HOW PARTNERS, IDENTIFIED SUPPORT PERSONS, AND FAMILY MEMBERS
OF MOTHERS UNDERSTAND POSTPARTUM DEPRESSION, USING A FEMINIST
POST-STRUCTURALIST LENS

by

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Dalhousie University is located in Mi'kma'ki, the

ancestral and unceded territory of the Mi'kmaq.

We are all Treaty people

DEDICATION

Dedicated to the inner child within me and all those who have had to struggle and make

sacrifices to attain a life of freedom

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Abstract

Postpartum depression (PPD) remains a significant mental health challenge for numerous families. Both mothers and their partners often lack sufficient knowledge and preparation for dealing with PPD. Additionally, discussions about mental health continue to be challenging for many people. The purpose of this qualitative study was to explore the experiences of partners' family members and identified support individuals of mothers with babies aged 0-12 months regarding PPD and answering these two questions:1) What are the experiences of partners, identified support persons and family members regarding PPD? 2) How are their experiences socially and institutionally constructed? Seven participants shared their experiences through in-depth, semi-structured interviews. Using the methodology of feminist poststructuralism during data analysis, their beliefs, values, and practices were identified. Four themes were found through the data analysis phase:1:) Challenge the Meaning of a Normal Mother, 2) Navigating Judgements about Mental Health, 3) A Family Affair: PPD No One's and Everyone's Business, and 4) Valuing Knowledge and Awareness of PPD. Various discourses about PPD and mental health during motherhood were navigated, accepted and challenged by participants. The discourse of mental health and PPD were revealed as taboo subjects, causing stigmatization. Participants were also aware of judgemental views around PPD that negatively affected their help-seeking behaviours. Participants highlighted the importance of family support, especially partners' support. They believed PPD was a family and societal issue as well as a personal issue. They believed that there should be more awareness and discussion about PPD and mental health in society, the health system, and among family and friends.

List of Abbreviations Used

PDD   Postpartum Depression

FPS   Feminist Poststructuralism

EPDS   Edinburgh Postnatal Depression Scale

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Chapter 1

Introduction

Having a baby can be a remarkable experience in a person's life. However, the postpartum period is also transformative and crucial in new parents' lives. This stage of life may include many challenges, demands, special needs, and concerns. Postpartum mothers are prone to mental health issues on account of experiencing considerable changes in their physiology, emotional state, financial situation, and social support (Cheng et al., 2022). Mental health issues are one of the potential challenges that parents with new babies may encounter. Maternal and child mental health has officially been recognized as a public health issue with high priority (Poreddi et al., 2020). Depression is a highly prevalent mental health issue among postpartum mothers (Tani & Castagna, 2017). It is also mentioned as a substantial health concern for mothers from diverse cultures (Lanes et al., 2011). Postpartum depression (PPD) is considered the most common complication of childbirth, diagnosed in 10–20% of new mothers in high- and low-income countries (Moore Simas et al., 2019). It is significant to note that PPD occurs in 8% of Canadian mothers (Dennis et al., 2012). PPD is characterized by severe episodes of depression that can cause disability, but with proper treatment, it can be effectively managed (Stewart & Vigod, 2016). PPD is more likely to happen within four weeks after birth and can last six months to two years after delivery (Liu et al., 2022). Although the symptoms can differ depending on the severity of the illness, PPD is recognized with symptoms like lack of interest, low self-esteem, tiredness, sadness, sleep disturbance, loss of appetite, hostile attitude towards infants, self-blame, and feelings of humiliation (Liu et al., 2022).

PPD is a priority for the healthcare system and must be studied from different perspectives as it is a highly prevalent social health problem that affects the mother, newborn, partner, and other family members who support the mother (Alshikh Ahmad et al., 2021). PPD can bring about negative maternal outcomes like high fatigue levels and adverse child outcomes such as child hyperactivity/inattention and physical aggression (Dol et al., 2021). Furthermore, PPD is also associated with adverse consequences related to suicide in mothers, maternal and child bonding, family relationships, and child development (Juntaruksa et al., 2017). It is also important to note that suicide is considered the leading cause of death in postpartum mothers (Praetorius et al., 2020). The presence of PPD can also increase conflict in a couple's relationship (Moore Simas et al., 2019). PPD symptoms can be associated with depression and anxiety during pregnancy, postpartum blues, past psychiatric history, childcare stress, marital conflict, and lack of social support (Dennis et al., 2012). There is also a significant association between the development of PPD and the mother's stress level during pregnancy and support availability after childbirth (Lanes et al., 2011).

