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Postpartum Depression

"Sufferers' point of view"

A Qualitative content analysis

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Abstract

Motherhood is a major milestone in the life of a woman. The birth of a child might bring pleasure, but it also produces rapid and significant physical and psychological changes. Consequently, the postpartum period is a high-risk time for the beginning of postpartum depression in mothers. Postpartum depression is undertreated. Many women believe that sadness at what should be a joyous time is embarrassing, while others are affected by society's overall stigma around mental health care. The study aims to explore mothers' holistic experiences with postpartum depression from their own narratives. In this qualitative study, Data was collected via primary sources such as blogs and narrative books and analyzed using inductive content analysis methodology. In total, 32 stories were used in this study, all written by women who suffer from postpartum depression.

Five themes emerged from the content analysis: "Onset of PPD, Underlying cause, Before getting help, Challenges with diagnosis, and Journey to recovery." The onset of PPD" describes the debilitating symptoms and emotional struggle the mothers face at the commencement of the depression. The second theme, "underlying causes," discusses what the mothers believe caused their depression; the Third theme, "Before getting help," is about how they try to control the situation before seeking help; The fourth theme, "Challenges with the diagnosis," indicates what hinders the women from not being diagnosed and the final theme "Journey to recovery" about how they acknowledge and were treated for their depression.

The finding could give insight that may be beneficial for potential mothers, those who live in the shadow of Postpartum depression, midwives, nurses, and clinicians, in getting a deeper knowledge of the experience of women suffering from the illness and their coping mechanisms and the challenges they confront. The outcomes indicated the most prominent symptoms, feelings, the advantages of various interventions, the mothers' coping strategies, and what works best for them during the recovery process.

Language: English Key words: postpartum depression, Mothers, Maternal Depression, Treatment, coping-mechanism

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Contents

1 Introduction

Postpartum depression is one of the emotional stress women struggle with during their lifetime. Untreated postpartum depression not only affects the mother, but the consequences could affect the infant, her family, and upcoming maternal periods. During my internship in the psychiatry ward, I come across women who suffer from postpartum depression with a pre-existing history of other mental disorders. Most of the women were previously treated for major depressive disorder, bipolar disorder, and schizophrenia. They were unaware of the cause of their new emotional changes or confused by the symptoms of the previous illness. I was interested in knowing the cause, risk factors, and coping mechanisms for depression. Moreover, I was keen to know the women's experiences; how they learned about their illnesses and got cared with or without clinical intervention.

The idea of having a child and experiencing motherhood is the most exciting phenomenon for most women. However, the period of pregnancy and motherhood could also be challenging mentally and physically (Jarosinski & Fox, 2016). The change in hormones during the perinatal period, social status, early age pregnancies, history of depression, and genetics, could make women vulnerable to developing depression (Alba, 2021).

According to the World Health Organization, mothers may not only suffer substantially in daily life as a consequence of depression, but they may also be unable to respond to the needs of the newborn and other children (WHO,2021). Evidence suggests that treating the mother's depression has a significant impact on the development of the newborn and raises the chance of the baby's well-being (Rodriguez-Cabezas & Clark, 2019).

The prevalence of PPD varies globally, based on the screening method, diagnostic tool, amount of stigma, and time frame used to determine the incidence (Slomian, 2019). Around one in every eight women worldwide suffers from postpartum depression symptoms (CDC,2021).

The cause of PPD is yet unclear (Alba, 2021). Despite numerous studies on PPD treatment and intervention guidelines, it is still underdiagnosed and undertreated (Fonseca et al., 2020). The reasons are a lack of awareness and confusion among women; they might not consider their depression as an illness and seek treatment. Furthermore, since the symptoms of PPD may overlap with those of postpartum blues and postpartum psychosis, an early diagnosis of PPD may be challenging (Alba, 2021).

2 Background

As a background study, previous research on maternal Depression, postpartum depression (PPD)and its symptoms, risk factors, screening, prevention, available treatment options, and obstacles are explored and presented as sub-chapters.

2.1 Maternal Depression

According to the American College of Obstetricians and Gynecologists (ACOG), During pregnancy (prenatal) or after delivery (postpartum), a significant percentage of women experience perinatal mood and anxiety disorders (ACOG,2017). Postpartum mood disorders occur shortly after delivery and may linger for up to a year (Thippeswamy & Davies, 2020).

A person with a mood disorder has trouble having a normal mood state. Inconsistent mood disturbance exhibits feelings of “high or low mood, extreme sadness or happiness, emptiness, irritability, cognitive disorganization, insomnia, hallucinations/delusions, and rare or frequent suicidal or infanticidal ideation “(Thippeswamy & Davies, 2020). In recent days Postpartum mood disorders encompass many conditions such as anxiety, depression, bipolar disorder, obsessive-compulsive disorder, and post-traumatic stress disorder (PTSD). Traditionally the most common postpartum mood disorders with the depression spectrum are baby blue, postpartum depression, and postpartum psychosis (Sharma et al., 2015).

Depression, commonly referred to as clinical depression, is a mood disorder characterized by depressive incidents(episodes) for two consecutive weeks. Depressive episodes are states of emotion with the symptoms of; lack of concentration, memory problems, insomnia, difficulty in making decisions, exhaustion, and feeling insignificant. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), the patient should exhibit at least five of these symptoms of to be diagnosed major depression (American Psychological Association, 2013). The intensity could differ from having episodes the whole day or every other day. Having a depressive episode prohibit one from being productive at work, school, or engaging in social activities(Alba, 2021).

Stress is considered one of the triggers for the brain's chemical imbalance, causing depression or mood disorder. Depression can affect women at any age, but pregnancy could be the most anxious period to initiate a depressive disorder or aggravate an existing one. Women are more likely than males to suffer from depression. When one's parents or a family member is diagnosed with depression, the chance of inheriting depression is 40% (American Psychological Association, 2013). About 10-12% of women experience depression during the "perinatal" period, during pregnancy, or postpartum for one year (Shidhaye, 2014). In Finland, Depression during pregnancy and postpartum is around10–20% among both mothers and fathers (THL,2022).

2.2 Postpartum Depression

Considering having a baby as an overwhelming experience, Women may normally experience more emotional distress after giving birth. The emotional distress might manifest by symptoms of crying, feeling of emptiness, inconsistent sleep, and being anxious. This feeling can be experienced by 50-80% of women who have given birth (THL,2022). The mood change might come along with chemical changes of quick decrement in hormones after delivery. The levels of estrogen and progesterone hormone increase during pregnancy, then it will fall after delivery (Alba,2021). Mild symptoms of this emotional distress referred to as “baby blue”, begins with the first week after delivery and usually disappear within two weeks (Alba, 2021). However, these symptoms could intensify till depression roughly in one fifth of the mothers. Persistent symptoms after two weeks could be an indication for PPD (THL,2022; Shidhaye, 2014).

PPD is a non-psychotic depression, the etiology being unknown, it might occur due a combination of psychological, physical, and behavioral change to a woman after delivery. It is expressed with range of emotional changes. Clinically PPD exhibits the same depressive episode as major depression, except the women experience it in the postnatal period (O'Hara & McCabe, 2013). With the guideline DSM-5, a manual used to diagnose mental disorders, it is a major form of depression that begins with four to six weeks after giving birth. The major difference of opinion to distinguish PPD from major depression is timing, the onset and duration period (American Psychological Association, 2013).

The depression might affect both individual mothers and infants, creating significant challenges for the family, parenting, and child development. Mothers who have PPD are more likely to have lower self- efficacy, emotions of sadness and worthlessness, feeling incompetent, and a diminished sense of self-esteem (Ghaedrahmati et al., 2017).

Between studies, the estimated prevalence of depression and the incidence varies. According to THL, the first three months following birth are the most typical time for PPD (THL,2022). It usually occurs between 2 and 6 months after birth (Frieder et al., 2019). One may recover from PPD, the recovery takes a few months, but it can relapse with possible future pregnancies at 50-60%. PPD symptoms may vary from moderate to severe, and although it is possible to recover completely, it can also result in long-term anxiety and despair (THL,2022).

According to a meta-analysis of 291studies from 56 countries, the global pooled prevalence of PPD was 17.7% in 2018. In developing countries, the occurrence is around 19 percent. In Asia, the prevalence of postpartum depression is relatively high and varies greatly, ranging from 26 to 85 percent (Hahn-Holbrook et al., 2018).

2.2.1 Symptoms and Signs

The commonly described signs and symptoms of PPD include experiencing mood disturbance, extreme exhaustion, low energy, sadness, feeling worthless, guilt, shame, thoughts of self-harm, loss of appetite, anorexia, hate the newborn, anxiety, and insomnia. However, the symptoms vary with the severity and onset of the depression(American Psychological Association, 2013).

symptoms	**Clinical presentation**
Fatigue	Despite sleep loss, depression-related tiredness is characterized by chronic weariness. energy loss in the absence of physical activity
Loss of interest(anhedonia)	owing to a lack of interest, unable to participate in social events, hobbies, or spend time with family
Weight / appetite fluctuation	Appetite or weight fluctuations. May not have a food appetite or have a unique eating behavior without actively dieting.
Insomnia/hypersomnia	Difficulty to seep when you don't have to nurse the baby or do other duties. Perhaps too much sleep or Sleep disturbances throughout the night/inability to fall asleep
Psychomotor change	Feeling agitated Physical and psychomotor skills such as walking, and speech are slowed.
Feeling worthless/guilt/shame	Constant negative thoughts, disconnection from oneself, loss of self-worth, and feelings of guilt.
Difficulty in concentration	Inability to concentrate on a single activity, difficulty making decisions, remembering information, and disoriented thinking.
Suicidal ideation	Imagining or being preoccupied with death, with or without preparing suicidal events and idealizing hurting the baby at times.
Depressed Mood	Depressive mood is mostly described by terms as; gloomy, feeling low, sadness, anger, restlessness, feeling empty and constant crying.
Anxiety	Despite anxiety is a typical symptom of depression, some women just experience anxiety. That is, they have anxious sensations but neither being in depressed mood or lack of interest.

