POSTPARTUM DEPRESSION: A SOCIOCULTURAL QUANTITATIVE 
AND QUALITATIVE ANALYSIS OF ADOLESCENT 
AND ADULT HISPANIC MOTHERS 

Melissa M. Gosdin, B.A., M.S.

Dissertation Prepared for the Degree of 
DOCTOR OF PHILOSOPHY 

UNIVERSITY OF NORTH TEXAS 
December 2010 

APPROVED: 
Erma Lawson, Major Professor 
Phillip Yang, Minor Professor 
Dale Yeatts, Committee Member 
Doug Henry, Committee Member 
Sandra Terrell, Chair of the Department of 
Sociology 
Tom Evenson, Dean of the College of 
Public Affairs and Community 
Service 
James D. Meernik, Acting Dean of the 
Robert B. Toulouse School of 
Graduate Studies
Gosdin, Melissa M. *Postpartum depression: A sociocultural quantitative and qualitative analysis of adolescent and adult Hispanic mothers.* Doctor of Philosophy (Sociology), December 2010, 165 pp., 13 tables, 1 figure, references, 171 titles.

This dissertation is a mixed methods analysis investigating postpartum depression as it is experienced by self-reported depressed Mexican American adolescent and adult mothers. The qualitative portion of this study explores pregnancy and motherhood to better understand meanings attached to depression. Six adolescent and six adult mothers, were recruited from the Dallas/Fort-Worth area. Each was interviewed twice, using semi-structured interview guides. The quantitative phase utilizes a national sample of self-reported depressed Hispanic mothers to identify breastfeeding behavior and mothers’ perceptions of the physical health of their babies. Specifically, a secondary analysis of the National Survey of Children’s Health, 2003 was used to supplement the qualitative data.

This study provides a theoretical framework of fragmented identity to explain socio-cultural factors contributing to postpartum depression among Mexican American adolescent and adult mothers. Common themes leading to a fragmented identify were indentified. Contributors to postpartum depression include: unplanned pregnancy, internal struggle between cultures, body image and family conflict. Stigma associated with teen motherhood also contributed to depression among adolescent mothers while the medicalization of childbirth was a contributing factor of depression among the adult mothers. Additionally, the duration of breastfeeding and mothers’ perceptions of their babies’ physical health were impacted by depression, but breastfeeding initiation was not.
ACKNOWLEDGEMENTS

I want to begin by thanking the twelve courageous mothers who shared their personal narratives. Their candor and bravery not only made this research possible, but helped create a finished work that will hopefully help women of all ages, socioeconomic backgrounds, racial and ethnic groups. It is my hope that they find relief from the depression that has compromised their quality of life.

I also want to express my gratitude and appreciation for my committee chair and mentor, Erma Lawson. I could not have conducted this research without her guidance and scholarly insight. Throughout the years Dr. Lawson has provided continuous support while challenging me to grow both professionally and personally and for that I want to say thank you!

I also want to thank my dear friend Carmen Blades-Green for her assistance in the interview process and for serving as Spanish to English translator. Carmen was always available to help and asked nothing in return.

As a 2009-2010 dissertation fellow recipient, I want to thank both the Department of Sociology and the Toulouse graduate school for awarding me financial support during the duration of the dissertation. A special thanks to the members of my dissertation committee, Doug Henry, Phillip Yang and Dale Yeatts for the feedback and guidance. I would also like to acknowledge Dr. Ralph Wittenberg, postpartum depression medical expert, for taking the time to provide insight and direction during the design phase of the dissertation.

Last but certainly not least I want to recognize my best friend and fiancé Robert Daniel Flowers for the love, support and balance he brings to my life along with my great friends who remind me to laugh. Thank you Mica Orton, Tejal Vyas, Helen Potts, Courtney Queen, Amber Deane, Anthony Guerrero-Soto and of course Sheila Locke, my mom!
TABLE OF CONTENTS

ACKNOWLEDGMENTS .................................................................................................................. iii

LIST OF TABLES AND FIGURES .............................................................................................. v

Chapters

1. INTRODUCTION ................................................................................................................ 1
2. REVIEW OF THE LITERATURE ......................................................................................... 10
3. DATA AND METHODS ....................................................................................................... 22
4. QUANTITATIVE RESULTS ................................................................................................. 35
5. QUALITATIVE FINDINGS ................................................................................................... 50
6. THEORETICAL FRAMEWORK ......................................................................................... 96
7. CONCLUSION .................................................................................................................... 112

APPENDICES ............................................................................................................................ 125

REFERENCES ........................................................................................................................... 152
LIST OF TABLES AND FIGURES

Tables

1. Summary of Qualitative Study ................................................................. 29
2. Summary of Variables and Operationalization ...................................... 32
3. Frequencies of Independent Variable .................................................. 36
4. Frequencies of Dependent Variables ................................................... 36
5. Frequencies of Demographic Variables .............................................. 38
6. Frequencies of Social Support Variables ............................................ 39
7. Correlations of Dependent Variables .................................................. 40
8. Ordinal Regression Estimates Predicting Perceptions of Child’s Physical Health ................. 43
9. Logistic Regression Estimates Predicting Breastfeeding ......................... 45
10. Estimates of OLS Regression Models Predicting Duration of Breastfeeding ................ 47
11. Demographic Table of Adolescent Mothers ....................................... 51
12. Demographic Table of Adult Mothers ................................................ 52
13. Major Themes ....................................................................................... 54

Figures

1. Fragmented identity model .................................................................... 104
CHAPTER 1
INTRODUCTION

Description of the Problem

This research explores how self-reported depressed Mexican American adolescent and adult mothers’ experience postpartum depression. Postpartum depression is a serious mental health issue that affects women irrespective of age, race or ethnicity. Although there has been an influx of postpartum depression literature, few studies employ a sociological perspective, and even fewer focus on Mexican Americans. This study provides a theoretical framework of fragmented identity to explain socio-cultural factors contributing to postpartum depression among Mexican American adolescent and adult mothers.

Research demonstrates that Hispanic adolescent postpartum depression has distinct features compared to that of adult women (Gosdin, 2005). For example, the stigmatization of teen pregnancy and motherhood, body image issues, changing identity and intergenerational conflict are problems faced by many adolescent mothers. Moreover, “Most Latinos, particularly immigrants, fail to seek mental health treatment, and approximately 50% of postpartum depression cases are undetected, and thus untreated” (Nhu-Le et al., 2004).

Grounded Theory

Grounded theory, theory derived from the data, examines the different ways in which Mexican American adolescent and adult mothers experience depression during the postpartum period while discovering specific socio-cultural meanings attached to pregnancy, motherhood and depression. Theory developed from the qualitative interviews is also used to analyze the impact of untreated postpartum depression. Specifically, the mothers’ perceptions of their child’s physical health and whether or they breastfed and for how long will highlight the complexities of
postpartum depression calling attention to the ways in which a depressed mother’s sense of self compromises perceptions of her child’s health and breastfeeding behavior. Medical research finds that mothers who breastfeed experience lower levels of stress than non-breastfeeding mothers, which can have positive health effects on both the mother and the child (Wimberly et al., 2002). Studies suggest that breastfeeding protects mothers from stress, often a precursor to anxiety and depression, and that depressed mothers are more likely to stop breastfeeding (Kendall-Tackett, 2006). Therefore, the relationship between postpartum depression and breastfeeding is scrutinized.

This study assumes that the mental health needs of self-reported depressed Mexican American mothers differ among adolescents and adults. Although the percentage of adolescent mothers affected by postpartum depression is unknown, the literature reports that teens are at higher risk compared to adult women. Several research studies indicate that approximately 48% of adolescent mothers experience depressive symptoms compared to 13% of adult mothers (Clemmens, 2002; Deal & Holt, 1998; O’Hara & Swain, 1996), while some studies report that rates of depression among adolescent mothers may be as high as 67% (Eshbaugh, 2006). Thus socio-cultural explanations must be explored examining postpartum depression among adolescent mothers, including stigma associated with teenage pregnancy and motherhood; and adolescents’ body image, (Gosdin, 2005), shame, loss of friends, and stress of adolescence itself (Prodromidis, Abrams, 1994; Gilliam, 2007).

Few studies have distinguished adolescent and adult postpartum depression. Fewer studies have focused on Mexican American mothers. Therefore, this research assists in bridging the knowledge gap by exploring stressors of Mexican American teenage mothers (intergenerational conflict, mother-daughter relationship, loss of identity, acculturation, dating,
peer pressure (Gilliam, 2007) compared to that of adult Mexican American mothers.

**Qualitative Research Questions**

The qualitative portion of the study answers the following questions:

- How does the transition into motherhood shape the everyday experiences of self-reported depressed Mexican American adolescent and adult mothers?
- How can the mental health of self-reported depressed Mexican American adolescent and adult mothers be understood within a socio-cultural context?
- How does the pregnancy experience influence motherhood among self-reported depressed Mexican American adolescent and adult mothers?

**Quantitative Research Questions**

- How does postpartum depression impact breastfeeding behavior among self-reported depressed Hispanic mothers?
- How does depression during postpartum affect self-reported Hispanic mothers’ perceptions of their babies’ physical health?

**Purpose of the Study**

This study focuses on the socio-cultural experiences of depressed Mexican American mothers. For instance, Gosdin (2005) found that stigmatization and the lack of accurate postpartum depression information prevented Hispanic adolescent mothers from seeking mental health care. The narratives compare self-reported depressed Mexican American mothers (i.e. adolescents and adults) to understand the complexities of barriers, beliefs, traditional healing systems; and views of depression. The following are goals of this study: (1) to identify cultural and age specific postpartum depressive symptoms, which could apply to various race/ethnic groups; (2) to identify the lack of detection of Mexican American postpartum depression by
mainstream medicine, and thus increase awareness of Mexican American postpartum depression; (3) to suggest culture specific postpartum behavioral interventions and (4) to explore the consequence of postpartum depression in regards to breastfeeding and mothers’ perceptions of their babies.

Significance

This research is important and significant. First, Hispanics are the fastest-growing ethnic group in the United States and are expected to comprise 25% of the U.S. population within the next 40 years (Aguilar-Gaxiola et al., 2002). The recent increase in Hispanics accounts for approximately half of the United States population growth in five years (Hakimzadeh, 2005). Specifically, Mexican Americans, the largest ethnic subpopulation, comprise more than 60% of the Hispanic community in the United States. The influx of Mexican immigrants has led to institutionalized discrimination including being denied access to health care, a livable wage and educational opportunities, thus negatively impacting one’s overall health (Escobar, Nervi & Gara, 2000). Therefore, an understanding of Mexican American mothers’ mental health issues is an important societal concern.

Second, because Hispanics comprise a large portion of the lower socioeconomic class, they experience high levels of stress, which has been linked to anxiety and depression (Abrams & Curran, 2007; Lopez, 2002). Third, Hispanic mothers, compared to other ethnic and racial groups, have higher fertility rates. As a result, they are at an increased risk (47%) of developing postpartum depression, compared to non-Hispanic Whites (31%). Hispanic mothers are also at a slightly higher postpartum depression risk compared to African Americans (45%) (Howell, et al., 2005). However few studies have examined the postpartum experiences of racial/ethnic women. Moreover, fewer studies have explored Mexican American adolescents’ beliefs and perceptions,
symptom experience, and postpartum help-seeking behavior. Research has suggested, however, a link between level of acculturation and depression among Mexican American teens (Escobar, Nervi & Gara, 2000). Explicitly, acculturation often creates intergenerational conflict, leading to depression. Thus, the need to further explore postpartum depression among Mexican American adolescents is crucial.

Fourth, approximately one million U.S. teens get pregnant each year with 500,000 babies born to teenage parents (Birkeland, Thompson & Phares, 2005) and for the first time in 15 years, the teen pregnancy rate has increased (National Institutes of Health, 2008). Explanations for the recent rise in teen pregnancy rates remains unknown, therefore the focus on mothers of all ages is not only significant, but also urgent.

In addition, although mental health disparities among Hispanics are well established, to my knowledge, there are no mixed methods comparative studies that focus on the experiences of self-reported depressed Mexican American mothers across age groups. This research is unique because it considers the overall experiences of Mexican American mothers of all ages, which is imperative to understanding the overall quality of maternal health. The qualitative portion of this study seeks to understand Mexican American postpartum depressive experiences, which may be applied to other racial/ethnic groups. Exploring postpartum depression from a holistic perspective, the quantitative phase of the study emphasizes the negative impact of maternal depression on the mothers’ perceptions of their child’s physical health along with breastfeeding behavior.

The quantitative portion of the study is significant and crucial because postpartum depression is associated with adverse maternal and infant/child outcomes (Logsdon, 2006; Lusskin el al., 2007). For instance, postpartum depression often prevents maternal/infant
bonding, prohibits breastfeeding; and often leads to child emotional and behavioral problems, resulting in child abuse or neglect (Logsdon, 2006). Studies have extensively documented a positive association between postpartum depression and child behavioral problems such as aggression, hyperactivity, anxiety and depression; as well as missed days from school (Lusskin, et al., 2007). Therefore, a qualitative and quantitative research design is significant and timely to explore depression among Hispanic mothers, and its influence on breastfeeding behavior and health perceptions.

The study employs a qualitative and quantitative research design. The major focus of this study is the qualitative in-depth interviews of Mexican American adolescents, using a comparative sample of adult Mexican American mothers, a within ethnic qualitative design. It explores postpartum depression within the context of pregnancy and motherhood to understand the socially constructed identities of self-reported depressed Mexican American adolescents and the meanings attached to depression compared to that of a Mexican American adult sample. While the qualitative analysis focuses on meanings attached to everyday experiences, the quantitative research uses a national sample of self-reported depressed Hispanic mothers to identify breastfeeding behavior and mothers’ perceptions of the physical health of their babies.

The less dominant phase of this mixed methods study consists of a quantitative component, specifically a secondary analysis of the National Survey of Children’s Health, 2003 national data set. The National Survey of Children’s Health, 2003 is a module of the State and Local Area Integrated Telephone Survey Program, which uses the National Immunization Survey’s sampling frame. The findings from the quantitative phase of this research assist in the interpretation of the dominant qualitative findings as suggested by Tashakkori and Teddlie, (2003) by providing insight into breastfeeding behavior and child health perceptions held by
Hispanic mothers.

This research presents a sociological approach to postpartum depression, which is most often viewed solely as a medical issue. Specifically, social and structural factors associated with the onset, diagnosis and treatment of postpartum depression have been largely neglected in previous studies. Therefore, unlike prior studies, this research explores the depressive experience and consequences of postpartum depression among Mexican American mothers while considering the role of culture, myths of motherhood, stigma and the medicalization of childbirth. This study also explores pregnancy as it relates to the depression experience. Research indicates the need for further exploration into the link between anxiety and depression, both during pregnancy and postpartum (Ross et al., 2003).

Justification for Mixed Methods

This research framework was chosen because it is best suited for exploring new phenomenon and has the capability to test theory grounded in the qualitative data (Taskhakkori and Teddlie, 2003). This study incorporates a parallel relationship between the qualitative and quantitative samples (Collins et al., 2006).

A mixed methods design framework was chosen for several reasons. First, the quantitative phase increases confidence in the qualitative findings (Cathain, 2007) by providing an examination of the effects of untreated maternal depression among Hispanics. Specifically it focuses on how the child’s physical, emotional and behavioral health is impacted by maternal depression. The second reason for mixing methods in this study is to neutralize biases (Johnstone, 2004) inherent in each method. Employing a mixed methods design provides a means to cross check the qualitative findings with the quantitative results (Kinn and Curzio, 2005). According to Denzin (2007), Morse (2007) and others, a true mixed-method design
utilizes separate samples (i.e. Qualitative Research Conference, Indiana, 2007).

Organization of the Dissertation

This study will be organized into seven chapters. Chapter 1 consists of an introduction or overview of the study. Specifically, the first chapter examines the socio-cultural dimensions of postpartum depression, why the research is significant, and a description of postpartum depression as a major health concern, along with research questions guiding both the qualitative and quantitative phases of the study.

Chapter 2 reviews the literature and includes definitions of terms related to and symptoms of postpartum depression, an overview of mental health issues facing Mexican American women, a comparison of postpartum depression among Mexican American adolescent and adult mothers, a synopsis of adolescent pregnancy, consequences of postpartum depression, the social construction of motherhood, female identity in the Mexican American culture and barriers to mental health care.

Chapter 3 includes an explanation of the methods including the design, hypotheses, procedures, data collection techniques, data analysis, validity procedures and limitations for the quantitative portion of the study.

Chapter 4 consists of the results from the quantitative portions, statistical analyses and tables summarizing the quantitative findings.

Chapter 5 encompasses qualitative findings from the narratives of adolescent and adult Mexican American mothers. Specifically, sample characteristics, key distinctions between the two groups and major themes are included.

Chapter 6 reveals and applies a theoretical framework for understanding the experiences of both groups of participants, which is grounded in the qualitative data.
A discussion of the findings, implications for future research and public policy are included in chapter seven—the conclusion.
CHAPTER 2

REVIEW OF THE LITERATURE

Postpartum depression, as a social phenomenon, is virtually absent from the literature. Very few studies examine mental health as it relates to motherhood, culture, gender and age. To accurately understand postpartum depression as it is experienced by Mexican American adolescents it is first necessary to consider the experiences of depressed Mexican American adult mothers. Comparing the two groups highlights the knowledge gap in the literature. Specifically, this study delves into pregnancy and motherhood while also considering the socio-cultural explanations of depression including its relationship to and perpetuation of socially constructed myths of motherhood. First, the definition of postpartum depression is examined along with specific symptoms and risk factors among both adolescents and adults. Additionally, pregnancy and motherhood are explored within the context of the Mexican American culture and adolescence. Consequences of untreated postpartum depression and its impact on the mother, baby and family is also investigated. Socio-cultural explanations of depression and specific barriers to mental health care are examined among both groups of mothers.

Definition of Postpartum Depression

Postpartum depression is a mood disorder that affects approximately 10-15 percent of adult mothers yearly with depressive symptoms lasting more than six months among 25-50 percent of those affected (Beck, 2002). Approximately 48 percent of adolescent mothers experience depressive symptoms (Clemmens, 2002). Postpartum depression often occurs between a few months to a year; studies report postpartum depression four years following birth (Mauthner, 1998). Postpartum mood disorders are classified into three categories according to the severity (O’Hara et al., 1990) The first, postpartum blues, which is the least severe form
typically lasting a few days to a couple of weeks after giving birth and affects approximately 50-85 percent of all new mothers and according to some studies is a precursor to postpartum depression (Watanabe et al., 2008). The second postpartum mood disorder, postpartum depression, is more severe, causing a great deal of problems for the mother. If left untreated postpartum depression often results in bouts of crying, guilt, feelings of inadequacy and detachment from the baby. A third type of postpartum mood disorder, postpartum psychosis, affects less than 2 women per 1,000 births, causes delusions, rapid mood swings, confusion and hallucinations (Leitch, 2002) and is most likely to occur during the first three months following delivery (O’Hara et al., 1990).

Symptoms and Treatment of Postpartum Depression

Previous research suggests that mothers suffering from postpartum depression do not always appear depressed rather some exhibit more visible warning signs including anxiety, insomnia, irritability and confusion (Dalton, 1996). Often such symptoms are often overlooked or ignored (Chaudron et al., 2005; Leitch, 2002). Other symptoms maybe obvious, for example, depressed mothers may experience uncontrollable crying spells and fear.

Mothers also learn to mask symptoms, thus making early detection difficult. Other latent symptoms of postpartum depression include guilt, inadequacy, changes in appetite and fatigue, which can led to medical misdiagnosis, or no diagnosis. Women and physicians do not always recognize subtle symptoms of postpartum depression (Chaudron et al., 2005). Mothers who are unable to recognize or identify depression often cannot articulate their feelings, thus postpartum depression persists untreated. Therefore, research strongly suggests screening for postpartum depression especially among racial and ethnic minority women because depressive disorders are often underestimated in such populations (Howell et al., 2005). Lack of detection of postpartum depression
depression can also be attributed in part to insufficient screening during the medical encounter. Fewer than 40 percent of depressed mothers seek help (Hayes, 2007) and estimates show that only 13 percent of women exhibiting signs of postpartum depression are under a physician’s care, despite the fact that the condition is easily treatable (Thio et al., 2006). The recovery rate for women who seek professional help is between 80 and 90 percent (Hayes, 2007). Although women have increased contact with healthcare providers during the postpartum period few of the encounters center around the mother, thus overlooking her needs.

Also, the onset of depression is often gradual, thus making postpartum depression screening at various points postpartum critical. Screening should begin during pregnancy as studies show a possible link between antenatal depression and anxiety and postpartum depression (Romans-Clarkson et al., 1991). Some studies report antenatal depression rates up to 50 percent (Bozoky and Corwin, 2001).

Adolescent Pregnancy

Teen pregnancy rates have increased in 2008 for the first time in more than 15 years (Center for Disease Control, 2006) and remain five times higher in the United States than any developed country (Clemmens, 2002). In the United States, Hispanic teens have the highest pregnancy incidence rate (8.2 percent in 2004) compared to 2.7 percent of White adolescent mothers (Nadeem et. al., 2006; Heavey et al., 2008). The consequences of teen pregnancy are great, not only for the mother, but for her child. Teen mothers tend to have lower educational attainment, life long poverty and an increase risk of child and substance abuse (Center for Disease Control, 2006). Such social factors increase their susceptibility to depressive symptoms.

Mental Health of Hispanic Women

One out of every 10 people in the United States suffers from depression and women are
twice as likely to be depressed as men (Hayes, 2007). Furthermore, research indicates that
Hispanic women have higher rates of depression compared to non-Hispanic women (Chaudron,
2005). According to the literature, Hispanic women experience numerous social stressors, while
some are acute others are chronic and have the potential to jeopardize their mental health. These
stressors include acculturation, intergenerational conflict (particularly for Hispanic adolescents),
icultural competency and the language barrier. Chronic stressors include poverty, racism and
sexism faced by many Hispanics, particularly women. The literature indicates a strong
association between the socioeconomic status, racism and health status (Williams and Collins,
1995). Studies have found that low socioeconomic status is a predictor of elevated rates of
psychiatric conditions (Williams and Collins, 1995).

Postpartum Depression and Hispanic Adolescent Mothers

The prevalence of depression among adolescent mothers compared to adult mothers is
significant. In general teen mothers are more depressed than adult mothers and more likely to
develop chronic depression later in life (Lanzi et al., 2009). Hispanic adolescent mothers,
specifically Mexican Americans, are at highest risk of moderate to severe depression compared
to all other racial and ethnic groups, minority adolescent mothers are least likely to report
symptoms of depression to healthcare professionals (Nadeem, 2006). Studies have found that
approximately 26 percent of adolescent mothers experience postpartum depression.

Numerous factors place Mexican American adolescent mothers at risk for postpartum
depression, including: low maternal competency; antenatal depression; conflicted social
networks; poor body image; self esteem; single parenthood; unmet emotional and physical needs;
no or limited partner support; turbulent partner relationship; and stigma associated with teenage
motherhood (Gosdin, 2005).
Transitioning into motherhood during adolescence often presents additional challenges for many Hispanic teens. For instance, an intergenerational conflict between Hispanic teens and their parents, caused by what some researchers refer to as an “acculturation gap” creates interpersonal stress and perpetuates conflict. Lags in acculturation occur when teens adopt ideas and behaviors typical of American culture while abandoning certain aspects of Hispanic culture. Alienation and misunderstanding develop when children acculturation at a faster pace than their parents (Pasch et al., 2006). Research indicates a link between acculturation and depression among Hispanic teens. For instance, Mexican Americans born in the United States have higher rates of depression compared to their non-native counterparts (Gonzales et al., 2004). Increased rates of depression found among Mexican Americans can also be explained through discrimination and prejudice attitudes often experienced by Mexican American youth (Gil, Vega, and Dimas, 1994). Institutionalized racism and discrimination should be considered when considering postpartum depression because studies highlight the relationship. “Women who report any kind of discrimination are more likely to have depressive symptomatology” (Surkan et al., 2006). Second, acculturation can also negatively impact body image among Hispanic mothers (Gosdin, 2005). Studies indicate that eating disorders are increasingly common among Hispanic teens. Media representations of ideal beauty emphasize smaller figures, therefore pressuring Hispanic females to drop weight. Studies show that Hispanic teens are progressively influenced by such media images becoming less comfortable with their body (Donnelly, 2005). Gaining weight during pregnancy can contribute to depressive feelings postpartum among adolescent mothers (Gosdin, 2005).

Postpartum Depression and Adult Hispanic Mothers

Hispanic women have higher rates of postpartum depression, but are less likely to be
identified as depressed compared to non-Hispanic women (Chaudron, 2005). Risk factors associated with postpartum depression among Hispanic adult mothers are similar to that found among adolescent mothers, and include maternal incompetency, antenatal depression, unplanned pregnancy, infant with the colic or other health problems, single parenthood, having several children at home and unmet needs both emotional and physical (Prodromidis and Abrams, 1994). However, few studies have examined how Hispanic adult mothers experience depression, and seek help compared to comparable adolescents.

Gender and the Hispanic Culture

Hispanic females, especially second generation immigrants, are often torn between two cultures. While they are bound to cultural norms and values, they are also expected to assimilate into American society. Therefore they experience an identity crisis, which often leads to depression (Turner et al., 2002). This is common among adolescent Hispanic females who report feeling torn between family and friends. Studies report that American Hispanic females desire to be autonomous, which often poses a threat to traditional cultural and family values (Turner et al., 2002). Hispanic adolescent females are particularly vulnerable to “intergenerational conflict,” which occurs when the adolescents’ values clash with those of their parents (Turner et al., 2002).

As a result, teenage Hispanic females often are caught between the traditions of their culture and the desire for independence, commonly idealized in America. Such conflict places Hispanic adolescent mothers at risk for depression, and often suicidal behavior (Turner et al., 2002).

Hispanic adolescent mothers’ stressors are enormous, and adversely affect their mental health postpartum. For instance, Hispanic women are socialized within “a highly traditional, gender-specific, patriarchal system” (Flores et al., 2006 p. 49). The contrast between traditional
roles and the push for gender equality create conflicting expectations among many Mexican American women (Goodkind et al., 2008). Disagreements concerning dating and career choices have been cited as major sources of intergenerational conflict, (Turner et al., 2002). Thus, understanding gendered experiences within the Hispanic community is an essential component of the meaning of the Hispanic postpartum depression experience.

Social Construction of Motherhood

Motherhood is constructed around traditional gender roles which create role strain and conflict (Edhborg et al., 2005; Turner et al., 2002). Due to the woman’s status in society (pay gap, segregated marital relationships, less occupational prestige) motherhood is often characterized by an additional loss—loss of identity (Edhborg et al., 2005). Pregnancy and motherhood are often viewed as battles in the gender equality fight. The motherhood role may be viewed as negative since mothers are often expected to delay personal and professional gratification, often neglecting their own needs. Additionally, motherhood is idealized, which often make women feel they are expected to do it all (house work, primary care taker, etc.) and retain their femininity. For example, myths of motherhood incorporates an ideology of intensive mothering thus creating and perpetuating the idea that mothers are solely responsible for the nurturing and well-being of their children (Hayes, 1996). Women who have children are expected to give up their individuality and fully devote themselves to motherhood, a full time and often devalued job. Mothers are constantly policed and those who do not fit the socially constructed profile of a “good mom” are socially sanctioned (Johnston and Swanson, 2003). Such expectations set women up for failure, especially those outside who lack access of social, economic and political capital, particularly Hispanics and adolescent mothers. “Mothers are under pressure to conform to societal standards and is not necessarily best for mothers or their
children” (Medina and Magnuson, 2009 p. 93).

