Postpartum Depression: A Metasynthesis

Cheryl Tatano Beck

Postpartum depression has been described as a dangerous thief that robs mothers of the love and happiness they expected to feel toward their newborn babies. Even though the number of qualitative studies on postpartum depression is increasing, knowledge development will be impeded unless the rich understandings gleaned from these studies are synthesized. Using Noblit and Hare’s 1988 approach, the author conducted a metasynthesis of 18 qualitative studies on postpartum depression. Four overarching themes emerged that reflected four perspectives involved in postpartum depression: (a) incongruity between expectations and the reality of motherhood, (b) spiraling downward, (c) pervasive loss, and (d) making gains. Implications for clinical practice and theory development are addressed.

Mothers suffering from postpartum depression often feel cheated and robbed of the first few months of their infants’ lives (Beck, 1999). Women who experience it have described feeling like “death warmed up” and being “afraid to be alive” (Dalton, 1996). Approximately 13% of new mothers experience this crippling mood disorder at some point during the first year after delivery (O’Hara & Swain, 1996). Over the past decade, qualitative researchers have tried to capture, from the mothers’ perspective, what it is like to live through this nightmare.

The two standard approaches for treatment of postpartum depression are pharmacological (Appleby, Warner, Whitton, & Faragher, 1997) and various forms of psychotherapy such as interpersonal psychotherapy (Stuart & O’Hara, 1995). Now that findings from a number of qualitative studies on postpartum depression are accumulating, a metasynthesis of these riveting findings can help provide direction for more interventions that are grounded in these data.

Metasynthesis refers to “the theories, grand narratives, generalizations, or interpretive translations produced from the integration or comparison of findings from qualitative studies” (Sandelowski, Docherty, & Emden, 1997, p. 366). However, the “meta” in metasynthesis differs in meaning from the meta in meta-analysis (Noblit & Hare, 1988). For a meta-analysis, it means developing overarching generalizations but for a metasynthesis, it refers to translating qualitative studies into each other. Meta-analysis involves aggregating data and metasynthesis involves interpreting the data.

Despite the fact that qualitative studies on postpartum depression have increased in number, knowledge development will be hindered unless the riveting findings from these research studies are synthesized through metasynthesis. Hindering the synthesis of qualitative studies is the erroneous belief that qualitative findings are ungeneralizable (Sandelowski et al., 1997).
Review of the literature did not reveal any metasyntheses on postpartum depression. Therefore, I conducted one on 18 qualitative research studies. My purpose was to enlarge the interpretive possibilities of the results of these 18 individual studies and construct a larger narrative. It is hoped that these results can have a greater impact on direction for clinical practice if they are situated in a larger interpretive context.

METHOD

Procedure
Online databases such as the Cumulative Index to Nursing and Allied Health Literature (CINAHL), Psychlit, Index Medicus, Social Sciences Citation Index, American Humanities Index, Anthropological Literature, and Sociological Abstracts were searched from the decades of the 1960s through the 1990s. Key words such as postpartum depression, postnatal depression, qualitative research, grounded theory, and phenomenology were used to narrow the search. To protect the metasynthesis from publication bias, attempts were made to locate unpublished qualitative studies as well, and through Dissertation Abstracts, two such studies were retrieved (Nims, 1996; Semprevivo, 1996).

There were only two criteria for inclusion into the metasynthesis: (a) The focus of the study was postpartum depression, and (b) the research design was qualitative. No specifications regarding type of qualitative design limited inclusion. Postpartum depression was defined as a nonpsychotic depression episode that starts in or extends into the postpartum period.

The retrieval process yielded 18 qualitative studies on postpartum depression. Three articles by Mauthner (1995, 1998, 1999) were all based on the same sample of 18 women in Edinburgh. Each focused, however, on a different aspect of the findings, such as a relational perspective on postpartum depression (1998) and the significance of social contacts between mothers (1995). Two articles published by Nicolson (1990, 1999) were based on the identical sample of 24 mothers suffering from postpartum depression but a different approach to data analysis was used in each one. In the first article, Nicolson (1990) used content analysis; in the later one (1999), she stated that “data were analyzed within a broadly symbolic interactionist framework” (p. 166), which led to identification of themes. For purposes of calculating a total sample of women included in this metasynthesis, the 18 women in Mauthner’s three studies were counted only once, as were the 24 mothers who participated in both of Nicolson’s studies. Different samples were used, however, in the three studies conducted by Beck (1992, 1993, 1996).