Table 1: Symptoms and Clinical presentation of PPD

(American Psychological Association, 2013)

2.2.2 Risk Factors

There are multiple underlying etiologies for PPD; however, no clear demarcation defines the cause of PPD (Yim et al., 2015). Generally, Social, lifestyle, psychological, biological, history of depression, and obstetric factors are considered risk factors for PPD (Ghaedrahmati et al., 2017).

Biological factors include self-efficacy, estrogen hormonal change, age, and change in the level of serotonin in the blood. The onset of early commence of depression is usually associated with hormonal changes. Women are more vulnerable to significant hormonal changes as rapid reproductive hormone changes happen after birth (Ghaedrahmati et al., 2017). However, the connection between the drop-down of the hormone and depression is still unknown (Schiller et al., 2015). Self-efficacy and age show a prevalence of developing depression after labor. The rate of developing depression is higher during young age (13-19) compared to aged (31-35) mothers (Silva et al., 2012).

Pre-existing mental illness may put women at risk for relapse or the development of postpartum mood disorders during pregnancy. Especially those who goes undiagnosed and untreated are at high risk. Many studies have found that major depression and anxiety among women is a causality of the onset of PPD. A controlled study shows women with a previous history of depression have a likelihood of having PPD than those who don't have a prior mental illness (Silverman et al., 2017). Women with a history of bipolar disorder have a 20-50 percent chance of relapsing and getting PPD (Ghaedrahmati et al., 2017). Even though gene variations have been detected in bipolar and major depression patients (Couto, 2015), the exact association between depression and pre-existing bipolar illness is still being researched (Rantalainen et al., 2020).

Due to pregnancy complications, some women have only the option of giving birth by cesarian section; the clash of expectations in giving birth naturally resulted in some mothers developing depression. Being able to breastfeed after expected delivery and getting epidural anesthesia shows a lesser chance of getting depression (Ghaedrahmati et al., 2017).

Psychosocial factors such as lack of support, violent relationships between partners, stress in life, low income or unemployment, low educational background, abuse from the previous life, and difficulty in the marriage cause the late development of PPD (Alba, 2021). Social support is a crucial phenomenon in the well-being of pregnant women during and after pregnancy. Support from partners has shown a significant increase in women's reproductive health. Support could be emotional, financial, and physical help. Unhealthy marital, intimate partner violence (IPV), and family relationships stimulate stressful events (Ghaedrahmati et al., 2017).

PPD can also be caused by lifestyle factors such as physical exercise, nutrition, smoking, and sleep patterns. Evidence predicts physical activity and exercise play a role in lowering or preventing depressive episodes. However, the correlation between diet and the prevalence of PPD is under study (Ghaedrahmati et al., 2017).

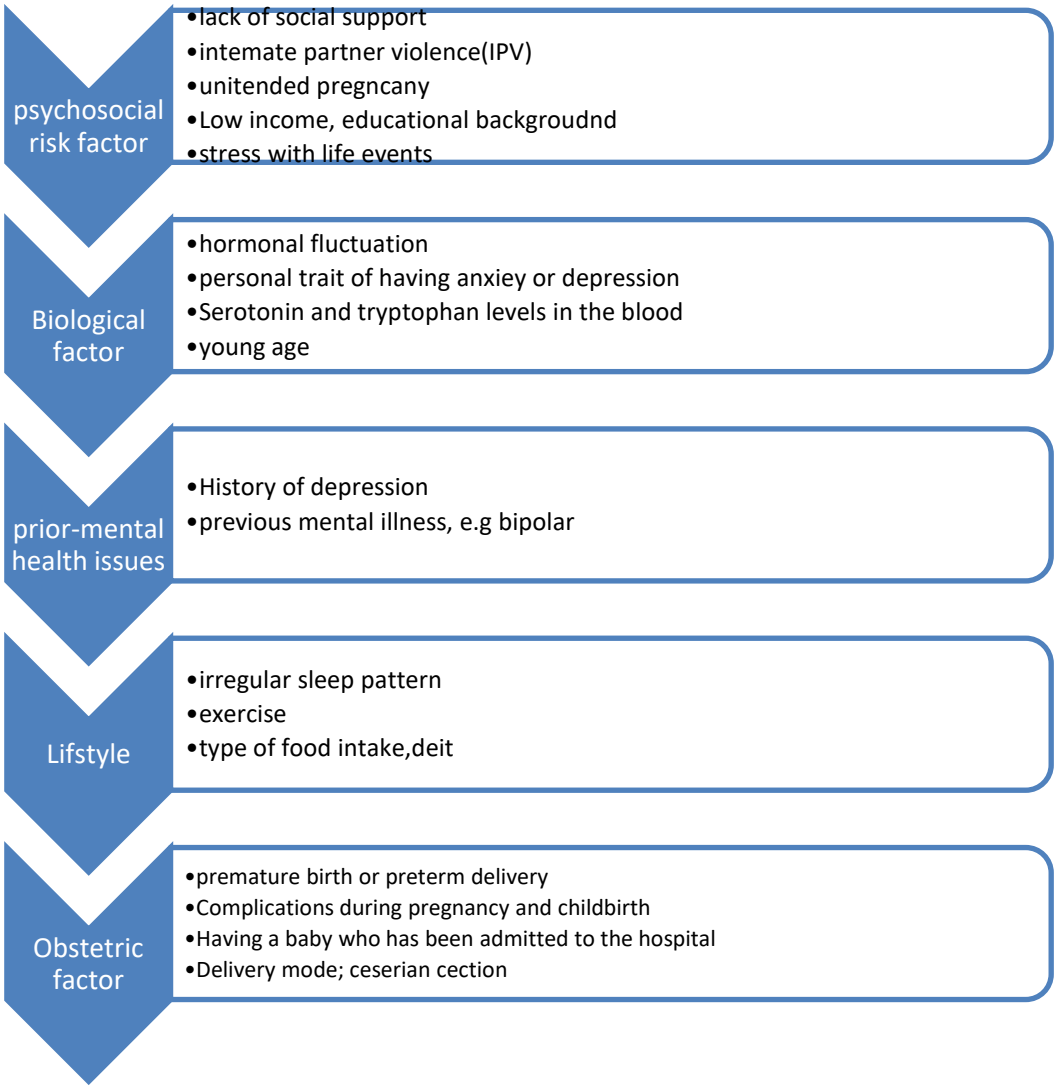

Table 2: Summary of risk factor of PPD.

2.2.3 Consequences of PPD and Stigma

Women who are depressed often struggle to come to terms with their infants and provide care. Maternal depression has been linked to unstable maternal bonds, parenting difficulties, and insensitive caregiving. There is a high prevalence rate of children with depressed mothers to experience behavioral issues and are frequently depressed as well (Drake et al., 2013)

Stigma is a typical concern for women with PPD, but it is exacerbated when depression and pregnancy contradict social standards associated with motherhood. This contrast, along with the psychological struggle to maintain a cheerful mother, usually discourages depressed women from seeking help (Clement et al., 2012).

Stigma is a barrier to early care. Women suffering from PPD seldom seek assistance, and when they do, it is often disguised as a physical disease (i.e., fatigue and lack of energy). When these women look for help, the primary concern for health care providers and family members is the newborn. Their problems are frequently attributed to hormonal changes rather than changes in mental health conditions. As a result, the underlying mental health issue is frequently left unaddressed. Midwives and nurses have a great responsibility to treat the women holistically and address maternal depression beyond Perinatal care (Jarosinski & Fox, 2016).

2.2.4 Diagnosis and Assesment

According to the Diagnostic and Statistical Mental Disorders Manual (DSM-IV), criteria for a major depressive episode do not differ in the postpartum period from other times. To be diagnosed with PPD, the women must exhibit five symptoms among the nine listed symptoms (see table 1), of which one must be a lack of interest or persistent depressed mood. And these symptoms must occur every or every other day (American Psychological Association, 2013).

PPD diagnosis and assessment might be challenging for nurses and other clinicians since typical emotional modifications to new parenting mimic depression. It is sometimes difficult to label a new mother suffering from mood swings, sleeplessness, or exhaustion as depressed. Other medical conditions may also exhibit symptoms similar to PPD. for instance, depressed mood and exhaustion may be caused by anemia, diabetes, or thyroid illness. Agitation, poor focus, and sleeplessness or hypersomnia may be signs of drug misuse. The diagnosis must be done with care and utilizing a different method(alba,2021).

In addition, it is essential to differentiate PPD from other psychiatric and nonpsychiatric postpartum mood disorders. The "postpartum blues" or "baby blues "are temporary mood disorders that affect up to 75% of new moms in the first ten days after birth (Alba, 2021). Symptoms include crying, irritability, exhaustion, anxiety, and emotional lability. Generally, symptoms are mild and self-limiting and do not include a complete loss of pleasure or interest, chronic depression, or suicidal thinking. On the other hand, postpartum psychosis is a medical emergency requiring prompt intervention with symptoms of high suicidal thought toward the infant and, within oneself, hallucination. Women who come with depressive symptoms, mood elevation, or psychotic symptoms should be evaluated for other mental illnesses (Batt et al., 2020).

2.2.5 Prevention and Screening

To avoid the adverse implications of PPD, early screening and assessment during pregnancy are essential. However, the overwhelming physical and emotional changes might make detecting depression in the postpartum period more difficult. Identification may be highly dependent on the

eagerness and willingness of health care professional. In addition, many women are hesitant to share their condition with PPD(THL,2022). They do not seek professional help, and many do not reach out to their families and social support for assistance due to stigma and ambiguity (Biaggi et al., 2016). It is possible to prevent depression from worsening and to promote parent-baby relationship if a parent experiencing depressed symptoms seeks care as soon as feasible. It is estimated that less than 40% of depressions are recognized and just 10% are properly treated (THL,2022). During home visits and follow-ups, family education, counseling, and support for a healthy lifestyle may help prevent PPD.

Prevention and care for PPD encompass an interdisciplinary team including nurses, midwives, social health workers, and psychiatrists (Lind et al., 2017). Screening for PPD is recommended at the postnatal follow-up visit, usually 4–6 weeks during the first three months following birth (ACOG,2017). Screening every two months until six months after birth has been shown to reduce PPD occurrence (van der Zee-van den Berg et al., 2016).