Hispanic mothers also cope with the stressor of paid labor force participation. Women confront demands associated with working outside of the home. Such stressors include finding affordable quality daycare, inflexible work schedules, the wage gap, etc. The role strain experienced by mothers can lead to depression when they fail to meet family and social expectations (Edhborg et al., 2005). The demands of motherhood, experienced by those who are limited by structural constraints are overwhelming and are likely to contribute to postpartum depression (Gaschler, 2008).

Medicalization of Childbirth

The medicalization of childbirth is directly linked to the social construction of motherhood. The United States has a long history of regulating the reproductive health of women including defining childbirth as a medical issue. Although the medical profession posits that hospital births minimize health risks for both the mother and child, there is a plethora of research suggesting that giving birth in a sterile hospital environment is not only unnecessary but actually alienates women from an otherwise natural and normal occurrence (Cahill, 1999). Medical dominance over childbirth disempowers women in several ways, thus increasing their risk of depression (Oakley, 1980). First, the medical setting is rarely patient centered; instead the needs of medical professionals are given priority. Medical intervention, for example, scheduling cesarean deliveries are often a matter of convenience for the obstetrician with little regard given to the best interest of the woman. Although, to my knowledge, there are no definitive studies linking cesarean births to higher rates of postpartum depression, researchers have found correlations between medical intervention postnatal mood disorders (Oakley, 1980). However, the issue warrants further exploration.
Second, hospital births are often impersonal and mundane giving women little control over their birthing experience, limiting individuality and comfort (Oakley, 1980). The medical setting is not always conducive to bonding with her partner or the baby during the process of labor. Numerous studies have found that depressed mothers have difficulties bonding with their infants (Fiori-Cowley et al., 1996, Gelfand et al., 2000), however it is not known there or not insufficient bonding contributes to depression.

Socio-Cultural Barriers to Mental Health Care

A number of barriers prevent depressed mothers from seeking mainstream treatment for postpartum depression. The literature identifies socio-cultural barriers such as attitudes toward mental illness and treatment, partner support, social support, family, poverty, social capital, education, lack of recognition of depressive symptoms and language barriers (Chaudron, 2005). There are also structural barriers, including lack of transportation, childcare, health insurance, knowledge regarding where to seek care, regular source of care and proximity to treatment centers (Lopez, 2002).

The nature of the typical medical encounter can also serve as a deterrent to treatment. For instance, the average medical encounter last approximately 18 minutes (Mechanic, 2001). Condensed medical visits can lead to patient dissatisfaction and insufficient time spent understanding patients’ needs therefore increasing the number of medical misdiagnosis. For example, when a mother seeks care for depression her symptoms are often minimized by health care professionals (Dennis and Chung-Lee, 2006) or dismissed as temporary resulting in a misdiagnosis 50% of the time (Godfrey, 2005).

Psychosocial barriers can also prevent Hispanic mothers from seeking care. For example, poor body image and unrealistic expectations of beauty, particularly among adolescent mothers
(Gosdin, 2005) can create barriers to mental health care. Cultural ideals of modesty must also be considered, particularly among Hispanic adolescent mothers. Because Hispanic adolescents have a higher fertility rate, compared to other ethnic groups, it is significant and crucial to explore socio-cultural barriers which prevent quality mental health.

Additionally, the Hispanic culture does not encourage open discussions about mental health and depression is considered by many a personal issue that should be kept private (Haynes, 2007).

Consequences of Postpartum Depression

There are numerous consequences of untreated postpartum depression. Not only is the mother’s mental and physical health in jeopardy, but also the child’s. For instance, the literature reveals a link between maternal depression and prevalence of early breastfeeding termination, reporting an inverse relationship (Hatton, 2005). Other studies have reported similar findings suggesting that problems associated with breastfeeding and postpartum depression should be addressed (Henderson et al., 2003). Specifically, breastfeeding among Mexican Americans appears to be impacted by levels of acculturation (Kimbro, Lynch and McLanahan, 2008). Studies indicate that the “Hispanic paradox” can be applied to breastfeeding behavior, thus less acculturated Mexican immigrants are more likely to breastfeed and for longer periods of time compared to more acculturated Mexican Americans (Kimbro, Lynch and McLanahan, 2008). The importance of breastfeeding is well documented as is known to have a positive effect on the mother’s mood while also lowering stress levels in both the mother and child (Kendall-Tackett, 2007).

Additionally, depressed mothers exhibit difficulty bonding and interacting with infants, which is associated with developmental problems. Maternal depression, during the first year
postpartum, is associated with aggression, hyperactivity and depression among children at age three (Lusskin et al., 2007). There is also evidence suggesting that chronic maternal depression can result in poor vocabulary skills among children (Leitch, 2002). Postpartum depression, if left untreated, negatively impacts the mothers’ ability to parent, thus negatively affecting her self-esteem while putting the child at unnecessary risks, both physical and mental (Perfetti, et al., 2004).

Untreated postpartum depression can also lead to physical and mental impairment, lifelong depression, infanticide or suicide. Although postpartum depression can have devastating effects on the mother and the child, it also has the potential to disrupt the family resulting in lower quality of life and dysfunction (Logsdon, et al., 2006).

Conclusion

While previous studies have examined socio-cultural aspects of mental health few have been applied to postpartum depression thus a significant gap in the literature remains. The relationship between society, culture and postpartum depression is examined throughout this dissertation. Focusing on the unique experiences of self-reported depressed Mexican American adolescent and adult mothers contributes to the postpartum literature while also suggesting cultural interventions necessary to treat this specific population.

Postpartum depression cannot simply be reduced to a chemical imbalance or hormonal abnormalities. Rather, depression after childbirth can be understood as a social phenomenon that exists and is maintained through an existing social structure found outside of the individual mother. The social construction of postpartum depression, including possible causes and affects must be explored through the experiences of motherhood, pregnancy and birthing all of which are typically examined through the lens of white, middle-class America, ignoring a variety of
socio-cultural factors and structural constraints unique to Mexican American mothers.

Consequence of untreated postpartum depression, among a national sample of Hispanic mothers, is analyzed through three types of regression analyses and is addressed in the next chapter. The quantitative findings are then integrated within the qualitative framework provided in chapter 6.
CHAPTER 3
DATA AND METHODS

Research Design

A mixed methods study including qualitative and quantitative phases was implemented utilizing separate samples, both from the same underlying population —self-reported depressed Mexican American mothers. The qualitative portion explores how the pregnancy, motherhood and depression experience shape the social identities of self-reported depressed Mexican American adolescent and adult mothers; while the quantitative piece examines consequences of untreated postpartum depression, specifically breastfeeding behavior and perceptions of the physical health of the child.

A mixed methods design was implemented because it is best suited for exploring new phenomenon and has the capability to test theory grounded in the qualitative data (Taskhakkori and Teddlie, 2003). Theory derived from the dominant qualitative phase will assist in the interpretation of the quantitative findings by providing insight into breastfeeding behaviors and perceptions of children’s health among self-reported depressed mothers.

Data were collected in two distinct phases; the first phase is the qualitative portion, and Phase 2 is the quantitative portion, which provides assistance to understand the effects of maternal depression on health perceptions and breastfeeding behavior. The qualitative and quantitative methods were integrated during the interpretation stage of the research process (Taskhakkori and Teddlie, 2003).

Institutional Review Board

The study was approved, after a few minor changes regarding specific terminology included in the minor assent forms, on April 16, 2009 by the Institutional Review Board at the
University of North Texas. I was contacted by email regarding the approval of the study, including the use of public secondary data specifically the National Survey of Children’s Health, 2003. Minor assent forms were signed and dated by both adolescent participants and their legal guardians prior to the interviews. Participants were guaranteed that all information shared during the interviews would be kept confidential and that no identifying information would be used. The approval letter and consent forms are located in Appendices A and B. Recruitment began immediately after receiving final IRB approval.

Qualitative Phase

Procedures

Six Mexican American adolescent mothers and six Mexican American adult mothers were interviewed twice using two distinct semi-structured interview guides totaling 24 interviews. Mothers were interviewed twice due to the sensitivity of the topic and the length of time needed for each question. Participants from both groups were recruited from the DFW metropolitan areas.

Recruitment

Recruiting qualified participants was a challenging and time intensive process. The combination of specific recruiting criteria, sensitivity of the subject matter and language barrier complicated the recruiting process. I began recruiting adult mothers in May 2009 with assistance from a key informant who is a native-Spanish speaker, health educator and active member of the Denton Hispanic community. The key informant arranged several public speaking engagements where I presented current literature and my previous research on postpartum depression while actively recruiting at churches, community health fairs and health clinics. Several recruitment strategies were employed including: creating and disseminating flyers, calls and emails to
various pregnancy centers, schools and health clinics throughout the DFW area, a radio interview, online and print ads, listserves, church bulletins and personal and professional contacts. Print ads in local newspapers, in both English and Spanish, and the radio interview proved most successful in recruiting adult participants while a personal contact assisted with accessing a teen parenting program at a local public high school, which led to adolescent participation.

The key informant previously mentioned also assisted with translating the interviews and served as a reference to increase cultural competency. Specifically, she proofread both interview guides and the demographic questionnaires providing feedback regarding wording and culturally specific concepts. A second native Spanish speaker assisted with recruitment by translating recruitment flyers from English to Spanish while also serving as the contact person for interested Spanish speakers. She was also included in the interview process with the adult mothers by translating interviews with two adult non-English speaking participants while also building rapport. The rationale for translating during the interview was to: (1) build trust and to establish comfort among participants; (2) to ensure the most accurate data by having participants speak their native language; (3) to ensure that sensitive information was communicated accurately and not subjected to a language barrier. The translator was not needed for the interviews with the adolescents because (1) they were fluent English speakers and (2) the parenting teacher, whom the students trusted and confided in, was nearby, putting the participants at ease and building report between the researcher and the teens.

Qualitative sample inclusion: Mexican American adolescent mothers were recruited based on the following criteria: (1) 18 years of age or younger; (2) self-reported depression; (3) eight weeks to a year postpartum, to distinguish depression from the more common “baby blues”
; (4) have never sought care from a mainstream healthcare professional for depression; and (5) have never taken medication to treat depression. Mexican American adult mothers were included based on the same criteria expect for age which was 19 years or older.

Qualitative sample exclusion: Mexican American adolescent and adult mothers were excluded from the study based on the following: (1) participants over the age of 18 were excluded from the adolescent group and mothers under the age of 19 from the adult group; (2) non-self-reported depressed mothers; (3) less than 8 weeks postpartum; (4) have sought care from a mainstream healthcare professional for depression; (5) have taken medication for depression.

Identifying Postpartum Depression

The Edinburgh Postnatal Depression Scale (EPDS) is the most widely used screening instrument for postpartum depression. The EPDS consists of 10 questions with a maximum score of 30 and a score of 10 indicating possible depression. This particular screening instrument has been tested among women of many cultures, including Hispanics. Also, the EPDS is closely correlated with other depression scales and is extensively used in both research and clinical studies (Boyd et al., 2005; Mason, Linda and Poole, Helen, 2008). While the purpose of a screening instrument is not to diagnosis postpartum depression, it identifies women who are at risk. Identifying mothers who are at risk of developing postpartum depression is extremely important considering approximately half of all cases go undetected (Abrams and Curran, 2007; U.S. Department of Health and Human Services, 2000). To determine if the scores on EPDS and the respondents’ narratives of depression match, each respondent completed the EPDS scale.

A Spanish version of both the demographic questionnaire and the EPDS were available for those participants who felt more comfortable reading and writing in their native language,
although only two of the adult mothers chose to do so.

Data Collection

Qualitative data collection began in July 2009 and was completed February 2010. In-depth interviews serve as the primary method of data collection, while a secondary data analysis supplements the qualitative findings. Data were collected through in-depth interviews of two groups—self-reported depressed Mexican American adolescent mothers and self-reported depressed Mexican American adult mothers.

The qualitative portion of this study consists of twenty-four semi-structured in-depth interviews resulting in 230 pages of transcripts. Group 1 consists of 6 self-reported depressed Mexican American adolescent mothers while Group 2 consists of 6 self-reported depressed Mexican American adult mothers, the interview guide was divided into two separate parts, thus participants were interviewed twice. The in-depth interviews lasted approximately one hour. Adult mothers were interviewed in either their home or a nearby public library while adolescent mothers were interviewed on the campus of the high school where the parenting program was based. Interviews with adolescent participants were conducted in a private area of the school library.

Each interview was audio recorded and transcribed verbatim; the tapes were stored in a private location for the duration of the study. No identifying information was revealed to anyone other than the researcher. Three of the interview transcriptions were contracted out, while I transcribed the remainder.

Interview Guide

The two groups of participants were asked questions from two different semi-structured interview guides. Both were geared to answer the same research questions, but varied slightly.
The main difference concerns the wording and addition of two questions created specifically for adolescent mothers. The supplemental questions were designed to uncover perceptions of stigmatized identity commonly expressed by teenage mothers (Gosdin, 2005). Specifically, adolescent mothers were asked to describe how parenting as a teenager differs from adult motherhood and how well people in general understand teen mothers.

Both interview guides categorized questions into four distinct sections: (1) pregnancy experience, (2) motherhood experience, (3) depression experience and (4) sociocultural explanations of depression and social barriers to mental health care. I began each interview with an ice-breaker to establish more of an open dialogue rather than a formal interview. For instance participants were asked to share something about themselves or their baby and what they do for fun. The first interview focused on the experience of pregnancy, motherhood and depression. For example, to elicit feelings that arose during pregnancy participants were asked how they felt when they first learned that they were pregnant, who they told first, to describe a typical day during their pregnancy and how they would describe their pregnancy experience.

Questions directly related to motherhood were also asked and included: “Describe a typical day now that you have had the baby” and “In what ways is motherhood similar to and different from what you imagined?” To best understand how self-reported depressed Mexican American mothers make sense of depressive symptoms questions such as “In what ways do you express sadness?” and “Do those closest to you understand why you get depressed?” the second interview focused on the relationship between the mother and her child and help-seeking behaviors. Participants were asked to describe the interaction with their baby and how their depression affects their bonding. Also, questions pertaining to the culturally influenced perceptions of mental health such as “How is depression viewed in the Mexican American
community?” and “What would prevent a depressed Mexican American mother from talking to a healthcare professional about depression? were included.

To supplement the qualitative data I wrote reflective memos immediately following the interviews. The purpose of memo writing in qualitative research is to further theoretical thinking strengthening the relationship between the researcher and the data (Birks, 2008). The memos include my own reflections, expectations, feelings and preconceptions toward the research.

Data Analysis

Qualitative data were analyzed using a grounded theory approach based on a multi step technique developed by Strauss and Corbin (Eaves, 2001). Each of the 24 transcripts and depression scales were hand coded by the researcher. After an initial read of each transcript, 29 codes were assigned based on emergent common themes. Codes included normalizing and controlling depression, pregnancy complications, social support, childcare stress, conflict within interpersonal relationships, perceptions of baby, body image, etc.

A separate codebook for the adolescent and adult mothers was created based on the same 29 open codes which were then collapsed into categories. For example, the code pregnancy related complications was deconstructed and grouped based on specific issues indicated by participants such physical and emotional difficulties. Upon categorizing codes, subcategories were created through the process of linking codes with specific statements illustrated in the data, which led to the development of themes, thus generating theory explaining how postpartum depression is socially constructed among Mexican American adolescent and adult mothers. Specifically this study examines how the experiences of pregnancy, motherhood and depression differ among these two groups of mothers.

Also, data obtained from the Edinburgh Postnatal Depression Scale (EPDS) were hand
scored and are displayed in Tables 11 and 12. The scale encompasses a maximum score of 30 with a score of 10 or greater indicating possible depression. Participants’ scores were compared to their corresponding demographic information completed at the beginning of each interview. The purposes of this comparison are to (1) determine the severity of the participants’ depression, and (2) to determine if the severity matches the qualitative in-depth-interviewing narratives.

Table 1

Summary of Qualitative Study

<table>
<thead>
<tr>
<th>Adolescents</th>
<th>Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 self-reported depressed Mexican adolescent mothers</td>
<td>6 self-reported depressed Mexican adult mothers</td>
</tr>
<tr>
<td>18 years &amp; younger</td>
<td>19 years and older</td>
</tr>
<tr>
<td>Demographic Questionnaire</td>
<td>Demographic Questionnaire</td>
</tr>
<tr>
<td>EPDS scale</td>
<td>EPDS scale</td>
</tr>
<tr>
<td>Two Interviews each</td>
<td>Two Interviews each</td>
</tr>
<tr>
<td>Total 12 Interviews</td>
<td>Total 12 Interviews</td>
</tr>
</tbody>
</table>

Reflexivity

I became interested in studying postpartum depression after learning about the 2002 Andrea Yates court case in Houston, Texas. I was perplexed by the media’s portrayal of postpartum depression and society’s response to mental illness in general. Why are we so quick to blame the victim? I felt that this question was never posited; instead it was questions of how could a mother commit such a horrible act and what would be the most fitting punishment. As Andrea Yates’ story became public, including her long history of depression with psychosis, it became clear to me that this case centered on an American sentiment based on revenge, misogyny and ignorance of mental illness, specifically postpartum depression. Postpartum depression, an issue typically reserved for psychiatry and psychology, can and should be
analyzed through a Sociological lens, thus leading me to the research topic.

Studying postpartum depression from a sociological perspective required re-thinking motherhood as a social construction, which rarely favors women. Having witnessed numerous friends’ transition into motherhood and dedicating much of my adult life to studying sociology I thought I had a good idea of the challenges facing mothers. In many ways I, like many of the women interviewed, thought that depression after childbirth was normal. Who wouldn’t be depressed being a mother in a society that devalues women while de-emphasizing the importance of motherhood? Although I had long realized that American society sets mothers up to fail by not providing the needed infrastructure required for a quality life, I had not fully realized the extent to which Mexican American mothers are negatively impacted or the direct effects that untreated postpartum depression has on the family.

The Quantitative Phase

Data Collection

The quantitative portion of this study utilizes secondary data from the U.S. Department of Health and Human Services, specifically the National Survey of Children’s Health, 2003. The National Survey of Children’s Health, 2003 is a national data set available through the Inter-University Consortium for Political and Social Research (ICPSR Study 4691) and was funded by the Maternal and Child Health Bureau. Data were collected via a telephone questionnaire form January 2003-July 2004. The study employs the following hypotheses that were tested during the quantitative phase of the project.

Hypotheses

Hypothesis 1: Depressed Hispanic mothers are more likely to have poor perceptions of their child’s physical health compared to non-depressed Hispanic mothers.
Hypothesis 2: Depressed Hispanic mothers are less likely to breastfeed compared to non-depressed Hispanic mothers.

Hypothesis 3: Depressed Hispanic mothers are less likely to breastfeed for at least one year compared to non-depressed Hispanic mothers.

Sample Selection and Operational Definitions

The data include a sample of 102,353 legal guardians living in all 50 states and the District of Columbia. Participants were selected through a random-digit-dial sample from households with children under the age of 18 (NSCH, 2003). Both the codebook and the data are available online and are free of cost to researchers. The original study was designed to measure children’s experiences with the healthcare system, assessing physical, emotional and behavioral health, (NSCH, 2003) for the purpose of evaluating strategic goals established by the Maternal and Child Health Bureau (MCHB) (NSCH, 2003). However, this study focuses on breastfeeding duration and perceptions of their child’s physical health as conveyed by self-reported depressed Mexican American mothers.

Although ethnicity is not indicated in the survey instrument, the question “Is the child of Latino or Hispanic origin?” (approximately 13,357) is used to identify the ethnicity of the mothers and is operationalized as Hispanic if the response is yes. Also, to determine mother/child relationship the question “What is your relationship to the child?” was used to identify mothers. Only those respondents who identify themselves as the mother (approximately 80,291) of the child were included in the study.

Operationalization of Dependent Variables

Mother’s Perceptions of Child Health: “In general, how would you describe your child’s health? Would you say his/her health is excellent, very good, good, fair or poor?” was reverse
coded. Specific questions aimed at uncovering breastfeeding behaviors include “Was your child ever breastfed or fed breast milk?” is coded as (yes or no). “How old was he/she when he/she completely stopped breastfeeding or being fed breast milk?” is measured in days.

Operationalization of Independent Variables

Postpartum depression was measured with the question “Would you say in general your mental and emotional health is excellent, very good, fair or poor?” This research filters for age of the child, to distinguish postpartum depression from other types of depression. Specifically, only those mothers with children ages 1 or younger were included.

Control Variables

While this research focuses on the consequences of one independent variable (maternal depression), various demographic variables were controlled for including: number of children living at home, whether or not the mother is native to the United States, level of poverty, primary language spoken at home (English or Spanish), number of adults living in household, level of education, family structure, and whether or not the mother receives support from her community/neighborhood. Analyzing both the depressed mothers’ perceptions of their baby’s physical health and breastfeeding behavior highlights the effects of untreated maternal depression. Importantly, maternal depression is commonly associated with child developmental and behavior problems and creates barriers to bonding, which can prevent mothers from breastfeeding (Lusskin, 2007).

Table 2

Summary of Variables and Operationalization

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>Dependent Variables</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Self-reported Depressed Hispanic mothers</td>
<td>• Breastfeeding behavior</td>
</tr>
<tr>
<td></td>
<td>• Mothers’ perceptions of babies’ physical health</td>
</tr>
</tbody>
</table>

(table continues)
Table 2 (continued).

<table>
<thead>
<tr>
<th>Demographic Control Variables</th>
<th>Social Support Control Variables</th>
</tr>
</thead>
<tbody>
<tr>
<td>• # of children living at home</td>
<td>• Neighborhood support</td>
</tr>
<tr>
<td>• Primary language spoken at home (English or Spanish)</td>
<td>• # of adults living at home</td>
</tr>
<tr>
<td>• Poverty level</td>
<td>• Emotional/parenting support (yes or no)</td>
</tr>
<tr>
<td>• Mother native to U.S.</td>
<td></td>
</tr>
</tbody>
</table>

Data Analysis

The quantitative phase of this study utilizes a total of nine nested logistic, ordinal and multivariate regression models to predict relationships between dependent variables (perceptions of physical health of the child and maternal breastfeeding behavior, specifically whether or not the mother breastfed and for how long). The only variable that required recoding was the mothers’ perceptions of their child’s health.

The dependent variables measuring whether or not the mother breastfed is a dichotomous variable that did not require re-coding therefore logistic regression is the appropriate statistical analysis (Allison, 1999). The second dependent variable also aimed at uncovering breastfeeding behavior was tested using three ordinary least squares regression models, best used when the dependent variable is continuous.

The independent variable (self-reported poor mental health among Hispanic mothers) tested the relationship among each dependent variable while controlling for demographic variables. Control variables in each regression model included (combined household yearly income, number of children living at home, age range of children living at home, whether or not the mother is native to the United States and primary language spoken at home (English or Spanish) and number of adults living in household.

Three models, using ordinal regression, tested the consequences of untreated maternal depression on self-reported depressed mothers’ perceptions of their children’s health. This focus
is important since many depressed women do often fail to recognize depressive symptoms. Moreover, those who recognize symptoms, particularly poor, ethnic/racial minorities often fail to recognize the effects of maternal depression on children.

**Ethical Considerations**

All participants were informed of the possible risks, which were minimal. Due to the sensitivity of the subject matter participants were referred to a culturally competent community mental health clinic in Dallas, Texas that provides both counseling and medical treatment to the indigent. Several mothers stated that they would seek mental health care upon receiving the information. Several of the adult mothers cried during parts of the interviews but also expressed emotional relief that they were able to openly talk about their feelings.

The remaining three chapters focus on key findings derived from both qualitative interviews with self-reported depressed adolescent and adult Mexican American mothers and a quantitative analysis of child health perceptions and breastfeeding behaviors among self-reported depressed Hispanic mothers in general. The social construction of postpartum depression as highlighted throughout this dissertation also calls attention to policy and clinical implications while considering future areas of research.
CHAPTER 4
QUANTITATIVE RESULTS

Introduction

The quantitative portion of this mixed methods study focuses on consequences of postpartum depression on both mothers and their children. Theory grounded in the qualitative data explains breastfeeding behaviors and child health perceptions among self-reported depressed Hispanic mothers, who have babies under the age of one. The quantitative analysis examines the relationship between self-reported depression during postpartum and whether or not mothers breastfeed, the number of days they breastfed and how they perceive the physical health of their children while controlling for various demographic and social support variables. Specifically, this chapter includes descriptive statistics of each variable, a correlations table depicting the relationship between variables and three regression analyses. Logistic regression is used to predict whether or not mothers’ breastfed their babies while ordinary least squares regression tests the relationship between breastfeeding duration and self-reported depression and ordinal regression predicts mothers’ perceptions of their babies physical health.

Descriptive Statistics

Frequencies of Variables

Table 3 provides frequencies for the independent variable, mothers’ self-reported mental health. The variable mothers’ self-reported mental health is divided into 5 categories ranging from poor to excellent. Of the Hispanic mothers sampled, 33% reported both good and excellent mental health while less than 1% reported poor mental health and 5% perceived their mental health as fair.
Table 3

**Frequencies of the Independent Variable**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Response</th>
<th>Frequency</th>
<th>%</th>
<th>Mean</th>
<th>SD</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-reported mental health</td>
<td>Poor</td>
<td>7</td>
<td>.4</td>
<td>3.887</td>
<td>.93997</td>
<td>1716</td>
</tr>
<tr>
<td></td>
<td>Fair</td>
<td>86</td>
<td>5.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Good</td>
<td>565</td>
<td>32.9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Very good</td>
<td>493</td>
<td>28.7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Excellent</td>
<td>565</td>
<td>32.9</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4 indicates frequencies of the three dependent variables, whether or not the mother breastfed, the duration of time spent breastfeeding and the mothers’ perceptions of her child’s physical health. As indicated below the majority of the mothers sampled, 81%, breastfed their babies. The average number of days spent breastfeeding is 142 days, or 4-5 months. Half of the mothers sampled perceive their children’s physical health as excellent, approximately 52, while no one reported their child as being in poor physical health and only 5% report fair.

Table 4

**Frequencies of Dependent Variables**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Response</th>
<th>Frequency</th>
<th>%</th>
<th>Mean</th>
<th>SD</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breastfed or fed breast milk</td>
<td>No</td>
<td>332</td>
<td>19.3</td>
<td>0.8065</td>
<td>0.395</td>
<td>1716</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>1384</td>
<td>80.7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Never</td>
<td>34</td>
<td>3.1</td>
<td>141.80</td>
<td>3977.224</td>
<td>1101</td>
</tr>
<tr>
<td></td>
<td>1-29</td>
<td>140</td>
<td>12.8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>30-90</td>
<td>389</td>
<td>35.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>91-180</td>
<td>252</td>
<td>22.9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>181-365</td>
<td>225</td>
<td>20.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>365 plus</td>
<td>61</td>
<td>5.3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*(table continues)*
Table 4 (continued).

