

“Having a Tough Time”

Towards an Understanding of the Psycho-social Causes of Postpartum Emotional Distress

The aim of this paper is to illuminate—according to the perspectives of mothers themselves—why some mothers have “a tougher time,” emotionally, in the postpartum than others. The paper is based on a qualitative analysis of interviews with 33 mothers from a range of postpartum emotional states, ranging from mostly and mainly happy to clinically depressed. The analysis describes how mothers who experience greater postpartum emotional difficulties attribute their distress largely to deficits in the following six resources: prioritizing self care; having manageable situational stress; having enough help; feeling understood; feeling ready for the baby; and having realistic/pragmatic, core beliefs and expectations. Another important thread running throughout the interviews is how mothers’ beliefs and ideas about what mothers “should” need, “should” be and “should” do play an influential role in determining the extent to which they are able to activate certain resources—resources which they themselves identify as being central to the protection/enhancement of their postpartum health. As such, this analysis reveals how broader discourses about “good mothering” function as an organizing structure for how women seek out and mobilize various protective resources.

This paper qualitatively examines how mothers from varying states of postpartum emotional wellbeing—ranging from mostly/mainly happy to suffering from postpartum depression—make sense of their postpartum experience. Specifically, by examining mothers’ own perspectives and beliefs about their postpartum emotional health, this paper aims to further illuminate how it is that some women move beyond the realm of typical or “normal” postpartum experiences and suffer severe levels of distress, while others do not. Based on the qualitative analysis of 33 interviews with mothers about their postpartum experiences, this study provides greater understanding into how broader cultural

“good mothering” discourses are taken up in mothers’ everyday lives, shaping and, in many respects, hindering their access to key adjusting resources—resources which mothers themselves identify as central to the preservation and enhancement of their postpartum emotional health.

Review of the literature

Postpartum depression (PPD) is a bio-psychosocial phenomenon (Driscoll, 2006: 40-42; Cooper and Murray, 1998: 1884; Miller, 2002: 762). Thus, while biological and hormonal factors do play a role, psycho-social and cultural factors are also highly important to the “what’s,” “hows” and “whys” of PPD (Corwin and Pajer, 2008: 1529-30; Thurtle 1995: 416; O’Hara, 1997: 3).

In this context, a major research focus is the identification of psycho-social stressors or risk factors for PPD. These include: financial hardship, a lack of social support, poor marital relations, stressful life events, a history of depression, maladaptive cognitive styles, a negative birth experience, low self-esteem, and large discrepancies between the expectations and realities of motherhood (Romito et al., 1999: 1651-61; Beck, 2002: 453-472; Ball, 1994: 8-25; Benoit et al., 2007: 719-725; Rich-Edwards et al., 2006: 221; Corwin and Pajer, 2008: 1530; Driscoll, 2006: 40-42). Recent research has also shown that, like other forms of depression, the risk for PPD tends to be higher among women of colour, immigrant women, and women of lower socio-economic status (Baker et al., 2005: 24; Templeton et al., 2003: 207; Abrams and Curran, 2007: 291-3; Benoit et al., 2007: 719-725).¹

Equally as important, socio-cultural and feminist research has shown how cultural factors, such as idealistic “motherhood mystique” discourses, motherhood’s devalued status, and a lack of positive social structuring of the postpartum period all contribute to the proliferation of emotional difficulties after childbirth (Wile and Arechiga, 1999: 89-90; Ugarriza et al., 2007: 795-6; Nicholson, 1998: 50-109; Taylor, 1996: 24-55; Barclay and Lloyd, 1996: 136-9; Mauthner, 1998: 337-45; Hall, 2006: 256-60, Berggren-Clive, 1998: 103-120). In this context, it is argued that PPD must be understood, at least in part, as a “natural response to the myths of motherhood, [which] have established certain expectations of motherhood that are impossible for women to maintain” (Berggren-Clive, 1998: 105). In this respect, psycho-social and cultural literatures typically conceptualize PPD as an issue of adjustment, which exists “at the extreme end of a continuum of postpartum adjustment experiences” (Christler and Johnston-Robledo, 2002: 187; see also Ball, 1994: 14; Chan et al., 2002: 571-2).

What remains underdeveloped in the social scientific literature, however, is not so much an identification of what the various factors are for the development of postpartum emotional difficulties, but *how* these various psychological, social and cultural factors interact to influence—or protect against—the development of PPD in specific women (Dennis, 2004: 536-7, Mauthner, 1998: 348, Knaak, 2008b: 28). In other words, further research is required in order

to better understand the *functions* of these various factors in the development of, and in the protection against, PPD.