The Edinburgh Postpartum Depression Screening (EPDS) and the Postpartum Depression Screening Scale Tool (PDSS) are the most widely used screening tools. EPDS is a screening easy to use instrument, Available in 23 languages. It is a self-report questionnaire containing ten questions focused on the emotional and functional ability of the women rather than symptoms. Giving attention to a positive answer to the tenth question, which assesses suicidal thought, a score of "thirteen" indicates the possibility of PDD. Total scores range from 0 to 30, with values greater than 13 suggesting an assessment of severe depression and values less than 9 indicating a probable diagnosis of mild depression. Considering Clinical implication is always vital, as the "score" is sensitive to social context, culture, and language. Some women fear getting criticism for expressing their emotions as a symptom, or it is not easy to accept their emotions negatively (Callister et al., 2010; Khanlari et al., 2019). EPDS is simple to use and reliable in identifying mood disorders. however, we cannot depend only on it as a diagnostic tool. Overdiagnosis and workload on health-care resources may come from screening without a comprehensive evaluation (THL,2022).

2.2.6 Nursing implication

Early and constant monitoring is critical given the devastating consequences of untreated depression. Screening enables health care practitioners to ascertain the scope and severity of a problem, set intervention timelines, and provide proactive care and treatment. Despite evidence that women who experience depression earlier in pregnancy are more likely to develop PPD, obstetricians advise taking EPDS during their initial maternity follow-ups (Alba,2021).

Nurses are well placed to screen, evaluate, educate, refer for, and assess PPD because they engage with women in various settings, from pregnancy through postnatal care. Nurses specializing in

maternity and child health care are usually the first to the early screening and intervention of depression after delivery. The screening might include the mother's mood changes and attachment to the newborn, using screening tools or subjective evaluation. Nurses in primary health care and pediatric settings have the opportunity to evaluate mothers during follow-up based on their behavior and communication. Screening is merely the beginning, as once depression is recognized, treatment is essential (Alba, 2021).

During a follow-up visit, nurses may educate and advise women and family members by raising knowledge of PPD, risk factors, and treatment choices. They may aid and educate women who feel criticized and stigmatized by using open dialogue (Alba, 2021).

Nurses can assist mothers who are having difficulty adapting to motherhood problems. They may work with mothers to help them communicate their anxiety or stress. Make a self-care, nutrition, exercise, or social support strategy, and link women to social groups. Whenever depression is detected, nurses may refer patients to medical or psychiatric treatment (Alba, 2021). Once treatment is sought, patients may proceed with appropriate counseling and medicine. When hospitalization is required, psychiatry nurses participate in the care process (Kendig et al., 2017).

Despite a commitment to holistic treatment, nurses tend to struggle with meeting the complex requirements of pregnant women with depression. While there are suggestions for the first assessment using the EPDS, there is no uniformity in the health care field regarding which tool to use and when for PPD (El-Den et al., 2015).

2.2.7 Treatment

Given the serious and potentially enduring consequences of postpartum, Effective treatment and prevention of depression are critical for Mothers. Caregivers and patients choose treatment based on the severity of symptoms, patient preferences, previous response to treatment(s), the availability of access to care, and patient breastfeeding preferences. Pharmacological, psychological, and psychosocial interventions are the available alternatives for treating PPD. However, the social norm put upon labeling depressed moms and the uncertainty of antidepressant medication harming the infant concern most mothers in choosing an intervention method (Bobo & Yawn,2014).

Pharmacological treatments

The most common pharmacological treatment is an antidepressant medication. Selective serotonin reuptake inhibitors (SSRIs) are the first line of antidepressant drugs (Frieder et al., 2019). Antidepressants alleviate symptoms and persistent negative thoughts. However, Due to the high level of dependency and adverse effects of medication, patients prefer therapy intervention over medication (Leight et al., 2010). Most guidelines recommend a two- to four-week course of

antidepressant medication. SSRIs (selective serotonin reuptake inhibitors) have little to minimal impact on breastfeeding, although informing parents about possible side effects is always essential. However according to Friedner et al. (2019) there is not enough knowledge on the effects of antidepressant drug exposure on infant and child development during breastfeeding (Frieder et al., 2019). For moderate to severe depression, psychotherapy, individual or group counseling is usually the recommended intervention (THL,2022).

Psychosocial and psychological interventions

Nonpharmacologic approaches have the potential for treatment without worrying Mothers about their newborns' being exposed to medication side effects. Psychological (psychotherapy) interventions include interpersonal therapy (IPT), cognitive-behavioral therapy (CBT), and supportive of nondirective psychotherapy (Werner, 2014).

Interpersonal therapy (IPT) focuses on improving the patient's social functioning and interpersonal relationship. It began as time-limited, weekly outpatient therapy for depression delivered by a certified mental health practitioner. While this technique makes no assumptions about the etiology, it does concentrate on the relationship between the development of depression symptoms and interpersonal difficulties. IPT is a kind of acute therapy designed to help patients by focusing on their experience and setting the framework for treatment in three phases.

(1) Interpersonal problem area(dispute): dispute with partner or argument.

(2) pursuit of strategies (role transition): transition to motherhood.

(3) Bereavement

(Werner, 2014)

Cognitive-behavioral therapy (CBT)is an approach designed to solve or break the thinking pattern of a patient developed due to depression. CBT psychotherapy helps women develop behavioral patterns that elevate positive moods, the ability to solve life problems, and maladaptive thinking (Werner, 2014).

CBT interevent in behavioral changes by understanding a person's perception and interaction with an event. According to cognitive theory, distorted beliefs, and the inability to process information appropriately cause many mental illnesses. Hence, CBT works toward correcting erroneous beliefs and detecting and improving a person's perception and processing of distorted information to alleviate discomfort and improve coping abilities (Stamou et al., 2018).

Hospitalization is rare in the case of PPD; however, it is necessary on symptom severity, especially for patients who have suicidal ideations. Women with mild PPD may benefit from treatment provided by non-mental health experts and individual or group counseling. However, women with more severe PPD may require antidepressant medication and clinical psychotherapy (CBT or IPT) from experienced practitioners (Stamou et al., 2018).

Nursing women may prefer psychotherapy over medication for the treatment of PPD. Psychotherapy participation is hampered by lack of time, workload from motherhood, stigma, limited access to trained therapists, and cost of treatment.

Nondirective counseling psychological it requires listening to patients with empathy and constructive respect. The psychotherapists usually do the intervention in the form of psychological interviews. The interview mainly focuses on discussing the labor experience, aiming to assess the traumatic event experienced by the women (PTSD). It is usually conducted Within one month following the delivery (Werner, 2014).

Peer support is a psychosocial intervention for supporting mothers to cope with their difficulties. It includes giving the mothers unjudgmental understanding, appraisal, comments, and information. It assists women in understanding that they are not alone or to blame, and it sometimes includes highly trained PPD survivors. Social assistance may be emotional as well as physical (caring for the infant, cleaning, and cooking). The social support could come from the mothers' social network or unrelated volunteers who have similar attributes and understanding of PPD. Friends, family, and spiritual communities are examples of support networks. The social support could come from the mothers' social network or unrelated volunteer but who have similar attributes and understanding of PPD (Leger & Letourneau, 2014).

3 Theoretical Framework

Beck's theory of PPD was employed as a theoretical framework in this thesis study. Beck has studied postpartum depression more than its symptoms and diagnosis. Her theory was more a qualitative one, she has done qualitative research to found out the social psychological problems of the depression.

The theorist had not stated about health clearly but one of her goals focused on mental health and postpartum disorder as a mental health problem. In her theory Holistic health was a dominate notion, according to her theory, referring to a person's "wholeness," as being, physically, emotionally, and psychologically entwined with the environment as one." Beck noticed that a woman's unstable interpersonal environment had an outward effect on her (Alligood, 2014, 690-702).

3.1 Assumption

Beck has defined 22 concepts related to causing PPD. And thirteen top risk factors for PPD have pinpointed in Beck's theory, which were: "infant temperament, prenatal depression, socioeconomic status, childcare stress, life stress, and social support, history of depression, maternity blues, marital status, relationship, self-esteem and unplanned/unwanted pregnancy, prenatal anxiety". Then her theory states the four stages how women carry on with the depression which are "dying of self, encountering terror, regaining of control, and struggling to survive. "Lastly tested the theory in clinical environment (Alligood, 2014, 690-702).

The Assumptions of Beck's postpartum depression theory includes:

- "Regardless of external or internal events of the body, the brain generates different stressors biochemically.
- Biochemical regulation of the brain can be interfered by stressful situations.
- Mood swings and disorders at certain events are results of women's unique hormonal characteristics and the brain.
- A mixture of biological, economic, social, psychological, relational factors has a cause in the occurrence of postpartum depression.
- Postpartum depression is not a homogenous disorder.
- Culture makes it difficult for women in expressing the emotions and the experiences with their stress.
- Women with postpartum depression are left alone, because the stigma of mental illness is even high with pregnancy."

  (Alligood, 2014, 690-702)

3.2 Concepts

The two concepts the theorist highlighted in the theory were postpartum mood disorders and loss of control. PPD has caused the women to lose control. Even though they cannot regulate their emotions, take action, or processes their feeling, they attempt to cope with their loss of control with the four stages she stated: "Teetering on the Edge." Qualitative techniques enable researchers to put themselves in the shoes of sufferers' to better understand their experiences. Beck investigated the women's experiences with loss of control in different stages.

3.2.1 Stages of coping with Loss of control

Stage 1. Encountering terror

The first stage highlights how women start to Possess terror after few weeks to six months after delivery. Women experiences unusual feel of anxiety along with obsessive thinking, which could be more than a normal depression. This could happen during daytime and while the person wants to sleep. The person describes their unusual feeling as they cannot control and shut their thoughts. This will lead to mental exhaustion and the person fail to concentrate and motor skills .

Stage 2. Dying of self

At this stage, the mother will experience the feeling being void from her previous identity. She will no longer be interested in her previous activities as having time with family and friends, eventually the thoughts of self-destruction and death or hurting the baby will appear.

Stage 3. Struggling to survive

The mother wants to cope up and survive. Beck states, at this stage mothers seek help from the system, she will find it difficult to function in daily routines. Due to lack of assistance in need of help form family, friend, or care giver they might feel frustrated and disappointment. She will encompass her survival through" seeking help, praying for God, and look for support centers." (Beck, 2006).