<table>
<thead>
<tr>
<th>Variable</th>
<th>Response</th>
<th>Frequency</th>
<th>%</th>
<th>Mean</th>
<th>SD</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perception of child’s health</td>
<td>Poor</td>
<td>N/A</td>
<td>N/A</td>
<td>2.2273</td>
<td>0.926</td>
<td>1716</td>
</tr>
<tr>
<td></td>
<td>Fair</td>
<td>77</td>
<td>4.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Good</td>
<td>355</td>
<td>20.7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Very good</td>
<td>385</td>
<td>22.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Excellent</td>
<td>899</td>
<td>52.4</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 5 reports frequencies of five demographic variables including, relationship to the poverty level, whether or not the mother is native to the United States, number of children living at home, mothers’ level of education and primary language spoken at home (Spanish or English). Approximately 40% of the mothers report the greatest amount of poverty, 50% of poverty or greater, but less than 100%. Based on the 2003 Federal Poverty Level guidelines a family of 5 living in continental United States earns $11,000 annually and can be compared with the 10% who fall within 400% poverty or greater. For example, a family of 5 that earns $86,000 annually is classified as 400% of poverty or greater. The vast majority of those sampled are native to the United States, 98% compared to 1% born outside of the United States.

Approximately half of the mothers sampled had only one child living at home, while 30% had two and 19% had three or more. Approximately 33% of the mothers sampled were high school graduates while 46% had additional education beyond the high school level. Slightly more than half of those sampled primarily speak English at home while 45% speak another language.
Table 5

Frequencies of Demographic Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Response</th>
<th>Frequency</th>
<th>%</th>
<th>Mean</th>
<th>SD</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poverty level (FPL)</td>
<td>Less than 100%</td>
<td>553</td>
<td>39.2</td>
<td>3.466</td>
<td>2.628</td>
<td>1409</td>
</tr>
<tr>
<td></td>
<td>100% to below 133%</td>
<td>190</td>
<td>13.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>133% to below 150%</td>
<td>61</td>
<td>3.6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>150% to below 185%</td>
<td>127</td>
<td>7.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>185% to below 200%</td>
<td>54</td>
<td>3.1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>200% to below 300%</td>
<td>152</td>
<td>8.8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>300% to below 400%</td>
<td>98</td>
<td>5.7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>At or above 400%</td>
<td>174</td>
<td>10.1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother born in U.S.</td>
<td>No</td>
<td>23</td>
<td>1.3</td>
<td>0.476</td>
<td>0.115</td>
<td>1714</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>1691</td>
<td>98.7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of children living at home</td>
<td>1</td>
<td>877</td>
<td>51.0</td>
<td>1.73</td>
<td>0.903</td>
<td>1718</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>522</td>
<td>30.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>211</td>
<td>12.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4 or more</td>
<td>108</td>
<td>6.3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of education</td>
<td>Less than high school</td>
<td>356</td>
<td>21.3</td>
<td>2.243</td>
<td>0.781</td>
<td>1669</td>
</tr>
<tr>
<td></td>
<td>High school graduate</td>
<td>551</td>
<td>33.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>More than high school</td>
<td>762</td>
<td>45.7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary language spoken at home</td>
<td>English</td>
<td>940</td>
<td>54.9</td>
<td>0.451</td>
<td>0.497</td>
<td>1713</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>773</td>
<td>45.1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 6 illustrates frequencies of four variables indicating social support, number of adults living in household, number of parents living in the household, whether or not the mother feels supported emotionally and whether or not her neighborhood is supportive. Approximately
58% of respondents reside with one other adult while 34% live with three or more adults. The majority of the mothers sampled lived with a co-parent while 26% lived alone. Approximately 67% of respondents report emotional support while 30 percent do not. Almost half the mothers sampled perceive their neighborhoods to be “somewhat supportive” compared to 11% who “definitely” perceive their neighborhood as unsupportive.

Table 6

*Frequencies of Social Support Variables*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Freq</th>
<th>%</th>
<th>Mean</th>
<th>SD</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of adults living in household</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>134</td>
<td>7.8</td>
<td>2.26</td>
<td>0.590</td>
<td>1717</td>
</tr>
<tr>
<td>2</td>
<td>1001</td>
<td>58.3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 or more</td>
<td>582</td>
<td>33.9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of parents living in household</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>450</td>
<td>26.2</td>
<td>0.262</td>
<td>0.439</td>
<td>1717</td>
</tr>
<tr>
<td>2</td>
<td>1267</td>
<td>73.8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>516</td>
<td>30.1</td>
<td>0.699</td>
<td>0.458</td>
<td>1715</td>
</tr>
<tr>
<td>Yes</td>
<td>1199</td>
<td>66.9</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 7 illustrates bivariate correlations related to included in each regression analysis. The table depicts statistically significant positive relationships between perceptions of children’s physical health and mothers’ self-reported mental health, relationship to the poverty level, mothers born in the United States, level of education and perceived emotional support. Negative, statically significant correlations exist between mothers’ perceptions of her children’s physical health and the number of children living at home, primary language spoken at home and both the number of adults and parents living in the household.

The table also illustrates statistically significant negative correlations between duration of breastfeeding and mothers born in the United States, primary language spoken at home and number of parents living in the household. Also, of statistical significance is the mothers’
birthplace, primary language spoken at home and number of parents living in the household.

Table 7

Correlations of Dependent Variable with each of the Independent Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Breastfed or Fed Breast Milk</th>
<th>Duration of Breastfeeding/ Fed Breast Milk</th>
<th>Perceptions of Child’s Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Reported Mental Health</td>
<td>.018</td>
<td>-.043</td>
<td>.354**</td>
</tr>
<tr>
<td></td>
<td>1716</td>
<td>1099</td>
<td>1716</td>
</tr>
<tr>
<td></td>
<td>(N)</td>
<td>(N)</td>
<td>(N)</td>
</tr>
<tr>
<td>Poverty level (FPL)</td>
<td>.043</td>
<td>-.007</td>
<td>.297**</td>
</tr>
<tr>
<td></td>
<td>1408</td>
<td>909</td>
<td>1408</td>
</tr>
<tr>
<td></td>
<td>(N)</td>
<td>(N)</td>
<td>(N)</td>
</tr>
<tr>
<td>Mother born in U.S.</td>
<td>-.079**</td>
<td>-.096**</td>
<td>.320**</td>
</tr>
<tr>
<td></td>
<td>1716</td>
<td>1096</td>
<td>1716</td>
</tr>
<tr>
<td></td>
<td>(N)</td>
<td>(N)</td>
<td>(N)</td>
</tr>
<tr>
<td>Number of children at home</td>
<td>.002</td>
<td>.007</td>
<td>-.094**</td>
</tr>
<tr>
<td></td>
<td>1716</td>
<td>1083</td>
<td>1716</td>
</tr>
<tr>
<td></td>
<td>(N)</td>
<td>(N)</td>
<td>(N)</td>
</tr>
<tr>
<td>Level of education</td>
<td>.046</td>
<td>.014</td>
<td>.318**</td>
</tr>
<tr>
<td></td>
<td>1667</td>
<td>1421</td>
<td>1667</td>
</tr>
<tr>
<td></td>
<td>(N)</td>
<td>(N)</td>
<td>(N)</td>
</tr>
<tr>
<td>Primary language spoken at home</td>
<td>-.076**</td>
<td>-.037**</td>
<td>-.358**</td>
</tr>
<tr>
<td></td>
<td>1711</td>
<td>1083</td>
<td>1711</td>
</tr>
<tr>
<td></td>
<td>(N)</td>
<td>(N)</td>
<td>(N)</td>
</tr>
<tr>
<td>Number of adults living in household</td>
<td>.031</td>
<td>.029</td>
<td>-.088**</td>
</tr>
<tr>
<td></td>
<td>1716</td>
<td>1083</td>
<td>1716</td>
</tr>
<tr>
<td></td>
<td>(N)</td>
<td>(N)</td>
<td>(N)</td>
</tr>
<tr>
<td>Number of parents living in household</td>
<td>-.074**</td>
<td>-.063*</td>
<td>-.063**</td>
</tr>
<tr>
<td></td>
<td>1715</td>
<td>1100</td>
<td>1715</td>
</tr>
<tr>
<td></td>
<td>(N)</td>
<td>(N)</td>
<td>(N)</td>
</tr>
<tr>
<td>Emotional support</td>
<td>-.024</td>
<td>.039</td>
<td>.266**</td>
</tr>
<tr>
<td></td>
<td>1713</td>
<td>1099</td>
<td>1713</td>
</tr>
<tr>
<td></td>
<td>(N)</td>
<td>(N)</td>
<td>(N)</td>
</tr>
<tr>
<td>Neighborhood support</td>
<td>-.005</td>
<td>.039</td>
<td>.032</td>
</tr>
<tr>
<td></td>
<td>1633</td>
<td>1044</td>
<td>1633</td>
</tr>
<tr>
<td></td>
<td>(N)</td>
<td>(N)</td>
<td>(N)</td>
</tr>
</tbody>
</table>

*p<0.05; **p<0.01; ***p<0.001
Analysis

**Ordinal Regression Models**

Table 6 presents three ordinal regression models predicting perceptions of children’s health among Hispanic mothers. The dependent variable, perceptions of children’s health, was reversed coded with four categories, thus higher values indicate better perceptions of child’s health. The categories are: fair, good, very good and excellent. It should be noted that self-reported mental health is statistically significant at the .001 level across all models, therefore mothers’ perceptions of their children’s physical health increase as their own mental health perceptions improve.

As evident in Table 7, Model 2 fits the data better than Models 1 and 3. A pseudo $R^2$ value of .237 indicates that Model 3 explains approximately 23% of the variation in perceptions of child’s health. Also, Model 2 has a $\chi^2$ 323, which is higher than the values for Models 1 and 3.

Five of the ten predictor variables are statistically significant in Model 2 and include: self-reported mental health, primary language, poverty and education level and whether or not the mother was born in the United States. Self-reported mental health and whether or not the mother was born in the United States appear to be the strongest predictors of mothers’ perceptions of their children’s physical health, both are statistically significant at the .001 level while primary, poverty and education level along with whether or not the mother was born in the United States are statistically significant at the .01 level and primary language is significant at the .05 level.

Model 2 demonstrates that mothers who self-report better mental health tend to view their children’s health more positively. For instance, with each increase in the level of self-reported mental health the odds of positively perceiving the child’s health, among those in the sample,
increases by .898 (1.898-1) holding all else constant, which is statistically significant at the .001 level.

Additionally, Model 2 illustrates a statistically significant relationship between education level and perceptions of child’s health. For example, for each additional level of education the odds of Hispanic mothers perceiving their child’s health more positively (less fair) increase .246 (1.246-1) holding all else constant, which is statistically significant at the .01 level. Also, the less impoverished a mother is the more likely they are to view their child’s health as good. For example, as indicated in Model 2 for each additional decrease in poverty level the odds of positively perceiving their child’s health, among the Hispanic mothers in the sample, is increased by .082 (1.082-1) holding all else constant, which is statistically significant at the .05 level.

Model 2 also demonstrates that of the mothers sampled the odds of those who primarily speak English are .303 (.697-1) times less likely to perceive their child’s health as fair compared to mothers who primarily speak another language holding all else constant. This is statistically significant at the .001 level.

Also, Hispanic mothers born in the United States are .49 (.510-1) times less likely to perceive their children’s health as fair compared to mothers born outside of the United States holding all else constant. This is indicated by an odds ratio of .510, which is statistically significant at the .001 level.

In summary, as illustrated by Model 2, a mother’s perception of her child’s physical health increases as her own mental health improves and demographic variables such as primary language, poverty level, education level and number of children living at home aids in this explanation more than variables measuring social support.
Table 8

**Ordinal Regression Estimates Predicting Perceptions of Child’s Physical Health among Hispanic Mothers: A Subsample of the National Survey of Children’s Health, 2003**

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Odds Ratio</td>
<td>B</td>
</tr>
<tr>
<td>Threshold 0</td>
<td>-2.42</td>
<td>.785</td>
<td>-1.220**</td>
</tr>
<tr>
<td></td>
<td>(.214)</td>
<td></td>
<td>(.351)</td>
</tr>
<tr>
<td>Threshold 1</td>
<td>1.840***</td>
<td>6.296</td>
<td>1.163***</td>
</tr>
<tr>
<td></td>
<td>(.200)</td>
<td></td>
<td>(.331)</td>
</tr>
<tr>
<td>Threshold 2</td>
<td>2.950***</td>
<td>19.105</td>
<td>-1.257***</td>
</tr>
<tr>
<td></td>
<td>(.208)</td>
<td></td>
<td>(.305)</td>
</tr>
<tr>
<td>Independent Variable</td>
<td>.784***</td>
<td>2.190</td>
<td>.641***</td>
</tr>
<tr>
<td>Self-reported mental health</td>
<td>(.053)</td>
<td></td>
<td>(.062)</td>
</tr>
<tr>
<td>Demographic Variables</td>
<td>- .360*</td>
<td>.697</td>
<td>-.349***</td>
</tr>
<tr>
<td>English Primary Language</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Reference=Other)</td>
<td>(.177)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poverty level</td>
<td>.079**</td>
<td>1.082</td>
<td>.063*</td>
</tr>
<tr>
<td></td>
<td>(.027)</td>
<td></td>
<td>(.028)</td>
</tr>
<tr>
<td>Education level</td>
<td>.220**</td>
<td>1.246</td>
<td>.177*</td>
</tr>
<tr>
<td></td>
<td>(.085)</td>
<td></td>
<td>(.087)</td>
</tr>
<tr>
<td>Mother born in U.S.</td>
<td>-.673***</td>
<td>.510</td>
<td>-.619***</td>
</tr>
<tr>
<td>(Reference=Other)</td>
<td>(.168)</td>
<td></td>
<td>(.172)</td>
</tr>
<tr>
<td>#Kids living</td>
<td>-.065</td>
<td>.933</td>
<td>-.089</td>
</tr>
<tr>
<td></td>
<td>(.060)</td>
<td></td>
<td>(.063)</td>
</tr>
<tr>
<td>Social Support Variables</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># Adults in household</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parenting support</td>
<td>-.219</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Reference=No support)</td>
<td>(.141)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family structure</td>
<td>.140</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Reference=2 Parent Family)</td>
<td>(.135)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*(table continues)*
Table 8 (continued).

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Model 1 B</th>
<th>Odds Ratio</th>
<th>Model 2 B</th>
<th>Odds Ratio</th>
<th>Model 3 B</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neighborhood support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-0.022</td>
<td>(0.062)</td>
<td>-0.022</td>
<td>(0.062)</td>
<td>0.978</td>
<td></td>
</tr>
<tr>
<td>-2 log likelihood</td>
<td>135</td>
<td>1,498</td>
<td>2,303</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Model $x^2$</td>
<td>234</td>
<td>323</td>
<td>293</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pseudo $R^2$</td>
<td>0.142</td>
<td>0.237</td>
<td>0.227</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>1,317</td>
<td>1,317</td>
<td>1,317</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p < .05   ** p < .01   *** p < .001 (one-tailed test)

Logistic Regression Model

Table seven presents three logistic regression models predicting the probability of breastfeeding among a sample of Hispanic mothers using several demographic and social support predictor variables. Consistently, as illustrated by each of the three models, self-reported mental health is not a significant predictor of whether or not a mother chooses to breastfeed.

It should be noted that Model 3 is a better fitting model than Models 1 and 2. First, Model 3 has a smaller -2 log likelihood of 1265.719 and a larger $x^2$ value of 34.401. Model 3 also demonstrates a pseudo $R^2$ of 0.041 therefore explaining approximately 4% of the variation in the likelihood of breastfeeding compared to Model 1 which explains only 0.1% and Model 2 which explains 3% of the variation.

Model 3 contains two statistically significant variables including education level and family structure. As illustrated, the more education a mother has the more likely she is to breastfeed. Specifically, an odds ratio of 1.295 illustrates that with each increase in one’s level of education the predicted odds of breastfeeding increases by a factor of 0.295 holding all else constant. (1.295 - 1 = 0.295). Education is statistically significant at the .05 level.

Model 3 also shows that family structure, specifically the number of parents living in the
household has a statistically significant impact on whether or not those sampled breastfed. For example, the logged odds of breastfeeding among mothers living single parent households is .356 less than those living in two parent households and is statistically significant at the .05 level. Specifically, mothers living in single parent households are 64% less likely than those mothers living in two parent households to breastfeed.

In conclusion, one’s social structure, specifically emotional and community support, is a greater predictor of whether or not one breastfeeds than self-reported mental health.

Table 9

*Logistic Regression Estimates Predicting Breastfeeding among Hispanic Mothers—a subsample of the National Survey of Children’s Health*

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Model 1 B</th>
<th>Odds Ratio</th>
<th>Model 2 B</th>
<th>Odds Ratio</th>
<th>Model 3 B</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Independent Variable</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-reported mental health</td>
<td>.063</td>
<td>1.065</td>
<td>-.044</td>
<td>1.045</td>
<td>.046</td>
<td>1.047</td>
</tr>
<tr>
<td></td>
<td>(.074)</td>
<td></td>
<td>(.078)</td>
<td></td>
<td>(.079)</td>
<td></td>
</tr>
<tr>
<td><strong>Demographic Variables</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>English Primary Language (Reference=Other)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poverty level</td>
<td>.081*</td>
<td>1.084</td>
<td>.064</td>
<td>1.066</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(.033)</td>
<td></td>
<td>(.035)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education level</td>
<td>.254*</td>
<td>1.289</td>
<td>.258*</td>
<td>1.295</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(.113)</td>
<td></td>
<td>(.114)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother born in U.S. (Reference=Other)</td>
<td>.386</td>
<td>1.471</td>
<td>.358</td>
<td>1.431</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(.222)</td>
<td></td>
<td>(.224)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>#Kids living</td>
<td>.045</td>
<td>1.046</td>
<td>.030</td>
<td>1.031</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(.079)</td>
<td></td>
<td>(.080)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Social Support Variables</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># Adults in household</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parenting support (Reference=No support)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>.064</td>
<td>1.066</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(.197)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*(table continues)*
Table 9 (continued).

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Model 1</th>
<th></th>
<th>Model 2</th>
<th></th>
<th>Model 3</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Odds</td>
<td>B</td>
<td>Odds</td>
<td>B</td>
<td>Odds</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ratio</td>
<td></td>
<td>Ratio</td>
<td></td>
<td>Ratio</td>
</tr>
<tr>
<td>Family structure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-.356*</td>
<td>.427</td>
</tr>
<tr>
<td>(Reference=2 Parent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(.166)</td>
<td></td>
</tr>
<tr>
<td>Family)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neighborhood support</td>
<td></td>
<td>-.006</td>
<td></td>
<td>.994</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constant</td>
<td>1.170***</td>
<td>-.084***</td>
<td>-.330</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(.299)</td>
<td>(.427)</td>
<td>(.522)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-2 log likelihood</td>
<td>1299.409</td>
<td>1271.114</td>
<td>1265.719</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Model $x^2$</td>
<td>.711</td>
<td>29.005</td>
<td>34.401</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pseudo $R^2$</td>
<td>.001</td>
<td>.035</td>
<td>.041</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Degrees of Freedom</td>
<td>1</td>
<td>6</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>1,317</td>
<td>1,317</td>
<td>1,317</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* $p< .05$  ** $p< .01$  *** $p< .001$ (one-tailed test)

Ordinary Least Squares Regression Models

Table 10 presents three ordinary least squares regression models predicting breastfeeding behavior among Hispanic mothers sampled. Model 3 explains more of the variance, approximately 2.2%, in the duration of time breastfeeding among Hispanic mothers when taking into account self-reported mental health, primary language spoken at home, poverty and education level, whether or not the mother is native to the United States, number of kids and adults living in the household, family structure, parenting and neighborhood support compared to the first two models. This is indicated by an $R^2$ of .022. Model 1 illustrates that self-reported mental health is statistically significant at the .01 level while Models 2 and 3 are significant at the .05 level.

In all three models only self-reported mental health was statistically significant. This indicates that the mother’s mental health is a stronger predictor of the duration of breastfeeding
than numerous demographic and social support variables including: primary language, poverty level, education level and emotional and community support. As indicated by Model 3, as self-reported mental health increases so does the duration of breastfeeding. For example, every one level increase in self reported mental health the duration of breastfeeding increases by 2.558 days, holding all else constant.

Table 10

*Estimates of OLS Regression Models Predicting Mothers’ Duration of Breastfeeding*

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Constant</strong></td>
<td>15.534**</td>
<td>13.648*</td>
<td>16.452</td>
</tr>
<tr>
<td></td>
<td>(4.902)</td>
<td>(6.217)</td>
<td>(8.787)</td>
</tr>
<tr>
<td><strong>Independent Variable</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-reported mental health</td>
<td>3.318**</td>
<td>2.490*</td>
<td>2.558*</td>
</tr>
<tr>
<td></td>
<td>(1.205)</td>
<td>(1.252)</td>
<td>(1.259)</td>
</tr>
<tr>
<td><strong>Demographic Variables</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>English Primary Language (Reference=Other)</td>
<td>5.773</td>
<td>5.220</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(3.610)</td>
<td>(3.682)</td>
<td></td>
</tr>
<tr>
<td>Poverty level</td>
<td>.712 (.532)</td>
<td>.477 (.547)</td>
<td></td>
</tr>
<tr>
<td>Education level</td>
<td>-.012 (.811)</td>
<td>-.208 (1.817)</td>
<td></td>
</tr>
<tr>
<td>Mother born in U.S. (Reference=Other)</td>
<td>-2.785</td>
<td>3.269</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(3.399)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#Kids living</td>
<td>.678 (1.271)</td>
<td>-.506 (1.276)</td>
<td></td>
</tr>
<tr>
<td><strong>Social Support Variables</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parenting support (Reference=No support)</td>
<td>4.057</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(2.995)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*(table continues)*
Table 10 (continued).

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Model 1</th>
<th></th>
<th>Model 2</th>
<th></th>
<th>Model 3</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>β</td>
<td>B</td>
<td>β</td>
<td>B</td>
<td>β</td>
</tr>
<tr>
<td>Family structure</td>
<td>-.5241</td>
<td>(2.790)</td>
<td>-.061</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Reference=2 Parent Family)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neighborhood support</td>
<td>-1.330</td>
<td>(1.241)</td>
<td>-.033</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R²</td>
<td>.007</td>
<td>.015</td>
<td>.022</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>7,581</td>
<td>2,648</td>
<td>2,323</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>1,060</td>
<td>1,060</td>
<td>1,060</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p< .05  ** p< .01  *** p< .001 (one-tail)

Summary

In conclusion, three hypotheses were tested. The first predicted that depressed Hispanic mothers are more likely to have poor perceptions of their child’s physical health compared to non-depressed Hispanic mothers. This statement is supported in the data, as evident in Table 7.

The second hypothesis predicting the likelihood of breastfeeding among depressed Hispanic mothers is rejected because the relationship between breastfeeding and self-reported depression is not statistically significant. The lack of statistical significance is depicted in all three logistic regression models (refer to Table 6).

The third hypothesis predicted that depressed Hispanic mothers are less likely to breastfeed for at least one year compared to non-depressed Hispanic mothers. The data does support the hypothesis, as illustrated in Table 5, explaining that the more positively a mother perceives her mental health the longer she breastfeeds.

The quantitative findings are explained within the theoretical framework presented in chapter 6. In-depth interviews with self-reported depressed Mexican American adolescent and adult mothers assist with the interpretation of breastfeeding behavior and mothers’ perceptions of
their children’s physical health among Hispanic mothers in general. Chapter 5 examines the pregnancy and motherhood within the context of depression as it is experienced by Mexican American adolescent and adult mothers.
CHAPTER 5

QUALITATIVE RESULTS

Sample Characteristics

*Characteristics of Adolescent Mothers*

Six self-reported depressed Mexican American adolescent mothers, ranging in age from 14 to 18, were interviewed and compared to an adult sample of six self-reported depressed Mexican American mothers ranging in age from 22-35. Both groups were interviewed twice. All adolescent participants spoke fluent English, and five were born in the United States. Only one of the teen mothers reported health-related complications during pregnancy. Five of the adolescent mothers sampled initiated breastfeeding, ranging from a few weeks to almost a year.

Before the initial interview, each participant completed an Edinburgh Postnatal Depression Scale (EPDS), the most common screening instrument used in both clinical and research settings (Boyd et al., 2005). The EPDS scale ranges from 0–30 with a score of 10 or greater indicating possible depression and 13 or greater signifying an increased likelihood of depressive illness of varying severity (Cox, Holden, & Sagovsky, 1987). Although participants were self-identified as depressed, only two of the adolescent mothers scored 10 or greater suggesting that they were less depressed than the adult mothers interviewed. At the time of the interviews, one adolescent mother was married and without exception participants identified their babies’ fathers as supportive and actively engaged in their lives (see Table 1). Both adolescent and adult mothers were asked questions aimed at uncovering partner support such as, “How does your partner deal with you being sad or upset?” and “What could your partner do to help you when you are feeling sad or upset?”
Other notable characteristics of the adolescent mothers interviewed include: four had vaginal births; none of the mothers were employed at the time of the interviews; all were full-time high school students; none had planned their pregnancies and all but one had plans to attend college.

Table 11

*Demographic Table Adolescent Mothers*

<table>
<thead>
<tr>
<th>ID #</th>
<th>Age</th>
<th>Marital Status</th>
<th># of Children</th>
<th>Birth Place</th>
<th>Age of Baby</th>
<th>Pregnancy Complications</th>
<th>Breastfed</th>
<th>EPDS Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lydia</td>
<td>18</td>
<td>Never Married</td>
<td>1</td>
<td>US</td>
<td>5 mo</td>
<td>No</td>
<td>Yes</td>
<td>5</td>
</tr>
<tr>
<td>Maria</td>
<td>14</td>
<td>Never Married</td>
<td>1</td>
<td>US</td>
<td>3 mo</td>
<td>No</td>
<td>No</td>
<td>1</td>
</tr>
<tr>
<td>Rosa</td>
<td>17</td>
<td>Married</td>
<td>1</td>
<td>US</td>
<td>12 mo</td>
<td>No</td>
<td>Yes</td>
<td>9</td>
</tr>
<tr>
<td>Anna</td>
<td>17</td>
<td>Never Married</td>
<td>1</td>
<td>US</td>
<td>4 mo</td>
<td>Yes</td>
<td>Yes</td>
<td>13</td>
</tr>
<tr>
<td>Michelle</td>
<td>15</td>
<td>Never Married</td>
<td>1</td>
<td>MX</td>
<td>2 mo</td>
<td>No</td>
<td>Yes</td>
<td>5</td>
</tr>
<tr>
<td>Dora</td>
<td>17</td>
<td>Never Married</td>
<td>1</td>
<td>US</td>
<td>2 mo</td>
<td>No</td>
<td>Yes</td>
<td>11</td>
</tr>
</tbody>
</table>

*Characteristics of Adult Mothers*

Four of the adult mothers interviewed were native to the United States and English speaking, while the remaining two spoke only Spanish and were born in Mexico. All of the adult mothers scored 13 or greater on the EPDS. Scores ranged from 13–23 with a mean of 19. Two of the adults interviewed reported health-related complications during pregnancy. Three of the adult mothers initiated breastfeeding, which ranged from a few weeks to approximately 9 months. Also, three of the adult participants identified themselves as married while four reported having supportive co-parents (see Table 2).

Compared to the adolescent mothers, four adult participants had cesarean births; five of the six births were unplanned; one mother completed some college; three had completed high
school; four expressed the desire to attend college; and one was employed at the time of the interviews.