Another area that remains under-researched is how the experiences of mothers with PPD compare to those of mothers who have not suffered severe emotional distress after childbirth (Chrisler and Johnston-Robledo, 2002: 184; Berggren-Clive, 1998: 117; Green and Kaftersios, 1997: 141). This is a notable gap, particularly given that: a) the constitutive boundaries of PPD have yet to be firmly established; b) there are considerable thematic overlaps between the experiences of mothers with postpartum depression and those of new mothers more generally; and c) many feminist researchers are critical of the current, dominant, framing of PPD as a mental disorder (Berggren-Clive, 1998: 103-120; Nicholson, 1998: 50-109; Taylor, 1996: 24-55; Barclay and Lloyd, 1996: 136-120; Mauthner, 1998: 337-345; Romito et al., 1999: 1651-61).

One way to overcome these gaps is to explore the perspectives and experiences of mothers from a *range* of emotional states following childbirth, and to solicit their opinions and perspectives and accounts about why and how they experienced what they did in the postpartum. This is the basis of the current study.

Methodology and study design

Using the methodology of grounded theory (Glaser and Strauss, 1967: 1-257; Charmaz, 2006: 1-185; Strauss, 1987: 1-39), the study addresses two main questions: what do mothers experience in the weeks and months after having a baby; and what are mothers' own understandings of why they experienced and felt what they did? This paper discusses the findings from the second of these two general research questions.²

Given the central problematic of the study, mothers from a range of postpartum emotional states were included in the sample: mothers clinically diagnosed with postpartum depression (group D), mothers who experienced significant distress but were not "officially" diagnosed with PPD (group C), mothers indicating moderate levels of postpartum distress (group B), and mothers indicating little to no postpartum distress/mothers who were generally quite happy (group A). This sampling framework, and the subsequent analyses, relied primarily on mothers' own assessments of their state of postpartum emotional wellbeing. In all, I interviewed 33 different mothers from one of Canada's major cities. Mothers ranged in parity from one child to four, resulting in interview data on 45 different postpartum experiences.

The final sample included mothers of varying ages (from 20 to 36 at the time their first child was born), income levels (ranging from dependence on social assistance to a household income of over \$100,000 per year), and education levels (from uncompleted high school to doctoral candidates). However, only one mother of non-Euro-Canadian origin volunteered for the study. Participants were interviewed anywhere from three months postpartum to five years after the birth of their last child. All coding and analytical activities were conducted

in accordance with the grounded theory approach (Charmaz, 2006: 42-70; Strauss, 1987: 55-128). In keeping with Research Ethics Board requirements, all interview excerpts rely on the use of participant pseudonyms.

Main findings

Mothers’ explanations of “why they experienced what they did” resulted in the identification of six main themes: prioritizing self care, having low situational stress, having enough help, feeling understood, feeling physically and emotionally ready for the baby, and having realistic core expectations and beliefs. These themes were central to the narratives of *all* the mothers who participated in this study—whether diagnosed with PPD (group D), felt mostly/mainly happy (group A), or felt somewhere in between (groups B and C).

Specifically, the mothers who experienced fewer postpartum emotional difficulties (i.e., groups A and B) ascribed all or most of the following as the main reasons for “why they felt they way they did:”

- they prioritized their own self care;
- they had enough help in meeting their day-to-day demands and responsibilities;
- they had manageable levels of situational stress;
- they felt emotionally understood by, and connected with, others;
- they had realistic “core” beliefs about mothering and motherhood;
- they felt “ready,” physically and emotionally, for the baby and all that that entailed.

By contrast, the mothers who experienced greater levels of postpartum distress (groups C and D) attributed their compromised emotional health to *deficiencies* in these same resources. In general, mothers’ varying postpartum emotional health reflected *how many* of these factors they described as being operant (see Table 1).³

*Table 1:
The Cumulative Impact of Resources on Postpartum Emotional Well-Being*

Categories of emotional well-being	No. of resources
Group A: mostly and mainly happy	5-6
Group B: low to moderate emotional distress	3-5
Group C: moderate to high emotional distress (suspected PPD)	1-3
Group D: diagnosed with PPD	0-2

Each of these six themes is described in greater detail below.