Stage 4. Regaining control.

The last stage of postpartum depression is getting back owns control. Having back control is a progressive process. The patient could grief from the moments she has not passed with the infant due to her depression.

The theory is a middle range, practice-level however, the theory has been broadened. Beck's theory has been given by global literature, letting nurses to use the research as a tool in studies how to improve maternal care and experiences during pregnancy. Nurses have used postpartum depression theory, as a nursing care framework in identifying women at risk of the depression, prevention, and screening tool. The theory has been used as a tool in the nursing process, in assessing and planning the PPD patients by nurses. The theory was a basis for "Postpartum depression predictor's inventory", which is a universal screening tool for PPD. The tool consists of structured interview questions, which will help the nurses to identify the risk factors for PPD. The depression can occur any time within a year after giving birth, especially mothers with premature baby or have infants at ICU are at high risk.

Beck's theory has a great importance and being used in health care and nursing fields, the theory has been used in study linked with the consequences of PPD on children with cognitive and emotional

characteristics they have in school. Domestic violence, substance abuse, employment, traffic accidents could have been as a negative consequence of PPD (Alligood, 2014, 690-702).

The postpartum theory developed by Beck was a helpful tool for nurses and health professionals in directing the patients how to identify the symptoms and the emotions that may experiences during the Depression and how to consult help. The theory uses a holistic approach to define the depression and correlated effect. It could be used as a framework for nurses to assess, reduce risk factors, and prevent postpartum depression and screening tool. The theory is useful tool to use as a background to investigate new risk factor for PPD and correlation with any factor as social, biological, physical, or cultural among a certain society. Beck believed the health of the women corresponds to their livelihood. In the internal environment of human being, an equilibrium of mental and physical health must be maintained, at the same time external factor such as culture, family and friends and the social environment affect the mental status. Giving education to women about the depression during pregnancy and prior to discharge at the hospital is very vital in the prevention of the depression, enable the client to identify the condition if it occurs and seek help in treating the depression (Alligood, 2014, 690-702). More importantly, Beck's concept" Stages of coping with Loss of control "could be used in interpreting the findings from the qualitative investigation in this thesis work.

4 Aim and Problem Definition

Many studies explore maternal depression from the clinical point of view, exploring the prevalence, risk factors, and interventions. However, little is known about sufferers' experiences from their points of view. Depression is the most common mental health problem, yet postpartum depression is taboo in many cultures; we do not speak about it, and many women are unaware of the illness until they become mothers. Moreover, there is a knowledge gap about the illness and intervention among nurses and health care practitioners. Exploring the Women's experiences could be a great help in creating more efficient care and treatment. Thus, this study aims to explore women's experiences with postpartum depression from their own narratives. The goal is to gain a comprehensive understanding of the illness from the mothers' perspective. To be more precise, the following questions will be addressed:

- How did women with PPD experience their illness?
- How did they learn about their illness?
- How did they cope with it?

The finding could give an insight to potential mothers, clinicians, and nurses about the illness in full depth. In addition, educate nurses on the issues women face during PPD and their expectations in terms of care, what was helpful and not.

5 Methodology

In order to answer the aim of the thesis work, a qualitative research method was chosen. In this chapter, the research method, data collection, analysis and ethical considerations will be discussed.

5.1 Qualitative Research

In healthcare, finding out patients' experiences from their point of view allows healthcare providers; to evaluate the intervention, recognize the patient's cultural interference with health care, and understand how patients perceived the care provided compared to their expectations. To grasp participants' experiences and understand their views better, researchers prefer the qualitative method as a tool (Chenail,2014).

Qualitative research is one form of research design, implemented to answer how and why one entity happens. It involves collecting and analyzing non-numeric data to find rich meaning in the answer. It is used to understand better or seek an answer on how people interact, their experiences, and opinions. Nursing and social science fields use this method with different approaches, phenomenology, ethnography, grounded theory, and narrative. All approaches have an adaptable nature while interpreting the data; the focus is to find comprehensive answers. However, they differ in perspectives. The findings from qualitative research can be used in developing concept, theory, or themes (Mollard,2014). Based on the characteristics of qualitative method, it was convenient to use it in answering the research question in this study.

5.2 Data collection

These days, the high usage of the internet and blogs to convey information allows researchers to use these tools as data collection channel in qualitative research (Willison; Kenny&Dickson-Swift,2015). Blogs conveys a variety of information used for different purposes. The posts are usually arranged in chronological order or stored to enable readers generate a theme using its comments. Blogs' descriptive, exploratory, and contemplative nature makes them similar to other qualitative methodologies and gives the advantage for researchers to utilize them in data collection methods (Harricharan & Bhopal, 2014).

The narratives in a blog are influential in providing persons' experiences by allowing the author to be anonymous. Authors can share or seek information that are Sensitive or shameful to express anonymously. Researchers argue, Blogs written in diary styles are the most likely natural, genuine, and written without premeditation . They also spot transparency as one beneficial entity in using data collection from blogs (Moravcsik, 2014). In addition, data from blogs are collected easily without transcription and recording as in interviews.

In this thesis work, to address the research question, data was gathered from women who share their personal experience with PPD in form of blogs, online posts and narrative diaries published as a book.

5.3 Conduct of study

The search of data was conducted through Google and Scribd database. The data sought from online was posted, as a personal blogs on private websites, women's' posts shared on national helplines websites and online community platforms formed to supports the mental health of parents and families during pregnancy and postpartum period. The title of the stories and address of platforms where the data was collected is listed in Appendix 1.

Scribd is a large digital library for eBooks, audiobooks, podcasts, magazines and news articles, sheet music, documents, and more. Narrative stories from two storytelling book called "beyond the blues" by Authors Shoshana Bennett and Pec Indman, and " Mothering Through the Darkness: Women Open Up About the Postpartum Experience" by She Writes Press ,were taken from Scribd database, to increase the reliability of data and the author, the rank of review was considered in choosing the book.

To fully answer the research aim, the stories are selected based on the following criteria:

- The stories/experience were taken only from women, who undergoes postpartum depression, not PP psychosis or other maternal mental illness.
- women sharing their symptoms and emotions in depth.
- Stories of women rich in narrating their experiences from start to recovery
- Women's highlighting How did they learn their illness and cope with it?
- Women stories telling; Challenges faced, what care and support were needed.

In a total of 13 blogs sites were visited and 41 stories were gathered from google searches and two books from Scribd database. Among the 41 stories, 29 were selected from the blogs and 3 stories were taken from the books. The books are written by Authors who are victims of PPD, it is about maternal and PPD in general, yet they included their stories as well as the stories of other women in the book. The description of some of the women were brief and narrative of their whole journey, yet others share experiences in a specific context as; challenges, coping mechanisms or expressing only the emotional and life change encounters. Mostly in the personal blogs women share their stories in depth however those who share short posts, what was interesting and could be helpful for others.

5.4 Qualitative Content Data Analysis

In research, Data analysis is a process of "making use of the collected data". To draw a conclusion, one must concentrate on the segments of the data which is most peculiarly essential to answer the research question (Kyngäs, 2019). Content analysis is a research method used to analyze different form of data (pictorial, written or auditory) in qualitative research (Beck,2016).

In nursing research content analysis is commonly used in the study of geriatrics, public and mental health studies. In content analysis, Organizing and analyzing data have no universal methodologies; the main aim is to organize the data, interpret it, search for similarities or patterns and draw a finding. The result from content analysis can be developed as concept, themes, or theory. Similar Segments of data can be categorized under a "theme" or pattern". The classification of "themes" relies on the content analysis, a well analyzed data indicates a credible research outcome and streamline the data in simplified way (Butina, 2015).

Inductive content analysis was chosen in this thesis work as data analysis method. The analysis process begins data collection and organization: the stories/ text will be collected and stored, with skimming the narratives and comprehensively reading to find similar texts, keeping in mind the aim and problem definition of the thesis. Considering the research question relevant concepts, the women's experience and suggestions, the text in the blogs and texts from the books were decontextualized. Using quotations, the direct expressions from the women were used in the result interpretation chapter as description.

- Organize the data: the researcher will be acquainted with the data by reading thoroughly and categorizing the data in consideration of the research question.....:
- Creating codes: after the data is Systematically categorized, it will be coded by combining data related to each code.
- Theme discovery: grouping codes into themes and collecting data relevant to each theme.
- Theme review: Confirming that the themes make sense regarding the code.
- Defining and naming themes: define the themes based on the content and narrative.
- Data validation: Validate the data for trustworthiness and credibility.
- Drawing a report is the last stage of analyzing the data and producing a report on the finding. The analyzed data should be related to the research question and the background literature. In this stage, the study's limitations and findings are also constructed.

(Butina, 2015)

After reading through 41 stories written by different women, 32 stories were used in this study. The stories were copied as text on 83 pages. Notes were taken from reading each story. Narratives that were helpful in addressing the research aim and criteria were selected. Experiences of women resembling similarity were grouped based on the information narrated under the same group themes, main themes and sub-themes were developed.

5.5 Ethical consideration

Using online data in qualitative research is plagued with ethical controversy, and various arguments have evolved about what is morally appropriate. (Markham & Buchanan, 2012; Roberts, 2015) have developed recommendations to guide several ethical issues raised by using online narratives. Informed consent, privacy, and anonymity are elements that must be approached with care. Still, the questioning of consent in using information available online for public reader remain unclear (Ackland, 2013).

According to ethic Finnish National Board on Research and Integrity (TENK), “ethical principles in the human sciences concern research ethics.” Research with human participants often requires processing the participants’ personal data with anonymously. (Finnish National Board on Research and Integrity; TENK, 2021). When the author's stories are used in qualitative research, anonymity and privacy must be protected, mainly because the data is easily identifiable (Roberts, 2015). Due to the apparent emphasis on subjective experiences and their meanings, these ethical norms are particularly relevant. As such, researchers should make personal judgments on; whether to get authorization from authors, determine how much the online material is public and if informed consent is needed (Roberts, 2015).