Table 12

*Demographic Table of Adult Mothers*

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Marital Status</th>
<th># of Children</th>
<th>Birth Place</th>
<th>Age of Baby</th>
<th>Pregnancy Complications</th>
<th>Breastfed</th>
<th>EPDS Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patricia</td>
<td>20</td>
<td>Never Married</td>
<td>1</td>
<td>US</td>
<td>9 mo</td>
<td>No</td>
<td>No</td>
<td>17</td>
</tr>
<tr>
<td>Jana</td>
<td>22</td>
<td>Married</td>
<td>1 and 2 step children</td>
<td>US</td>
<td>5 mo</td>
<td>Yes</td>
<td>Yes</td>
<td>17</td>
</tr>
<tr>
<td>Angie</td>
<td>27</td>
<td>Married</td>
<td>3</td>
<td>MX</td>
<td>9 mo</td>
<td>No</td>
<td>Yes</td>
<td>13</td>
</tr>
<tr>
<td>Silvia</td>
<td>35</td>
<td>Married</td>
<td>3</td>
<td>MX</td>
<td>12 mo</td>
<td>No</td>
<td>Yes</td>
<td>21</td>
</tr>
<tr>
<td>Mary</td>
<td>23</td>
<td>Never Married</td>
<td>1</td>
<td>US</td>
<td>12 mo</td>
<td>Yes</td>
<td>No</td>
<td>23</td>
</tr>
<tr>
<td>Joanna</td>
<td>20</td>
<td>Never Married</td>
<td>2</td>
<td>US</td>
<td>3 mo</td>
<td>No</td>
<td>No</td>
<td>20</td>
</tr>
</tbody>
</table>

*Key Demographic Distinctions*

As indicated by the disparity between EPDS scores and across both groups, adolescent mothers scored significantly lower than the adult mothers, indicating that teens reported less depression than adult mothers did. Although few adolescent mothers appear depressed, several factors may explain this finding. First, currently not one screening instrument is designed specifically to measure postpartum depression in adolescent mothers (DeRosa, 2006). Thus, the questions that measure depression may reflect adult mother depression symptoms. For example, there are currently three categories of depression-screening instruments: (1) instruments designed to detect general depression, (2) instruments specific to children and adolescents, and (3) postpartum depression instruments (DeRosa, 2006). Thus, it possible to miss symptoms of postpartum depression unique to adolescent mothers. Second, screening should be conducted at various times during postpartum. A single measure of depression at one time may be inadequate
because of the higher rates of postpartum clinical depression compared to rates of postnatal depression found among teen mothers compared to adult mothers (Lanzi et al., 2009). Third, fear associated with written documentation of depression can prevent adolescent mothers from identifying depressive symptomology as measured by questions included in depression scales (Gosdin, 2005).

Only one of the adolescent mothers was married compared to three of the adult mothers interviewed. Five adolescent mothers lived with their families, and often included extended family members. Although family support is often considered a buffer from depression for Mexican American adolescent mothers, it may lead to conflict, which increases stress and depression.

**Breastfeeding Behavior**

The demographic information obtained from both groups of mothers also indicates that five adolescent mothers compared to three adult mothers attempted breastfeeding. This was somewhat unexpected considering studies have reported numerous barriers to breastfeeding common to adolescents including embarrassment, pain, and inconvenience (Wambach & Koehn, 2004).

Additionally, as indicated earlier, all of the adolescent participants were first-time mothers compared to three of the adults interviewed. Research shows a correlation between the number of children living at home and increased rates of depression (Zayas et al., 2002). However, the transition into motherhood, especially among first-time adolescent mothers, is difficult and goes against societal expectations, thus increasing the risk of depression (Lanzi et al., 2009).

It should also be noted that the majority of both adolescent and adult mothers were native
to the United States, thus issues pertaining to acculturation are explored throughout this chapter including the relationship between depression and intergenerational conflict, stigma associated with teen pregnancy and motherhood, expectations of motherhood, gender roles, and resistance to the myth of true motherhood. Additionally, reactions, perceptions, and meanings attached to depression are explored through the individual experiences of adolescent and adult mothers.

Data from in-depth interviews with adolescent mothers are compared to those of adult mothers that highlight the differences and commonalities shared between the two groups of Mexican American mothers. Major themes (see Table 3) common to both groups of mothers are explored in great detail while specific manifestations of depression and experiences associated with pregnancy, motherhood, and sociocultural attitudes of mental health are compared and contrasted throughout the remainder of this chapter.

Table 13

Major Themes

<table>
<thead>
<tr>
<th>Major Themes</th>
<th>Adolescent Mothers</th>
<th>Adult Mothers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fragmented Identity and Depression</td>
<td>Stigma of depression and teen motherhood</td>
<td>Stigma of depression</td>
</tr>
<tr>
<td>• Internal struggle between cultures</td>
<td>• Stigma of depression and teen motherhood</td>
<td></td>
</tr>
<tr>
<td>• Stigma of teen motherhood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unplanned Pregnancy and Depression</td>
<td>Fear and shame</td>
<td>Disappointment and guilt</td>
</tr>
<tr>
<td>• Shock of pregnancy</td>
<td>• Fear and shame</td>
<td></td>
</tr>
<tr>
<td>• Partners’ reactions</td>
<td>• Disappointment and guilt</td>
<td></td>
</tr>
<tr>
<td>• Mothers’ reactions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Disconnect between pregnancy and its consequences</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Body Image and Depression</td>
<td>Fixation of partner and peer reactions to weight gain</td>
<td>Self-imposed preoccupation with weight gain</td>
</tr>
<tr>
<td>• Partners’ reactions to weight gain</td>
<td>• Fixation of partner and peer reactions to weight gain</td>
<td></td>
</tr>
<tr>
<td>• Mothers’ perceptions of weight management</td>
<td>• Self-imposed preoccupation with weight gain</td>
<td></td>
</tr>
<tr>
<td>• Overall appearance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*(table continues)*
Table 13 (continued).

<table>
<thead>
<tr>
<th>Family Conflict and Depression</th>
<th>Adolescent Mothers</th>
<th>Adult Mothers</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Complexities of mother/daughter relationship</td>
<td>Desire to protect</td>
<td>Desire to protect</td>
</tr>
<tr>
<td>- Feeling torn between partner and family</td>
<td>mother from depressive</td>
<td>partner from depressive</td>
</tr>
<tr>
<td></td>
<td>feelings</td>
<td>feelings</td>
</tr>
<tr>
<td>Medicalization of Childbirth and Depression</td>
<td>Minimal impact</td>
<td>Significant impact</td>
</tr>
<tr>
<td>- Cesarean Births versus Natural Births</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Buffers to Depression</td>
<td>Family support</td>
<td>Partner support</td>
</tr>
<tr>
<td>- Supportive families</td>
<td>emphasized</td>
<td>emphasized</td>
</tr>
<tr>
<td>- Supportive partners</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Fragmented Identity

The findings presented in this chapter show the ways in which young motherhood, primarily a social construct that involves a gap between expectations and reality, creates tension resulting in a fragmented identity. With the exception of one adult participant, all pregnancies were unplanned thus the shock coupled with reactions from partners and family members created a foundation in which identity fragmentation forms. Unplanned pregnancy creates a state of normlessness where young mothers are expected to transform themselves from teenager to mother with little to no direction. The transition into motherhood is met with resistance and fear, which creates a fragmented identity composed of internal struggles among cultures, stigma of teen motherhood, weight gain and body image, family conflict, and among adult mothers the medicalization of childbirth. The cumulative effect of each aspect of fragmented identity contributes to postpartum depression among Mexican American adolescent and adult mothers.

The concept of fragmented identity expounds on previous studies that report depressed mothers struggle on many fronts including adjusting to a new identity requiring renegotiation
(Edhborg et al., 2005). “Mothers are overwhelmed with failure, guilt, disappointment, worry, loneliness, uncertainty, bereavement, and unfulfilled expectations and they struggled with life related to self, the child, and the partner” (Edhborg et al., 2005, p. 261–267). As Mexican Americans transition to motherhood, often they confront poverty, discrimination, and low educational attainment thus increasing depressive symptoms (Brown, Elder, & Meadows, 2007). Depression in both groups stemmed from a fragmented identity that must be examined through the intersection of Mexican American culture and American society.

Internal Struggle between Cultures

Motherhood among self-reported depressed Mexican American adolescent and adults is embedded within Mexican American culture. However, because of acculturation, mothers are heavily influenced by American culture, therefore creating an internal struggle between two ways of life while desiring acceptance of both. This struggle is best explained as a resistance to the “Myth of Motherhood,” coined by feminist scholars (Braverman, 1989), and can be applied to postpartum depression. The Myth of Motherhood refers to the idea that women are expected to become mothers at some point in their lives, and that mothers are held to an unrealistic standard. Mothers, more than fathers, are supposed to be self-sacrificing, placing their children above themselves, also referred to as the ideology of intensive mothering (Hayes, 1996). Mothering and femininity are closely linked in American society with a collective sentiment reflecting nurturing behavior as an exclusive, innate characteristic of all women. The Myth of Motherhood serves as a barrier, preventing women from accessing the same opportunities as men. Recognizing the commonly accepted ideals about motherhood establishes a framework to analyze the experiences of self-reported depressed Mexican American mothers compared to adult Mexican American mothers.
Both adolescent and adult mothers revealed how traditional Mexican values combined with American culture shape their expectations and social identities. Interviews reveal how acculturation influences gender roles and adds to the frustration they experience in trying to negotiate their new identities. Differences between adolescent and adult mothers are highlighted throughout the narratives presented next.

All adolescent mothers expressed that their partners are supportive of both them and their babies while the majority of the married adult mothers interviewed mirrored the sentiment. Without exception, adolescent mothers are more likely to characterize their partners as supportive while expressing frustration with their situations. Adult mothers, however, were polarized according to marital status. While labeling their partners as supportive, the adolescent mothers gave contradictory evidence. Without exception, adolescent mothers and married adult mothers stated that their partners were supportive. However, they were frustrated and disappointed because they assumed most of the childcare and housekeeping responsibilities.

All of the adolescent mothers were frustrated with the traditional gender roles placed on them although they did not appear to fully understanding the extent and impact of their gendered lives or the source of their frustration. Lydia, a 10th grade high school student, and mother of a 5-month-old girl, believed that her boyfriend made sacrifices for the baby. With some hesitation, she said, “I think yes because he has to drop out to help us out. And he’s just been there for me. He helps to take care of the baby.” When asked if her boyfriend interacts with the baby much, she explained:

Yeah, he feeds her and plays with her. Even sometimes when she is crying he just sits there, I say she’s crying try and do something different with her. He just thinks that playing with her is going to solve everything….

Lydia also confided that her boyfriend, although supportive, is having a difficult time providing
financially for the baby because he has a criminal record and is unable to find a stable job. Lydia’s contradictory statement about her boyfriend’s parenting role and support is not uncommon among the teen mothers. Seventeen-year-old Rosa, who lives with her family and her husband’s family, also described her husband as very interactive with their baby. For example, she reported: “Yeah, on the weekends he’s with her all the time. So he plays with her all of the time.” Another teen mother, Michelle, admitted that her partner has always worked a lot even during her pregnancy thus making motherhood more difficult. When asked if they spent time together during the pregnancy she reported:

No, not that much because he was working out of state. So I didn’t get to spend that much time. It’s been hard because he’s always been here for the baby so it’s been kind of hard because I am like the father and mother at the same time. Not literally, but I am. Like I take care of her and always take care of the baby. But he like supports me economically he does. Like he’s going to work this month, but the next month he’s going to be here. He just wanted to go out of state because they pay better over there. So, we would have money earned up.

Evidence of an internal struggle between two cultures is also illustrated in the expectations and future goals shared by adolescent mothers. Eighty-three percent of teen mothers included attending college as part of their future, although often unsure about how to achieve their goals. For example, 17-year-old Dora explained her strong desire to have a career. She reported, “I never wanted to have kids. So, that was weird. I always wanted to be a career woman and have my own house and work, just have a big business or have a good job and not worry about kids. I was always saying I’m not having kids, I’m not having kids!” Dora further described uncertainty about her future goals. She reported, “I still want a career…I’m going to have to go to a community college…but I would rather go to a big college like out of state, but I don’t want to leave my baby with my mom or leave my boyfriend alone with the baby because he doesn’t know what to do….” Dora felt torn between achieving career success while balancing
motherhood. Dora like other adolescent participants exhibited a fragmented identity, which resulted in depression.

**Adult Mothers**

Married adult mothers described their husbands as supportive whereas single adult mothers often elaborated on the uncooperativeness of the fathers of their children. As consistent with previous research, a lack of partner support is an important factor in the development of postpartum depression (Henshaw & Cox, 1995).

For instance, Mary, a 23-year-old single mother, said that her baby’s father did not care that she was pregnant, and although he told her he would support her, he did not. Mary explained, “He was pretty neutral, it was either way. He suggested I do whatever I wanted to do. He said he would be supportive, but that didn’t last long. I think I told him and about a month later we didn’t have any communication with each other.” She also stated that he was there for the birth of the baby, but the only support he ever gave her was buying a crib and he has had no contact with their son.

Patricia, another unwed mother, age 20, explained that her partner ignored her most of the time. “When I was pregnant he never paid attention to me. He preferred going out with his friends and leaving me at home and that made me feel like so depressed.”

Previous research demonstrates how both adolescent and adult Mexican American mothers are at higher risk of developing postpartum depression because of social isolation, lack of partner support, and difficulties associated with acculturation (Beeber, 2003). Participants in both groups demonstrate the relationship among social isolation, perceived social support, and adherence to traditional gender roles. Jana, a 22-year-old stay-at-home mother, discussed her feelings of depression associated with social isolation. She reported, “There are some days where
I just sit at home because I stay at home with the baby. I told my husband that sometimes it just gets the best of me.”

Another adult mother, Joanna, who quit high school to be at home with her two children, also expressed boredom and isolation resulting in depression. “I spend all day with them. When I’m in one room and then one’s over there running over there, I gotta put him down and go get him and, I gotta give him a bath and come back and put his clothes on and the other one and take him a bath.”

Adult mothers also expressed depressive feelings when they discussed their future goals, indicating fragmented identity caused by role conflict. For instance, Joanna discussed what her life could have been without children. She described, “I probably would have been graduated. I would have graduated from school, been in college, living on my own, had a car. And you know I didn’t graduate because when I got pregnant I dropped out.” Joanna, like the remaining 66% of adolescent mothers who expressed the desire to attend college, believes that getting pregnant and having babies interrupted their lives in such a way that they feel trapped. Jana, who describes herself as a former professional dancer, described her life as a mother. She said, “For 7 years before my pregnancy, I danced professional in Salsa and Mambo…so when I found out I was pregnant I had to stop.” She further explained her plans for a career change. She reported, “I want to go back to school to study professional education…I have been at a community college, but stopped for a while, put that on hold.”

As illustrated here, both adolescent and adult mothers indicated dissatisfaction with their new roles. One reason was the lack of parenting support dictated by traditional gender roles, which also contributed to a fragmented identity. Additionally, depression among adolescent mothers forms when their expectations do not correspond with the reality of the situation. For
example, five adolescent mothers and five adult mothers expressed disappointment with their current situations. Adolescent mothers illustrated a desire to finish high school as soon as possible and attend college and adult mothers expressed the desire to find jobs to contribute to their household income, to learn English, and attend college or trade school. In sum, the desire to meet the many needs of their families both emotionally and economically highlight the internal struggle between upholding traditional values while adhering to American expectations and definition of success.

Stigma of Teen Motherhood

Stigma connected to teen motherhood is another factor associated with the fragmented identities of adolescent participants and contributes to depression. Without exception, adolescent mothers expressed shamefulness about getting pregnant at such a young age because of the negativity attached to teen motherhood. For example, Anna, a 17-year-old mother living with her parents, described feeling conflicted about becoming a mother. She explained:

So, I didn’t know how to feel, I felt embarrassed. I can say I was embarrassed. I felt embarrassed of being a young mom and how everyone would treat me. “I just felt really depressed. I didn’t know how to feel, if I should feel happy or sad. I just didn’t know how to accept it and sometimes I just didn’t want to be around my baby. But then I got better.

Anna’s story is similar to the majority of teen participants and reveals the stigma of teen motherhood. Without exception, the teens interviewed felt stigmatized by family, friends, peers, and society in general. Anna believed that her parents blamed her for setting a bad example for her younger sister. “Everything was put on me. Like everything that my younger sister did and she would get in trouble they would say she was doing that because she’s trying to copy you. That would upset me because I was doing good in school.”

Anna also explained how she felt judged by her peers for being a young mother and made an example of what not to do by her family:
I messed up but I am doing better. It’s just things that upset me was like people talked behind my back. I just didn’t feel like they should do that. When asked who was talking about her she said, just overall people around the school and friends that use to be friends of mine.

Anna’s comments further illustrate how teen mothers are stigmatized, which further fragmented the participant’s identities. For instance, 17-year-old Dora, mother to a 2-month-old son, explained the difficulties of teen motherhood by demonstrating how young mothers are often misunderstood. She also illustrated the challenges of teen motherhood compared to parenting as an adult. She explained:

When you are older I guess you have more time to do things with your baby. Because you are already grown, people look at you like you’re older you can do it. You know how to do things. And when you are younger people look at you and say oh wow that’s a young mom and she’s not a good mother. Or whenever, I go to the store and I am with my baby people stare and wonder if that’s her son. They stare at him too because they are trying to see if I have him in a jacket or something so they try to see if I am being a good mom.

In addition to feeling constant surveillance, Dora also explains her frustration about feeling criticized by strangers. Feeling judged by everyone they meet lowers maternal competency and contributes to depressive symptoms. Many of the teen mothers felt the need to justify all parenting decisions and to accept unsolicited advice, which fragmented their identities and led to depression. Dora explained:

Sometimes it bothers me because they are like oh my gosh, she has a baby. It makes me feel good because I know that I am feeding him and changing him and doing all that I can. I mean I know what I am doing. They think oh it’s your fault you have to do it, you have to learn. And with older moms, it’s like oh you have a baby oh it’s so cute. They don’t ever ask you oh how old are you? Or say oh you’re so young and I’m like yeah, just have to have a big smile on my face all of the time. I’m like I know she’s going to ask me.

Inconsistent with previous research, and without exception, Mexican American teen mothers expressed feeling stigmatized by motherhood, which fragmented their identities and placed them at risk for depression. The literature highlights stigma as it is experienced by non-
Hispanic White adolescent mothers, but rarely acknowledges the affects on Hispanic mothers. For instance, one study found that reports of stigma are more common among Whites compared to Mexican American teen mothers (Wiemann et al., 2005). Research also illustrates a connection between social stigma and mental health, specifically stating that a stigmatized identity often leads to negative outcomes including depression and social isolation (Wiemann et al., 2005).

The stigmatized identity as experienced by adolescent mothers was not shared by adult mothers. Although adult mothers experienced depression resulting from a fragmented identity, they did not mention feeling stigmatized for getting pregnant, with the exception of a few unmarried adult mothers. For example, Joanna said that the news of her pregnancy created conflict in her relationship with her mother because she was not married. She said, “With my first one, it was … my mom started crying. We didn’t talk for a couple of months. I just stayed to myself. And then she…I guess she got the point that there’s nothing we could do about it and she helped me through everything.” Mary, who is also unmarried, said that she felt judged when she shared the news of her pregnancy and “that no one would have ever thought that I would end up pregnant.”

Unplanned Pregnancy and Depression

Studies have shown that approximately one-third of all pregnancies are unplanned (Zahumensky et al., 2008). Research also indicates that the majority of unplanned pregnancies occur among young, single mothers with lower education levels (Zahumensky et al., 2008). Consistent with previous studies, approximately 91% of the births in this study were unplanned and unexpected. The findings from this study showed that the timing of births was significantly related to depressive symptoms. One important aspect of the pregnancy timing was the shock
and disbelief of the pregnancy. A representative comment was, “I cannot believe that I am pregnant.” For instance, 18-year-old Lydia, who was in the 10th grade, and reported a moderate EDS score, reported reactions upon discovering the pregnancy. She reported, “I was shocked, I was scared. I didn’t know what my mom was going to think. I did not know what I was going to do with a baby at this age.”

Lydia, also paused, and noted, “I took two pregnancy tests because I could not believe that I was pregnant.” Similarly, Michelle, age 19, was born in Mexico and delivered a healthy baby boy with a moderate EDS score, remarked, “…At first, I did not believe it. It was just like, whatever. I don’t think I can believe it, and then after meditating on it, well I did something wrong, but I cannot do anything about it.” Finally, Dora, age 17, explained her boyfriend’s reaction to a positive pregnancy test. She stated, “My boyfriend said, ‘I do not believe it. Show me the pregnancy test.’”

Research has shown that often an initial shock of an unexpected event leads to depression (Bouchard, 2005). However, in this study, depression was related to informing family members and the stigma attached to an unwed pregnancy. Like the adolescent mothers, single adult mothers revealed a similar reaction to their pregnancies, whereas the married adult mothers did not. For example, Jana, who was pregnant before she got married, explained, “I was overwhelmed. I knew my parents were absolutely going to freak out because I was not married at the time…so it was a huge shock. I was freaking out and I didn’t know how or where to start to tell them, not only because I was young but I wasn’t married.” Another unmarried mother, Mary, reported a similar reaction. She reported, “I was scared and very surprised.”

These comments demonstrated that the discovery of pregnancy might be a defining factor for teens and for adult mothers. Perhaps the tendency of teens to separate sex from pregnancy
may be a consequence of the media portrayal of sexual fulfillment. Indeed, studies have shown that the media depicts sexual intercourse in a misleading way and adolescents are inundated with between 10,000 and 15,000 sexual references each year (Strasburger, 2005).

Another factor may be the lack of sexual education. Studies have shown that the lack of sex education and focus on abstinence-only programs are ineffective in reducing sexual activity among teens (Kirby, 2007). Programs that focus on abstinence and contraception are more effective in either delaying sexual activity or improving contraceptive use (Kirby, 2007). The disbelief and shock experienced by both groups of mothers indicate a lack of understanding regarding sex and pregnancy. Narratives illustrate how unplanned pregnancy contributes to identity fragmentation among Mexican American adolescent and adult mothers and marks the beginning of powerlessness leading to role captivity and depressive symptoms.

Partner’s Reactions and Role Captivity

As illustrated by the previous statements, an unplanned pregnancy results in depression and is in the center of a power struggle among many conflicting forces including their parents, partners, and extended families. Unplanned pregnancy contributes to depression when one’s voice is ignored. Adolescent and adult mothers expressed evidence of role captivity, which occurred immediately upon revealing their pregnancies.

Teen mothers expressed throughout the interviews that decisions were made for them and reported mixed feelings about their voices not being heard. It was clear that their partners had more of a say in their decisions than they did. For example, 17-year-old Rosa, who was recently married, explained how working at a fast food restaurant was her main social outlet until she was told to quit. She said, “Well, I use to work, but I stopped working cause my boyfriend didn’t want me to work. He wanted me to spend more time with the baby and be there for her until
she’s like 3 years old.” Rosa also explained how her coworkers really wanted her to go back to work, but she could not. When asked if she does anything else for fun she said, “Well, I use to party but that went away too.” Rosa’s comments demonstrate how her life was controlled by a baby and her schedule was arranged by her boyfriend. Moreover, she was frustrated by how her leisure activities are now nonexistent. She also explained that when she first told her boyfriend that she was pregnant he did not believe it, and that she had to prove it by showing him the pregnancy tests. She explained, “He thought about it for a while and said that I needed to have that baby.” Rosa’s comments illustrate that the decision of whether or not to keep the baby was not hers to make.

Fifteen-year-old Michelle explained a similar situation when her 20-year-old boyfriend learned that she was pregnant. She described, “Well, he told me the same thing that my mother-in-law did that we already did it and that we can’t go back. So, he was like we’ll just get married and take care of the baby together.”

Another teen mother, 17-year-old Dora, explained that she thought about abortion and adoption. She reported:

I know abortion is out there but I don’t like the idea of people killing something that’s not been born but my boyfriend didn’t want to give it up for adoption. He wanted the baby and said he would help me out; he wanted to get married when I was pregnant but I told him I would rather wait until I was 18. [Immediately following her explaining that she wanted to wait, she went on to say that] they are trying to get married through court and then later on we are going to Mexico to get married in a church.

Parents’ Reactions and Role Captivity

The parents of the adolescent mothers influenced their decisions about their future while also determining consequences of their pregnancies. Anna, a 12th grader who lives with her family, explained that her parents were against giving the baby up for adoption and that they would not let her even though she felt it would be best for both her and the child. When asked
what would have happened if she would have made the decision for adoption, she explained, “I think it would have been really hard for me, but it would have been different for me. But my parents did not want me to do that. My mom was like you can give her a good life and there’s no reason to give up a baby you know?” Anna’s comments highlight that a majority of the teens were not allowed to decide on life-changing decisions, leading to fragmented identities and depression. The majority of the teen mothers interviewed expressed not having control over their decisions, including whether or not to keep their babies. This lack of control coupled with the strong need to please their families contributed to identity fragmentation because they felt trapped between what they wanted to do and what was expected of them.

Seventeen-year-old Dora explained that her parents acted similarly. She stated, “The next day after that my boyfriend came over and we were discussing the options that I had. Well, I didn’t really have options it was up to my parents…they didn’t want me to lose my baby. Most Hispanic parents will tell their daughters to go with your boyfriend or you need to lose the baby.” Dora believed that she had shamed her parents and felt guilty for disappointing them, thus leaving the decision about her pregnancy up to her family. Dora’s experience illustrated how pregnancy is viewed as a punishment for irresponsible behavior. Neither abortion nor adoption was discussed. She further explained, “My mom was like well if you were adult enough to have a sexual relationship with a guy then you’re going to be adult enough to take care of the baby.”

These comments demonstrate the interconnectedness between young Mexican American mothers and their parents, thus illustrating the multifaceted role the family plays in the decision-making process and the consequences of the decisions such as depression and the impact on their mental health. Although the family is thought to buffer depression, in the case of teenage mothers, in this study the strong family influence often created frustration, leading to depression.
Although the mothers felt comfort knowing they were not alone, they also expressed a disconnection between themselves and their new roles because the decisions were made by their partners and parents, leaving them without options.

**Adult Mothers**

Although the majority of the adult participants no longer lived with their parents, four expressed the significant influence their own mothers had over their lives, which at times contributed to depression. Unlike adolescent mothers, the control given to the partner was minimal among adult mothers. Role captivity, as experienced by three of the adult mothers, led to depression. Jana, who married her baby’s father after she discovered her pregnancy, described her relationship with her mother: “I think I call her about 15 times a day. If I have questions and me and my husband ask for her advice a lot and we take it.” She also explained that she has tried numerous times to discuss her depression with her mother but she refused to really listen. She said, “My mom is more of the like get-over-it type. I’ve been there done that so just get over it…sometimes it just makes me mad because I’m like no really you don’t understand because you have never gone through it.”

Twenty-year-old Joanna also expressed guilt when informing her mother that she was pregnant. She said, “…my mom started crying and we didn’t talk for a couple of months. I just stayed to myself.” Although Joanna’s parents wanted her to keep her baby, she said they have very little time to help her with childcare. She explained, “I have to wake up and do everything myself…they help when they want to.”