Sample
The sample for this metasynthesis consisted of 18 qualitative studies published between 1990 and 1999. Nine appeared in nursing journals, 5 in psychology journals, and 2 in women’s studies journals. Two unpublished studies were included in the metasynthesis, both from the discipline of nursing. One was a doctoral dissertation and one was a master’s thesis. Located in Tables 1 and 2 are, respectively,
<table>
<thead>
<tr>
<th>Study</th>
<th>Sample Size</th>
<th>Age Range</th>
<th>Parity</th>
<th>Marital Status</th>
<th>Delivery Type</th>
<th>Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beck (1992)</td>
<td>7</td>
<td>22-38 years</td>
<td>4 primiparas; 3 multiparas</td>
<td>Married</td>
<td>4 vaginal; 3 cesarean deliveries</td>
<td>Caucasian</td>
</tr>
<tr>
<td>Beck (1993)</td>
<td>12</td>
<td>20-38 years</td>
<td>5 primiparas; 7 multiparas</td>
<td>Married</td>
<td>8 vaginal; 4 cesarean deliveries</td>
<td>Caucasian</td>
</tr>
<tr>
<td>Beck (1996)</td>
<td>12</td>
<td>Not specified</td>
<td>5 primiparas; 7 multiparas</td>
<td>Married</td>
<td>Not specified</td>
<td>11 Caucasian; 1 Asian</td>
</tr>
<tr>
<td>Berggren-Clive (1998)</td>
<td>8</td>
<td>26-40 years</td>
<td>3 primiparas; 5 multiparas</td>
<td>Married</td>
<td>Not specified</td>
<td>Canadian</td>
</tr>
<tr>
<td>McIntosh (1993)</td>
<td>38</td>
<td>50% of sample age 20 or younger</td>
<td>38 primiparas</td>
<td>31 married or cohabiting; 7 single</td>
<td>Not specified</td>
<td>Not specified</td>
</tr>
<tr>
<td>Morgan, Matthey, Barnett, and Richardson (1997)</td>
<td>34</td>
<td>23-36 years</td>
<td>16 primiparas; 18 multiparas</td>
<td>Married</td>
<td>Not specified</td>
<td>Not specified</td>
</tr>
<tr>
<td>Nahas and Amasheh (1999)</td>
<td>22</td>
<td>Not specified</td>
<td>Not specified</td>
<td>Not specified</td>
<td>Not specified</td>
<td>Jordanian</td>
</tr>
<tr>
<td>Nahas, Hillege, and Amasheh (1999)</td>
<td>45</td>
<td>19-38 years</td>
<td>22 primiparas; 23 multiparas</td>
<td>Married</td>
<td>45 vaginal</td>
<td>Middle Eastern</td>
</tr>
<tr>
<td>Nicolson (1990, 1999)</td>
<td>24</td>
<td>21-41 years</td>
<td>18 primiparas; 6 multiparas</td>
<td>Married or cohabiting</td>
<td>21 vaginal; 3 cesarean deliveries</td>
<td>2 Black; 1 Irish; 21 British</td>
</tr>
<tr>
<td>Nims (1997)</td>
<td>4</td>
<td>29-36 years</td>
<td>2 primiparas; 2 multiparas</td>
<td>Married</td>
<td>3 vaginal; 1 cesarean delivery</td>
<td>Not specified</td>
</tr>
<tr>
<td>Semprevivo (1996)</td>
<td>20</td>
<td>18-34 years</td>
<td>10 primiparas; 10 multiparas</td>
<td>12 married; 3 divorced; 5 single</td>
<td>Not specified</td>
<td>16 Caucasian; 1 Black; 1 West Indian; 1 Indian; 1 other</td>
</tr>
<tr>
<td>Sluckin (1990)</td>
<td>2</td>
<td>Not specified</td>
<td>2 primiparas</td>
<td>Married</td>
<td>Not specified</td>
<td>British</td>
</tr>
<tr>
<td>Stewart and Jambunathan (1996)</td>
<td>52</td>
<td>18-44 years</td>
<td>7 primiparas; 45 multiparas</td>
<td>Married</td>
<td>Not specified</td>
<td>Hmong</td>
</tr>
<tr>
<td>Wood, Thomas, Dropleman, and Meighan (1997)</td>
<td>11</td>
<td>20-31 years</td>
<td>8 primiparas; 3 multiparas</td>
<td>Married</td>
<td>Not specified</td>
<td>Caucasian</td>
</tr>
</tbody>
</table>
TABLE 2: Methodological Characteristics of the Qualitative Studies Included in the Metasynthesis

<table>
<thead>
<tr>
<th>Author</th>
<th>Discipline</th>
<th>Year</th>
<th>Country</th>
<th>Data Analysis</th>
<th>Qualitative Research Design</th>
</tr>
</thead>
<tbody>
<tr>
<td>Berggren-Clive</td>
<td>Social work</td>
<td>1998</td>
<td>Canada</td>
<td>Constant comparative method (Strauss &amp; Corbin, 1990)</td>
<td>Feminist research, grounded theory</td>
</tr>
<tr>
<td>McIntosh</td>
<td>Sociology</td>
<td>1993</td>
<td>Scotland</td>
<td>Thematic analysis</td>
<td>Descriptive</td>
</tr>
<tr>
<td>Morgan, Matthey, Barnett, and Richardson</td>
<td>Occupational therapy</td>
<td>1997</td>
<td>Australia</td>
<td>Thematic analysis</td>
<td>Descriptive</td>
</tr>
<tr>
<td>Nahas and Amasheh</td>
<td>Nursing</td>
<td>1999</td>
<td>Australia</td>
<td>Leininger’s method (1991)</td>
<td>Ethnography</td>
</tr>
<tr>
<td>Nahas, Hillege, and Amasheh</td>
<td>Nursing</td>
<td>1999</td>
<td>Australia</td>
<td>Colaizzi (1978)</td>
<td>Phenomenology</td>
</tr>
<tr>
<td>Nicolson</td>
<td>Psychology</td>
<td>1990, 1999</td>
<td>United Kingdom</td>
<td>Content analysis and thematic analysis</td>
<td>Descriptive</td>
</tr>
<tr>
<td>Nims</td>
<td>Nursing</td>
<td>1996</td>
<td>United States</td>
<td>Colaizzi (1978)</td>
<td>Phenomenology</td>
</tr>
<tr>
<td>Semprevivo</td>
<td>Nursing</td>
<td>1996</td>
<td>United Kingdom</td>
<td>Colaizzi (1978)</td>
<td>Phenomenology</td>
</tr>
<tr>
<td>Sluckin</td>
<td>Psychology</td>
<td>1998</td>
<td>United Kingdom</td>
<td>Case study</td>
<td></td>
</tr>
<tr>
<td>Stewart and Jambunathan</td>
<td>Nursing</td>
<td>1996</td>
<td>United States</td>
<td>Sensitization method (Knafl &amp; Webster, 1988)</td>
<td>Ethnography</td>
</tr>
</tbody>
</table>

descriptive and methodological characteristics of the sample. To condense information in some of the tables, multiple studies by the same researcher were combined and placed in one column.

These studies were conducted in various countries throughout the world. Six studies took place in the United States, 8 in the United Kingdom, 3 in Australia, and
1 in Canada, involving 309 mothers. Various qualitative research designs were used in these studies. The most frequently used qualitative design was phenomenology (N=6), followed by a general descriptive design (N=4), ethnography (N=2), grounded theory (N=2), and one case study.