Prioritizing self-care

One of the most central explanations mothers' gave about "why they felt the way they did" had to do with the extent to which they were able to prioritize their own self care, including their ability to get sufficient sleep/rest, to eat nutritionally, to get adequate exercise/activity, and to "get a break" when needed. As the following excerpts illustrate, self care emerged as a central resource because it actively *enabled* and strengthened mothers' coping abilities:

If you can get a break when you really need it, that keeps it down ... but if you don't get that break the stress just keeps adding and adding and adding up. (Indri, group C)

I certainly always found emotional strength because of some of the physical activities that I do ... that helps calm things down. (Tammy, group A)⁴

In this same context, mothers who "had a tough time" in the postpartum identified an inability to prioritize their own self care as a key reason for their difficulties:

I think what triggered a lot of [my PPD] or at least aggravated it—is I wasn't getting enough sleep ... and I wasn't eating properly. (Danielle, group D)

If the prioritization of self care is a central resource for the protection of postpartum emotional wellbeing, what are the main factors that prevent some mothers from being able to do this? In this study, three interconnected factors emerged: a lack of naturally-occurring opportunities for self care, not having enough support or "help," and feeling a lack of entitlement to prioritize self care.

First of all, mothers' "naturally occurring" opportunities for self care—as determined by their day-to-day circumstances, responsibilities and demands—influenced the extent to which they were able to meet their self care needs. And while some of the mothers did have sufficient "naturally occurring" opportunities for self-care,⁵ most did not. It was in this particular context that mothers articulated the importance of "having help" as a key condition for self care. "Having help"—from husbands/partners, from other family members or friends, or by utilizing forms of paid care—enabled the creation of time and space for self care.

Notably, however, many of the mothers who lacked support for the purposes of self care indicated that they did not feel *entitled* to this kind of help:

I was so physically tired and so emotionally drained all the time ... [but]

I felt bad asking for help, from anybody, family or whatever. ‘Cause you feel you have this responsibility of this little child, you know, and it’s yours. You’re all by yourself, totally. (Beth, group C)

Many mothers spoke about how the thought of prioritizing self care felt somehow “wrong” or inappropriately selfish, especially if it meant relying on help from others to do so. These mothers also described how—if and when they did attend to their own self care without there being a “naturally occurring” opportunity to do so—it induced feelings of guilt:

guilt has been a huge issue for me. The biggest one, the one I felt most guilty about, was having my older son watch TV in the afternoon so I could go have a nap. I’d feel really guilty about that ... and guilty for feeling so tired. (Leslie, group D)

In this respect, mothers felt that needing/asking for help in order to prioritize self care was somehow “wrong.” They expressed a belief that they really should be able to handle things on their own. Self care, in other words, was something that was to be attended to around the edges of daily life—a belief that has its roots in broader cultural discourses about mothering (Knaak, 2007: 7-11; Kendall-Tackett, 2005: 28; Miller, 1995: 27; Hays, 1996: 1-69). In this context, access to this resource often required, for the mothers in this study, engaging in resistance to dominant cultural norms:

I know for me, having time away from the baby [was really important]. And it sounds like a terrible thing. And I think it goes back to this notion of what is the good mother supposed to be like—that it’s supposed to be somebody who never wants time away. Somebody who is so thrilled to be with the baby that they don’t need time away. And they don’t get mad and they don’t get frustrated and tired. As a methodology that’s pretty dangerous. Because you know, we’re only human. (Ingrid, group A)

Having enough help

The mothers in this study identified two main dimensions of support as being integral to their postpartum emotional health: emotional support and material support. This section describes the dimension of material support, commonly articulated by mothers as the experience of having enough help. Having enough help, according to the mothers I interviewed, served two main purposes. First of all, having enough help mitigated mothers’ levels of situational stress. Secondly, having help was often necessary for mothers be able to prioritize to their own self care:

without the support, you don’t get a chance to kind of regroup and feel like, “okay, I’m okay now.” And move on. (Indri, group C)

Mothers who described deficiencies in terms of having enough help articulated a number of different reasons for why this was the case. Some described having negative support relationships with their spouses/partners or other family members: relationships that “should be” supportive but in fact *added* to mothers’ day-to-day strains, effectively “dragging them down” (Carla, group D). Other mothers noted that the high degree of energy and effort required to access/mobilize supports was sometimes a barrier to them having enough help.