Additional evidence of depression presented itself in the form of not having feelings validated by those closest to the adolescent mother. For instance, 66% of the teen mothers admitted their boyfriends or parents decided the consequence of the pregnancies whereas 66% of
adult mothers reported being influenced by their parents. Mothers from both groups stressed the important role of the family and the influence their parents have in their lives. Although often a source of comfort, the families of the participants were also a source of strain, which is consistent with previous research. Studies have shown that although social networks can safeguard depressive symptoms, they can also create stress and conflict contributing to postpartum depression (Mayocchi & Hynes, 1996). While all of the teen participants and nonmarried adults reported feeling scared when they learned the news of their pregnancy, married adult mothers reported disappointment. Participants were disjointed from themselves and their new roles, leaving many powerless and bound to a role they were not ready to take.

Body Image and Depression

Participants from both groups illustrate that body image is a source of concern, and when perceptions are negative, contribute to depression. Whereas adolescents were more concerned with the changes to their bodies during pregnancy, particularly pain-related symptoms, adult mothers focused on both.

Approximately 50% of adult Americans are overweight (National Institute of Diabetes and Digestive Kidney Diseases [NIDDR], 2002). Between 1984 and 1997, Americans increased daily caloric intake by 15% (Blumenthal, Hende, & Marsillo, 2002; http://Obesity1.tempdomainname.com/som/subs/fastfacts/obesity_Minority_pol.html, 6/6/2010). Importantly, U.S. Mexican American adults are more overweight and obese than White non-Hispanic adults. Furthermore, between 1999 and 2000, 79% of Mexican American, 78% of Black (non-Hispanic) and 57% of White (non-Hispanic) women developed an overweight status indicated by a body mass index (BMI) greater than 25.

Previous research has shown that women are often dissatisfied with their bodies during
pregnancy. In fact, studies have reported that changes due to pregnancy reflect the greatest deviation from ideal body image that women experience. Therefore, as weight increases, pregnant women often report feeling anxious over physical appearance. For example, Leifer (1977) found that pregnancy triggered negative feelings, irrespective of pre-pregnancy body satisfaction. Moreover, bodily disgust during pregnancy has been associated with anxiety, frustration, and depression (Skouteris, Carr, Watheim, Paxton, & Duncombeancy, 2005). Studies have shown that women’s dissatisfaction with body size and shape may result in unhealthy dieting and eating habits (Conti, Abraham, & Taylor, 1998) and unhealthy pregnancy behaviors such as smoking and substance abuse. Furthermore, studies have reported that negative body image occurs during adolescence and among young adulthood among Mexican American women.

Reactions to Weight Gain

Inconsistent with previous research, five of the six adolescent participants expressed little concern about gestational pounds gained. However, they were frustrated by pregnancy weight-related symptoms. During pregnancy, increased fatigue, increased appetite, sweating, morning sickness, edema, and backache were reported. For instance, a typical adolescent mother comment was, “I would swell up, and I didn’t like that.” In fact, a majority of the adolescents focused on body parts affected by increased weight. Bodily changes experienced by adolescent mothers stigmatized their appearance, and created a fragmented identity. Lydia stated, “...My feet looked big and fat and ugly. I didn’t like anyone looking at my feet. It was during the summer, my due date was like August.” She also reported making efforts to conceal her feet. Instead of wearing sandals during the summer, she wore closed-toe shoes. She explained, “When I would go to the store or something, I wouldn’t let anyone see my feet. I would try and put on shoes cause I didn’t
want anyone to see my feet, but they wouldn’t fit.” Other teens mentioned changes in breast and uterus size and facial blemishes. A typical comment was “Well, my breasts got bigger, or I was just all baby, not stomach.” In fact, one teen mentioned the way in which pregnancy affected her facial appearance. She remarked, “… my body changed…I never had pimples in my life until after I got pregnant…I think I am uncomfortable in my skin.”

Reactions to Weight Gain

Being dissatisfied in one’s skin was often associated with depressive symptoms when boyfriends or parents expressed disgust regarding increased weight. Indeed, the way in which pregnant adolescents felt about their bodies was a consequence of how other people treated them. Women felt annoyed, frustrated, and hurt when boyfriends and parents expressed negative body remarks.

Anna, a 12th grader who reported no pregnancy-related complications, also explained: “I was just really big at first, and my parents told me I was big.” She also reported that she felt “abnormal.” She recalled: “I just felt so uncomfortable. I didn’t feel like I use to....” According to Anna and others, the way in which parents or boyfriends viewed the enlarging belly was as a visible sign of pregnancy, and often evoked depressive symptoms.

The amount of pounds gained caused adolescent participants little distress because postpartum weight loss was viewed as nonproblematic. However, the participants reported that pregnancy-related symptoms resulted in depressive symptoms. Some teens recalled specific pounds gained and stated, “It was not a ‘big deal’ translated to mean that pounds gained caused little distress because some believed it was ‘water weight.’” For example, 14-year-old Maria remarked, “I gained 23 pounds, but did not have trouble losing the weight.” Michelle, a 15-year-old, reported, “Before I was pregnant I weighed 103 pounds, but at birth, I weighed 135 pounds.
So I gained 27 pounds. I weigh 115 pounds now, and lost the weight.” A teen mother named Rosa, who found out she was pregnant at age 15, elaborated on weight gain during pregnancy. She revealed, “I still fitted into my jeans. My family was scared and asked why I was wearing jeans instead of sweat pants or something. . . I did not have to spend money buying clothes because I was getting bigger.” Indeed, Rosa perceived little weight gain as a financial asset, even though it could have represented fetal distress or death. Indeed, prematurity, low birth weight, and infant mortality have been associated with low maternal weight gain.

In sum, inconsistent with previous research, a large majority of adolescents were not overly concerned with gestational weight gain. They were frustrated by pregnancy weight-related symptoms that affected their appearance. A representative comment was “. . . I was like skinny, but then, I had a huge stomach. I had backaches. . . I am happy with my weight now.” In fact, another adolescent stated that her boyfriend called her “toothpick” postpartum, which made her “happy.” One reason for this finding may be that because pregnancy is temporary, societal conformity to an ideal body size is reduced. Additionally, adolescent mothers believed that postpartum weight loss posed little difficulty, and thus adapted to weight gain with little distress. Therefore, among adolescent mothers body-image changes involved not only increased weight but also pregnancy-related symptoms. Such physical appearance alterations fragmented the identities of adolescent mothers, which often led to depression.

**Adult Mothers**

Similar to adolescents, adult mothers were often distressed by alterations of body image caused by increased weight, which included swollen ankles and painful breasts. Women who had visible, pregnancy-related appearance alterations experienced fragmented identities. A representative comment was, “I didn’t think that my body would change the way it did.” A
further explanation was expressed by 20-year-old Patricia who reported, “I started noticing stretch marks, and that got me a little crazy because I did not want to have stretch marks.” Patricia and other women rubbed lotion on their skin daily to avoid stretch marks. Similarly, another adult mother focused on the size of her breasts, which caused frustration with bodily changes during pregnancy. She recalled, “Well they were already big to begin with, and they hurt so bad that I just wanted to walk around with ice packs on them.” The pain associated with enlarged breasts resulted in some women feeling weak, fragile, and vulnerable. As several adult respondents emphasized, “Feeling physically ill during pregnancy also contributes to depression.”

_Self-Perceptions of Weight Management_

Unlike adolescent mothers, however, four of the six adult women were overwhelmed by the difficulty of losing weight postpartum, which often led to depression. A representative comment was, “It’s just after you have them, it is hard to get rid of the weight.” Jana, a 22-year-old mother who reported having numerous pregnancy-related complications, further explained that time constraints prevented daily walking to help with weight reduction postpartum. She recalled, “It is so hard to lose weight. Me and my husband go walking and jogging everyday or as much as we can, but things come up and we can’t really go to the park and do that.” However, unlike adolescent participants, adult mothers’ husbands were supportive of their weight gain. Four of the adult mothers stated, “He never said anything negative about my body” when they expressed their husbands’ reactions to pregnancy-related weight gain. In fact, “He was like happy when I was getting big...He was ok with it” were representative adult mother comments.
Family Conflict and Depression

Intergenerational Conflict

The transition into motherhood for Mexican American adolescent mothers is complicated by anxiety and fear resulting from intergenerational conflict between teens and their parents. Inadequate social support is a contributing factor to postpartum depression. One study found that family conflict is the most significant predictor of chronic stress among new mothers (Seguin et al., 1999).

Intergenerational conflict between teen mothers and their parents is found throughout the data and takes many forms. A strained relationship between the adolescent mothers and their parents usually begins immediately after learning about the pregnancy. For many, the conflict caused feelings of being torn between their parents and boyfriends and not knowing who to turn to for support. Adolescent participants expressed shame for doing something they knew was “wrong.” Anna, age 17, described how she felt isolated during her pregnancy and could not freely discuss her problems with her parents. She said her parents’ reaction to her during this time made her feel bad about herself. She explained, “Everyone would gang up on me. They were always like it’s your fault so I was always like I know but it wasn’t getting through to them. I talked to my mom but she just said I needed to deal with it, that it was something you need to deal with that you can’t take it back.” Eighteen-year-old Lydia explained that she keeps her depression to herself, because she does not trust her mother: “Like if I told my mom that I feel depressed today she would call my aunts and tell them and then one of my aunts will go and tell someone else in the family.” Although Lydia described her relationship with her mother as close, she stated, “Sometimes we don’t get along.”

Dora, an 11th grader who ran away from home when she discovered she was pregnant,
reported that she tried to discuss her depression with her mother but she felt like she was misunderstood. She explained, “I would talk to my mom…but my mom would say, ‘well, I’ve been through it.’ She would just tell me that I would get over it. I wanted to say oh really?”

Other teen mothers felt caught in the middle of an ongoing conflict between their parents and their boyfriends, who caused them stress. For example, 14-year-old Maria explained her situation, and why her boyfriend was not there for her during her pregnancy. “My mom looked at it a different way. She didn’t want him around as much. So, I could focus more on school. When asked how her boyfriend reacted she said, “He was not happy.” She added that she wishes she could have spent more time with her boyfriend.

Maria’s experience was not uncommon among the teen mothers interviewed. For instance, when recalling feelings during pregnancy Anna said that she and her boyfriend did not have the opportunity to spend time together. She explained, “It was really weird because I didn’t know if I should say something to my parents or if they were right. I didn’t know if I should go against them so I just felt I was stuck either defend him or go against my parents. He felt that he had a right to be around me.”

Intergenerational conflict is not unique to adolescent mothers. Adult mothers, even those living with their husbands, expressed a strong desire to please their parents, especially their mothers, although they did not believe that their parents understood their situations. Although 22-year-old Jana described her relationship with her mother as close, she admitted that her mother is her main source of depression. Jana explained a recent conflict: “Last week we were at my mom’s house and like I feel that I know how to be a mother. I’m not going to do anything that’s going to like harm my baby. It’s just the littlest things that she says like don’t do this or don’t do that.” Jana believed that nothing she does is good enough for her mother and that she
does not trust her parenting ability. Pleasing her mother is an impossible task thus decreasing confidence in her parenting ability.

Mary, age 23, also stated that she and her mother have many disagreements about her current boyfriend and said that she often feels caught in the middle. She explained how her mom interferes in her relationship. She reported, “I tell him that I’m sad and that we can have everything but it’s not going to make me happy, but he doesn’t know how to handle it so he calls me names… (her mother doesn’t like that and blames him). I am very frustrated because she can be so aggressive.” Mary went on to explain that she believes the conflict between her mother and her boyfriend contributes to her depression.

Medicalization of Childbirth and Depression

Adult mothers articulated suspicion with medical care providers and the health care system whereas adolescent mothers did not. Issues related to the medicalization of childbirth such as medical equipment, monitors, and the formality of medical professionals and the use of medications appear to be part of the postpartum depression experience for adult participants but not for adolescents. Fifty percent of adult mothers reported being traumatized by their birthing experiences, all of which occurred in a hospital setting.

Consistent with medical sociology literature, this study found that medicalizing childbirth disempowered Mexican American adult mothers, which resulted in alienation from the birthing process thus contributing to depression (Oakley & Rothman, 1984). Research further illustrates that motherhood is largely shaped by the birthing process (Oakley & Rothman, 1984), thus highlighting the need to better understand the labor experience as it relates to depression.

Twenty-three-year-old Mary, who scored a 23 on the EPDS, described a traumatic birthing experience. She remarked:
I was in labor for about 24 hours, I think…6 hours, something like that. And then at the last minute the doctor told me that the baby wasn’t coming down, that the heart rate was dropping, so I had to go have a c-section. So I had about 10 minutes to accept it.

She said her mother was in the delivery room with her, but no one else. She was in the hospital for 7 days total.

Mary’s mother was disappointed about the quality of care her daughter received during her hospital stay and wanted to complain to human resources, but Mary would not let her. Jana, an adult mother who delivered preterm, also described the fear she experienced during labor, which resulted in an emergency cesarean. She explained:

The monitors and everything started going off. And that was the first time the baby’s heart rate dropped. And, um, I was, you know, freaking out. And they had gotten me ready for a c-section because they said that if it drops again we’re going to have to do an emergency c-section and get him out. Well they had prepared me. They gave me my epidural. They, they, you know, got everything ready. And, um, then um, I went to sleep again. Next thing you know I had 14 nurses and doctors around me like, flipping me over, getting me onto another bed. Like trying to push, get the baby into a different position because his heart rate had dropped big time. And at that moment I was so scared. They had to do an emergency c-section and the baby was premature.

Jana explained feeling helpless during the moment she was told she would be having surgery. She reported disappointment and guilt because she believed that she had failed as a mother. She provided a poignant explanation for birthing failure. She reported:

I felt like I didn’t give birth the way I was supposed to. First thing, I had a c-section and I wanted to have a regular vaginal birth. And, and then, you know, so I was like “God, you know, I failed at that. I felt like it was my fault.” I’m just like oh gosh. My baby’s in, in there with these nurses and doctors and, and I couldn’t be there.

Patricia, who miscarried during her first pregnancy, also described frustration and a painful 19-hour labor experience that like Jana’s ended in an emergency cesarean. She explained:

They just did a c-section because my baby didn’t have oxygen anymore. They broke my water down there…they broke everything… so that’s why my baby had lost all the water and everything. And so she was losing oxygen and I was losing oxygen because it was hurting really bad, like the contractions. They hurt really bad, because they were giving me medicine so I could have them.
According to Patricia, another part of her frustration originated from nurses contradicting physicians. She felt that she was being misled or tricked into a cesarean when it was not necessary. She reported:

The nurses told me, ‘Oh, that doctor always wants to do the c-sections on young girls.’ Because the baby, like I was really pushing; and the baby like she was still like up high. So, and I had a lot of water. The nurse told me, ‘well you still have a lot of water you can just wait.’ My mom got really mad….

Although the adult mothers exhibited frustration and sadness caused by the labor experience, adolescent mothers reported few problems. For example, 14-year-old Maria described her experience. She explained, “I actually had the epidural so it wasn’t as painful, but during the last 5 minutes when I was about to give birth it started fading away, but it wasn’t that bad. I didn’t stay in labor that long.” Michelle, a 15-year-old mother, also described the birthing experience, which like Maria, focused more on the relief of physical pain. She explained:

It was hurting real bad and I called the doctor and they said when I needed the epidural I need to call them. So, she waited like 30 minutes and she came in there and was still talking on the phone. I was like oh, my God hurry up. She was on the phone being lazy and stuff like that, then I got the epidural like an hour later and it didn’t hurt me. I slept after that.

Although adolescent mothers recalled the pain associated with labor, they expressed indifference about the amount of medical intervention involved. However, four adult mothers expressed frustration and disappointment, which fragmented their identities and triggered depression.

Consequences of a Fragmented Identity and Depression

A fragmented identity among adolescent and adult Mexican American mothers, as illustrated throughout this chapter, is linked to postpartum depression. Both adolescent and adult mothers provided evidence of depression as a direct result of identity fragmentation. A fragmented identity has numerous negative consequences that affect both the mother and her
children. The consequence of a gestational fragmented identity is untreated depression. Importantly, depression, if untreated, alters a mother’s reality, therefore, their ability to meet the physical and emotional needs of their infants is compromised. Studies have reported that postpartum depression can negatively affect one’s ability to parent while decreasing maternal competency, thus intensifying depression (Perfetti, Clark, & Fillmore, 2004). Depressed mothers often have difficulty interacting and bonding with their children, which can create and perpetuate feelings of guilt and inadequacy. Adolescent participants reported faulty ideas regarding infant development, both physical and emotional. Without exception, teen mothers described babies as happy because they rarely cried. Consistent with previous research, infants of depressed mothers are less expressive than infants with nondepressed mothers. Specifically, infants of depressed mothers’ exhibit lower activity levels, are less vocal, and make less eye contact (Lundy, Field, & Pickens, 1996).

**Faulty Ideas Regarding Infant Development**

Data gleaned from the interviews with the adolescent mothers highlight ways in which a fragmented identity leads to skewed perceptions and unrealistic expectations of their babies. Sixty-six percent of adolescent mothers said that their babies are well behaved because they rarely cry, which they viewed as successful parenting. “My baby never cries,” is a representative comment expressed by teen participants. For instance, Lydia, an 18-year-old mother living at home with her mother and brother, said her baby only cries when she is sick. When asked how often her daughter cries she explained, “Only last week because she got sick. My mom doesn’t even wake up, but last week she was crying loud, and we have never heard her crying like that so my mom got up. We were scared. She had a fever and an ear infection, but she is better now.” She also reported that being a mother is easier than she thought because her baby rarely cries and
sleeps often. She explained, “I’m not saying it’s easy, but it’s not as hard as people say. I do still have time to myself when she’s asleep. I can still watch TV or go on the computer and do stuff for myself.” Another teen mother, 17-year-old Dora, explained that the most rewarding thing about motherhood is having a happy baby. She reported:

Just seeing her happy. I know that I am doing a good job with her…she’s happy and that makes me happy. Also too, just being with her and how your life changed. It’s just you have another person who was in your stomach and you were carrying her and can you believe she came out of you? It’s just different.

When asked if motherhood is as difficult as expected, Dora laughs and said, “No, because they told me that babies are always crying but it’s not like that. I think my baby is like a really good baby, he’s not a fussy baby he let’s me do my thing.” Dora’s comments could explain how depression hinders bonding.

As illustrated, the adolescent mothers interviewed held common perceptions about their babies. They believed that their babies were easy to care for because they rarely cry. Dora further explained her perceptions of her baby when she was asked to describe him. She said:

He’s really awkward. He does things like he just surprises me a lot. Sometimes I get up at two o’clock in the morning or three o’clock just to check up on him just to make sure the covers aren’t over him and he’s just like staring, talking to himself… Like last night I got up and he was just talking to himself. He was just staring at his hand there in the dark. I was like how can you see it’s dark and why are you talking to yourself…I was like okay, random.

The comments and stories told about their babies indicate a lack of understanding of child development, thus skewing their perceptions of their babies. Overall, compared to adult mothers adolescent mothers held unrealistic expectations of their babies while holding them to a higher standard. For example, Dora explains how she has to eat often and feels pressure to eat healthy because she is breastfeeding. She expressed her fear about having what she defines as an unhealthy baby:
I don’t want him to get too big. Because some babies if they get too big they aren’t going to be able to communicate good. I don’t know it’s something with their minds because they are more sleepy so you have to eat things that will give them energy. So you can drink like a cup of coffee a day and that will give them a boost. If you drink it with milk coffee is good for the baby. It makes them alert and aware of things. But if you are eating junk food it makes your baby lazy and sleepy.

Adult Mothers

While adult mothers held more realistic views pertaining to child development compared to adolescent mothers, there was one exception. For example, Angie, a 27-year-old married mother of three born and raised in Mexico, believed that her baby is healthy, even though his physician expressed concerns. Angie described her baby. She stated, “He’s very calm and doesn’t cry a lot. He’s very loving and very affectionate, but the other two kids were just a little more energetic. He just had a 9-month checkup yesterday and the doctor said he should be at the stage where he’s standing up and pulling himself up, but he’s not. He’s not crawling either…the doctor thinks he is weak in the muscles so they talked about referring him to another doctor, but I think he’s fine and don’t see any health problems with him.”

Infants Replacing Emotional Void

A fragmented identity created gaps in the mothers’ perceptions and expectations of their babies. Many of the adolescent mothers viewed their babies as a source of comfort and happiness, thus creating unrealistic expectations of the mother–child relationship. Seventeen-year-old Rosa described the bond she has with her infant. She explained:

She always tries to keep me happy. That’s what I like. Like sometimes I’m just there staring at the TV because I am tired she’s like always saying “mama, mama.” She pretends like she’s talking on the phone and wants me to get the other phone so I can talk to her. Then she says bye to me or she wants me to play with her but I don’t want to but she knows so she will just lay down by me and stares at me. She makes me laugh and tries to talk to me.

Infants of depressed mothers are often regarded as fulfilling the mothers’ needs and that
becomes the center of the interaction. Rosa’s comments illustrate that emotional boundaries become blurred when an infant is made responsible for the mother’s happiness. Dora, who is 17, explained how her depression affected her baby negatively, thus compromising their interaction. She explained:

Whenever I was in a huge depression, because I was like crying and crying all the time and I was like what am I supposed to do because I didn’t know what I was doing. Then I was breastfeeding and he would just cry randomly. He would shake a little bit. I guess he was feeling depressed too because I was feeling depressed.

Dora further explained how her son’s reaction to her depression made her feel. She reported, “It made me feel sad that he was feeling that way so I tried to become more active and get more happy.”

Adult Mothers

Perceptions held by adult mothers did not focus on emotional voids; however, their interaction with their babies was compromised because of their depression. For example, 35-year-old Silvia described feeling depressed with all three of her children and admitted that the depressive episodes have worsened with each pregnancy. She explained:

About two times a week I feel really sad and goes into a very deep sadness. I cry, feel like the world is over, and don’t know what to do… it lasts maybe 15 or 30 minutes because my daughter says, “mommy, mommy, what’s wrong?” There have been times when I felt that way and my daughter takes care of him and I leave the room to get myself together.

Twenty-year-old Joanna also described how her depression affects her two sons. She explained, “Sometimes if I am crying I really don’t want to mess with them and he will come over and want to play…it’s really frustrating.” She further added that the most rewarding thing about being a mother is “having someone to love you....”
Research has shown depressed mothers often have difficulty bonding with their babies and that insecure attachments are associated with social, emotional, and cognitive development (Belsky & Fearon, 2002).

Breastfeeding Difficulties

Breastfeeding behavior, another important consideration for new mothers, is often understood and valued in Mexican culture, but it is not always possible. Both adolescents and their adult counterparts expressed the importance of breastfeeding and the positive health effects for their babies. Although research illustrates that breastfeeding often serves as a protective buffer against depression by decreasing stress (Groer & Davis, 2002) and improving the health of the infant, findings from this study indicate how difficulties with breastfeeding actually contribute to depression among Mexican American adult mothers, but did not appear to negatively impact adolescent mothers.

A number of factors were cited contributing to shorter durations of breastfeeding including problems lactating, physical pain, prescription medications, unsupportive infrastructures, and inadequate social support. For instance, 50% of adolescent participants attempted breastfeeding but were unable to while the remaining 50% reported success. Without exception, teen mothers recalled experiences of breastfeeding with little emotion, including those who were unable to breastfeed for the desired amount of time. For instance, 9th grader Maria describes her thoughts about breastfeeding. She explained, “I wanted to, but I couldn’t….I would rather have instead of giving him formula.” Another teen mother, 15-year-old Michelle, who reported breastfeeding for approximately 1 month, described how lactation problems prevented her from continuing for as long as desired. She reported, “I was okay with it…I wanted to stay
with breastfeeding because they told me it was better to breastfeed and I wanted to keep my baby healthy.”

Comments by Maria and Michelle were expressed with little emotion; feelings of guilt or inadequacy were not apparent, dissimilar to the adult mothers interviewed. Other teen mothers expressed difficulties in breastfeeding, although such obstacles did not act as a deterrent. Teen mothers also reported greater obstacles to breastfeeding compared to adult mothers. For instance, Dora, who was breastfeeding at the time of the interviews, explained her experience as difficult although she planned to continue breastfeeding for a year. She reported:

It’s hard because I’m at school and I just feel milk coming out and I am like oh my God I have to go pump, I have to go pump they let me pump at school. But sometimes I feel like I am not getting enough milk so I have to constantly be eating. When you are breastfeeding you get so hungry, more so than when you are pregnant. So you are always eating and always thirsty. But when you think about it it’s better for your baby.

Adolescent participants expressed more concern over the physical aspects of breastfeeding while often overlooking the emotional benefits. Without exception, adolescent mothers did not emphasis bonding with their babies as a reason to continue breastfeeding; rather it was to meet the physical health needs of their babies. Adult mothers on the other hand recognized both the physical and emotional benefits of breastfeeding and expressed sadness when unable to provide breast milk.

Adult Mothers

Whereas adolescent mothers expressed apathy toward breastfeeding, adult mothers voiced guilt and shame when they had planned to breastfeed but were unable to. A representative comment, expressed by 22-year-old Jana, captures the feelings expressed by adult participants. She reported, “I feel like such a failure.”

Adult mothers, unlike adolescent mothers, placed pressure on themselves to breastfeed,
which they associated with taking care of their babies. Jana described her perceptions of mothers who cannot breastfeed. She explained, “I am glad that I was able to do it because there were some moms in the NICU that couldn’t make breast milk at all and they really couldn’t help their babies and that’s what they want. That’s what doctors want. We want your breast milk.”

Other adult mothers reported similar perspectives. Difficulties breastfeeding, in some cases, created frustration among adolescent mothers while adult mothers attributed fault. For example, one adult mother believed her inability to breastfeed contributed to depression. Mary said, “It was something I was going to do when I had a baby. I read it gets you closer to your baby but I wasn’t able to do it.” Mary desired a stronger attachment to her infant, but felt that her inability to breastfeed prohibited bonding from occurring. The relationship between guilt and postpartum depression is well documented. Depressed mothers often berate themselves and hold rigid expectations of themselves, which can result in guilt (Blum, 2007).

Patricia described how depression and physical pain prevented her from breastfeeding for very long. Mothers suffering from postpartum depression commonly report pain, which can be a cause of breastfeeding difficulties (Kendall-Tackett, 2007). She explains:

Like every time I would like be breastfeeding I was just crying and my mom was like “that’s going to be bad for the baby, so just don’t cry” and then everything happened. Like whenever I had the baby he was with me but then he would leave me like to go take care of his sisters…and he was never with me and that make me really sad.

These statements illustrate the guilt and sadness associated with the inability to breastfeed among Mexican American adult mothers. More than 50% of adult mothers recognized that the difficulties breastfeeding contributed to their depression; none of the mothers believed that depression prevented them from breastfeeding. Feeling like a failure at something that is often defined as natural caused mothers to feel guilty and ashamed, thus contributing to depressive symptoms. Without exception, participants across both groups recognized the importance of
breastfeeding and all intended to do so, highlighting the expectations placed upon mothers while social support remains inadequate.