**Data Analysis**

Noblit and Hare’s (1988) approach for synthesizing qualitative studies was used to conduct this metasynthesis on postpartum depression. Their approach consisted of a series of seven phases that overlap and repeat as the metasynthesis progresses.

(a) Getting started and deciding on a phenomenon of study.
(b) Deciding what qualitative studies are relevant to the initial interest.
(c) Reading the qualitative studies.
(d) Determining how the studies are related to each other. In this phase, the synthesizer makes a list of the key metaphors in each study and their relations to each other. The term metaphor refers to themes, concepts, or phrases. Three different assumptions can be made about the relationships between the studies to be synthesized. These key assumptions are: “(1) the accounts are directly comparable as ‘reciprocal’ translations; (2) the accounts stand in relative opposition to each other and are essentially ‘refutational’; or (3) the studies taken together present a ‘line of argument’ rather than a reciprocal or refutational translation” (Noblit & Hare, 1988, p. 36). In this metasynthesis, the synthesis took the form of reciprocal translations because the studies were about similar things. With reciprocal translations, each study is translated into the metaphors of the others and vice versa.
(e) Translating the studies into one another. As Noblit and Hare (1988) explained, “Translations are especially unique syntheses, because they protect the particular, respect holism, and enable comparison. An adequate translation maintains the central metaphors and/or concepts of each account in their relation to other key metaphors or concepts in that account” (p. 28).
(f) Synthesizing translations. This involves creating a whole as something more than the individual parts imply. The translations as a group are one level of a metasynthesis. Next, the translations can be compared to decide if the same metaphors/themes or concepts can be encompassed into those of others. This is a second level of synthesis.
(g) Expressing the synthesis through the written word, plays, art, videos, or music.

As I progressed through Noblit and Hare’s (1988) seven phases in this postpartum depression metasynthesis, I kept in mind Sandelowski and colleagues’ (1997) warning:

> Qualitative metasynthesis is not a trivial pursuit, but rather a complex exercise in interpretation: Carefully peeling away the surface layers of studies to find their hearts and souls in a way that does the least damage to them. Synthesists must analyze studies in sufficient detail to preserve the integrity of each study and yet not become so immersed in detail that no useable synthesis is produced.” (p. 370)

**RESULTS**

To facilitate the reciprocal translations needed to conduct this metasynthesis, I constructed a detailed table of the metaphors and concepts from each of the 18 studies. Noblit and Hare’s (1988) steps of reciprocally translating individual studies’ meta-
phors into one another and then synthesizing these translations into a whole that is more than the individual studies’ metaphors implied yielded four overarching themes (see Table 3). In synthesizing the translations, it became apparent that these themes reflected four perspectives involved with postpartum depression: (a) incongruity between expectations and reality of motherhood, (b) spiraling downward, (c) pervasive loss, and (d) making gains (see Figure 1).

As illustrated in Figure 1, mothers can move back and forth between these differing perspectives, and they can be in more than one at any time. Following is an in-depth description of these four perspectives of postpartum depression that emerged from the metasynthesis of the 18 qualitative studies.

Incongruity Between Expectations and Reality of Motherhood

Dangerous myths operating among both professionals and lay people equate becoming a mother with total fulfillment and happiness (Nicolson, 1990). These myths of motherhood created by our society set expectations that are impossible for mothers to attain and place women’s mental health at risk (Berggren-Clive, 1998). Eight of the studies included in this metasynthesis focused on the key role conflicting expectations and experiences of motherhood played in the development of postpartum depression. The dreams and unrealistic expectations held by mothers were shattered by the reality of motherhood. Women experienced conflict between how they expected motherhood to be and their own experiences as mothers (Mauthner, 1999). They became disillusioned with motherhood, as they perceived that they failed to fulfill their expectations of themselves as the perfect mother (Berggren-Clive, 1998). Emotions of despair and sadness started the mothers’ spiral downward into postpartum depression. The women in Berggren-Clive’s study described the incongruity between their expectations and the realities associated with motherhood in seven areas: labor and delivery, life with their infants, self as mother, relationship with partners, support from their family and friends, life events, and physical changes. A series of unfulfilled expectations occurred as women attempted to adjust to motherhood.

Because these destructive myths are so rampant in our society, women believed that no other mothers shared their negative reactions to childbirth. They viewed themselves as bad or abnormal mothers. They also feared moral condemnation and being labeled as failed mothers. As one mother in Mauthner’s (1995) study revealed, “I felt like a freak, like I was the only one in the world who couldn’t cope with their baby, and . . . the only one who felt so miserable about it all” (p. 316).

Mauthner (1998) identified three kinds of conflict in mothers’ narratives, all of which centered on their desire to be that “perfect mother.” One area of conflict concerned how to care for their infants regarding such topics as breast-feeding and being employed. The second set of conflicts revolved around women’s depression and unhappiness, which was in direct conflict with their expectations that they would be happy with their infants. The third conflict area concerned women’s expectations that they could cope with their new infants although the reality was that they needed help.