Again, however, perhaps the most commonly mentioned barrier to having enough help had to do with feeling un-entitled to ask for, and expect, higher levels of support:

I had friends and family around, but they never seemed really like a support to me.... that's where my guilt comes in. I feel, I don't want to overuse [my supports], burn them out. Or have them think that I'm taking advantage of them. I feel quite nervous and difficult to ask for help.
(Danielle, group D)

As indicated by Danielle’s comment, many mothers felt guilty about asking for help. They worried about imposing on the people in their lives, and/or thought they should, in fact, be able to handle things “on their own.”

Thus, for many mothers who faced obstacles in getting enough help, the primary issue was not one of access or availability of support, but about a more deep-seated sense of entitlement to material support. Similar to the issue of self care, these beliefs have their roots in broader cultural discourses about motherhood and mothering—specifically, in the idea that “good mothers” shouldn’t need to depend on the assistance of others; that they should be able to handle things all on their own (Hays, 1996: 21, Maushart, 2007: 460-70).

Feeling understood

The third major resource—that of feeling understood by, and connected to, others—was articulated as feeling able to reach out, and therefore supported, emotionally. The function of this resource, according to the mothers in this study, was that it enabled them to feel that, on some level, their feelings, experiences, and responsibilities were shared and understood by others:

a friend of mine ... had her baby two weeks before me. We would talk on the phone six to ten times a day. Like we were constantly on the phone together, we were both pregnant together and worked together at the same place, and personally, I think if it hadn't been for that I probably would have been a basket case. I think I probably would have been on like antidepressants or something like that.... I personally don't know how new moms get through that time without someone you can call ten times a day. And someone who can totally understand what you're going through. (Holly, group B)

The mothers also talked about how feeling connected functioned as a source of information/knowledge, helpful for “figuring out what to do.”

In general, the mothers who experienced deficiencies in this resource described how they didn’t feel safe reaching out emotionally. Many feared they would be “judged as bad mothers,” (Anabelle, group D) or seen as “failing as a mother” (Beth, group C) if there were to speak openly about their experiences:

I felt like there was no real strong support network or people to turn to to talk about my feelings and what I was going through. One of my friends who does have kids, well she’s very much that “perfect mother” type and so I felt very hesitant about talking to her about anything. (Nancy, group D)

For these mothers, the “mask of motherhood” (Maushart, 2007: 460-463)—a culturally-entrenched, ideologically-driven, conspiracy of silence about the highly varied and ambivalent realities of mothers’ experiences and feelings—played a central role in hindering their ability to access this protective resource (see also Hall, 2006: 257).

Having manageable situational stress

The fourth major theme in mothers’ narratives pertained to the amount of situational stress they faced. Similar to the theme of self care, having manageable situational stress enabled and strengthened mothers’ coping abilities, whereas “too much” situational stress hindered this ability.⁶ And while mothers attributed the degree of stress in their lives as being a central factor in their explanation of why they felt the way they did, they had different measures of how much stress was “too much.” In other words, two mothers with very similar situational stressors could—and often did—appraise the manageability of their situations in different ways.

Most typically, mothers assessed the manageability of their particular situations largely in terms of the relationship between the *intensity* of their responsibilities and demands, and the amount of help and support they had in meeting those responsibilities and demands.⁷ Thus, mothers who felt that they could lean on others for assistance and emotional support were much less likely to experience their situations as overwhelming. These mothers were, in the words of Tianna (group D), less likely to feel that “it was all up to [them].”

Feeling ready for the baby

The fifth major theme, feeling ready for the baby, has a physical dimension, an emotional dimension and a knowledge dimension. Firstly, mothers spoke about the significance of their physical wellbeing during pregnancy. They talked about the importance of getting adequate rest, sleep, and “down time” while pregnant as crucial to their ability to cope in the postpartum. In general, access to this resource was influenced by the stresses of mothers’ day-to-day life,

including the physical stresses associated with pregnancy, work, and childcare responsibilities, and feelings of entitlement to prioritize self care.

Another way mothers spoke about feeling ready had to do with “knowing what to expect.” In this context, knowledge and information provided coping skills, in that “if you know what to expect, you’re better prepared to handle what comes along” (Astrid, group B). In general, mothers whose preparations about “what to expect” encompassed a wider range of scenarios—including the possibility of experiencing negative realities, emotions and outcomes—generally described feeling more ready in this regard.