It is typical for researchers to use the raw data from internet research as "quotes" in the findings. However, this makes the information readily traceable. This raises concerns about confidentiality in comparison to other data gathering techniques. As a result, the author's privacy must be protected to the greatest extent possible. To reduce traceability, distinguishing data may be eliminated, or direct quotes can be slightly altered (Roberts,2015). Furthermore, privacy may be safeguarded by not disclosing personal information (Markham,2012). When numerous narratives from different authors are gathered, similar concepts may be pooled and put together as a broad meta-narrative summarizing the author's experience (Lamprell & Braithwaite, 2017).

6 Presentation of Result

After analyzing the data, the result was presented in the form of themes and subordinate themes. Five themes were developed: ”Onset of PPD” consisted of two main-themes “debilitating symptoms" about mothers' unexpected symptoms and "doomed by emotional struggle" about mothers' new experiences with emotional roller-coaster and perception of their illness; The second theme “underlying causes” discussing about the cause of the depression, Third theme "Before getting help" about how they try to manage the situation before seeking help; The fourth theme “Challenges with diagnosis”indicating what hinder the women not being diagnosed and the final theme "Journey to recovery" about how they discovered and were treated for their depression.

These themes are made up of subordinate themes that offer detailed descriptions with exact quotes taken from the mothers to validate the concepts. The themes and sub themes are shown in Table 1 below.

Table 3: table showing the themes, main- theme and sub theme resulting from the data analysis

Themes	Main-theme	Sub-theme
Onset of PPD	Debilitating symptom	Becoming dysfunctional and emotionally drowned
		When Anxiety strikes
		Never ending tear
		Suicidal ideation and hurting the baby
		Depersonalization
		Self-hatred from unable to Brest feed
	Doomed by emotional struggles	Confusion and denial at glance
		Guilt and shame
Underlying cause	Ambivalence	
	Unplanned pregnancy and life challenge	
	Childbirth trauma	
Before getting help	Trying to take control of situation	
	Self-efficacy	
Challenges with diagnosis	Misconception of PPD	
	Identifying and accepting depression	
	Lack of experience in health practitioners	
	stigma	
Journey to recovery	Seek for help personally	
	Help comes from others	
	Acceptance	
	Psychotherapy and counselling	
	Medication	
	Self-care as complementary therapy	

6.1 Onset of PPD

Under this main theme, two sub-themes are classified as; Debilitating symptoms and doomed by emotional struggles. It describes the symptoms and emotional battles women experience from the onset of depression.

6.1.1 Debilitating symptoms

All women who share their stories commence narrating their experiences by describing how their psychological and functional disabilities in their daily life begin after becoming a mother. The theme" debilitating symptoms" is characterized by sub-themes that elaborate on these new changes and symptoms; becoming dysfunctional and emotionally drowned, losing sleep, guilt and shame, anxiety, never-ending tear, social ideation, and hurting the baby.

Becoming dysfunctional and emotionally drowned

Most women mentioned they encounter new emotional instability, feeling sad, empty, and tired all the time. Even the emotional distress was not easy to describe, but they felt something was wrong. The loss of motivation and happiness makes them not even care for their baby.

> *"A simple phone call became too much to handle. The isolation bred isolation and now a trip to the store exhausted me for days beforehand and afterward. It was all I could do to get out of bed in the morning."*

Not knowing how to react to the unwelcoming feeling of being unhappy, losing motivation, and being unable to do even simple routines was overwhelming. one woman described even doing simple tasks as profounding,

> *"Months passed as I had no motivation to try and make a call to find someone. At this point in the journey, I was beyond anxious and could barely make any phone calls. Everything seemed so overwhelming."*

When anxiety strikes

Almost all the women revealed they had experienced anxiety at some point as a symptom. However, most of them start to be anxious in the later weeks after they have developed other emotional changes. For a few, it was in the first week; it started as a baby blue symptom but developed into more severe symptoms like suicidal thoughts later. When does anxiety start to appear, and what is the severity of anxiety?

"in week two, I grew increasingly anxious. I needed to get some rest but could not sleep for the life of me. I became so restless, just pacing the room. I couldn't stay still in one spot for too long. I became terrified that the baby was going to starve to death. At the moments when I should have slept, I was on Google looking for answers for the breastfeeding and sleep issues."

For many, anxiety was developed after two to three weeks of seeing the first instance of PPD symptoms, accompanied by panic attacks; the fear was about the baby being hurt, starving to death from not getting breastmilk, and feeling endangered for themselves. They fear being attacked, going outside in public, or, as one woman described, she will be suffocated. Anxiety was a more prominent symptom that made the women more aware that something was going wrong with them.

Never ending tear

Another common symptom mentioned by all mothers was crying tremendously without knowing the reason. The symptom of constant crying comes along with other debilitating symptoms; however, the women could not explain the reason.

"The tears started flowing pretty heavily around days 7-10. I remember a home visit from my dear midwife when I just cried. You know, those tears that just keep coming and don't stop as if a water hydrant won't shut off. Now here is the interesting thing: I started shifting from a place of "Poor me, I hate my new life. I want to run and hide" to "What the heck?

But crying became a big part of my experience of early motherhood, especially after the birth of my second child. I remember too many nights of putting the kids to bed, and then sitting on the couch and crying. For hours, the tears wouldn't stop. That wasn't me. Motherhood had transformed me. And I didn't know into what. I simply knew I didn't want to be broken, crying on my couch each night. "

"I started feeling symptoms during the first two months after my son was born. At first it was constant anxiety, worry, and a state of despair and hopelessness. I was crying all the time, but I didn't know why."

Suicidal ideation and hurting the baby

For some women, the idea of hurting the baby comes from resentment; from a constantly crying baby and unable to make a bond. However, for some, it was just an ideation of hurting the baby; they are unaware of why they felt like that or the inception of having a horrifying imagination.

All I could see when I went up the stairs were images of my daughter falling to the ground below and smashing her head open. I knew I would never deliberately hurt them, but those frightening images wouldn't leave me alone.

"I would not trust myself to be alone with her. Not even my husband knew about these horrible thoughts—I could barely admit them to myself. If I could sleep at all, I awoke in a full panic attack, wondering if I could sur- vive another day."

Not all women develop suicidal thoughts; however, for those who experienced it, even describing it was profound, the suicidal thoughts were just thoughts; it was only in their minds, not acted upon it or planned it. They imagine their death incident or the death of their babies, "what if a car crashed me or what if I lit the house on fire." And again, they have the most profound feeling their kids need them, and they should live for them.

"Then the suicidal thoughts came. I was terrified that I would never get better. I was afraid I wouldn't be able to function normally or go back to work, then I'd just be a useless burden forever. I had fantasies about how to end it all. I prayed to not wake up, and that's a pretty awful prayer."

"The most terrifying parts of my postpartum depression were the intrusive thoughts. As I made dinner in the kitchen, I had disturbing images of dropping a knife on my daughter."

Depersonalization

Women feel disconnected from themselves, struggling to feel or do something but are incapable. They mentioned that they have the need to make connections with themselves, their partner, and the baby or other children, but it was difficult to find themselves; they simply felt alone. One woman described her experience as follows;

"Even something that was so natural to me became difficult. I lived and breathed yoga and had a passion for all the moms that came into my studio. But, I found myself struggling to teach. I would step out of class because I could not fight the tears anymore. It was all just too much … talking about birth, being a mother, teaching to be authentic and speak your truth, but I was totally a wreck inside. My brain, heart, and body were disconnected. I was in a deeply sad place."

Self-hatred from unable to breast feed

Most mothers mentioned the hate for themselves comes from; being unable to care function properly, unable to create a bond with their newborn, and self-hatred from being unable to breastfeed, and for some, it was unknowingly.

"There did not seem to be a lot of support around formula use either. This was possibly due to my seeing the world through the lenses of anxiety and depression, but all I noticed were the messages that "breast is best," shame on you for using formula, and get her to sleep or you'll train her for bad habits."

6.1.2 Doomed by emotional struggles

Confusion and denial at glance

The women notice and acknowledge their new mood change and symptoms differently. For some women the new feeling creates confusion and denial at glance, as the experience is new to them. Other women have a knowledge of PPD prior to pregnancy, some get insight during pregnancy from obstetric visit, some have experienced PPD after previous pregnancy, and others experience similar symptoms from other mental illness.

The women have experienced an emotional struggle, having a sudden change in mood was perplexing. One mother described her constantly changing mood with laughter and sadness, made her to question what was happening.

> *"After I had my first baby I really struggled with emotions—one minute I would be laughing with my husband, the next I'd be screaming at him and then I'd sob because, well, where did that even come from? What was happening to me?"*

Another mother described her experience beyond asking what was happening, she was confused if she was faking it, or will it be shameful if she didn't accept it. she was in denial about her feelings; on the contrary questioned what cause it, she felt down at some point, but she acts strong, and denied help.

> *"Postpartum depression is confusing. I felt like I had to fake it. Would it make me ungrateful if I didn't? What attributed to my postpartum depression? Maybe it was nothing, maybe it was everything. A difficult pregnancy, long labor that played out nothing like my birth plan, a very long recovery, difficulty breastfeeding, all while leaving no time for myself and denying help."*

> *"So sad, exhausted, numb but mostly sad, sad, sad. I can't laugh, just cry and cry. When will these feelings go away? Will I ever feel happy again? My family is better off without me. "This is what I felt after the birth of my second child."*

Denial seems very common at the beginning of PPD, it could be denial of feelings or denial for the need of help. The shame is either within themselves or the judgment of others. For some women, even if they had some know- how about PPD, either it was shameful to accept it, deny they don't fit in the criteria of being depressed by misconception.

> *"After my second son was born, I was so depressed that I could barely eat, and I lost 50 pounds in 10 weeks. But I thought women with PPD were suicidal or didn't want their babies, and I was neither of those things. So I thought I was fine."*

To label oneself as suffering from depression was confusing while performing daily work tasks, as usual, the woman below mentioned she was able to operate normally in her work but had a sensation that she was not herself.

"I want to be clear … I knew how to function. I knew how to run board meetings, I knew how to run errands (I loved doing those), I could easily love up my two step kids (they brought me so much joy), and I could easily put on my face. I was "getting by" and I really knew how to hide my darkness IF I wanted to. But I knew in my heart that I was not OK."

"I get out of bed every day and go to work and make dinner—if I were depressed, I wouldn't be able to function! I was also scared to get help."