All 18 postpartum-depressed mothers in Mauthner’s (1998) study experienced one or more of these sets of conflicts. For each woman, however, the conflicts she experienced depended on her notion of what makes “a good mother” and what
<table>
<thead>
<tr>
<th>Study</th>
<th>Incongruity Between Expectations and Reality of Motherhood</th>
<th>Spiraling Downward</th>
<th>Pervasive Loss</th>
<th>Making Gains</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nicolson (1990, 1999)</td>
<td>Disappointed expectations of motherhood</td>
<td>Guilt; anxiety over relationships with friends; initial insecurities/overwhelmed</td>
<td>Loss of autonomy and time, appearance, femininity, sexuality, occupational identity, support, control</td>
<td>Reintegration and acceptance of change</td>
</tr>
<tr>
<td>Mauthner (1995, 1998, 1999)</td>
<td>Conflicting expectations and experiences of motherhood; fear of rejection and moral condemnation when judged as a “bad mother”</td>
<td>Social withdrawal; isolation; guilt for being “bad mother”; going mad; anxiety/panic attacks; failure and inadequacy/inability to cope</td>
<td>Lack of support; did not recognize the person they had become</td>
<td>Resolution or acceptance of difficulties and conflicts</td>
</tr>
<tr>
<td>Morgan, Matthey, Barnett, and Richardson (1997)</td>
<td>Place high expectations on self</td>
<td>Loneliness; anxiety; irritated behavior/angry attempts/resentments</td>
<td>Loss of control of negative emotions</td>
<td></td>
</tr>
<tr>
<td>Berggren-Clive (1998)</td>
<td>Shattered dreams; incongruity between expectations and reality</td>
<td>Isolation of oneself; vulnerability</td>
<td>Lack of support; changing relationships with partner; “Who am I?”; losing control</td>
<td>Surrendering; help seeking, dealing with the label, medication struggle; creating of hope: feeling better, I’m not alone; rebuilding of self: adjusting expectations, recognizing and meeting needs, coming to terms</td>
</tr>
<tr>
<td>Nahas, Hillege, and Amasheh (1999); Nahas and Amasheh (1999)</td>
<td>High cultural expectations of motherhood; fear of failure as mother and wife; fear of being labeled</td>
<td>Loneliness/isolation; guilt; poor self-image; worry over every little thing/panicky; overwhelmed</td>
<td>Loss of life of her own; lack of family support</td>
<td>Solace in support groups</td>
</tr>
<tr>
<td>Wood, Thomas, Droppelman, and Meighan (1997)</td>
<td>Total isolation; façade of normalcy; obsessive thoughts; pervasive guilt; panic/overanxious/feels trapped; completely overwhelmed by infant demands; anger</td>
<td></td>
<td>Inability to control; death of spirit; loss of former self</td>
<td></td>
</tr>
<tr>
<td>Study</td>
<td>Incongruity Between Expectations and Reality of Motherhood</td>
<td>Spiraling Downward</td>
<td>Pervasive Loss</td>
<td>Making Gains</td>
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<td>------------------------------------------</td>
</tr>
<tr>
<td>Nims (1997)</td>
<td>Isolation; loneliness; reoccurring obsessive thoughts; feeling of remorse/guilt; confusion; craziness; uncontrollable anxiety; doubting competence</td>
<td>Loss of interest; loss of self; out of control</td>
<td>Deep sense of faith</td>
<td></td>
</tr>
<tr>
<td>Sluckin (1998)</td>
<td>Quiet over lack of emotional connection with baby; anxious concerning baby</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Semprevivo (1996)</td>
<td>Isolation; reoccurrent thoughts; guilt; delusional ideas; irrational thinking; anxiety/panic; inadequacy in maternal role</td>
<td>Loss of personal identity; loss of former self; loss of control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beck (1992, 1993, 1996)</td>
<td>Isolating anxiety; relentless obsessive thoughts; guilt; going crazy/fogginess/irrational thinking; horrifying anxiety; overwhelmed by responsibilities of motherhood insecurity; uncontrollable anger</td>
<td>Loss of relationship with spouse and children; loss of interest and goals; alarming unrealness; robot/acting; loss of control</td>
<td>Battling the system; praying for relief; solace in support groups; unpredictable transitioning; mourning lost time</td>
<td></td>
</tr>
<tr>
<td>Stewart and Jambunathan (1996)</td>
<td>Difficulty in making decisions/trouble concentrating; nervous and fidgety</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>McIntosh (1993)</td>
<td>Loneliness; isolation/suffer in silence; guilt/shame; walls squeezing me tighter; overwhelming responsibility</td>
<td>Loss of freedom; loss of time to oneself; loss of support; loss of control</td>
<td>Help seeking; professional help</td>
<td></td>
</tr>
</tbody>
</table>
aspects of motherhood were especially significant to her. Parity influenced the conflicts that some women struggled with during their postpartum depression. The conflicts that the 12 first-time mothers found centered on trying to live up to their image of the "perfect, ideal mother" (Mauthner, 1999). The 6 multiparas, on the other hand, were well aware that there was no such thing as a perfect mother. Their conflicts revolved around trying to live up to their expectations of being able to cope with their newest child.

Cultural context can intensify these conflicting expectations and experiences of motherhood. Jordanian women, for instance, are held to very high expectations of motherhood. Nahas and Amasheh (1999) explored the experiences of postpartum depression among Jordanian women living in Australia. Jordanian women are not supposed to be sad because in their culture this means that the women are not at all able to cope and are bad mothers. Living in a country that was not their homeland only accentuated these conflicts. Jordanian mothers living in Australia did not have the strong family support they were used to in their own country (Nahas, Hillege, & Amasheh, 1999). These depressed women experienced helplessness due to their inability to fulfill their traditional gender roles as wife and mother. Both primiparas and multiparas expressed their struggles with living up to the high expectations of

![Four Perspectives Involved With Postpartum Depression](image)
motherhood while living in a new country without family support. Middle Eastern women feared being labeled a bad mother if they showed any signs of not being able to cope.

Spiraling Downward

Soon mothers began the downward spiral of postpartum depression as their feelings worsened. All 18 studies included in the metasynthesis addressed aspects of this downward spiral. These emotions did not include just depression and sadness (Wood, Thomas, Droppleman, & Meighan, 1997). Women covertly suffered through a myriad of distressing emotions such as anger, guilt, being overwhelmed, anxiety, and loneliness. Some mothers also experienced obsessive thoughts or cognitive impairment and contemplated harming themselves or their infants. Postpartum depression can be likened to a chameleon. It takes on a different appearance depending on which specific mother is experiencing it. One might experience anxiety, guilt, and thoughts of harming herself; another experiences obsessive thoughts, anger, and loneliness. As mothers are spiraling downward, this chameleon-like characteristic of postpartum depression further complicates health care professionals’ recognition of a mother in need. Demographic or obstetric characteristics are not predictive of which constellation of depressive symptomatology a mother may experience.