Teen participants expressed less guilt when unable to continue breastfeeding than adult participants did. One explanation for this finding is that 83% of the adolescent mothers lived at home with their families and or extended families, thus receiving the social support needed to continue breastfeeding even when faced with numerous obstacles. Previous studies indicate that mothers, particularly adolescents, are greatly influenced by cultural issues and family, both of which play a crucial role in breastfeeding initiation and duration (Akman et al., 2008). The guilt associated with the inability to breastfeed demonstrates inconsistency between the reality of the situation and what they believe constitutes “good mothering.” For example, Mary explained, “I was breastfeeding in the hospital, but my milk didn’t come down, I guess. So the nurses just kept advising me to keep trying. I tried the whole week and nothing happened to me…so I had no choice but to give him a bottle.” Studies show that breastfeeding reduces maternal stress thus positively affecting the mother’s mental health, but only when minimal obstacles are encountered (Kendall-Tackett, 2007).

Among the mothers interviewed, the majority of both adolescent and adults expressed difficulty with breastfeeding, at least initially. Adolescent mothers expressed frustration with the process whereas adult mothers described feelings of guilt and inadequacy.

Bridging the gap between the actual situation of one’s life and societal expectations of motherhood is often overwhelming, leading to a fragmented identity that creates and perpetuates depression among Mexican American adult mothers.

*Inability to Identify and Articulate Depressive Symptoms*

Although all of the mothers sampled reported depressive symptoms since giving birth,
there is confusion between feeling depressed and being depressed. For example, most the adolescent mothers admitted to feeling angry, stressed, sad, and worried but were less definitive when asked directly about depression. Among teen mothers interviewed, emotions such as sadness and anger were often used interchangeably while other words such as depression were avoided or denied.

Adolescent mothers used vague but convoluted language to describe depressive symptoms. For example, teen participants doubted their feelings more regularly than adult mothers did. When asked what types of things upset her while she was pregnant, Michelle said, “I would get like mad and sad at the same time. Because sometimes at home we would just discuss things or fight over things that you weren’t suppose to fight over. Sometimes I would get tired from school and someone would tell me something that I didn’t like and I would get sad.” Michelle said that she was unsure why she felt the way she did, but that she was told it was hormonal. Eighteen-year-old Anna expressed how feelings could often be confused and difficult to express. She reported, “Everyone has a way of explaining how they feel and some don’t know how to explain it to some people, but sometimes we just need to talk to someone.”

Additionally, 17-year-old Dora, when asked if she believed depression is a problem for young mothers, she explained, “I think it’s a big, big problem because some mothers get really depressed or sad or angry because their babies cry…and they are really stressed out.” Dora’s comments illustrate the difficulty adolescent mothers have in expressing and understanding depression. Depressed teen mothers were more likely to express depression as anger.

**Adult Mothers**

While adolescent mothers were unable to identify and articulate their feelings, adult mothers made a conscious effort to avoid certain stigmatized terms when describing their own
feelings. Patricia, age 20, elaborated on the confusion commonly felt by many depressed mothers: “Sometimes we don’t know how to tell the difference between depression and sadness. We just think everything is sadness.”

Jana explains her depressive episodes: “Sometimes I can’t even describe it. Ugh, sad all the time, angry, just can’t even crack a smile. Most of the time I can, but when it’s bad I just walk around the house like a zombie and will just be so sad. Sometimes I don’t even know what it is that’s making that way.” Many adult mothers doubted they were depressed because they did not feel sad all of the time, indicating they had been given little information on postpartum depression. Some took comfort in believing because they were not always sad they were not depressed, justifying nondisclosure.

An illusion of depression is evident among both adolescent and adult participants, and encompasses controlling and normalizing depression, confusion, and denial. Data collected from adolescent mothers demonstrates efforts to protect their own mothers from their depressive thoughts and behaviors whereas adult mothers are more compelled to shield their partners.

**Normalizing Depression**

Both groups of participants viewed depression as normal and controllable. Adolescent and adult mothers failed to recognize the severity of their own depressive symptoms while defining depression as a normal occurrence. Mothers do not always realize that they are depressed because they believe that depression is a natural part of motherhood, thus normalizing depression (Dennis & Chung-Lee, 2006). Teen mom Anna explained without hesitation that mothers could be depressed and fail to recognize it:

Yes, I think that’s what happened to me because I just felt so bad, I didn’t want to do anything. So, I had a messy house and I knew I wasn’t right but you don’t accept it. Because how is depression supposed to feel? So, I think that’s normal sometimes you just don’t know it’s depression you just think you’re having a bad day or a lazy day.
Seventeen-year-old Dora also elaborated on her failure to recognize depression:

…You can get so used to being depressed that it’s so normal for you. You don’t recognize it, but other people can recognize that you’re depressed, but you are so used to it you don’t even know.

Adult Mothers

Similar to teens, adult mothers also normalized depression but to an even greater extent. Angie, 27-year-old mother of three, said that she never talked about her depression because she felt it was normal to be sad after a pregnancy. Patricia, a single 20-year-old mother, agreed that it is possible to be depressed and not know it. She said, “Sometimes you get confused with depression and sometimes that is a normal thing.” Mexican American adult mothers exhibited difficulty recognizing the severity of their symptoms. Normalizing depression prevented 22-year-old Jana from seeking help. She explained:

Sometimes I thought about going, but then I was like no it’s not that bad, it can’t be that bad. I have insurance, I guess I would go to the doctor by myself without my mom knowing it, but I guess it’s just the thought of it. I’m not that extreme to where I need it. But then sometimes whenever I have my breakdowns I feel like I need it.

The normalization of depression, as indicated among both adolescent and adult mothers, guards mothers against being labeled “depressed.” The stigma associated with depression prevents disclosure (Dennis & Chung-Lee, 2006). As evident in this study, the normalization of depression often coincided with controlling and concealing depression.

Controlling Depression

Denying depressive symptoms is one variety of control and often takes the form of concealment among both adolescent and adult mothers. For instance, Dora, 17, said, “They [depressed mothers] know they are but they do not notice it and don’t want somebody else to know.” Dora added that depression is viewed as a weakness and that many work to conceal their feelings from others, and in her opinion that is why depressed mothers do not ask for help. She
added, “They don’t want anyone to know they are depressed because they don’t want to feel weak.”

Several respondents also believed in their ability to control depressive symptoms. For instance, when Anna, who scored a 13 on the EPDS, was asked if she was currently depressed she said, “Sometimes I do think that I am depressed. I just feel like I push myself and get nowhere but I want to keep on pushing myself. I feel so depressed and can’t do anything about it. I guess I don’t know why I am depressed it’s just a feeling that you have.” Anna’s explanation of depression illustrates how a young mother can realize that she is depressed while believing that she can overcome it by continuing her daily routine even though it is clearly not working.

Adult Mothers

Unlike adolescents, adult participants expressed a strong desire and believed that they had the ability to manage their depression. Mary, a 23-year-old single mother, described protecting her baby from her depression. She said, “I really try to keep it the same so he doesn’t get affected by it. I mean, I’m pretty like numb I think, like…I’m just like a zombie. Mary’s description indicates how depression can spiral out of control. Jana, a married 22-year-old, does not believe that her son is affected by her depression. She reported:

I cry and my son laughs because he has no idea what’s going on. I try not to do it in front of my son. So if my husband is not there, I won’t ever leave the baby to go off and be sad. I sometimes snap myself out of it and will say okay I am acting a little bit ridiculous.

Among adults the belief that depression can be controlled was relative to depression. They believed that their children would help them come out of it. When asked why depressed mothers rarely get help, Angie, a 27-year-old Mexican immigrant, said:

It’s just something that is expected, you’re sad after you have a baby and you let them go through their sadness because we feel that they will come out of it. A lot of times when they are depressed it doesn’t matter. They have to get up because they had other children to take care of. They don’t have the time to focus on the fact that they are depressed.
As evident throughout the data, teen motherhood among Mexican Americans is structured around notions of frustration and guilt that emphasize depression as selfish behavior and a sign of poor mothering. Frustration and guilt are deeply ingrained within Mexican American teen mothers, thus depression is viewed as a selfish behavior and a sign of poor mothering. Young mothers, similar to adult mothers, are blamed for their depression. Depression is seen as a behavioral problem or as a “bad attitude” perpetuating the myth that depression can and should be controlled as later illustrated. For instance, Michelle, a 15-year-old born in Honduras, describes the interaction between her and her son when she feels depressed:

When I’m tired I just don’t want to play. But if my boyfriend finds out he’ll be all like why are you being like that, you shouldn’t be depressed. He tells me too because I always tell him everything and I tell him too that the baby was wanting me to play but I didn’t want to. He tries to talk to me about it and asks me why I didn’t want to play how do I feel? I just say sometimes it’s just not my day you know. So he tries to work it out with me and tries to get me to just forget about it.

Michelle’s description of her boyfriend’s reaction to her depression reveals commonly held misperceptions about mental health. Depression is viewed as an individual choice or problem rather than a societal trouble, and if it is forgotten, it will disappear. Also, the belief that one does not have reasons to be depressed reiterates the idea that motherhood is a happy, joyous occasion. Such view provides evidence of the ways in which motherhood is socially constructed.

As indicated here, self-reported depressed Mexican American adolescent and adult mothers buffer depression in a variety of ways: (1) family support, (2) language used to describe depression, (3) normalizing, and (4) controlling depression. The buffers mentioned here help to determine whether a depressed mother will seek help for depression and from whom.

Help-Seeking Behavior

Adolescent and adult mothers did not believe that seeing a health care professional about their depression would help. Anna admitted that she is still feeling depressed and expressed
doubts about seeking help. She explained: What would be the difference between talking to a
doctor and a friend? Who knows you better than your friends or family? She added that while a
doctor may understand why she’s depressed her or she would not really help her. What can they
do and if there is something I want to know about it.

Dora, 17, explained that she has tried talking to both her mom and boyfriend when she
first began feeling sad, but felt ignored. She reported, “Sometimes they are like well you are
going to get over it and sometimes I do but sometimes I think this is going to be the same as
yesterday.”

Adolescent mothers in this study illustrate help-seeking behaviors that correspond with
their parent’s attitudes of mental health. Mothers whose parents are perceived as judging are less
likely to seek professional help for depression.

*Adult Mothers*

Twenty-year-old Patricia shared Anna’s distrust in the medical treatment commonly used
to treat depression. She said that she has not considered going to a health care professional for
treatment because “they’re going to tell me the same thing everybody tells me, that it’s normal
and they’re just going to give me pills or something like that.” Patricia’s views illustrate
frustration with medical encounters often experienced by depressed patients.

Silvia expressed reluctance to seek professional help for depression based on her bad
experience with community health clinics. She explained, “I have not found a doctor that I have
connected with or that has really cared about me.”

Jana, a 22-year-old married mother, said she would have a difficult time seeking help for
depression because of her mother’s views of mental health. When asked how her mom would
react if she expressed a desire to seek help she reported, “She would probably say, ‘why are you
crazy? Do you need to be in a mental institution?’ She would take it to the extreme because I have tried talking to her before and she just said ‘what are you out of your mind?’ So I stopped expressing it.”

Participants expressed a variety of reasons why they would forgo medical care for depression. Issues related to the family’s attitudes toward mental health, stigma, inaccurate information, and frustration with the health care system prevented mothers in this study from being treated.

Buffers to Fragmented Identity and Depression

Family Support

Studies indicate that social support often buffers depression, especially in high stress situations such as motherhood (Willis, 1985; Seguin et al., 1999). Without exception, both adolescent and adult mothers perceived their families as supportive. Adolescent mothers, many of whom lived with extended family, expressed gratitude for the support offered to them and their babies. Michelle, a 15-year-old mother, reported the benefits of living with a supportive family. She explained, “Like our family we have always lived together and so have always been supportive to each other. She further explained how her sister helps her with childcare. She stated, “Sometimes when I get home they are already eating and if she is finishing she will take care of the baby while I eat. Like if I am washing the dishes she will take care of her.” Also without exception, teen participants stressed the important role of their mothers. Lydia, 18, described her relationship with her mother. She explained, “We are close, I tell her everything. I guess I have friends but I don’t tell them everything. I tell my mom everything. Like if I have problems with a girl or something. We are close.” Maria, like Lydia, described the supportive relationship between her and her mother and when asked who helped her most during her
pregnancy she stated, “My mom…she’s really supportive.” Seventeen-year-old Anna, who previously described her living situation with her parents as stressful also, expressed the support that her mother provides her. She reported, “I think she’s like another friend to me. She’s supported me and has always been there as a friend…she makes me feel better.”

*Adult Mothers*

Adult participants also expressed benefits of having a close, supportive family. Patricia, a 20-year-old single mother, described how her parents help take care of her baby girl when she is working. She stated, “They spend most of their time with her…sometimes I get jealous because she’s always calling my mom mama.” Without exception, adult participants described their families as supportive. Although 50% of the adult mothers lived in separate households, they remain close. For example, Silvia, who rarely gets to visit her mother because she lives in Mexico, reported talking to her often. She also explained that her mother was her main source of social support when she feels sad. She reported, “We are very close with one another. We have a very adult woman-to-woman relationship; she is my best friend. She gives me a lot of support and tells me to hang in there.”

Although family support is one buffer to depression described by both adolescent and adult mothers, nondisclosure of depression is another. Both adolescent and adult mothers were resistant to admitting to being depressed. Self-denial and nondisclosure served as a means to protect mothers from their feelings. Nondisclosure includes the inability to identify and articulate depressive symptoms.

*Summary*

The results from this research have significant implications for identifying, diagnosing, and treating postpartum depression among Mexican Americans. As illustrated throughout this
chapter, postpartum depression is socially constructed and maintained through cultural ideals of pregnancy and motherhood.

The data illustrate specific ways in which a fragmented identity, unplanned pregnancy, body image, family conflict, and the medicalization of childbirth contributes to depression among Mexican American adolescent mothers compared to Mexican American adult mothers. The consequences of depression included faulty ideas regarding infant development, infants replacing emotional void, and breastfeeding difficulties. The interviews also reported barriers to fragmented identities and depression characterized by family support; an inability to identify and articulate depressive symptoms; normalizing depression; and controlling depression. The next chapter provides a theoretical framework for understanding the social construction of postpartum depression among Mexican American adolescent mothers, which can be applied to other ethnic and racial groups.
CHAPTER 6

THEORETICAL FRAMEWORK

The research findings demonstrate both commonalities and variations pertaining to the depression experiences of Mexican American adolescent and adult mothers. Specifically, this chapter integrates the qualitative findings, demonstrating the connection between pregnancy, motherhood, and depression, with quantitative data primarily explaining sociocultural factors attributed to breastfeeding behavior among a national sample of self-reported depressed Hispanic mothers. An alternative interdisciplinary theoretical framework, emerging from the data, is used to explain a process of fragmented identity and is applied to postpartum depression.

Thus, a model depicting the formation of fragmented identity is employed to explicate the social construction of postpartum depression among Mexican American adolescent mothers compared to adult mothers. Unlike previous studies, this research emphasizes the role culture plays in actively shaping and defining postpartum depression while shifting focus from the individual mother to external forces created and maintained within society. Consequences pertaining to the fragmentation of the identities of Mexican American adolescent and adult mothers incorporate theoretical concepts borrowing from medical sociology, feminist theory, and public health, thus explaining the socially constructed properties and consequences of postpartum depression. Postpartum depression is a complex phenomenon with social origins that is best understood through employing an interdisciplinary approach. As illustrated throughout this dissertation, Mexican American adolescent and adult mothers experienced fragmented identities that resulted from a combination of cultural and societal factors including an internal struggle between cultures, stigma of teen motherhood, weight gain and body image, family conflict, and the medicalization of childbirth.
Fragmented Identity

The connection among unplanned pregnancy, the gap between the actual situation, and societal expectations creates a fragmented identity among adolescent and adult Mexican American mothers, thus exploring postpartum depression and the sociocultural context in which it exists. Fragmented identity among both adolescent and adult mothers begins with unplanned pregnancy. Teenage pregnancy in the United States increased among all racial groups in 2006 for the first time in 10 years, according to the Guttmacher Institute. Although teen pregnancy rates continue to rise, teen motherhood remains stigmatized in American society and social support is limited. Whereas the existing social structure does not provide the necessary resources for adolescent mothers to succeed, societal expectations remain high and for many of the teen participants unrealistic, thus contributing to depression.

Adolescent Mexican American mothers were expected to confront difficult decisions without being prepared to deal with the situations that arose. Teen participants reported feeling frustrated and to some extent solely responsible for the care and welfare of their children. Adolescent mothers are constantly struggling to make sense of the double standard that they are young and should not have children, but because they have become mothers, they are expected to alter their lives to fit their new roles with little or no guidance. Many of the teen mothers expressed that they felt set up for failure, which included pressure to better perform in school, deciding on daycare, enrolling their infants in social service programs, and so on. Role conflict was commonly experienced by teen participants and without exception, teen mothers expressed difficulty balancing school and motherhood.

Adult participants, similarly to teens, expressed role conflict resulting from unplanned pregnancy; however, unlike the teen mothers their transition into motherhood was not
stigmatized. The process of becoming a mother was especially difficult for the younger, unmarried adult mothers because they had other plans for their lives.

Many of the adult mothers explained that the transition into motherhood required giving up their identities as women thus highlighting how mothers of all ages are expected to sacrifice their individuality. This further demonstrates how the myth of motherhood affects the lives of Mexican American mothers. The myth of motherhood presented in the literature directly correlates with the idea of “intensive mothering” meaning that women learn through the socialization process that a good mother will channel all her time and energy toward her children (Hays, 1996). The experiences noted throughout the previous chapter indicate that Mexican American mothers are not exempt from the myth of motherhood, although little research has been conducted with this specific population.

Components of Fragmented Identity

Postpartum depression, as it is experienced among Mexican Americans adolescent and adult mothers, are attributed to sociocultural factors creating a fragmented identity. The findings from this study pinpoint specific causes of postpartum depression unique to Mexican American adolescent and adult mothers (see figure 1).

Internal struggle between cultures: One cause of fragmented identity leading to postpartum depression is the internal struggle between the Mexican and American cultures. Both adolescent and adult mothers in this study were expected to balance expectations of two very different cultures. Approximately 75% of all participants were born in the United States, thus such feelings may be more common to acculturated mothers.

Adolescent mothers grappled with the many responsibilities of motherhood while also feeling pressure to perform well in school and plan for college whereas adult mothers expressed
being overwhelmed, believing that they alone were responsible for providing care for their babies while feeling pressure to work outside of the home to contribute to the household income, resisting traditional gender roles. When a mother’s identity is fragmented and the social roles and obligations are unclear, motherhood provides little fulfillment leading to stress, anxiety, and depression.

**Stigma of teen motherhood:** A second cause of identity fragmentation is the stigma associated with teen motherhood, which leads to postpartum depression. A fragmented identity is a direct result of the prejudice and discrimination toward teen mothers in society along with an insufficient social infrastructure.

The stigmatization of teenage motherhood is documented in the literature although few studies examine the perceived stigma among Mexican American teens because motherhood is highly regarded among this ethnic population. According to Wiemann et al. (2005), rates of stigma are more commonly found among Whites compared to Mexican American teen mothers and are consistent with much of the literature. However, this research indicates that Mexican American mothers experience stigma relating to teen motherhood. Acculturation affects the stigmatized identities of Mexican American mothers, as findings presented in the previous chapter indicate. Higher levels of acculturation led to greater perceptions of stigma.

All adolescent participants were part of a teen parenting program in a predominately non-Hispanic White public high school, where they were already considered “outsiders,” increasing perceptions of stigma that they associated with teen motherhood.

**Unplanned pregnancy:** The concept of fragmented identity is also caused by unplanned pregnancy, creating a lack of control over daily decision making pertaining directly to the teen mother and her baby. For many mothers fragmented identity began immediately after disclosing
pregnancy to their family and boyfriends. All of the adolescent participants described a minimal role in deciding what options were available to them and the affect of others’ decisions. Adoption is stigmatized in the Mexican American community whereas abortion is rarely spoken of; therefore, young mothers have limited choices regarding pregnancy.

Unplanned pregnancy led to role captivity among self-reported depressed Mexican American adolescent and adult mothers who reported feeling shocked on learning of their pregnancies and the lack of perceived options regarding the pregnancy lead to confused feelings about their babies, especially among teens who wanted to give their babies up for adoption but were told no by their partners and/or families. Several of the teens described not knowing how to accept their babies, often blaming their babies for their unhappiness, and then feeling guilty placing blame. Adult mothers experienced role captivity resulting from adhering to traditional gender roles, which left many feeling isolated.

Body image: Another contributing factor associated with the fragmented identities of both adolescent and adult Mexican American mothers is body image, which can also lead to postpartum depression. Both groups of mothers expressed concerns about their changing bodies; adolescent mothers were focused on weight gained during pregnancy and their partners’ reactions to their bodies. Teen mothers, with unsupportive partners, also expressed depressive symptoms associated with weight gain.

Adult mothers however expressed surprise by their bodies during pregnancy such as sore breasts and fatigue. They demonstrated more concern with losing weight during the postpartum period and the inability to meet such expectations contributed to depression. Unrealistic perceptions of the body contribute to depression in both groups of mothers.

Family conflict: Family conflict is also linked to fragmented identities. Self-reported
depressed Mexican American adolescent mothers viewed themselves as burdens to their families. Shame, frustration, and anger comprise teens’ perceptions of motherhood, resulting in depression. The majority of adolescent participants attempted to conceal their emotions from their families in an effort to protect their mothers, who they viewed as their main source of social support. Concealing authentic feelings creates a fragmented identity, thus disconnecting from their many roles including mother, daughter, girlfriend, student, and so on.

The relationship between adult participants and their families is also complex. Although their mothers were their primary source of social support to a large extent, their relationships were also characterized by conflict and stress. The mothers collectively felt that their ability to parent is continuously under surveillance. The participants believed that their maternal competency was constantly called into question, which is consistent with the myth of motherhood. Doubting one’s competence often creates alienation and nondisclosure. Mothers are forced to mask any difficulties they may be having in fear of being questioned by their families and perceived as inadequate. The failure to meet the expectations of their families leads to depressive feelings.

Medicalization of childbirth: Exclusive to the adult mothers interviewed, the medicalization of childbirth is also a contributing factor of postpartum depression. A fragmented identity is connected to the medicalization of childbirth and is evident among adult mothers who perceived the birthing process as traumatic. The majority of the adult mothers interviewed expressed frustration with their hospital experience. Mothers described the fear and anxiety they felt when the alarms on the monitors attached to either them or their babies sounded. Fragmented identity was initiated by a lack of control during labor.

Those who had cesarean births expressed feeling detached from their babies. In several
cases, mothers were not able to hold their infants immediately following delivery. Although this was also the case for a few of the adolescent mothers, they were not negatively affected. This was especially true among those who had emergency cesareans due to health complications because it was not what they expected. The fear of failure often accompanies cesarean births. It appears that the mothers associated vaginal births as being more respectable. Other adult mothers perceived their physicians as lacking empathy, only wanting to discuss their physical bodies when the mothers only cared about their babies’ health, which is closely tied to the mother’s mental health state. Whereas issues pertaining to the medicalization of childbirth were frequently highlighted among adult mothers, the adolescent mothers expressed very few if any concerns with the birthing process. Teen mothers appeared more troubled with the physical pain of labor, which they soon forgot after receiving their epidurals.

Social Construction of Postpartum Depression

Postpartum depression as it is experienced by Mexican American adolescent and adult mothers can be best understood as a social construct. The creation and perpetuation of depression is intertwined with the meanings attached to maternity. Postpartum depression as it is experienced by Mexican American mothers does not exist in isolation but rather is part of a much larger cultural framework. Narratives of self-reported depressed Mexican American adolescent and adult mothers revealed the strong influence of culture influencing both the pregnancy and motherhood experiences. Culturally produced attitudes and perceptions regarding specific attributes constituting good mothers are evident throughout the interviews. Even the most depressed mothers were hesitant to complain about their depressive experiences or situations. Many of the mothers expressed willingness to accept their situations, often without question. Adolescent mothers viewed motherhood as a punishment for irresponsible sexual
behavior while both groups of mothers normalized depressive symptoms.

Postpartum depression is closely tied with the ideals and myths of motherhood. All of the adolescent and adult mothers expressed the desire to be good mothers and reiterated the love they felt for their babies. Although many of the adolescents recognized that they were not ready for motherhood, they believed that with enough motivation and effort, they could learn to accept their situations and connect with their children.

The makeup of depression, including symptoms and causes, is embedded within the Mexican American culture and is consistent among both adolescent and adult mothers. Viewing postpartum depression as a social construct exposes social factors that contribute and in some causes cause depression among teen and adult mothers. Ignoring the social factors perpetuates victim-blaming mentality while ignoring the structural constraints contributing to this social condition.

Previous Key Theoretical Frameworks

The theoretical framework originating from this study assists in bridging the gap between sociological, feminist, and public health theory focusing on the fragmented identities resulting in postpartum depression among Mexican American adolescent and adult mothers. More specifically, explanations of postpartum depression derive from medical sociology and feminism while help-seeking behavior and structural determinants of mental health pertaining to both Mexican American adolescent and adult mothers are best understood applying a public health framework. Although the exact causes of postpartum depression are unclear, the literature focuses predominately on three commonly cited theoretical orientations: the medical, psychosocial, and feminist models. Each approach to postpartum depression differs in scope and across discipline and is examined next.
Unplanned Pregnancy – creates a fragmented identity

– Shock of pregnancy
– Partner & family reactions
– Disconnect between pregnancy and its consequences (unattainable expectations)

Actual Situation                 [State of Normlessness]      Expected Occurrence
(Teenage Motherhood)                                                           (Childless Adolescence)
[Gap between actual and expected behavior]

Fragmented Identity

– Internal struggle between cultures (traditional gender roles, expectations of women)
– Stigma of teen motherhood
– Weight gain/body image
– Family conflict (causing them to doubt parenting ability)
– Medicalization of childbirth

Postpartum Depression

Figure 1. Fragmented identity applied to postpartum depression.
Medical Approach

The medical model of mental illness is frequently applied to postpartum depression as evident throughout the literature. The medical model views causes and symptoms of mental illness as existing solely within the individual (Scheff, 1984). For example, medical explanations of postpartum depression include sudden hormonal changes, issues related to the thyroid gland, and poor diet (Doermann, Davidson, & Longe, 2007). The medical model assumes that postpartum depression is best handled through medical intervention and will worsen if left untreated. Studies suggest that postpartum depression can effectively be treated through a combination of antidepressants and psychotherapy (Doermann, Davidson, & Longe, 2007; Zieman, 2010). The Mayo Clinic also suggests that in some cases postpartum depression may be treated through hormone replacement therapy although effectiveness is limited (2008).

Although medicalizing postpartum depression has called attention to the serious nature of the condition, aiding in the fight against the stigma of mental illness, it ignores structural determinants of mental health specifically poverty, discrimination, and gender inequality. All of these issues must be considered when examining postpartum depression among Mexican American mothers in particular. Mexican Americans encounter multiple stressors directly linked to lower socioeconomic positions and difficulties accessing culturally competent and affordable health care and social services (Goodkind et al., 2008). The medical approach to postpartum depression often neglects the connection between the social self and the physical body, thus discounting cultural variations in mental health.

Psychosocial Approach

The psychology literature focuses on psychosocial explanations of postpartum depression emphasizing the mind/body connection. For instance, low self-esteem, stress, lack of social
support, and marital dissatisfaction are a few of the social factors commonly associated with postpartum depression (Leitch, 2002). Unlike much of the medical literature, the discipline of psychology has expanded to include postpartum depression among adolescents, focusing predominately on the connection between depression and substance abuse (Barnett et al., 1995). Although psychosocial explanations of mental health apply various social factors to the study of postpartum depression, as mentioned earlier, the role of society remains underemphasized while the focus remains on the individual.