Moreover, for some even the criteria are confusing and unclear; The woman above quoted she was able to function properly with her daily task.

Guilt and shame

The women found themselves accountable and guilty for not being able to control their emotions and resembling only the notion of a joyful mother; shame comes from being unable to care for the newborn and take responsibility for being a mother. The loss of control in feeling down and depressed and being helpless to resolve the distress kept them conscious of guilt, as one mother describes her sense of guilt as;

"I felt like I was living with a veil over my eyes. I could see everything everyone else was seeing, but blurred. Life was so, so hard with a baby that never stopped crying, and coupled with extreme sleep deprivation, I just couldn't find happiness anywhere. There were weeks I cried every day, feeling utterly broken by this experience." I've never felt so trapped or hopeless and I didn't think this could be a temporary feeling either. I couldn't blame hormones, I couldn't blame colic, and it never even crossed my mind that I might be depressed. I thought I needed to take responsibility for these feelings— it was no one's fault but my own. After all, I chose to have a baby."

Other mothers felt guilt from denying in accepting what goes wrong with them; they only felt like it was their will to feel this way which in turn made them suffer for themselves and their newborn. The wish to feel better but not seeing improvement or regaining control also arouses the feeling of guilt.

"Denying help was easy; I didn't want others to see me sad. I thought it would make me a bad mom. The guilt I carried plus the changing hormones put my mental state to the test. I felt like I was drowning in my pity party, but also like I had to be stronger than this."

6.2 Underlying cause

During their journey with PPD, the women mentioned their perception on what causes their symptoms.

Ambivalence

One woman explained, she thinks the underlying cause for her emotional roller coaster comes from maternal ambivalence. The shift in lifestyle change, responsibility of caring for a child was overwhelming for some of the women, they miss their previous life or not ready for the life change. They were independent, have a big carrier and responsibility at work. The concept of being a mother, on maternal leave with a crying baby was a less desirable and unfulfilling task compared to their duties prior to motherhood.

> *"I think many of our postpartum struggles derive from this ambivalence, from wrestling With this absolutely normal part of motherhood that is demonized in our culture. What mom would admit that sometimes she doesn't like being a mother? Though I couldn't put it into words in my plate-smashing days, I can see now that ambivalence was at the heart of my postpartum depression".*

> *"I felt huge waves of anxiety and pressure to love her more then I was. I was deeply sad and found little room to come up for air. As a dear friend of mine said, "It's like you're homesick." And I was. I was homesick for my old life. After 38 years of independence and entrepreneurship, I felt so trapped and so sad."*

Unplanned pregnancy and life challenge

Nevertheless, the women cannot tell the cause of their depression for sure; unintended pregnancy and life challenges, as well as relationship problems, could be the manifestations.

> *"It was unplanned and I had little to no support throughout the pregnancy, along with the baggage of a toxic relationship. Despite all of this, I was optimistic about making the most out of my circumstances, and took a proactive approach to preparing myself for labor and life as a mom and student."*

> *"I believe I suffered from postpartum depression because of all the events leading up to birth and the trauma I suffered after. I loved being a mom, and I loved my daughter, but she also had the resemblance of her father. At the time of her birth I was no longer in a relationship with her father, but he was still the continuous source of my emotional and*

mental trauma. It was a very dark time in my life. I felt helpless and alone.The thoughts that ran through my head were both confusing and terribly intrusive."

Childbirth trauma

Having birth with c-section after a painful contraction in most cases was a traumatizing event, led them to developed posttraumatic stress disorder. Most of the women were happy and excited for their pregnancies and wanted a baby eagerly. But The expectation of natural birth replaced with cesarean section led them down. The labor hours were long, tiresome, and painful. Caring for the baby with unhealed wound was too much and stressful. In addition, lactation problem caused by unnatural birth, difficulty in breast feeding was profound and was the starting point for developing PPD.

"The birth of our son ended with an immediate emergency c-section. I had contractions without any rest, and at 8 centimetres I got a weird awful pain in my back and my stomach got hard and really painful. The heart rate of our son dropped and disappeared. It was full alarm. They rushed me to the operation table. My husband was told not to come with me. I was in shock, but in too much pain to even speak. And I remember they pulled me away and I saw him alone and devastated in the end of the hallway. It took 7 minutes. Our son was born and in the safe hands of his dad. Together they stayed in the emergency section for newborns. I woke up in the post operation section without my son or husband. It took 5 hours before I held my newborn for the first time. After this, I developed PTSD. I also has depression.

If my daughter was fussy at night, I could simply page the nurse and she would whisk her away to the nursery, where, I assume, because I never actually saw it, a combination of swings, warm blankets, and kind night-shift nurses would rock and soothe my fussy child so I could sleep. Approximately every half hour I was warned that, by virtue of having a C-section, I was at greater risk for postpartum depression; I should call them if the baby blue lasted longer than a few weeks.

They were there to help me. I'll be fine, I told them. How hard could it be? I felt the first stirrings of ambivalence when I arrived home after my three-day stay in the hospital."

6.3 Before getting help

For most women, acknowledging the situation and moving on to get help at first was a conflict. The women felt helpless and started normalizing what happened, either not

knowing what to do or hoping things changed as time passed. Sometimes, it was more accessible to make speculations about their new behavior causes, as it could be a result of the role transition to motherhood.

> *"Every day I felt like I was drowning in my own stuff. Nothing was enjoyable, and sadly, I was still not connecting to my child. I couldn't find my groove with her. It was like I kept asking myself, when is this ever going to end? Why am I in so much pain?I couldn't find my groove with my child. It was like I kept asking myself, "When is this ever going to end? Why am I in so much pain?"*

Trying to take control of the situation

Even when the women accept their situation as wrong, the first measure is to control the situation by themselves.

> *"When my mother and my husband encouraged me to see a psychiatrist, I thought, No one can give me a pill that will make me a normal mom! I figured I would just have to make peace with the fact that I would be a mom who didn't really like motherhood,who played the part even though it didn't feel quite right. I can't reveal these terrible thoughts to anyone, I told myself. I can make this work. "*

Self-efficacy

Lastly, self-efficacy; comes to the sense that they are able and empowered to ask for help and believe in themselves; they can find a solution.

> *"A few weeks after I had my first-born baby boy, I remember sitting on my patio while breastfeeding him for what felt like the 10th time that morning. My nipples hurt. I was crying, sleep deprived, hungry, in major pain from my Caesarean, and I thought to myself, "So, this is motherhood? Where did my life go? Who am I?" It was at this moment; I knew I needed support. I quickly gathered my tribe; I called upon my doula, my mom, a lactation consultant, and found a local mom community and a postpartum group. I quickly realized that I wasn't alone, that my feelings and emotions were completely normal and common among mothers. "*

6.4 Challenges with diagnosis

From the women' narrative, the challenge with being diagnosed lie under; lack of professionality on PPD, resemblance feature with other mental illness, assumption of symptoms caused from other disease the women had, difficulty of accepting being depressed, misconception about PPD and stigma.

Misconception of PPD

Two women mentioned they had misconception of what PPD and its symptoms. Even if they were aware of the depression existence. The misunderstanding led them to acknowledge their illness and went undiagnosed. One woman mentioned she knew about PPD but thought of its as only exhibiting psychotic feature, made her to assume her issue was different.

> *"After my second son was born, I was so depressed that I could barely eat, and I lost 50 pounds in 10 weeks. But I thought women with PPD were suicidal or didn't want their babies, and I was neither of those things. So, I thought I was fine."*

Another woman said,

> *"I had this stereotype in my head of what PPD was, and it wasn't what I was going through."*

> *"Despite numerous doctors, hospital visits, and well-intentioned "counsel," no one diagnosed or recognized my postpartum illness. No one thought to run bloodwork or ask the right questions, and was, at times, advised to go into a secure psychiatric facility, without knowing what specifically the cause was. It was hell on earth, in the most literal sense."*

Identifying and accepting Depression

The concept of being depressed is confusing. The mothers could be depressed and have difficult life situations in their life before motherhood. To consider the new experiences as PPD or "I am being stressed" in my life, was unclear.

> *"Certainly, my life was stressful. But my life has always been stressful. I'd had to quit my job and money was tight, something my new husband worried about often and loudly. I'd been depressed before, but the feelings I was experiencing were new. I felt like I was mired in quicksand, rooted in one spot, unable to move forward. Always a social beast, I could barely leave my house. "*

Lack of experience in health practitioners

Women describe their experience with healthcare practitioners and midwives as contributing to their recovery; however, the experience was both positive and negative. The lack of inexperienced clinicians with PPD makes a difference, and some might not be familiar with PPD. Moreover, the resemblance of symptoms with other illnesses might make PPD misdiagnosis and untreated.

One mother mentioned she suffered form hyperthyroidism in her life even before pregnancy, which made it difficult for her to be diagnosed with PPD as her symptoms are similar to her previous illness.

> *"I thought the thyroid was the root of all my problems, but after having my second child, 7 years later, I was shocked when the exact symptoms started with the first few days after birth."*

> *"I ended up calling my doctor to get an appointment. I started to suspect I was experiencing postpartum depression but didn't know much about it. When I saw my doctor I filled out a depression score sheet."*

Another women said,

> *"Despite numerous doctors, hospital visits, and well-intentioned "counsel," no one diagnosed or recognized my postpartum illness. No one thought to run bloodwork or ask the right questions, and was, at times, advised to go into a secure psychiatric facility, without knowing what specifically the cause was. It was hell on earth, in the most literal sense. "*

The lack of health practitioners' experience in not offering diagnosis was mentioned by one woman;

> *"One day, while in a physician's waiting room before a meeting, I came across a brochure from Postpartum Support International that described post- partum depression. I scribbled down the address, thinking, "I need to learn more about this." After receiving more information about PPD, I had a very mixed emotional response. I experienced sadness, extreme anger, frustration, and outrage. In all my years of training, I had learned nothing about perinatal mood disorders. I thought back to some of the women I had probably misdi- agnosed. Why aren't health practitioners taught about PPD? My anger pro- pelled me into action."*

In addition, the lack of consideration in diagnosing women for PPD in the healthcare system makes them feel uncared for.