Screening PPD symptoms is an essential element of care for mothers. Unfortunately, many mothers may suffer in silence due to a lack of awareness about PPD symptoms, so PPD incidence can be underestimated easily. Therefore, a reliable screening tool for early and precise symptom identification is crucial. The Edinburgh Postnatal Depression Scale (EPDS) is a widely used self-reporting scale for assessing the risk of depression in postpartum mothers. However, a further psychiatric assessment is required for a depression diagnosis (Hanna et al., 2004). Nonetheless, diagnosis can be pointless without effective and early treatment (Goodman, 2009). Treatment for PPD is

usually provided in both pharmacological and nonpharmacological types, and these treatment options are received by a low percentage of postpartum mothers diagnosed with PPD (Goodman, 2009). Early help-seeking can diminish adverse outcomes of PPD (Swami et al., 2020). Nevertheless, a vast number of people who are suffering from mental health issues are not provided with prime help (Swami et al., 2020). So, as Goodman (2009) states, it is critical to understand the facilitators and barriers to mothers' early help-seeking and the factors affecting their preference for the treatment they decide to receive.

Mothers often turn to partners, family members, friends, other mothers, and healthcare providers for their primary source of support during the postpartum period, as noted by Letourneau et al. (2007). Furthermore, postpartum mothers highlight the crucial role of having a supportive spouse to provide emotional support in coping with PPD symptoms (Letourneau et al., 2007). According to Vliegen et al. (2014), poor relationships with partners and social support are critical risk factors for PPD, and mothers diagnosed with PPD often experience dissatisfaction with spousal support and relationships. However, partners, family members, and identified support persons can play a critical role in preventing and managing symptoms of PPD by providing support during the postpartum period (Tani & Castagna, 2017). Mothers' partners can facilitate access to professional help for mental health problems during the postpartum period (Luís et al., 2019). While many mothers consider their partner as their primary support person, some postpartum women face challenges in expressing mental health issues and demonstrating the severity of symptoms and the need for help from their partners (Letourneau et al., 2007). Letourneau et al. (2007) conducted a descriptive qualitative

study on the perceived support needs of Canadian mothers during PPD, examining their preferences for support intervention, support resources, and barriers to support. The study found that mothers identified a lack of understanding and knowledge of PPD in their partners, as well as a perceived inability of partners to assist them in adjusting to their new role and the implications of PPD symptoms.

Letourneau et al.'s (2007) study identified stigmatization, marginalization of symptoms, and discouragement from seeking help as factors that hindered help-seeking for PPD among mothers. Unfortunately, despite the high prevalence and importance of PPD, social stigma, discourses, and labelling often lead to the underestimation and untreated nature of this issue. For instance, families often view mothers as playing a crucial role and having mental health problems is stigmatized and goes against their values (Sampson et al., 2021). Mishra (2022) points out that mental attitudes and inadequate individual and social understanding of PPD can lead to mothers suffering in silence and without support. Furthermore, a lack of knowledge, beliefs, values, and poor mental health literacy by mothers and their relatives or partners can lead to increased untreated PPD symptoms. According to Letourneau et al. (2007), a better understanding of PPD is crucial in facilitating the recognition of symptoms and help-seeking for postpartum mothers and their significant others. Unfortunately, despite considerable research on maternal mental health and PPD, there is limited knowledge about the experiences, including beliefs and values, held by partners and relatives who play a significant role in supporting mothers. To contribute to the existing literature, this study examines the experiences, including beliefs and values, held by partners and relatives toward PPD.

Purpose of the Study and Research Questions

This qualitative study utilized a feminist post-structuralist lens (FPS) to explore the experiences, including beliefs and values of partners, identified support persons, and family members of mothers with babies aged 0-12 months regarding PPD. Although the study's recruitment criteria were open to individuals of any gender identity, all the participants who ultimately took part in the study referred to the person they were supporting as "mother" and used the pronouns "she/her." Furthermore, all of the mothers referred to in this study gave birth to their babies within 0-12 months of the date of the interviews. The study addressed the following research questions: 1) What are the experiences of partners, identified support persons and family members regarding PPD? 2) How are their experiences socially and institutionally constructed? By examining the experiences of those in close contact with new mothers, this study filled gaps in the literature and used FPS to uncover the values, beliefs and practices of partners, support persons, and family members. The study's findings have implications for healthcare providers, aiding in the design of appropriate health service delivery for postpartum mothers, partners, identified support persons and family members to reduce the negative consequences of PPD. Additionally, the results provided essential information about partners', identified support persons', and family members' beliefs and values about PPD that the healthcare system could use to increase awareness, education, or preventive health services.