Feminist Approach

Unlike the medical and psychosocial models of mental health, the feminist perspective argues that postpartum depression is not an illness residing within the individual mother, but rather a response to gender inequality perpetuated by patriarchal misconceptions of motherhood. The myth of motherhood includes the idea that all women desire to become mothers and when anyone deviates from this socially constructed ideal, they are perceived as flawed and in many cases stigmatized in society (Braverman, 1989; Bassin et al., 1994). The notion that motherhood is the sole reason for existing limits the life chances of women and holds those who do become mothers to unrealistic standards, thus setting them up to fail. The thought of failing at something thought to be natural often manifests in depression (Choi, Henshaw, & Tree, 2005). From a sociological perspective, the main critique of feminist theory is its historical failure to recognize multiple dimensions of inequality, specifically the intersection of race, class, and gender (Chafetz, 1997).

The three most commonly applied theoretical approaches illustrated earlier substantiate the varied explanations of postpartum depression. These frameworks present distinctive ways of viewing mental health issues, but fail to comprehensively represent postpartum depression as it is
experienced among Mexican American adolescent and adult mothers. Thus, a theoretical framework illustrating identity fragmentation is applied.

**Symptoms**

Adolescent and adult mothers experienced similar symptoms of postpartum depression revealing a fragmented identity. Social alienation in the forms of detachment and isolation is a predominant symptom of depression among the mothers interviewed. Self-reported depressed adolescent and adult mothers disconnect from themselves and thus exist in isolation, sometimes physically but more often mentally. Adolescent mothers exclude themselves from their peers, whom they believed no long understood them, and depending on the severity of their depression, from their families and partners. Teens also reported alienation from their selves and as a result were unable to openly express their emotions. Self-reported depressed adult mothers isolated themselves emotionally more often than adolescents. Adult mothers lived with their husbands and children rather than with their extended families, therefore they were unable to remove themselves physically to the same degree adolescent mothers were. However, adult mothers learned to detach themselves, thus many reported going through the motions required for daily survival. Adult mothers describe motherhood while depressed as “walking around like a zombie.”

Although the symptoms of depression between both groups of mothers are similar, their interpretation of depressive symptoms differs. Adolescent mothers used the terms anger and stress interchangeably with sadness and depression whereas adult mothers reported depressive symptoms but made the distinction between *feeling* depressed and *being* depressed. The confusion expressed by both groups of mothers regarding depressive symptoms highlights the stigma of depression in Mexican American culture. The stigma of mental illness, prevalent in
Mexican American culture, prevents depressed adolescent and adult mothers from communicating their feelings, thus suffering in isolation.

Participants from both groups explain the unwillingness of Mexican Americans to acknowledge depression. Mental health issues, particularly postpartum depression, are viewed as a weakness, embarrassing, and in many cases are not taken seriously. Those mothers who expressed depressive feelings were silenced, which deterred them from disclosing depression in the future.

Help-Seeking Behavior

Self-reported depressed Mexican American adolescent and adult mothers were hesitant to seek mental health care for a variety of reasons. Both groups of mothers normalized depression and believed that they had the ability to control the severity of their depressive symptoms. Both teens and adults expressed difficulties identifying and expressing depression. The inability to recognize and articulate depression is in part because of the stigma associated with mental illness in Mexican American culture. As expressed by both groups of mothers, depression in Mexican American culture is viewed as a weakness and is rarely discussed. The role of the family must be understood when examining help-seeking behavior. The families’ attitudes toward depression greatly influenced the mothers’ perceptions and were a barrier to mental health care among both adolescent and adult mothers. Although participants also identified frustration with the health care system, lack of health insurance, reliable transportation, and childcare as barriers to treatment, none were emphasized to the same extent as the normalization of depression and stigma.

Consequences of Postpartum Depression

The theoretical framework presented here demonstrates how social identities of Mexican
American adolescent and adult mothers become fragmented, which illustrates the social construction of postpartum depression. Consequences of postpartum depression shape virtually every area of a mother’s life, affecting the mothers’ mental and physical health and the infant’s development. A fragmented identity creates confusion, guilt, and shame among Mexican American adolescent and adult mothers, thus causing and perpetuating depressive symptoms.

**Infant Development**

Self-reported depressed Mexican American mothers, both adolescent and adults, described feeling detached from their babies from time to time and for the most part exhibited guilt for feeling the disconnection. Postpartum depression led to faulty ideas about infant development. For instance, adolescent mothers described feeling emotionally distant and dependent on their infants for love and affection. Teen mothers expressed that the most rewarding aspect of motherhood is having unconditional love from their children, and when feeling depressed, their babies generate interaction. The mothers’ happiness is often intertwined with their perceptions and expectations of their babies. The majority of the adolescent participants perceived their babies as happy because they rarely cried. Babies who do not cry were considered by most of the teen mothers as well behaved. Such perceptions were unique to the adolescents, whereas the adult mothers appeared to be more realistic regarding their babies’ development.

The consequences of postpartum depression can be severe. Postpartum depression creates detachment that can interfere with maternal bonding and infant development as documented in previous studies involving adolescent mothers (Holub et al., 2007). Numerous studies have reported the importance of maternal attachment and the difficulties that depressed mothers have bonding with their babies. For instance, maternal depression is linked to increased cognitive and
behavioral problems along with poor social and emotional adjustment beginning in infancy (Goodman et al., 2007). Depression also contributes to parenting difficulties thus many depressed mothers’ ability to empathize with their child is compromised (Goodman et al., 2007).

**Breastfeeding Behavior**

This research indicates that breastfeeding behavior is a contributing factor to postpartum depression among Mexican American adult mothers, but affected adolescent mothers to a lesser extent, and more frequently influenced the duration of breastfeeding rather than the initiation. Without exception, both adolescent and adult mothers initiated breastfeeding and four of the teen mothers were successful whereas none of the adult mothers were, meaning they all wished they could have prolonged breastfeeding and expressed guilt when they were unable to.

**Integration of Qualitative and Quantitative Findings**

Data gleaned from the qualitative interviews are consistent with the quantitative data displayed in chapter 4. There does not appear to be a relationship between the decision to breastfeed and self-reported mental health, which in part may be explained by the emphasis society places on breastfeeding and the association with good mothering. Another explanation may highlight the differences between the “baby blues” and postpartum depression. While mothers remained in the hospital they received social support from health care professionals, but the situation changed on returning home. Adolescent and adult mothers reported feeling depressed after being released from the hospital. This would also explain the significant relationship between the duration of breastfeeding and self-reported mental health. Quantitative findings from this study also indicate that as perceptions of mental health increase, so does the number of days spent breastfeeding. Therefore, as indicated throughout the narratives, depressive systems are more likely to accompany the inability to breastfeed among adults compared to
adolescent mothers; however, the efforts of many participants were met with a variety of obstacles.

Although there was a consensus among teen mothers, all expressing the belief that breastfeeding is the best option for their babies, they remained unemotional when discussing reasons for discontinuing. Factors associated with breastfeeding difficulties as reported by teen participants include: the inability to breastfeed, physical health issues, insufficient lactation, and uncooperative infants. Adolescent mothers expressed frustration with breastfeeding and were affected by the inconvenience.

While adult mothers also expressed the desire to breastfeed for as long as they were physically able, they expressed guilt and inadequacy when breastfeeding became difficult. Negative feelings associated with the inability to breastfeed demonstrate perceived failure and “bad mothering.” Adult mothers related breastfeeding with providing proper care of their infants and were disappointed when they were unable to meet their expectations. Studies show that breastfeeding reduces maternal stress thus positively affecting the mother’s mental health, but only when minimal obstacles are encountered (Kendall-Tackett, 2007). Adult mothers who perceived themselves as unable to provide the basic physical needs of their infants form a fragmented identity and are at risk of developing postpartum depression.

Summary

Postpartum depression is a complex phenomenon with social origins that is best understood by employing an interdisciplinary approach. As illustrated throughout this study, Mexican American adolescent and adult mothers experienced fragmented identities resulting from a combination of cultural and societal factors that shaped the pregnancy and motherhood experience thus contributing to postpartum depression.
CHAPTER 7

CONCLUSION

Discussion

Postpartum depression is a serious social problem affecting both adolescent and adult Mexican American mothers. As illustrated throughout this study, postpartum depression is closely associated with the socially constructed ideals and expectations of motherhood. The transition into motherhood is a complex process presenting numerous obstacles for both adolescent and adult mothers. Although similarities in the depressive experiences between both groups of participants were discovered, there are also some fundamental differences in the ways teen mothers construct meaning of their pregnancy and motherhood experiences, many of which revolve around the stigmatization of teen pregnancy and parenting.

Major Findings

The findings showed that teens and adult mothers normalized the myth of motherhood while also resisting commonly held gender roles and expectations of women, thus creating and upholding depression. The socially constructed premise of motherhood also demonstrates attitudes toward breastfeeding between both groups of mothers. Breastfeeding is one of the many expectations of mothering recognized by the majority of participants. Although breastfeeding is optimal, it is not always possible for many mothers. Mothers who felt pressured or guilty from an inability to breastfeed their babies often internalized societal expectation, which created guilt, disappointment, and subsequently, depression. As a result, the findings reported that both groups experienced a fragmented identity.

Most importantly, this research found that both adolescent and adult mothers expressed unconstructive feelings, thoughts, and behaviors because transitioning into motherhood often
created fragmented identities. However, specific manifestations of such negativity varied between the two groups. Although both adolescent and adult participants expressed powerlessness associated with an unplanned pregnancy, their experiences differed. For instance, teen mothers describing a more direct type of social control centered on the views and expectations of both their parents and boyfriends whereas adult mothers were controlled in more covert ways, both filtered through culture. For example, adult mothers believed they were in control of their decisions to a much greater extent than the adolescent mothers were; however, the relationships between adult participants and their mothers indicated the significant influence the family has concerning everyday life events.

Also, this study reported that between both groups an illusion of depression existed. There was a shared misunderstanding of postpartum depression. As a result, the participants normalized and attempted to control depressive symptoms often leading to denial and nondisclosure of the pain associated with depression. Normalization of depression is consistent with other studies indicating that new mothers sometimes mistake fatigue and weight loss for normal adaptation of motherhood (Chaudron et al., 2004). However, unlike previous studies, this research focuses on societal expectations associated with mothering as the main source of normalization.

Adolescent mothers often confuse depressive feelings with shame, stress, and anger and when relating their experiences such descriptions are sometimes used interchangeably with sadness and depression. Although some teen participants did use the term *depression* to describe their feelings, they denied depressive symptoms. Adult mothers appeared less confused about their feelings, but still unable to fully come to terms with their depressive state. As illustrated throughout this dissertation, such contradictory descriptions can be attributed to confusion, lack
of understanding, and stigma associated with depression.

Moreover, there were disparities between feeling depressed and identifying as depressed among teen mothers. The adult participants were less likely to describe their feelings as anger or stress, but rather used the terms sad and worried to convey their depressive experiences. Overall, adult mothers were more likely to admit depression although, similarly to adolescents, they resisted the depression label. Postpartum depression in the Mexican American community is perceived as a weakness and invokes ideas of poor mothering.

Both groups of mothers believed that depression is something that is largely ignored in their culture, but should be openly discussed. With this said, however, they did not feel comfortable for the most part discussing their feelings openly with those closest to them. Many indicated that they were more comfortable discussing depression during this study then they would be with those they consider key players in their lives.

Nondisclosure of depression was an important finding among both adolescent and adult mothers. Mothers from both groups expressed similar reasons for not wanting to openly discuss their depression. Many of the mothers said that the fear of being the subject of gossip prevented them from disclosing depression to others within their community, including some family members, friends, and acquaintances. Also, adolescent and adult mothers expressed that they were responsible for protecting their loved ones from their depression, clearly not wanting to “burden” them with their feelings. Teen mothers masked their depression from their mothers whereas several of the adult mothers prevented their husbands from learning their true feelings. The relationships that provide them the most social support were those they felt responsible for protecting the most.
Social Construction of Postpartum Depression

The interviews revealed how adolescent and adult mothers make sense of their depressive symptoms. Although both groups of mothers expressed similar obstacles since giving birth, the degree and consistency of emotional distress varied greatly between adolescent and adult mothers. The socially constructed makeup of postpartum depression is highlighted throughout this dissertation, thus enforcing the need for a greater understanding of the intersection of society and culture among both adolescent and adult Mexican American mothers.

Adolescent mothers: Adolescent mothers were hesitant to describe depressive symptoms as depression; rather, negative emotions such as anger, frustration, and sadness were expressed. Teen mothers also communicated contradictory feelings when asked to describe the affect of depression on their lives. The news of an unplanned pregnancy created feelings of shock, guilt, and fear among the adolescent participants. Pregnancy created anxiety among many of the teen mothers, but the severity of the negative emotions depended on how their families and to some extent partners perceived the news. Many of the teens concealed their pregnancies as long as possible because of the shame they felt. Those whose families were supportive from the very beginning said they were less depressed than those whose families were not understanding. Unplanned pregnancy created a gap between the actual situation (teen motherhood) and societal expectations (childless adolescence), thus forming a state of normlessness for teen mothers. Adolescent mothers were expected to transition into parenthood with little to no guidance. During this period of normlessness, teen mothers go through the motions required for survival but exhibit confusion and frustration while transitioning into their new role “teen mom.” The transitional period for the teen mothers created a fragmented identity composed of an internal struggle between cultures, including intergenerational conflict between themselves and their
parents; stigma of teen motherhood; weight gain and body image; and conflict with families, partners, and peers. The combination of the elements comprising fragmented identity contributed to postpartum depression among adolescent Mexican American mothers.

Adult mothers: Adult mothers, although hesitant to describe themselves as depressed, expressed a clearer understanding of what depression is, but were reluctant to apply it to their own situations compared to adolescent mothers. Although the adult mothers also expressed shock and disappointment on learning about their pregnancies, they were less concerned about the reactions of their families, partners, or friends, but instead immediately worried about their futures and the disruptions having a child creates. Adult participants expressed more realistic views concerning the responsibility of caring for and providing for a child, compared to the adolescent mothers. Although adult mothers experienced difficulties transitioning into the role of motherhood while internalizing the societal and cultural norms applied to mothers, they did not experience the state of normlessness common to adolescent mothers because society does not stigmatize adult pregnancy as it does teen pregnancy. However, the transition into motherhood was met with mixed feelings, including happiness and sadness, duration and suffering, inadequacy and sufficiency. Because of the unplanned nature of their pregnancy, adult mothers also exhibited features of a fragmented identity. Like the adolescents’, fragmentation time began upon learning the news of their pregnancy, causing anxiety and depressive symptoms resulting from an internal struggle between cultures, including the stress of resisting traditional gender roles, the expectations of mothers, weight gain and body image issues, and family conflict. However, unlike the teen mothers, adult participants expressed feeling detached from their babies and alienated from the labor experience because of the medicalized nature of giving birth in a traditional hospital setting. The factors listed earlier along with the medicalization of
childbirth created fragmented identities among Mexican American adult mothers.

Research Questions Answered

The qualitative portion of the study illustrates how social issues, external to the individual and occurring during the transitional stage of motherhood, contributes to postpartum depression among Mexican American adolescent and adult mothers.

For example, societal expectations of teen mothers are great, but they are given very little support and virtually no learning curve regarding parenting. They are expected to fulfill their role as teenager (study hard, graduate, and go to college) while also being the good mother that society expects them to be, which includes putting their children’s needs before their own, demonstrate effective parenting, meet the emotional needs of both their babies and partners while also keeping their own families happy. Adult mothers were also expected to instantly become self-sacrificing mothers who face enormous pressures associated with caring for a child while also working, attending college, and so on.

Data gleaned from in-depth interviews of both adolescent and adult mothers also reveals a connection between levels of acculturation and postpartum depression, thus calling attention to specific ways in which sociocultural factors shape motherhood among Mexican American mothers while distinguishing between risk and protective factors of postpartum depression.

The interviews from both adolescent and adult participants reveal the significant affect that both social and cultural factors play in shaping the motherhood experience. Both adolescent and adult mothers expressed guilt and shame for causing stress to their families, especially the teen mothers considering they received emotional and financial support from their immediate families. Although the family often serves as a buffer against depression, it can also intensify depressive symptoms, depending on the level of understanding and support offered. The strong
solidarity found among all of the participants and their families can intensify or lessen depression and anxiety and appears to fluctuate depending on the situation. All participants reported being close to their families while illustrating ways in which the boundaries become blurred if they went against the advice provided by their parents. The stress of wanting to please their families was often a source of frustration contributing to their depression.

Additionally, the qualitative phase of the study demonstrates how the pregnancy experience creates a foundation for motherhood among self-reported depressed adolescent and adult Mexican American mothers.

The pregnancy experiences for both adolescent and adult mothers created anxiety and negative emotions because they were unplanned. Adolescent mothers experienced shock, anger, and guilt when they learned they were pregnant. They believed they had disappointed their families, particularly their mothers, by becoming pregnant during adolescence. The negative feelings caused by the pregnancy contributed to depression by creating a normless state. The adult mothers, while also expressing shock and disappointment about becoming pregnant, felt torn between what the actual situation (being pregnant) and how they envisioned their lives (preparing for their careers and attending college). The gap between the actual situation and the reality began the process of identity fragmentation.

The quantitative portion of this study tested the relationship between breastfeeding behavior and self-reported depression among Mexican American adolescent and adult mothers.

As indicated in chapter 4, depression did not affect breastfeeding initiation but did decrease the duration of breastfeeding. Thus, self-reported depressed mothers were more likely to discontinue breastfeeding than nondepressed mothers were.

Also, three ordinal-regression models were employed that tested the relationship between
Mexican American mothers’ self-reported mental health and their perceptions of their babies’ physical health. The data show that mothers who self-report better mental health tend to view their children’s health more positively. Thus, depression does have a negative affect on health perceptions.

Implications for Future Research

There is a strong need for additional research pertaining to postpartum depression among Mexican American mothers, currently an area where few studies have been conducted. As evident throughout this research, culture plays a significant role in determining how mothers experience pregnancy and motherhood. Although there is a considerable body of literature aimed at understanding the symptoms and causes of postpartum depression, few focus on the sociocultural context in which it exists. Neglecting the fastest growing ethnic group in the United States presents an inadequate depiction of a very serious problem. An interdisciplinary approach to the study of postpartum depression is essential considering there is no consensus on the causes of maternal depression. Researchers from a variety of disciplines must work together to explore the needs and concerns of depressed Mexican American mothers.

Additionally, research focusing on adolescent mothers is crucial considering that they are at higher risk for developing postpartum depression compared to adult mothers. This research highlights the different ways in which depression is experienced among teen mothers compared to adults presenting specific areas requiring further study. For example, the connection among the stigma of teen motherhood, issues pertaining to intergenerational conflict, acculturation, and depression should be explored in greater detail and applied to other racial and ethnic groups, particularly second-generation immigrants. The theoretical framework of a fragmented identity as illustrated in chapter 6 can be applied to a variety of mental health disorders.
Policy Implications

This research involves a number of implications for health policy and advocacy pertaining to Mexican American mothers. This research clearly indicates the consequences of untreated postpartum depression among a vulnerable population. As explained by many of both adolescent and adult participants, postpartum depression often remains hidden because of the combination of cultural factors and meaning applied to mental illness. Mexican American mothers explained their reluctance to disclose depression to their families, friends, and partners, therefore diminishing the possibility of seeking care from a health care professional. Thus, mandatory screening of postpartum depression should be implemented throughout various time points. Many of the mothers interviewed expressed that they did not begin feeling depressed until they were released from the hospital and very few indicted that their primary care providers inquired about their emotional state during checkup visits.

This lack of investigation into the mother’s mental state may indicate that health care providers are often untrained and feel uncomfortable to address issues related to postpartum depression and that depressed mothers are not forthcoming with such information (Leiferman et al., 2008; Olson, Ardis et al., 2002). Therefore, it is not enough to depend on a depressed mother to disclose depressive symptoms or to simply trust nonverbal cues considering many mothers are socialized to mask depression (Olson et al., 2002). Instead, health care providers should probe by asking questions that are more detailed geared at uncovering latent characteristics of depression. Both groups of mothers fail to differentiate between depressed and nondepressed states, which in part are explained by the myth of motherhood. Health care providers should be both culturally competent and aware of Mexican American mothers’ failure to understand and articulate their emotions specifically those considered to be negative.
Maternity care should also be patient centered (Dipl et al., 2006), which requires a certain level of cultural competency among health care providers including providing Mexican American mothers with information about postpartum depression in both English and Spanish. Previous research indicates that White women receive more education on depression than Hispanic mothers (Wei et al., 2008). For example, in the initial prenatal visit, physicians and nurses should include depression and stress as disorders that can adversely affect pregnancy. Heath care professionals should obtain stress and depressive scores throughout the pregnancy. They could refer women to stress-reduction groups tailored to pregnant women. Health insurers should consider the inclusion of coverage for stress-reduction interventions for pregnant women and their immediate family members in all contracts. Such activities should be part of standard medical coverage. Additionally, because women and their families have long waits in maternity clinics, this time could be for health education regarding postpartum depression. Videos and DVDs on postpartum depression as well as the physical challenges during pregnancy could be used to educate while patients wait for physicians.

This study also calls attention to cultural factors associated with postpartum depression. It is not enough to assume that depression is experienced the same way across all races and ethnicities and classes. Therefore, medical, nursing, and allied health education should incorporate cultural competency, and promote an open dialogue between health care providers across specialties.

Interviews with Mexican American adolescent mothers also illustrate the consequences of abstinence-only sex education in public schools throughout the United States. For instance, Texas public schools emphasize abstinence only but it has the third highest teen birthrate in the United States compared to all other states (The University of Texas Prevention Research Center,
Reform in sex education is crucial considering many teen mothers do not understand the basics about birth control. It is also evident in this study that teens are not taught sex education at home. Additionally, pregnancy education should include the stress of pregnancy, postpartum depression, and the long-term consequences of depression on the fetus, infant, and childhood development. Moreover, it is essential for gestational education to be linked to broader societal issues. Instead of “blaming” pregnant women for depression, it is important for policy makers to understand the social pressures associated with the myth of “ideal motherhood” and the fragmented identity it perpetuates among many Mexican American women.

Conclusion

Postpartum depression can be viewed as a socially constructed phenomenon that affects both Mexican American adolescent and adult mothers. This dissertation compared the pregnancy and motherhood experiences of both groups while calling attention to breastfeeding behavior. Postpartum depression can best be explained through a process of a fragmented identity through which a disconnection forms between the actual situation and societal expectations. Mexican American adolescent mothers begin forming detachment from themselves, their babies, and society immediately after disclosing their pregnancies. Detachment often leads to social alienation in which young mothers are isolated and stigmatized by their peers, families, and society as a whole. Many mothers are unaware that they are withdrawing or confused as to why; therefore, they blame themselves, which prevents them from connecting with their social networks. Alienation among adolescent mothers produces a mechanical approach to mothering. Specifically, their daily lives are reduced to matters of emotional survival leading to depression.

Compared to adolescent mothers, adult mothers construct motherhood in a similar manner. Although adult mothers do not endure the stigma experienced by teen mothers, they do
experience motherhood as a fragmented identity, leading to postpartum depression.

Framing postpartum depression as a social construct calls attention to the numerous social, cultural, and structural dimensions of a condition often labeled and treated solely as a mental disorder.

Limitations

There are limitations to this study, some of which are methodological in nature whereas other constraints pertain directly to the nature and sensitivity of the topic. Due to the integration of both qualitative and quantitative techniques, studies employing a mixed-methods design encompass the limitations commonly associated with both methods. Therefore, special attention should be given to the “Fundamental Principle of Mixed Methods,” which states that all methods have strengths and weaknesses and that the strengths are complementary and the weaknesses do not overlap (Tashakkori & Teddlie, 2003). For instance, the qualitative findings cannot be generalized to larger populations of self-reported depressed Mexican American adolescent and adult mothers because of a relatively small number of participants and use of nonprobability sampling. Another limitation involves the restrictions of quantitative data analysis including lack of depth and breadth.

In addition to the constraints facing the separate qualitative and quantitative components of this study, there is also the limitation of priority that in this case is given to the qualitative phase of the study. Research giving priority to one method over the other could result in a less rigorous study (Tashakkori & Teddlie, 2003).

Additionally, there are limitations that apply to the specificity of this study. One limitation is the lack of current and available data examining postpartum depression in general and specifically Mexican American mothers of varying ages. Also, the stigma attached to the
topic of mental health made it more difficult for an outsider to elicit sensitive information.

Additionally, the adolescents sampled were all students at the same high school and part of the school’s parenting program, thus sharing similar socioeconomic backgrounds.
APPENDIX A

IRB APPROVAL LETTER
April 16, 2009

Melissa Gosdin
Department of Sociology
University of North Texas

Re: Human Subjects Application No. 08419

Dear Dr. Gosdin:

As permitted by federal law and regulations governing the use of human subjects in research projects (45 CFR 46), the UNT Institutional Review Board has reviewed your proposed project titled “The Social Construction of Postpartum Depression among Mexican American Mothers: A Mixed Methods Analysis.” The risks inherent in this research are minimal, and the potential benefits to the subject outweigh those risks. The submitted protocol is hereby approved for the use of human subjects in this study. **Federal Policy 45 CFR 46.109(e) stipulates that IRB approval is for one year only, April 16, 2009 to April 15, 2010.**

Enclosed is the consent document with stamped IRB approval. Please copy and use this form only for your study subjects.

It is your responsibility according to U.S. Department of Health and Human Services regulations to submit annual and terminal progress reports to the IRB for this project. The IRB must also review this project prior to any modifications.

Please contact Shelia Bours, Research Compliance Administrator, or Boyd Herndon, Director of Research Compliance, at extension 3940, if you wish to make changes or need additional information.

Sincerely,

Patricia L. Kaminski, Ph.D.
Associate Professor
Chair, Institutional Review Board

PK: sb
CC: Dr. Erma Lawson
University of North Texas Institutional Review Board

Minor Assent Form

Before agreeing to your child’s participation in this research study, it is important that you read and understand the following explanation of the purpose and benefits of the study and how it will be conducted.

**Title of Study:** The Social Construction of Postpartum Depression among Mexican American Mothers: A Mixed Methods Analysis

**Principal Investigator:** Melissa Gosdin, a graduate student in the University of North Texas (UNT) Department of Sociology

**Purpose of the Study:** You are being asked to allow your child to participate in a research study which involves questions about her personal experience with pregnancy, motherhood and health (both emotional and physical). The purpose of the study is to better understand the health needs of Mexican American mothers.

**Study Procedures:** Your child will be asked to participate in 2 interviews. She will also be asked to complete a questionnaire with basic information such as age, marital status, etc., and a health related form with 10 questions about her physical and emotional health. The interviews will take about 60-90 minutes.

**Foreseeable Risks:** The potential risk involved in this study is possible discomfort talking about emotions. However, your child will have the opportunity to talk with a healthcare professional if she is feeling sad after each interview.

**Benefits to the Subjects or Others:** We expect the project to benefit your child by giving the opportunity to talk openly about her experiences which will provide a better understanding of the health needs of Mexican American teen mothers.