Stigma

Acceptance of feelings and emotions was stigmatized some mothers, which led them to reach for help. To tell others they have hatred for their child or unable to feed their new born was not ease topic to talk about. They described their experience as shameful incident, hiding their symptoms when they had the chance to be diagnosed for PPD.

> *"It hit me that I lied when I had filled out the sheet before because I thought I would get better and had pushed all those feelings aside. This time I had to make myself tell the truth.*

6.5 Journey to recovery

The women share their recovery experiences beginning with different occasions; some women acknowledge their problems and seek help by themselves; others identify the illness through others. Selfcare, health care system, community, and family support were the mainstream to recover from their depression.

Seek for help Personally

Having previous awareness about PPD helps women to take over their situation Personally and start looking for help in medical care, as two women shared their experiences;

> *"And then one day I smashed a plate on the kitchen counter out of frustration with my children. It wasn't working. I hadn't found peace. I picked up the phone and told my doctor, "My baby is already sixteen months old, but I think I have postpartum depression."*

This same mother described that when things get out of control, It led her to accept something is wrong. her worries elevate, and she becomes more concerned and standout to get help.

> *"Things changed after I had my third child. I was severely agitated and cried a lot. I couldn't stand myself, and I felt like I was a terrible person because I was mean to my husband and aggravated with my kids." That's when I found HOPE, a PPD-based support group in Carlisle, PA, where we lived at the time. Hearing their stories was like a lightbulb going off in my head. I sought out a counselor and was officially diagnosed with PPD."*

" I'd visualize ways to hurt myself and end my life, mapping out in my head exactly how it would happen. I never acted on those thoughts, but I felt insane. I was yelling at my family, crying, and at one point I started to pound my head against the wall. That was the day I took myself to the ER."

Another woman mentioned that her current symptoms resemble to her previous mental illness, which helped her to identify her situation and take measures.

"Because I had experienced major depression during college, I suddenly had a moment when I was able to recognize that this was the return of a mental illness. That's when I stopped nursing and started taking antidepressants, which made a big difference. But I had to go off the medication to get pregnant with my next child. I braced myself and tried desperately to prevent my depression from returning. Still, the same symptoms emerged: Constant crying, self-doubt, persistent negative thoughts about how I'm a failure, and eventually, severe psychotic thinking—like my nanny was plotting against me or trying to prevent me from being a good mom.

This time, I was able to catch things sooner. I stopped nursing when my second child was six months old and went back on antidepressants. I also started spending time in cognitive therapy—a form of talk therapy that teaches you how to manage dysfunctional thinking."

Help comes from others

Luckily for some of the mothers they accepted their distorted behavior, life change and seek for help themselves on different occasions, but for others someone identify something is wrong and offer help.

"Luckily one dear friend could see the anxiety I was going through. She could tell that I was spinning in a way that was not "normal." She suggested I seek help from a professional postpartum depression counselor."

"Then help came from the amazing women in my life. They asked the hard question, "Are you okay?" They asked me what I needed. They did the research and made the phone calls to find a therapist – all the work I had been avoiding. With the help from these friends, I was in the therapist's office within the week. Speaking to the therapist and my OB, it was very apparent – I had postpartum depression and I needed help. I don't know what I would have done without these women that saw a problem and spoke up. Then, they carried the

weight that I could not, and held my hand (physically and metaphorically) as I made some progress forward."

Acceptance

Almost all women consider acceptance as a significant milestone in their recovery; whether they accept their depression as an illness or accept their emotional battle as wrong, it makes them start taking action.

"I was doing everything in my power to balance my state of mind: eating well, going outdoors when I could, hiring lactation consultants, and visiting so many doctors to have them "fix" me."

"Recovery it is an ongoing process, you don't get healed in a day"

"I worked to shed perfectionism by sharing my shame. It started to lose its power after that."

"I stopped stuffing my emotions, and they lost their power, too"

"I got help despite my pessimism. What matters is the willingness to take action."

"For me, the best therapy has been to stop ignoring my feelings and pretending like I don't feel bad sometimes."

"Find what you need to feel heard and validated. It could be therapy or medication or a combination of both."

"There's no one right "cure," but the common thread is that you find a way to reconnect to yourself."

"Learning about my disorder helped me intellectualize it."

Acceptance of the situation made the women feel less guilty and lookout for help. Getting more information about the illness led them to acknowledge their struggle, realizing the symptoms and emotional distress resulting from depression. Above all, it led them to cope or look for a cure for their illness.

Psychotherapy and counselling

Talk therapy during a support group helped the women to acknowledge their illness; hearing it from a professional gave them recognition, and they moved forward with their depression. One woman also mentioned the importance of finding a support group as;

> *Joining HOPE was the start of my recovery. But what truly helped the most was a professional telling me that what I had was actually real—that I wasn't crazy. I had this stereotype in my head of what PPD was, and it wasn't what I was going through. I had no idea anxiety and agitation could be a part of it. And I didn't know it could be different after every baby.*
>
> *"Hearing their stories was like a lightbulb going off in my head. I sought out a counselor and was officially diagnosed with PPD."*

Finding support group was helpful as hearing stories of other victims were comforting in a sense of not being alone.

> *"I hope this can be a place where people know they won't be alone, criticized or judged. There is help, and they will get better. I truly believe that I was meant to have postpartum depression so that I could help others and help bring awareness to the Peoria area."*

A few women pointed out that finding a support group was challenging; besides the idea of PPD is stigmatized, it is taboo at some point to talk about PPD. This causes a gap in creating awareness among mothers about the depression.

> *"Unfortunately, no one talks about postpartum depression, and this shouldn't be such a hush, hush topic. I wished there was a place where I could talk with other people about what I went through who might be going through the same thing."*
>
> *"When I looked for a support group in the Peoria area, I couldn't find one – so I worked with OSF HealthCare Saint Francis Medical Center to start one."*

Medication

The use of antidepressant medication was helpful for some mothers. For other, it was helpful only in alleviating some of the symptoms but not all symptoms were gone away. For Another blogger, combination of therapy and medication was beneficial. However, to find the right antidepressant can be problematic and the use of medication while breastfeeding was something that the women considerer.

> *"My counselor recommended antidepressants. I was against medication at first, but after a while, I realized I needed it. I've been taking an antidepressant on and off for two years now. It helps, but I've yet to feel fully like myself without it. I've been pregnant or*

breastfeeding for the past seven years, and I'm hopeful that once I'm done nursing this baby, that I'll be able to get off the meds and go back to 'normal.'"

"Within three weeks of taking the medication as well as starting up weekly therapy again I started to feel better. With cognitive therapy, I learned how to flip my negative thoughts into ones that were more positive. The support of my spouse, parents, siblings, and a strong network of female friends was also invaluable."

"I tried all the traditional things your doctor tells you to do: I exercised, made plans with friends, and tried to get enough sleep. But none of it worked. It got to the point where I'd start having obsessive suicidal thoughts."

My ER visit started me on the journey of getting the help I needed. It took a while, but eventually, I found the right antidepressant medications and have been on them for over a year. I stopped having suicidal thoughts, but the anxiety, worry, and down feelings never quite went away."

"I was then diagnosed with postpartum depression and started taking medication. Even with medication, I was still missing work because of my crying. I ended up taking a leave from work until it got under control, which took about three months."

Overall the doctor has had to up my medication dosage three times because I would still be in what I would call "funk (have been feeling sad)." At times I still did feel not quite like myself."

The healing process, after all, from medication and psychotherapy is personal; every woman responds to the treatment differently.

Self- Care as complementary Treatments

For some mothers, alternative interventions and self-care overruled the use of antidepressant medication and therapy or were very beneficial in harmony with clinical intervention.

"Antidepressants were a start but prioritizing self-care and eating better helped me recover fully."

Self-care was essential to distract the emotional disturbance of negative thoughts. It has built a sense of self-importance and bring joy by doing something they enjoy. The overwhelming and piled responsibility of being a new mom left out the women to care for themselves.

"I started to build a mini tool kit for myself to help me during challenging times. This included things that bring me joy: books, writing in my journal, a few essential oils that I love adding to my baths or on my pillow before bed, an online yoga session or meditation, calming and delicious tea, walking around the block, and taking a bath. This helped my

emotional state tremendously, as it allowed me to fill any negative or sadness emotion with something I loved and enjoyed doing."

"Few minutes of self-care for myself, which I learnt is very important. Like in an airplane, we need to put on our own oxygen masks first, in order to help our loved ones around us. This often get's so naturally forgotten in motherhood".

In addition to self-care, a diet plan designed by nutritionists specifically to reduce hormonal issues was mentioned by some women as helpful.

"I started taking additional steps to help myself feel better. I read Unstuck by James Gordon, M.D., which had some really helpful exercises. I started journaling about the things that brought me joy, then found ways to do those activities more often. I started taking martial arts and singing lessons, got more massages, and went on more hikes. I also started working with a nutritionist who specialized in postpartum hormonal issues. After eight weeks, I started to notice a big difference. I finally feel like I woke up from my sleepy haze. Now, I'm actually happy."

All women made their perception of treatment "unique "every person's healing process entirely depends on the severity of their illness and their body and consciousness response. For some, medication was the answer, but it only suppresses depressive symptoms but not the distorted thinking of having suicide.

Around eight to 10 weeks postpartum, I started to suspect that I might have postpartum anxiety or depression, so I reached out to my doctor. We discussed the option of taking anti-anxiety or antidepressant medications. But what ultimately ended up helping me was making sure that I had things to do each day. I found group activities and scheduled play dates, classes, and lunches. I'd take my son to a new mom group, head to the library, and take music classes. Getting out of the house, talking to other moms, and sharing my feelings helped me realize that I wasn't alone in going through this. It took some time to open up, but once I did, it was such a relief.

From the women's quotes above, self-care and complementary treatment come from the unfulfilled recovery of their symptoms. Diet, meditation, exercises, physical activity, yoga, journaling experiences, leisure activities, essential oils, socializing, and listening to music were mentioned as alternative or complementary treatments.

7 Discussion and Critical Results

In this chapter the method as well as the result used will be examined.