The third main dimension of readiness is that of emotional readiness—feeling emotionally prepared for one’s new responsibilities as a mother. In general, the mothers who felt emotionally unready for the entry of the new baby into their lives experienced greater postpartum distress. These mothers typically experienced considerable ambivalence about the timing of their pregnancies, and felt unsure about whether they had enough physical and emotional strength to take on the responsibility of becoming a mother at that time in their lives:

I think for me, emotionally, I think that I was ready for the birth, but I wasn't ready for a baby. (Chris, group D)

In essence, “readiness” articulates mothers’ pre-birth state of physical and emotional wellbeing. As such, the connection mothers made between their own sense of physical and emotional readiness and their resulting postpartum emotional health adds support to research showing that mothers’ state of emotional wellbeing in pregnancy is an important factor for understanding postpartum emotional wellbeing (St. Pierre, 2007: 24, Corwin and Pajer, 2008: 1530).

Having realistic core beliefs and expectations

Virtually all of the mothers in this study experienced some gap between what they expected their early mothering experience to be like, and the reality of that experience. As such, they all described needing to find a way to *reconcile* this gap between expectations and reality (Knaak, 2008b: 129-138). For the mothers who experienced greater postpartum emotional difficulties, however, this gap between expectations and reality was particularly salient to their stories (see also Beck, 2002: 458; Berggren-Clive, 1998: 104; Mauthner, 1998: 337; Hall, 2006: 257). These mothers, however, described that the source of their difficulty laid not so much in the incongruity between expectations and reality *per se*, but that the incongruity represented a violation of, or threat to, a core belief or expectation.

Core beliefs, as described by the mothers in this study, represent deeply-held beliefs and expectations foundational to one’s self concept or “picture of self” (Mercer, 1995: 118). Some of the main core beliefs described by the mothers in this study were: the belief that the process of mother/baby bonding should be instinctual and immediate; the belief that breastfeeding is necessary for

“good mothering;” and the belief mothers must always “be there completely” with/for their babies. Two examples are highlighted below:

it got to that point where I could not imagine not being successful with [breastfeeding]. And that, I just thought, “I can’t even go there” with it, because it truly I think would have totally spiraled me into a serious probably state of depression.... And so failure—it really seemed to me, I thought, was a real sense of failure in myself and even as a mother. (Natasha, group A)

when I went back to school ... I would drop [baby] off, go to school, come right home, and go get her, you know. I never ever took any time to do anything besides what I absolutely had to do.... because I felt really guilty about leaving her.... There was a mental obstacle in my way, where I thought that I had to be home with her all the time. (Fran, group C)

Notably, the various core mothering beliefs central to many of the mothers in this study—the importance of breastfeeding, the idea of “being there completely,” and the expectation that connecting to one’s baby occurs naturally and instantaneously for example—are once again part and parcel of culturally constructed, scientifically dubious, ideological tenets of contemporary “good mothering” (Eyer, 1996: 13; Knaak, 2008a; Thurer, 2007: 331-40).

In this context, many mothers described how having core beliefs which, on some level, *went against* the ideals embedded in contemporary mothering discourses, was significant for the preservation of their emotional wellbeing:

definitely, there’s an ideal out there about what the perfect mother is. It’s not me. And that’s fine.... I know you can be different than this perceived ideal. And still be a great mother. You know, that’s never been a question to me.... I think in one way, with my mom working, it developed the sense of it’s okay to be selfish sometimes....it also teaches you, boundaries are okay. And it’s okay to have them ... and you really learn to not feel guilty about it. (Ingrid, group A)

I think it helped that I intellectually knew...[that] not everybody feels that bond at the start. Otherwise I think I would have been totally like more depressed ... [because] like I said, I think there’s that expectation that you do feel like that from the start, like the second you lay eyes on your child you have this overwhelming sense of love and all that stuff. (Suzanne, group B)

Thus, according to the mothers’ own explanations, having more “realistic” core beliefs and expectations—which often required something of a conscious resistance to dominant cultural norms about good mothering—was helpful

because it increased the likelihood that their core ideas *would not* be violated or threatened through the actualities of their new realities.

Discussion

This study was undertaken with the intention to provide further insight into our understanding of how and why some mothers suffer from PPD while others do not. Towards this end, there are a number of important connections to be made from this analysis back to the existing PPD literature.

First of all, these findings provide additional support to existing literature on the various risk factors for PPD. However, as illuminated through this analysis, these risk factors—such as lack of material and emotional support, stressful life events, or an incongruity between expectations and reality, for example—also emerged as integral resources for the protection of postpartum emotional health (see also Ugarriza et al., 2007: 795-81; Dennis, 2004: 536-7). As such, I argue here for a reconceptualization of these variables, from risk factors to resources. Highlighting them as resources better emphasizes their active and integral role in *facilitating* mothers' coping abilities, and reminds us that we cannot adequately understand PPD without also understanding the demands and processes associated with postpartum adjustment more generally (Ball, 1994: 14).