Anxiety. When someone says “postpartum depression” to clinicians, often the immediate association made is to sadness, depression, and crying. Anxiety, however, can be a major component of this postpartum mood disorder for women. Uncontrollable anxiety led women to a feeling of being on the edge of insanity (Beck, 1992). Semprevivo (1996) reported that mothers diagnosed with postpartum depression suffered from intense anxiety and feelings of panic that overwhelmed their very existence. In Wood et al.’s (1997) study, the anxiety and panic were a pervasive part of the mothers’ lives as illustrated by the following quote: “I was frantic . . . absolutely frantic . . . I couldn’t sleep because I was so wired.”

In Beck’s (1993) grounded theory study of “Teetering on the Edge,” two women vividly related their experiences with this intensive overpowering anxiety:

It was like every nerve in my body was exploding. Like little fireworks were going off all over my body. I felt like I was going crazy. My skin felt like it was literally crawling. I wish I could rip it off and put it on another body. I would try and wipe my skin off. (p. 45)

Overwhelmed. Women suffering from postpartum depression were overwhelmed by the responsibilities of caring for their infants to such a degree that they were petrified that they would not be able to cope (Beck, 1996). While fighting the crippling effects of this mood disorder, women felt weak, fragile, and vulnerable. If these mothers could not control their own thoughts and emotions, how could they depend on themselves to care for their helpless newborns (Beck, 1992)? In Wood et al.’s (1997) study, the mothers described their increasing distress as totally overwhelming. As one mother expressed, “Even the smallest task just felt monumental . . . even to change a diaper was just overwhelming” (p. 313).

Being overwhelmed can be culturally influenced. For the Jordanian mothers living in Australia, the arrival of their infants in a new country without the family
support the women needed magnified their becoming overwhelmed (Nahas & Amasheh, 1999). Stewart and Jambunathan (1996) investigated postpartum depression among Hmong women living in Wisconsin. These mothers did not, however, report being totally overwhelmed. This was attributed to the high levels of support they received from their husbands and family and to their cultural practice of a 30-day rest period. The authors concluded that this support and the cultural practices protected the Hmong mothers and made them less vulnerable to postpartum depression. The Jordanian mothers living in Australia were not protected in this way.

**Obsessive Thinking.** Obsessive thoughts were intrusive and prevailed until they became intolerable. Inability to control this obsessive thinking led women to ruminate over such distressing thoughts as being a failure as a mother, fearing that they might be harmed, questioning whether they would ever be normal again, and worrying unnecessarily over the baby. An example of obsessing over fears of being harmed comes from one mother in Wood et al.’s (1997) study:

- I remember being obsessed . . . sitting in the living room nursing the baby at night and the curtains, the draperies, didn’t quite meet in the middle. And I remember every night I was convinced there was somebody out there with a gun who was going to shoot me. (p. 312)

From Nims’ (1996) study comes the following quote, which illustrates obsessive thinking about being a failure as a mother:

- I kept saying I’m not a good mother. I just couldn’t see myself as a mother anymore. I started having thoughts about giving my baby up for adoption. I didn’t have control over my thoughts. I would just keep ruminating over and over about these things [adoption]. (p. 39)

**Anger.** For many mothers suffering from postpartum depression, anger was a new and frightening emotion. For the first time in their lives, some mothers were terrified that their anger would explode to such a degree that they could hurt their children, as in the following experience:

- I would get really angry. It’s really scary because you’ve heard these stories about mothers being in court for smothering their baby and my first thought was fry the woman [in the electric chair]. I mean can you believe they’d do that to a helpless child? And to be able to understand that! (Beck, 1996, p. 102)

As Wood and colleagues (1997) discovered, anger was “fierce,” and the postpartum-depressed women directed their anger at multiple targets such as themselves, children, other mothers, families, and health care professionals. One mother admitted that she was so angry that she “felt like taking a hammer and pinging [the baby] on the head but instead banged her own head against the wall and kicked a hole in it” (p. 313).

At times, mothers directed their anger at clinicians and family members because they trivialized the mothers’ complaints.

**Cognitive Impairment.** Postpartum-depressed mothers reported that their minds seemed to be filled with cobwebs and their ability to concentrate was diminished (Beck, 1992). Mothers also described this cognitive impairment, saying, “The
fogginess would set in” (p. 169). Stewart & Jambunathan (1996) reported that half of the Hmong women in their sample experienced difficulty concentrating. One woman shared that she had “so many problems with concentrating. Sometimes I feel like my breath is short, and my head is pounding so big I feel like I’m going to fade away, so I can’t concentrate” (Stewart & Jambunathan, 1996, p. 325).

Irrational thinking plagued some women as they interacted with their infants. One mother in Beck’s (1996) study described the following incident:

For me, what was out of control and still is to this day is the irrational thoughts that keep racing through my mind as I cared for my baby. I would be going along and being okay, and then I would get up to that changing table and in a matter of seconds my mind would have started with, Oh, the baby is going to fall off the table. I don’t care if she falls off the table. Why did I think that I don’t care if she falls off the table? Of course I care. (p. 102)

Isolation/Loneliness. As mothers silenced themselves and withdrew socially, they felt a profound sense of isolation and loneliness. Postpartum-depressed women were enveloped in unbearable loneliness due to the discomfort they felt being around others and their belief that no one else really understood what they were experiencing (Beck, 1992).