**Compensation for Participants:** No compensation will be given.

**Procedures for Maintaining Confidentiality of Research Records:** This study is confidential and only the Principal Investigator, the translator and the faculty sponsor will have access to your child’s personal information; collected data will be maintained for 3 years past the end of the study per federal regulations. All information will be stored in a locked filing cabinet until the research is completed, in which it will then be destroyed. The interviews will be tape recorded for the purpose of collecting accurate information. All recordings will also be destroyed once the study is complete. The confidentiality of your child’s individual information will be maintained in any publications or presentations regarding this study.

**Questions about the Study:** If you have any questions about the study, you may contact graduate student Melissa Gosdin at telephone number (214)

Office of Research Services
University of North Texas
Last Updated: August 9, 2007
797-5458 or faculty advisor and professor, Dr. Erma Lawson, UNT Department of Sociology at telephone number (940) 565-2296.

Review for the Protection of Participants: This research study has been reviewed and approved by the UNT Institutional Review Board (IRB). The UNT IRB can be contacted at (940) 565-3940 with any questions regarding the rights of research subjects.

Research Participants' Rights: Your signature below indicates that you have read or have had read to you all of the above and that you confirm all of the following:

- Melissa Gosdin has explained the study to you and answered all of your questions. You have been told the possible benefits and the potential risks and/or discomforts of the study.
- You understand that you do not have to allow your child to take part in this study, and your refusal to allow your child to participate or your decision to withdraw him/her from the study will involve no penalty or loss of rights or benefits. The study personnel may choose to stop your child's participation at any time.
- You understand why the study is being conducted and how it will be performed.
- You understand your rights as the parent/guardian of a research participant and you voluntarily consent to your child’s participation in this study.
- You have been told you will receive a copy of this form.

______________________________
Printed Name of Parent or Guardian

______________________________
Signature of Parent or Guardian       Date

For the Principal Investigator: I certify that I have reviewed the contents of this form with the parent or guardian signing above. I have explained the possible benefits and the potential risks and/or discomforts of the study. It is my opinion that the parent or guardian understood the explanation.

______________________________
Signature of Principal Investigator     Date

Office of Research Services
University of North Texas
Last Updated: August 9, 2007
Minor Assent Form

You are being asked to be part of a research project being done by the University of North Texas Department of Sociology.

This study involves two interviews. You will be asked to share your experiences of pregnancy and motherhood. You will also be asked to fill out two questionnaires. One includes general information while the other asks health related questions.

You will be asked to talk to me on two different days. I will ask you questions about your pregnancy, what it’s like being a young mother and how you feel both emotionally and physically since becoming a mother. Each interview will take about 60-90 minutes.

If you decide to be part of this study, please remember you can stop participating any time you want to.

If you would like to be part of this study, please sign your name below.

Printed Name of Minor

Signature of Minor Date

Signature of Principal Investigator Date

APPROVED BY THE UNT IRB FROM 4/1/09 TO 4/15/10

Office of Research Services
University of North Texas
Last Updated: August 9, 2007
APPENDIX C

EDINBURGH POSTNATAL DEPRESSION SCALE
Edinburgh Postnatal Depression Scale\(^1\) (EPDS)

Name: ___________________________ Address: ___________________________

Your Date of Birth: ___________________________ Phone: ___________________________

Baby’s Date of Birth: ___________________________

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

Here is an example, already completed.

I have felt happy:
- Yes, all the time  
- Yes, most of the time  
- No, not very often  
- No, not at all  

This would mean: “I have felt happy most of the time” during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
- As much as I always could
- Not quite so much now
- Definitely not so much now
- Not at all

2. I have looked forward with enjoyment to things
- As much as I ever did
- Rather less than I used to
- Definitely less than I used to
- Hardly at all

3. I have blamed myself unnecessarily when things went wrong
- Yes, most of the time
- Yes, some of the time
- No, not very often
- No, never

4. I have been anxious or worried for no good reason
- No, not at all
- Hardly ever
- Yes, sometimes
- Yes, very often

5. I have felt scared or panicicky for no very good reason
- Yes, quite a lot
- Yes, sometimes
- No, not much
- No, not at all

6. Things have been getting on top of me
- Yes, most of the time
- Sometimes
- No, not at all

7. I have been so unhappy that I have had difficulty sleeping
- Yes, most of the time
- Yes, sometimes
- No, not very often
- No, not at all

8. I have felt sad or miserable
- Yes, most of the time
- Yes, quite often
- No, not very often
- No, not at all

9. I have been so unhappy that I have been crying
- Yes, most of the time
- Yes, quite often
- Only occasionally
- No, never

10. The thought of harming myself has occurred to me
- Yes, quite often
- Sometimes
- Hardly ever
- Never


Users may reproduce the scale without further permission providing they respect copyright by quoting the names of the authors, the title and the source of the paper in all reproduced copies.
Edinburgh Postnatal Depression Scale\(^1\) (EPDS)

Postpartum depression is the most common complication of childbirth. The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for “perinatal” depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt during the previous week. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the websites of the National Women’s Health Information Center <www.4women.gov> and from groups such as Postpartum Support International <www.chisp.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

<table>
<thead>
<tr>
<th>SCORING</th>
</tr>
</thead>
<tbody>
<tr>
<td>*<em>QUESTIONS 1, 2, &amp; 4 (without an <em>)</em></em></td>
</tr>
<tr>
<td>Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.</td>
</tr>
<tr>
<td>*<em>QUESTIONS 3, 5-10 (marked with an <em>)</em></em></td>
</tr>
<tr>
<td>Are reverse scored, with the top box scored as 3 and the bottom box scored as 0.</td>
</tr>
<tr>
<td>Maximum score: 30</td>
</tr>
<tr>
<td>Possible Depression: 10 or greater</td>
</tr>
<tr>
<td>Always look at item 10 (suicidal thoughts)</td>
</tr>
</tbody>
</table>

Users may reproduce the scale without further permission, providing they respect copyright by quoting the names of the authors, the title, and the source of the paper in all reproduced copies.

Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.
2. All the items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.


APPENDIX D

DEMOGRAPHIC QUESTIONNAIRE
Name: (First and Last) ____________________________.

Age: ____________________________.

What is your marital status? (Please Circle)

Never married

Married

Divorced

How many children do you have?

What are their ages? ____________________________.

Who do you currently live with? ____________________________.

Where were you born? ____________________________.

Do you currently attend school? ____________________________.

How many hours a week do you spend going to school (including homework and all school related activities)? ____________________________.

What is the highest grade level you have completed in school?

__________________________________________.

Do you have a job? ____________________________

If yes, how many hours per week do you work? ________.

Approximately how much money does your family make in a year?

(Leave blank if you do not know)

__________________________________________.

Date of delivery ____________________________.

Are you breastfeeding? ____________________________

Did you receive regular prenatal care? Please explain ____________________________.
When was your last postpartum visit (from your healthcare provider)?

______________________________.

Were you ever given information about postpartum depression? ________.

If yes, who gave you the information? ____________________________.

Do you have a family history of depression (please circle)

Yes, please explain ____________________________.

No

Do you have a primary care doctor? ________________.

When did you last see a doctor? ________________.

Do you have health insurance? ________________.

Do you have reliable transportation? ________________.

Sex of Baby: (Please Circle)     Girl       Boy

Baby’s Birth Weight: ________________, Gestational Age: ____________.

Did you experience any pregnancy related complications? (Please Circle)

Yes          No

If you circled yes please explain: ____________________________.

______________________________.

______________________________.

Number of people living in the house with you: ____________.

Describe your long-term goals: ____________________________.

______________________________.

______________________________.

Do you have plans to attend college? ____________________________?

Is your family supportive? (Please Explain)
Are your friends supportive? (Please Explain)

Has the father of your baby been supportive since giving birth? (Please Explain)

Is the father of your baby involved in the child’s life? (Please Explain)

Thank you. Your answers are helpful and very much appreciated!
APPENDIX E

ADOLESCENT INTERVIEW GUIDE
Instructions

Thank you for coming here today and for making time to participate in this study. Our discussion will help to understand the emotional health needs of Mexican American teenage mothers. I will first explain the study to you and then ask that you sign a consent form stating that you understand the purpose and your role in the study. Also, I will ask that you please fill out a brief questionnaire before we begin. The purpose of the questionnaire is to get some basic information from you.

The purpose of this study is to explore the emotional needs of Mexican American teenage mothers and to understand why they are not getting help from professional health care providers when they feel sad or depressed.

Please know that I am only interested in your experiences and opinions and that there is no right or wrong answers. Please know that you may choose not to answer any question and you may also end the interview at any time. You will not be penalized in any way for doing so.

The information that you share with me today will help other sad or depressed mothers in the future. Please know that our discussion will be kept confidential. In order to make sure that any identifying information is kept private all interview transcripts will be stored in a locked file and will be destroyed after the study is completed. With your permission I would like to audio record our conversation to ensure everything you say is remembered, with only the researcher having access to the tapes. The tapes will also be stored in a locked file and will be destroyed after the study is completed.

Do you have any questions or concerns before we begin? Today is the first of two interviews and will most likely last for an hour. When we are finished talking today we will schedule a time for you to come back for the second interview, a time that is most convenient for you of course. The reason for interviewing you twice at two different times is to keep the interview relatively short because I know that your time is valuable. If any questions come to mind during the interview please feel free to ask me afterward and I will be more than happy to answer any questions that you may have or if you are feeling sad or depressed when you leave here today I will refer you to a health professional for you to talk to. If you do not have any questions let’s go ahead and begin.

**The first few questions will help me to understand what your pregnancy was like.**

(1) If you would, tell me your name and where you are from. Then I would love to hear something about you.

(2) If you would think back to when you first learned that you were pregnant how did you feel?

*Probe:* Were you surprised?
*Probe:* Who did you tell first?
*Probe:* What was your partner’s reaction?
*Probe:* What was your family’s reaction?

(3) Thinking back what was a typical day like for you while you were pregnant?

*Probe:* What was working like while you were pregnant?
*Probe:* What was it like attending school while you were pregnant?

(4) When thinking back to when you were pregnant how do you remember feeling during that time?

*Probe:* Did you have morning sickness?
*Probe:* What types of things did you get upset or sad about?
Probe: What types of things stressed you out?

(5) When you were pregnant tell me in what ways did your body change?
   Probe: How did you feel about your changing body?
   Probe: How did you partner feel about your changing body?
   Probe: What types of things did your friends or classmates notice about your changing body?

(6) When thinking back to when you were pregnant tell me what types of things you and your partner did together?
   Probe: Did your partner go to the doctor with you?
   Probe: Did you and your partner go shopping for the baby together?

(7) Remember back to when you were pregnant who did you talk to about your feelings?
   Probe: How did you feel after talking to your partner?
   Probe: How did you feel after talking to your family?
   Probe: How did you feel after talking to your friends?
   Probe: Who helped you the most?

The next few questions will help me understand what it is like being a young mother.

(8) Describe a typical day.
   Probe: In what ways is motherhood like you imagined?
   Probe: In what ways is motherhood different than you imagined?
   Probe: What is the most difficult thing about being a young mother?
   Probe: What is the most rewarding thing about being a young mother?
   Probe: Have you always wanted to be a mother?

(9) Describe the time that you spend with your baby. What types of things do you do with your baby daily?
   Probe: How much time do you spend interacting with your baby daily?
   Probe: How much time does your partner spend interacting with the baby daily?
   Probe: How much time does your family spend interacting with the baby?

(10) How would you describe your relationship with your own mother?
    Probe: In what ways does your mother offer you support?
    Probe: In what ways has your relationship with your own mother changed since becoming a mother yourself.

(11) In what ways do you think being a teenage mother is different from being an older mother?
     Probe: In what ways do you think being a teen mother is similar to being an older mother?

(12) How well do you think people understand teen mothers?
     Probe: In what ways do you think people misunderstand teen mothers?
The next few questions will help me understand how feeling sad or upset affects your daily life.

(13) Since becoming a mother, tell me what types of things make you sad or upset?
   Probe: How often do you feel sad or upset?
   Probe: What do you do when you are feeling sad or upset?
   Probe: In what ways do you express your sadness?
   Probe: When you are feeling sad what types of things do you do to feel better?

(14) In what ways has your life changed since you first started feeling sad after your baby was born?
   Probe: When you are feeling sad how would you describe your interaction with your baby? Do you think that your sadness/depression affects your baby?
   Probe: When you are feeling sad how would you describe your interaction with your partner? What about interaction with your family?

(15) When you get sad or upset who do you talk to?
   Probe: Who in your life is the most supportive?
   Probe: Do they understand why you get sad?
   Probe: What kind of advice do they give you when you are feeling sad or depressed?

(16) How does your partner deal with you being sad or upset?
   Probe: What does your partner do when you are feeling sad?
   Probe: What could your partner do to help you when you are feeling sad or upset?

(17) Some people believe that depression is a personal issue and should not be talked about. What are your thoughts about that?

(18) How does talking about your being sad or upset make you feel?
   Probe: Does talking about feeling sad or upset make you feel better?
   Do you believe that your partner, family and/or friends understand why you get sad or upset?

(19) Who do you talk to when you are feeling sad or depressed?
   Probe: Have you talked to your partner about feeling sad or depressed? Your family? Your church minister or priest? Friends? Your teacher?

(20) Sometimes young mothers are depressed and do not know it. What do you think about this?
   Probe: Do you know young mothers who are depressed?

(21) How would you describe your overall health, both physically and emotionally?
   Probe: Do you consider yourself to be depressed?
   Probe: What does depression mean to you? How would you describe it?
Probe: In your opinion, how serious of a health problem is depression after childbirth?

(22) How is depression viewed in the Hispanic community?
Probe: What have you heard about depression?
Probe: What have you heard about postpartum depression?
Probe: Is depression something that is openly talked about?

That’s all we have to talk about for today. Do you have any questions for me? Before you leave can be decide on a time for the second interview?

Interview #2

Hello! Welcome back. I enjoyed our last conversation and would like to take the next hour or so to finish up where we left off. Do you have any questions or concerns before we begin today?

Once again, if any questions come to mind during the interview please feel free to ask me afterward and I will be more than happy to answer any questions that you may have or if you are feeling sad or depressed when you leave here today I will refer you to a health professional for you to talk to. If you do not have any questions let’s go ahead and begin.

The questions today focus on getting medical help from a doctor or other healthcare professional.

(23) Some young mothers feel sad or depressed often but do not get the help they need why do you think that is?

(24) How do you feel about talking to a doctor or counselor about feeling sad or depressed?
Probe: Have you ever talked to a doctor or other healthcare professional about being sad or depressed? If so can you explain how it went?
Probe: Has any doctor ever talked to you or given you information about depression since giving birth?

(25) What are some reasons that might keep you from going to see a doctor or any other healthcare provider about feeling sad or depressed?
Probe: Do you believe that a doctor, nurse, counselor etc. can help young mothers who are feeling sad or depressed?
Probe: If you were to see a doctor would you have a way to get there?
Probe: If you were to see a doctor could you take time off work to go or do you have someone to watch your child?
Probe: If you were to see a doctor who would you bring with you for support?

(26) In your opinion, tell me how doctors or other healthcare professionals relate to depressed young mothers?
Probe: Do you think doctors or other healthcare professionals listen to what
young depressed mothers have to say?

Probe: Do you think doctors or other healthcare professionals understand how young depressed mothers feel?

Probe: Do you think doctors feel comfortable talking to young mothers about sad or depressed feelings?

Probe: How can doctors make mothers feel more comfortable about talking about sad or depressed feelings?

Probe: How important is it that your doctor or counselor be a fluent Spanish speaker?

(27) What would you want doctors or other healthcare professionals to know about young Hispanic mothers?

Probe: Do you believe doctors or other health care professionals understand your culture?

(28) Some people choose not to see a doctor when they are feeling sad or depressed because it goes against their religious beliefs. What are your thoughts about that?

Probe: Can you think of other reasons why young mothers may choose not to go to a doctor or other healthcare professional when feeling sad or depressed?

(29) If you were to tell your partner that you were considering talking to a doctor or other health care provider about feeling sad or depressed what do you think he would say? What do you think your family would say? What kind of advice/support would they give you?

(30) Tell me what you know about mental health professionals and if anyone you know has ever been to one (counselors, psychologists, psychiatrists, social workers, etc.?)

Probe: What are your thoughts about talking to such a person about your feelings?

Probe: Where would you go to see a mental health professional?

(31) If a doctor thought you needed treatment for depression would you ever consider taking medication? Would you consider talking to a counselor on a regular basis?

(32) a. In what ways does NOT having health insurance affect your healthcare decisions, particularly concerning your emotional health and wellbeing?

Probe: Which doctor, hospital or clinic would you go to if you decided to talk to someone about feeling sad or depressed?

Probe: Would you consider talking to a doctor about feeling sad or depressed if you had health insurance?

Probe: Do you know what doctors or clinics take patients without health insurance?

If participant has health insurance then ask:
b. In what ways does HAVING health insurance affect your healthcare decisions, particularly concerning your emotional health and wellbeing?

Probe: Does having health insurance make doctor visits affordable?

Probe: Can you see a mental health specialist if you choose to? Do you know how much it might cost?

We are just about finished with the interview.

(33) Before we finish I would like to ask if you can think of other reasons that may keep young Hispanic mothers from seeing a healthcare professional when they are feeling sad or depressed that I may have forgotten to ask?

(34) Is there anything else you would like to share with me?

(35) Do you have any questions that you would like to ask me?

I appreciate you coming to talk to me again today and thank you for sharing your thoughts and experiences with me. It has been a great experience for me and I know that your information will help other mothers.
APPENDIX F

ADULT INTERVIEW GUIDE
Instructions

Thank you for coming here today and for making time to participate in this study. Our discussion will help to understand your experience as a Mexican American teenage mother. I will first explain the study to you and then ask that you sign a consent form stating that you understand the purpose and your role in the study. Also, I will ask that you please fill out a brief questionnaire before we begin. The purpose of the questionnaire is to get some basic information from you.

The purpose of this study is to explore your feelings about becoming a mother.

Please know that I am only interested in your experiences and opinions and that there is no right or wrong answers. Please know that you may choose not to answer any question and you may also end the interview at any time. You will not be penalized in any way for doing so.

The information that you share with me today will help other mothers in the future. Please know that our discussion will be kept confidential. In order to make sure that any identifying information is kept private all interview transcripts will be stored in a locked file and will be destroyed after the study is completed. With your permission I would like to audio record our conversation to ensure everything you say is remembered, with only the researcher having access to the tapes. The tapes will also be stored in a locked file and will be destroyed after the study is completed.

Do you have any questions or concerns before we begin? Today is the first of three interviews and will most likely last for an hour. When we are finished talking today we will schedule a time for you to come back for the next interview, a time that is most convenient for you of course. The reason for interviewing you three times at three different times is to keep the interview relatively short because I know that your time is valuable. If any questions come to mind during the interview please feel free to ask me afterward and I will be more than happy to answer any questions that you may have or if you are feeling sad or depressed when you leave here today I will refer you to a health professional for you to talk to. If you do not have any questions let’s go ahead and begin.

The first few questions will help me to understand what your pregnancy was like.

(1) If you would, tell me your name and where you are from. Then I would love to hear something about you.

(2) If you would think back to when you first learned that you were pregnant how you feel?
   
   Probe: Were you surprised?
   
   Probe: Who did you tell first?
   
   Probe: What was your partner’s reaction?
   
   Probe: What was your family’s reaction?

(3) Thinking back what was a typical day like for you while you were pregnant?
Probe: What was it like working while you were pregnant?

(4) When thinking back to when you were pregnant how do you remember feeling during that time?
   Probe: Did you have morning sickness?
   Probe: What types of things did you get upset or sad about?
   Probe: What types of things stressed you out?

(5) When you were pregnant in what ways did your body change?
   Probe: How did you feel about your changing body?
   Probe: How did you partner feel about your changing body?

(6) When thinking back to when you were pregnant what types of things did you and your partner do together?
   Probe: Did your partner go to the doctor with you?
   Probe: Did you and your partner go shopping for the baby together?

(7) Remember back to when you were pregnant who did you talk to when you were having a bad day or feeling sad?
   Probe: How did you feel after talking to your partner?
   Probe: How did you feel after talking to your family?
   Probe: How did you feel after talking to your friends?
   Probe: Who helped you the most?

The next few questions will help me understand what it is like being a mother.

(8) Describe a typical day.
   Probe: In what ways is motherhood like you imagined?
   Probe: In what ways is motherhood different than you imagined?
   Probe: What is the most difficult thing about being a mother?
   Probe: What is the most rewarding thing about being a mother?
   Probe: Have you always wanted to be a mother?

(9) Describe the time that you spend with your baby. What types of things do you do with your baby daily?
   Probe: How much time do you spend interacting with your baby daily?
   Probe: How much time does your partner spend interacting with the baby daily?
   Probe: How much time does your family spend interacting with the baby?

How would you describe your relationship with your own mother?
   Probe: In what ways does your mother offer you support?
   Probe: In what ways has your relationship with your own mother changed since becoming a mother yourself.

The next few questions will help me understand how feeling sad or upset affects your daily life.
(10) Since becoming a mother what types of things make you sad or upset?
   *Probe:* How often do you feel sad or upset?
   *Probe:* What do you do when you are feeling sad or upset?
   *Probe:* In what ways do you express your sadness?
   *Probe:* When you are feeling sad what types of things do you do to feel better?

(11) In what ways has your life changed since you first started feeling sad after your baby was born?
   *Probe:* When you are feeling sad how would you describe your interaction with your baby? Do you think that your sadness/depression affects your baby?
   *Probe:* When you are feeling sad how would you describe your interaction with your partner? What about interaction with your family?

(12) When you get sad or upset who do you talk to?
   *Probe:* Who in your life is the most supportive?
   *Probe:* Do they understand why you get sad?
   *Probe:* What kind of advice do they give you when you are feeling sad or depressed?

(13) How does your partner deal with you being sad or upset?
   *Probe:* What does your partner do when you are feeling sad?
   *Probe:* What could your partner do to help you when you are feeling sad or upset?

(14) Some people believe that depression is a personal issue and should not be talked about. What are your thoughts about that?

(15) *How does talking about your being sad or upset make you feel?*
   *Probe:* Does talking about feeling sad or upset make you feel better?
   Do you believe that your partner, family and/or friends understand why you get sad or upset?

(16) Who do you talk to when you are feeling sad or depressed?
   *Probe:* Have you talked to your partner about feeling sad or depressed? Your family? Your church minister or priest? Friends?

(17) Sometimes mothers are depressed and do not know it. What do you think about this?
   *Probe:* Do you know mothers who are depressed?

(18) How would you describe your overall health, both physically and emotionally?
   *Probe:* Do you consider yourself to be depressed?
   *Probe:* What does depression mean to you? How would you describe it?
   *Probe:* In your opinion, how serious of a health problem is depression after childbirth?
(19) How is depression viewed in the Hispanic community?

*Probe:* What have you heard about depression?
*Probe:* What have you heard about postpartum depression?
*Probe:* Is depression something that is openly talked about?

That’s all we have to talk about for today. Do you have any questions for me? Before you leave can be decide on a time for the second interview?

**Interview #2**

Hello! Welcome back. I enjoyed our last conversation and would like to take the next hour or so to finish up where we left off. Do you have any questions or concerns before we begin today?

Once again, if any questions come to mind during the interview please feel free to ask me afterward and I will be more than happy to answer any questions that you may have or if you are feeling sad or depressed when you leave here today I will refer you to a health professional for you to talk to. If you do not have any questions let’s go ahead and begin.

The questions today focus on getting medical help from a doctor or other healthcare professional.

(20) Some mothers feel sad or depressed often but do not get the help they need why do you think that is?

(21) How do you feel about talking to a doctor or counselor about feeling sad or depressed?

*Probe:* Have you ever talked to a doctor or other healthcare professional about being sad or depressed? If so can you explain how it went?
*Probe:* Has any doctor ever talked to you or given you information about depression since giving birth?

(22) What are some reasons that might keep you from going to see a doctor or any other healthcare provider about feeling sad or depressed?

*Probe:* Do you believe that a doctor, nurse, counselor etc. can help mothers who are feeling sad or depressed?
*Probe:* If you were to see a doctor would you have a way to get there?
*Probe:* If you were to see a doctor could you take time off work to go or do you have someone to watch your child?
*Probe:* If you were to see a doctor who would you bring with you for support?

(23) In your opinion, how do you think doctors or other healthcare professionals relate to depressed mothers?

*Probe:* Do you think doctors or other healthcare professionals listen to what depressed mothers have to say?
*Probe:* Do you think doctors or other healthcare professionals understand how
depressed mothers feel?

 Probe: Do you think doctors feel comfortable talking to mothers about sad or
depressed feelings?

 Probe: How can doctors make mothers feel more comfortable about talking about
sad or depressed feelings?

 Probe: How important is it that your doctor or counselor be a fluent Spanish
speaker?

(24) What would you want doctors or other healthcare professionals to know about
Hispanic mothers?

 Probe: Do you believe doctors or other health care professionals understand
your culture?

(25) Some people choose not to see a doctor when they are feeling sad or depressed
because it goes against their religious beliefs. What are your thoughts about that?

 Probe: Can you think of other reasons why mothers may choose not to go to a doctor or
other healthcare professional when feeling sad or depressed?

(26) If you were to tell your partner that you were considering talking to a doctor or other health
care provider about feeling sad or depressed what do you think he would say? What do you think
your family would say? What kind of advice/support would they give you?

(27) Tell me what you know about mental health professionals and if anyone you know has ever
been to one (counselors, psychologists, psychiatrists, social workers, etc.?)

 Probe: What are your thoughts about talking to such a person about your feelings?

 Probe: Where would you go to see a mental health professional?

(28) If a doctor thought you needed treatment for depression would you ever
consider taking medication? Would you consider talking to a counselor on a
regular basis?

(29) In what ways does NOT having health insurance affect your healthcare
decisions, particularly concerning your emotional health and wellbeing?

 Probe: Which doctor, hospital or clinic would you go to if you decided to talk to
someone about feeling sad or depressed?

 Probe: Would you consider talking to a doctor about feeling sad or depressed if
you had health insurance?

 Probe: Do you know what doctors or clinics take patients without health
insurance?

 If participant has health insurance then ask:

 In what ways does HAVING health insurance affect your healthcare decisions, particularly
concerning your emotional health and wellbeing?

 Probe: Does having health insurance make doctor visits affordable?

 Probe: Can you see a mental health specialist if you choose to? Do you know
how much it might cost?

**We are just about finished with the interview.**

(30) Before we finish I would like to ask if you can think of other reasons that may keep Hispanic mothers from seeing a healthcare professional when they are feeling sad or depressed that I may have forgotten to ask?

(31) Is there anything else you would like to share with me?

(32) Do you have any questions that you would like to ask me?

I appreciate you coming to talk to me again today and thank you for sharing your thoughts and experiences with me. It has been a great experience for me and I know that your information will help other mothers.
REFERENCES


Groer, Maureen, Daivs, Mitzi 7 Hemphill, Jean (2002). Postpartum stress: Current concepts


Lagomasino, Isabel T., Dwight-Johnson, Megan, Miranda, Jeanne, Zhang, Lily, Liao,


Mann, Mary Beth, Pearl, Peggy T. & Behle, Pamela (2004). Effects of parent education
on knowledge and attitudes. *Adolescence, 39*(54), 355-360.