Secondly, this analysis extends current understandings by highlighting the centrality of *self care*. This issue was a dominant theme in virtually all of the mothers' narratives, and emerged as the most direct link to their emotional health. However, the theme of prioritizing self care—as well as the more specific variables of sleep deprivation, fatigue, and lack of respite, for example—*have not* been a part of dominant models of PPD and postpartum emotional distress, despite being acknowledged in health literature as having important consequences for psychological wellbeing (Kendall-Tackett, 2005: 28; Corwin et al., 2005: 577-86; see also Olson, 1997: 93-99).

Lastly, this analysis provides greater understanding into how broader cultural discourses are taken up in mothers' everyday lives, shaping and, in many respects, hindering access to key emotional health resources. An important thread running throughout the analysis is how beliefs about what mothers "should" need, "should" be and "should" do play a key role in determining the extent to which they are able to activate certain resources—resources which mothers themselves identify as being central to the protection/enhancement of their postpartum emotional health.

One of the historical limitations of the cultural/feminist perspective—which emphasizes the role of oppressive cultural discourses in the production of PPD, for example—has been its relative inability to answer the question, "why, given that mothers live in the same cultural context, some become depressed while others do not" (Mauthner, 198: 348)? The analysis presented here suggests the beginnings of a more comprehensive understanding to this question. Specifically, this analysis reveals how broader discourses about "good mothering" function

as an organizing structure for how women seek out and mobilize various protective resources. As such, this analysis illuminates how the embracing of various tenets of intensive mothering ideology (Hays, 1996: 21) can be (and often is) detrimental to emotional health precisely because it creates barriers to accessing important—and necessary—postpartum coping/adjustment resources.

Conclusion

In as much as this analysis illuminates various ways in which broader discourses about “good mothering” function as an organizing structure through which access (or lack of access) to key coping/adjusting resources is mediated, I conclude with the suggestion that this study offers a way to begin integrating cultural-feminist understandings of PPD (which emphasize the role of oppressive cultural discourses) with the psychosocial literature on PPD (which emphasizes individual risk factors).

Specifically, this analysis highlights how broader cultural beliefs are internalized by mothers in ways that shape, in very practical and identifiable ways, their abilities to access and mobilize key adjusting resources—such as prioritizing self care; having enough help; having manageable situational stress; having realistic core expectations and beliefs; and feeling ready for the baby. Thus, in as much as these resources have been identified as functioning to protect and enhance mothers’ postpartum emotional health, this analysis highlights how broader cultural discourses and specific risk factors (or emotional health resources) *work together* to produce, or protect against, PPD and postpartum emotional difficulties in individual women.

A final note for future research. Given the qualitative nature of this study, it is limited in its ability to adequately discuss broader socio-demographic variations with respect to access to various resources. As such, further research with larger samples of mothers would be useful to better establish the various ways in which broader discourses about “good mothering” may mediate access to key coping/adjusting resources variably, according to socio-economic status, race and ethnicity, and other socio-demographic variables.

¹Research also suggests that lower income mothers and ethnic minority mothers face greater barriers to diagnosis and treatment of PPD (Abrams and Curran, 2007: 293; Teng et al., 2007: 93; Amankwaa, 2003: 26–7).

²Findings from the first of these two research questions are discussed in detail in Knaak (2008b: 48–138).

³Quantitative research would be needed to determine how and if this general pattern holds up in larger population samples.

⁴Interestingly, none of the mothers in this study who engaged in regular physical activity or exercise suffered from PPD. And while many did describe experiencing lower or more mid-range levels of postpartum emotional health, they specifically emphasized that, were it not for their ability to exercise and

be active, they would have experienced even greater difficulties.

⁵These mothers, more often than not, were first-time mothers who described having relatively “easy” babies, and who also had low levels of additional life stresses and responsibilities.

⁶The most common sources of stress for the mothers in this study were: care demands of the baby, care demands of other children, marital or other relationship stresses, financial worries, and other stressful events occurring during pregnancy or in the postpartum.

⁷Mothers’ interpretations of their degree of situational stress as being more or less manageable were also intimately connected with the extent to which they were able to engage in self-care.

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