7.1 Trustworthiness

Trustworthiness implies the degree of truthfulness of the finding in research. Confidentiality and integrity of the study's conduct in harmony with trustworthiness, determine the usefulness of the finding (Polit & Beck,2012). To assure the trustworthiness of a qualitative research; conformability, credibility, dependency, and transferability of the finding needs to be considered by the researcher. (Polit&Beck,2012). Different techniques were were defined by Lincoln and Guba (1985) to test trustworthiness.

In this study, "thick description "technique was used to validate the transferability of the data collected from the blogs,

Credibility measures the accuracy of the finding, the researcher should be confident with the research in generating a truthful finding (Polit & Beck,2012). credibility limitation was a disadvantage during data collection in this study, using blogs and stories from the internet could raise a question about the experience written by real women. The authenticity of the authors in the blog as well as the stories can be questionable, as authors falsify information and be a scam blogger (Ackland, 2013). Although the lack of validity or falsification of information could occur in other data collection tools as interviews and surveys (Hookway,2008). Narratives in Blogs are highly subjective and personal. To strengthen the credibility of data, only repetitive and similar information among different authors from different Blogs were taken. In the result interpretation the credibility of the descriptions each category and theme was validated using direct quotation from the authors.

Confirmability insures the consistence of the finding and degree of reusability. Results and Interpretation of findings from data analysis is only generated from the collected data without the bias of researchers' imagination (Polit & Beck, 2014). The similarities of the concepts stated in Becks' theory of PPD from the theoretical frame work of the study, validate the conformability of the findings

Triangulation is the strategy of collecting data from different sources, employing different research methods, techniques or even mixing two different paradigms. Triangulation strategy helps to compensate weaknesses of one method or technique of data collection with alternative strategy (Noble & Heale, 2019).

the trustworthiness technique of "Thick Description" can also contribute to establishing this criterion of utility, since it is only by the detailed description of the context and the actions situated within that context can the answers raised, and meanings made be transferred to a different and yet similar context (Loh, 2015).

7.2 Discussion of Result

This thesis work aimed to gather insights about the experience of women suffering from PPD in terms of how they recognize, diagnose, and deal with their illnesses. This chapter discusses the qualitative research findings in support with the background study and additional literature.

The discussion focuses on the perceptive areas in which women share their experiences. First, the experience of becoming a mother; including posttraumatic stress from delivery and nursing difficulties.

Second, symptoms and feelings such as anxiety, alienation, and overwhelmed developed. Third, the recovery experience, support, self-care, health care intervention, and alternative therapies.

Understanding the surroundings and how the mother perceives it is the first step in delivering assistance. The goal of complementary therapy is to identify and confirm this sensation. Activities as part of the therapy should aim to restore the sensation of depersonalization.

Many women who shared their experiences were highly enthusiastic and eager to be mothers throughout their pregnancy. Even some women were overjoyed after being infertile for an extended period. According to (Egan, Kane, Winton, Eliot, & McEvoy, 2017), perfectionism was one of the reasons for the development of PPD. Women in their third trimester to postpartum period were the most likely to be affected. The mothers from the blogs said they experience unfulfilled expectations due to their inability to bond with their infant, breastfeed, and enjoy motherhood. Perfectionism is distressing behavior that develops due to a missed prospective objective and hope.

Women experienced a role transition with motherhood. According to the research findings, ambivalence was caused by a missing previous life and a duty shift. Maternal ambivalence is defined as "a love-hate relationship that mothers develop with their offspring." Women with high-level occupations have developed lower self-esteem because they see the responsibility of caring for a newborn as less worthwhile or gratifying (Amankwaa,2015).

Women who had lengthy, difficult labor and delivery through cesarean section experienced posttraumatic stress. Evidence suggests that postpartum stress may be a risk factor for developing mental health problems, although there is no clear link between PPD and posttraumatic stress disorder following delivery. The rate of cesarean section has increased at the national level.

Other research suggests that cesarean surgery increases the incidence of PPD. According to the study's result, women who wanted cesarean birth but delivered vaginally had greater posttraumatic stress symptoms than women who requested vaginal delivery and delivered vaginally (Garthus-Niegel et al., 2014).

Despite the fact that vaginal birth is usually the best option in the absence of medical grounds, some women may choose a cesarean section (Garthus-Niegel et al., 2014). Recent research found that women who wanted an elective caesarian section throughout their pregnancy were more likely to develop PPD symptoms and posttraumatic stress disorder (PTSD) if the delivery was not approved and gave birth vaginally (Olieman et al., 2017).

In both circumstances, women who give birth by cesarean section can be vulnerable to developing PPD; counseling, thorough follow-up, and screening should be carried out to prevent PPD.

The women in the study cited breastfeeding as a challenge. They were unable to breastfeed due to factors such as insufficient milk production, physical incapacity from unrecovered labor, and the baby having a tied tongue. In addition, nursing a baby every couple of hours was an exhausting experience. Breastfeeding is considered a preventive measure against developing depression. Not being able to Breastfeed has been identified as a risk factor for maternal depression in some research. However, some research has connected PPD to the mother's inability to breastfeed (Da Silva Tanganhito et al., 2020)

Previous psychiatric illness was listed as a potential risk factor in the study's background literature. According to (Ertmann et al., 2021), women who indicated previous mental issues might be associated with an increased risk of depressive symptoms. The healthcare providers who see pregnant women in their early stages of pregnancy have a solid chance to identify these women as susceptible and ask additional inquiries about the women's past experiences with psychiatric issues.

During follow-up visits, mothers' emotional stability is not considered in every country's health care. One study addressed the need for mental health screening during routine obstetric follow-up; the standard obstetric visit after six weeks focuses mainly on physical checks, such as breastfeeding and contraception. Furthermore, screening for PPD after one week of discharge after birth is not done regularly (Corrigan et al., 2015).

Mindfulness and self-compassion have been shown to help avoid depression and anxiety disorders. Mindful self-compassion intervention is useful in reducing postpartum depression and enhancing the well-being of mothers and infants (Guo et al., 2019). The article (Dipletro etal,2019) provides evidence that women who engage in greater physical activities have fewer symptoms of PPD than sedentary women.

The women highlighted the importance of healthcare professionals in intervention. But for some, the negative side of lacking proficiency in diagnosing the illness was a barrier to getting care. During their visit to the hospital, their illness did not receive enough attention. The nurse's journal (Alba, 2021) also discusses the knowledge gap among healthcare workers. Unclarified notions lead to misinterpretation of PPD symptoms with unusual emotional changes associated with pregnancy. For

instance, Exhaustion, insomnia, and difficulty concentrating could be common symptoms of pregnancy and mood disorders. A more detailed definition of PPD would aid nurses , midwives and physicians in accurately diagnosing mood disorders.

8 Conclusion

In this thesis, postpartum depression has been explored through the suffers' experiences. The findings showed that PPD is a common maternal depression during the prenatal period; however, many go untreated because of a lack of knowledge, misconception, and stigma.

The results also show an essential interpretation of the incidence of PPD. Depression is not something one goes through while staying the same person. Instead, one is experiencing depression. The study points out how women identify and process their postpartum depression in terms of psychological distress and challenges, as well as their coping mechanisms. The experience of encountering depression can commence because of pivotal changes before and after the delivery of a child. The women arrayed some of the causes as being inexperienced, having life challenges, traumatic childbirth experiences, and lack of support. The beginning of their journey was paved by emotional struggles and debilitating symptoms, which led them to confusion and denial. The situation was overwhelming for a new mother, who is expected to be joyful. Self-efficacy and acceptance were essential for the women to start their recovery.

Even though the symptoms of PPD mood disorders overlap and make diagnosis difficult, nurses' role in avoiding, or at least limiting, the devastating consequences of PPD by education, screening, and referral should not be diminished.

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Appendix 1: table of Data sources

platform	Address	Title
Online Personal blogs	https://www.postpartum.net/my-battle-with-postpartum-depression-anxiety/	A Therapist's Story : My Battle with Postpartum Depression & Anxiety
	https://www.osfhealthcare.org/blog/the-sun-will-shine-again-my-postpartum-depression-story/	"The sun will shine again: My postpartum depression story"
	https://postpartumny.org/sharingourstories/	"You are Not Alone. Sharing Our Stories of Hope and Healing."
	https://www.badyogi.com/blog/my-experience-with-postpartum-depression/	"My Experience with Postpartum Depression"
	https://twincitiesmom.com/overcoming-postpartum-depression/	"Overcoming Postpartum Depression"
	https://www.badyogi.com/blog/my-experience-with-postpartum-depression/	"My experience with Postpartum Depression"
	https://postpartumprogress.com/find-moms-like-you	"Postpartum depression stories"
stories on Postpartum progress	https://postpartumprogress.com/aunt-becky-from-mommy-wants-vodka-on-being-depressed-pregnant	"Aunt Becky from Mommy Wants Vodka on Being Depressed & Pregnant"

stories on mindfulmamasclub	https://www.mindfulmamasclub.com/bloghub/tag/postpartum	7 stories
Stories on “national perinatal mental health helpline is Australia’s only free, national helpline service for people affected by perinatal mental illness (PANDA).”	https://panda.org.au/stories/?tags=postnatal-depression	Michelle's story | PANDA Josephine's story | PANDA https://panda.org.au/stories/jane-s-story/
Online Personal posts	https://www.self.com/story/postpartum-depression-and-anxiety-stories	5 mothers stories were taken "Antidepressants, talk therapy, and a strong support network helped get me through." "Antidepressants were a start, but prioritizing self-care and eating better helped me recover fully." "Learning about my disorder helped me intellectualize it." "I had this stereotype in my head of what PPD was, and it wasn’t what I was going through." "I made sure I had something to do every day, and let myself open up to the new moms I would meet."
	6 Moms Share What Postpartum Depression Really Feels Like (whattoexpect.com)	6 women share their experience “Most of the time, I felt like I was in a fog” “I worried about everything”

		"PPD was feeling overprotective to a detriment" "I felt that I'd done harder things and I could just cope" "I didn't think it could be PPD because I didn't have it with my first two kids" "I would stare at the mirror and not recognize who I was"
Stories from the Books	Beyond the Blues (2019 Edition): Understanding and Treating Prenatal and Postpartum Depression & Anxiety By Shoshana Bennett and Pec Indman Mothering Through the Darkness: Women Open Up About the Postpartum Experience By **She Writes Press**	2 stories 1 story