free to contact the researcher, Natalie Nicholson at 218-333-3573, and or the faculty sponsor, Dr. Bette Ide at 701-777-4531. If you have questions regarding your rights as a research subject or any other matters, you may contact the UND Department of Research, Development and Compliance at 701-777-4279.

University of North Dakota
Institutional Review Board

Approved on MAR 14 2008

Expires on MAR 13 2009

Statement of Consent:

Your signature below indicates that you have read and understood the information above, have had an opportunity to ask questions, and agree to participate in this research study. You will be given a copy of this form to keep for your records.

Participant's Signature

Researcher's Signature Witness

Date

Date

University of North Dakota
Institutional Review Board
Approved on MAR 14 2008
Expires on MAR 13 2009

Edinburgh Postnatal Depression Scale¹ (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:

- Yes, all the time
- Yes, most of the time This would mean: "I have felt happy most of the time" during the past week.
- No, not very often Please complete the other questions in the same way.
- No, not at all

In the past 7 days:

- 1. I have been able to laugh and see the funny side of things
 - As much as I always could
 - Not quite so much now
 - Definitely not so much now
 - Not at all
- 2. I have looked forward with enjoyment to things
 - As much as I ever did
 - Rather less than I used to
 - Definitely less than I used to
 - Hardly at all
- *3. I have blamed myself unnecessarily when things went wrong
 - Yes, most of the time
 - Yes, some of the time
 - Not very often
 - No, never
- 4. I have been anxious or worried for no good reason
 - No, not at all
 - Hardly ever
 - Yes, sometimes
 - Yes, very often
- *5. I have felt scared or panicky for no very good reason
 - Yes, quite a lot
 - Yes, sometimes
 - No, not much
 - No, not at all
- *6. Things have been getting on top of me
 - Yes, most of the time I haven't been able to cope at all
 - Yes, sometimes I haven't been coping as well as usual
 - No, most of the time I have coped quite well
 - No, I have been coping as well as ever
- *7. I have been so unhappy that I have had difficulty sleeping
 - Yes, most of the time
 - Yes, sometimes
 - Not very often
 - No, not at all
- *8. I have felt sad or miserable
 - Yes, most of the time
 - Yes, quite often
 - Not very often
 - No, not at all
- *9. I have been so unhappy that I have been crying
 - Yes, most of the time
 - Yes, quite often
 - Only occasionally
 - No, never
- *10. The thought of harming myself has occurred to me
 - Yes, quite often
 - Sometimes
 - Hardly ever
 - Never

Administered/Reviewed by _____ Date _____

¹Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

²Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

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