A participant in Nims’s (1996) study captured these feelings of loneliness in the following passage:

I’m just all alone. Like there is no one there for me. You know no one there for me to talk to. My husband he’s a big armrest. But, I don’t feel that I could go to him and tell him my feelings. You know, like I would say, “I really don’t want anything to do with our son. I don’t want anything to do with him”. Um, my husband doesn’t understand that. And um, so at that point I just feel alone. (p. 38)

Semprevivo (1996) reported that some mothers with postpartum depression found solace in isolation as they shielded themselves from the outside world. Their isolation was perceived as an escape from the critical eye of the external world.

Different cultural contexts influenced the degree of isolation and loneliness. Because of the high level of family support and the 30-day protected period, Hmong mothers living in the United States did not experience the isolation and loneliness (Stewart & Jambunathan, 1996) that the Jordanian mothers living in Australia suffered (Nahas & Amasheh, 1999). Jordanian women often felt isolated and helpless because of the lack of family support in a new country.

Not only culture but parity was found to influence the degree of isolation and loneliness postpartum-depressed mothers experienced. Mauthner (1995) reported that 12 first-time mothers in her study described their sense of being physically isolated from other mothers, but the multiparas already had developed a network of other mothers from their previous children.

Depending on the reaction of coworkers to mothers’ return to employment outside the home, postpartum-depressed mothers’ sense of isolation could be increased or decreased. Some mothers in Mauthner’s (1995) research shared that they valued the companionship of their colleagues at work but at the same time, these women felt that they were missing out on the support from the network of mothers who stayed at home. Some women revealed that their isolation increased when they returned to work because some of their colleagues disapproved of
working mothers. As one postpartum-depressed mother in Mauthner’s study pain-
fully shared,

When you go back to work . . . your whole social network is again completely dif-
ferent. You then . . . very quickly lose the contacts that you’ve made. . . . I was made to
feel really much of a second-class citizen when I went back to work. . . . A lot of them
were very critical of me going back to work. (Mauthner, 1999, p. 315)

Guilt. Postpartum-depressed mothers bore the heavy burden of guilt for multi-
ple reasons, such as being a “bad mother” (Mauthner, 1995, 1998, 1999), failure to be
the perfect mother (Wood et al., 1997), and lack of an emotional connection with
their babies (Beck, 1996; Sluckin, 1990). At times, some of the women contemplated
harming their infants (Beck, 1992; Semprevivo, 1996) and were so horrified by these
thoughts that they were consumed with guilt. Semprevivo (1996) reported that a
recurrent theme among her depressed mothers was the unsettling rumination of
their desire to harm their babies. Eight of the 10 women in the study admitted to
such thoughts.

One mother graphically described how her initial intrusive thoughts of harm-
ing her infant progressed to fears she might actually act on her impulses:

Originally it had been about all kinds of horrific ways of hurting her. . . . I could
hardly bear to look at like the creases on her neck and I’d imagine someone cutting
them with a razor blade. I couldn’t stop them, but think it was just stabbing her in
the stomach, it just changed to that, stabbing her in the stomach all the time. . . . then
the things became more like urges to hurt her and that really scared me. That shook
me up, you know? It felt like in the very kind of marrow of my being, the very
depths of my soul. (Semprevivo, 1996, p. 86)

Contemplating harming oneself. For some women, contemplating their own death
provided a glimmer of hope to the end of their living nightmare. At this point in
their postpartum depression, mothers had bottomed out to a place of complete
hopelessness and helplessness (Berggren-Clive, 1998). Contemplation of or
attempts at suicide occurred for varying reasons such as the tremendous guilt the
women carried due to their perceptions of being failures as a mother and their hor-
rific thoughts of harming their babies. Thoughts of suicide provided a much-
coveted escape from the intolerable pain of living with postpartum depression. As
women described this state, “everything was black.” These suicidal tendencies
ranged from death wishes to actual planning to attempt to end their lives (Wood
et al., 1997).

Tormented, the women were torn between life and death. One mother in Wood
and colleagues’ (1997) study shared that her life was “on a fence” between the two:

Over there are all these thorns and they pick at your skin and they hurt and you can’t
get any relief. Over there’s nice soft cotton and all you have to do is jump right over
there. When you’re so desperate that’s the only way you can see out. You will stay in
the thorns or you go to the cotton. And the only way you can go to the cotton is to
end your life. (pp. 314-315)

In Berggren-Clive’s (1998) study, one of her participants revealed that “there
were moments when I was opening the can, the Enfalac®, and the moment I opened
it I wanted to take a knife and cut my wrists” (p. 112).
The overpowering burden of guilt prompted some mothers to the desire to hurt themselves:

I would go into my baby’s room and think, put the blanket over his head. He’s nothing. Then I’d start crying hysterically, I felt like the worst person in the world, the worst mother in the world. I felt tremendous guilt and just wanted to hurt myself. (Beck, 1993, p. 45-46)

Differing findings were reported in the two studies where postpartum depression was examined in the Jordanian and Hmong cultures. Four out of the 52 Hmong mothers shared that they had thoughts of harming themselves (Stewart & Jambunathan, 1996). Nahas and Amasheh (1999) did not, however, report any suicidal ideation among the Jordanian mothers living in Australia, even though they felt robbed of their cultural practice of 40 days of recuperation after childbirth that they would have had back in their country.

Pervasive Loss. Loss permeated deep into the crevices of depressed mothers’ lives. It insidiously seeped into the very fiber of their beings. Fifteen of the 18 studies synthesized in this metasynthesis revealed this pervasive loss. In Beck’s (1993) grounded theory study, loss of control emerged as the basic social psychological problem the postpartum-depressed mothers had to contend with. As one mother shared, “I had absolutely no control, and that was the scariest thing, because I always had control” (p. 44). Women experienced loss of control in all aspects of their lives, such as their thought processes and emotions.

Nicolson (1999) reported that for postpartum-depressed mothers in her study, a loss of autonomy and time were precursors to their feeling out of control because they no longer had time to consider themselves or to process their daily experiences. Loss of autonomy and time also “conspired” (p. 169) to result in a loss of the mothers’ former physical appearance. This loss of time limited their attention to taking care of themselves. The women also experienced other types of loss, for example, loss of self, loss of relationships, and loss of voice.

Loss of self consists of two components: a loss of who you are and a loss of a former self. In asking “Who am I?” postpartum-depressed mothers struggle with their identity (Berggren-Clive, 1998). These women felt alarmingly unreal. Mothers’ normal selves were no longer present (Beck, 1993). Wood et al. (1997) called this the “façade of normalcy.” This mother in Berggren-Clive’s (1998) study spoke of this loss of self:

You know how water runs over the rock and it eventually smoothes them down and then you end up with the Grand Canyon. Well, that was very much what it was like. You can maintain your boundaries for so long, but the water wears you away. It doesn’t matter if you are made of rock or you are made of paper, the water wears you away. I lost completely who I was. Completely. (p. 112)

Mothers continually tried to explain what this loss of self was like to live through. A vivid quote from one woman in Beck’s (1992) study illustrates this unnerving transformation:

I’d be having guests or family over for dinner and laughing and talking. All of a sudden, it was like my personality was pulled right out of me and I’d just be quiet and look around. I’d start acting again. (p. 169)
Also, as part of loss of self, women experienced a loss of their former selves (Nicolson, 1990, 1999; Wood et al., 1997). This loss of former identity entailed loss “in body image, loss of sexuality, loss of personal space, perceived loss of intellectual ability and memory, loss of power in the family, loss of occupation, occupational status . . . and change from being a liberated to traditional woman” (Nicolson, 1990, p. 693).

Loss of identity, especially occupational, was magnified for women who had worked outside the home before delivering their infants (Nicolson, 1999). These women felt a loss of power and intellectual challenges since they had given up their paid employment to become full-time mothers.

Loss of relationships ran rampant through the lives of women as they agonized with their postpartum depression. Beloved and valued relationships with the mothers’ infants/older children, partners, and family/friends were lost. In Mauthner’s (1998) study of postpartum depression, she used relationships as the unit of analysis and examined women’s feelings regarding their relationships with themselves and others. Postpartum depression was perceived as a thief, robbing mothers of love and intimacy with their children. Just how it robbed women of these beloved relationships varied. For some mothers, it was through resentment and anger; for some, it was through anxiety, whereas for others it was by an aching void and an absence of loving and positive emotions toward their babies.

Semprevivo (1996) reported that resentment resulted when mothers came to feel guilty for not being able to cope with the daily demands of their infants. One mother revealed, “I was getting really resentful, really angry, every time I just put my head down, she’d be crying again. And I felt really guilty about those feelings as well, and then really weird odd things started to come over me” (p. 79).

Some women admitted that their infants made them extremely anxious to the point where they could not physically be near them. As one mother painfully shared, she had to distance herself from her baby: “I had these really weird feelings toward my baby. I couldn’t be around him. He gave me anxiety as if he were something bad. I couldn’t walk past the door of his room without becoming anxious” (Beck, 1993, p. 45).

Loss of meaningful relationships occurred not only with their infants but with the mothers’ older children. Due to their inability to cope with more than one child at a time, the women came to resent their older children and pushed them away (Beck, 1996). They felt as though their older children were suffocating them whenever these children were trying to get their attention.

Lost relationships between postpartum-depressed women and their partners also occurred. Relationships with partners were often perceived by the mothers as strained (Morgan, Matthey, Barnett, & Richardson, 1997). Women who were tormented by their postpartum depression became irritated with their partners and resented them. The women expected their partners to be able to read their minds and take some initiative in helping them live through this hellish nightmare. Some mothers were embarrassed and ashamed to approach their partners and other family members because they felt that admitting their feelings was a sign of personal inadequacy and failure as a mother (McIntosh, 1993).

Because women afflicted with postpartum depression felt “different” and “abnormal” compared to other mothers, they withdrew from these relationships (Mauthner, 1995). They spoke of difficulty being around other mothers:
It’s really awful being with other women that look as if they’re coping . . . that’s just as bad as being with nobody. I can remember thinking, “Oh, look at them, they’re so happy.” You see all these people looking so happy, it just makes you feel worse, you just think, “Oh they’re so happy with their family and I’m not.” (p. 317)

Mauthner (1998) discovered that postpartum-depressed women made an active and conscious decision to silence their own voices. For some mothers, it was their fear of what might happen if they revealed what they were feeling that kept them silent. Others feared burdening their loved ones and being misunderstood, morally condemned, or rejected. One mother in Mauthner’s study explained that she felt “imprisoned in my own prison” (p. 345) because she had actively made the decision not to disclose the anguish she was feeling due to her postpartum depression. She shared that “the depression was like having sand banks on each door, and even though I knew I could open them and walk out, I didn’t” (p. 345).

When women would muster enough courage to disclose their feelings to their partners, often the partners silenced and rejected them, further adding to their loss of voice. As mothers’ pleas for understanding many times were ignored, they began to isolate themselves. Loss of voice and loss of relationships fed off of each other and resulted in a vicious cycle.

Making Gains

Surrendering. Aspects of mothers’ recovery from postpartum depression were revealed in 11 of the 18 qualitative studies. For postpartum-depressed mothers to receive much-needed treatment, they first had to seek help. This was a tremendous hurdle to get over. Postpartum depression is a mental illness that often is covertly suffered. For example, only 18 of 38 depressed mothers in McIntosh’s (1993) study sought help from anyone. The main reason these mothers chose to suffer in silence was that they were ashamed and embarrassed. They feared being labeled bad mothers or failures at mothering. The stigma associated with being depressed after childbirth was another source of concern that at times prevented women from seeking help (Berggren-Clive, 1998).

For the Jordanian mothers living in Australia, their culture added additional deterrents to their seeking help for their postpartum depression (Nahas et al., 1999). Women in Middle Eastern culture are expected to not complain about their difficulties or inability to cope with their new infants. As one mother revealed,

I have to cope with everything. I have to show them [family] that I am coping very well and that I am happy. If I say one bad thing about my life now, they will say that I am not good for my husband who has been working so hard to support the children and me. They expect me to be like them [other mothers], especially those who have six to ten children. (p. 70)

As Berggren-Clive (1998) discovered, for postpartum-depressed mothers, the first part of the process of healing dealt with surrendering. In this context, surrendering did not imply giving in but rather recognizing that something extremely serious was wrong and that they needed to get help.
Struggling to Survive

For most women, once they made the difficult decision to seek professional help, they began a tortuous road to finding appropriate treatment (Beck, 1993). Sometimes their cries for help were ignored or minimized (Berggren-Clive, 1998). Disappointment, frustration, humiliation, and anger were experienced by mothers in Beck’s (1993) study when they made their initial call to a health professional.

In addition to battling the health care system, another strategy some mothers used to help them survive postpartum depression was praying for relief. As one mother shared in Beck’s (1993) study,

> I used to go to church and pray for hours. “My God, how much more can I endure! You’re not a vindictive or hateful God, but why is this happening to me? You have to get me out of this because I cannot take this any longer.” (p. 46)

Nims (1996) reported that 2 of the 4 women in her study reported a spiritual component to their recovery. A strong sense of faith gave them solace.

Creating hope through attendance at postpartum depression support groups was yet another strategy used to survive. As women sat around in the groups, what helped to create hope in their lives was their realization that they were not alone (Berggren-Clive, 1998). Mothers in Beck’s (1993) research shared how they found solace in these support groups. Attending the groups helped to counter their isolation and loneliness and provided hope that they could overcome their depression and regain control of their lives. These women were also allowed to openly question the ideals of motherhood they struggled to fulfill (Mauthner, 1995).

Jordanian women did not attend specific postpartum depression support groups, but they did attend Arabic community centers. Although the main purpose of these centers was to provide classes such as English, sewing, and cooking, postpartum-depressed women found it beneficial and supportive to be able to sit in groups with other women and talk about life in general (Nahas et al., 1999).

Reintegration and Change

Adjusting unrealistic expectations mothers had for themselves was cited by most women in Berggren-Clive’s (1998) study as one means of freeing themselves from the constraints they had imposed on themselves. Postpartum-depressed women shifted expectations with respect to themselves as mothers, partners, and family members. This shifting was necessary in rebuilding self. In the healing process, recognizing and meeting their needs was a necessary step for these mothers. For example, the women shifted their belief that mothers must be self-sacrificing for their children. As one woman admitted, “So I began to realize that this is about taking care of me. But it was also about reaching out and asking for help, which is still hard for me to do” (p. 114).

The mothers began to regain control in their lives as they recognized their needs and found ways of meeting them. Regaining control, however, was a slow, unpredictable process. The women related that gradually the number of “good days” would increase until only a couple of bad days cropped up every now and then. As the depression lifted, mothers began to mourn the lost time that they would not be able to recapture with their infants. The following quote illustrates this point: “I feel
robbed of the first 6 months of my daughter’s life. I never really got to hold her as a baby and I feel cheated” (Beck, 1993, p. 47).

Most of the mothers in Nicolson’s (1999) study shared that they felt a sense of change following the losses they had experienced with postpartum depression. Successful handling of a series of losses leads to reintegration of an increased sense of strength and competence (Nicolson, 1999). Mothers who resolved the difficulties surrounding their losses, such as the loss of an autonomous self, experienced a deep level of acceptance of change that occurs every time a woman gives birth.

Women in Mauthner’s (1998) study all expressed that their recovery from postpartum depression involved acceptance or resolution of the conflicts they had experienced during their transition to their new role as mother. These mothers needed to accept themselves for who they were.

DISCUSSION

Schreiber, Crooks, and Stern (1997) identified three uses of a metasynthesis: theory building, theory explication, and theoretical development. This third use, theoretical development, was one of the purposes of this metasynthesis of qualitative studies on postpartum depression. This approach involves the synthesis of results into an end product that can be described as comprehensive and thickly descriptive. Schreiber and colleagues asserted that this metasynthesis approach provides an excellent foundation for concept or theory development. The four overarching themes and their subsumed metaphors and concepts that emerged from the synthesis of the 18 qualitative studies can be used for a concept analysis of postpartum depression or for the development of a middle-range theory of this mood disorder. One benefit of a middle-range theory is the ability to deduce hypotheses, which can then be tested as nursing interventions for mothers suffering from postpartum depression.

Not only do the results of this metasynthesis of postpartum depression have implications for theory development, they provide implications for clinical practice. Examples of two such implications can be derived from the overarching themes of (a) incongruity between expectations and the reality of motherhood and (b) pervasive loss.

The women held unrealistic expectations of motherhood, which were shattered by the reality of their own lives as new mothers. These conflicting expectations and experiences of motherhood led them down the path to becoming overwhelmed, perceiving themselves as failures as mothers, and bearing a suffocating burden of guilt. Health care professionals have a responsibility to take an active role in putting an end to the harmful myths of motherhood that are so prevalent in our society and that put our mothers’ mental health at risk.

Loss emerged as a pervasive component of postpartum depression. The typology of losses revealed in this metasynthesis can help clinicians differentiate the many forms of loss that mothers may be grappling with. A decade ago, Driscoll (1990) and Nicolson (1990) proposed the use of loss and grief frameworks to explain postpartum depression. The results of this metasynthesis support Driscoll and Nicolson’s frameworks as a key model for clinicians to use in designing interventions for postpartum-depressed women.
Giving birth to a baby is universally viewed as a gain rather than a loss (Nicolson, 1990). Loss must first be identified as such before the healing grief work can occur. As a postpartum-depressed mother puts her losses into perspective, she can then move into the final stage of grief work, which is healing and restoration.

REFERENCES


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