Locating Myself in the Research

According to Creswell and Poth (2016), qualitative researchers' writing inherently reflects their biases, cultural background, gender, social class, and political

beliefs. In other words, the author cannot be separated from the writing in a qualitative study. To account for this, qualitative researchers must practice reflexivity and "position" themselves in their writing to gain self-understanding of the biases, values, and experiences they bring to the study. In this study, the author's experience as a nurse and woman has influenced the ideas and approach. In February 2017, I earned a bachelor's degree in nursing from Tehran University of Medical Sciences. From then until July 2022, I worked at a major hospital in Iran, gaining experience in various units. Throughout my years of practice, I have developed a particular interest in mental, maternal, and child health. I have focused on postpartum care, an area of personal concern and fascination. As a registered nurse, I have provided care to postpartum mothers in various settings, including the post-delivery unit, ICU, CCU, general, and COVID units.

The field of postpartum care has always fascinated me due to the complexity of the issues that mothers face and the diverse coping styles and methods they adopt. Specifically, I became intrigued by PPD as a broad field full of gaps and untouched areas. This led me to pursue graduate studies, allowing me to explore this interest area from an academic perspective, leveraging my work experience in the field. During my master's program, I was fortunate to have a supervisor with similar research interests, which helped me to delve deeper into the study of feminist poststructuralism methodology and qualitative research. This methodology resonated with me as it closely aligns with my research interests. In my research, I position myself as a woman and a nurse, utilizing my experiences to better understand research participants' positions, experiences, beliefs, and values.

Chapter Two

Literature Review

While there is a wealth of literature on postpartum depression (PPD), there is a notable gap in the literature regarding the experiences and understanding of partners, identified support persons, and family members of mothers of PPD. Although numerous articles have addressed the prevalence, side effects, and determinants of PPD, a clear gap remains in the knowledge, beliefs, and values of the mothers' partners, identified support persons, and family members of PPD. This literature review examines the experiences of identified support persons of PPD and the stigma and discrimination associated with the condition. Specifically, this review evaluates discourses and definitions of PPD, help-seeking behaviours, and individual experiences. It is important to acknowledge that the term "mothers" used in this study refers to postpartum mothers who identify themselves as mothers, including individuals of various gender identities such as female, woman, male, man, non-binary, fluid, et cetera. The use of terms such as fathers, men, and couples in this literature review is based on the articles cited and not directly from this study. The subsequent section is structured as follows: First, the proposal reviews the existing literature on the role and significance of partners, identified support persons and family members in the postpartum period and the onset of PPD symptoms. Next, the review explores the literature on help-seeking behaviours, the challenges faced by mothers, and the coping strategies used to manage PPD. The review also examines studies investigating how stigma and discrimination may affect the experiences of mothers and their partners, identified support persons, and family members. Finally, the review assesses the literature on the experiences of PPD, focusing on beliefs, values, and

attitudes. The literature review identifies a significant gap in research related to the experiences, beliefs, and values of partners, identified support persons, and family members of mothers of PPD; the review then outlines the purpose of the present study and its research questions.

Partners, Identified Support Persons, and Family Members

The immediate social network surrounding mothers plays a significant role in their ability to cope with PPD and seek assistance. Extensive research has demonstrated that PPD is a phenomenon that extends beyond the individual mother and involves the entire family system. To identify the role of family members in reporting depressive symptoms of PPD, a cross-sectional study was conducted by asking family members to report depressive symptoms observed in new mothers and new mothers were also screened for PPD using the Edinburgh Postpartum Depression Scale (EPDS) (Nguyen et al., 2022). Depressive symptoms observed by family members in the study of Nguyen et al. (2022) were predictors of PPD, which indicates the importance of family members' role in detecting early PPD symptoms in mothers. Moreover, Magistris et al. (2013) conducted a systematic review to understand how PPD impacts the couple's relationship and found that the couple's relationship assumes a primary support role when symptoms of PPD first emerge. Extensive research has examined the association between PPD risk and different sources of social support (Honjo et al., 2018; Negron et al., 2013; Chi et al., 2016). Also, many studies found consistent evidence indicating that support from a woman's family, specifically her partner and mother, is a protective factor against the risk of PPD (Honjo et al., 2018; Negron et al., 2013; Chi et al., 2016). Conversely, women

experiencing PPD often report lower levels of approval, satisfaction, and support from their partners (Magistris et al.,2013).

Family relationships are also crucial to maternal mental health and PPD development. A descriptive, cross-sectional study conducted by Çankaya & Alan Dikmen (2022) showed the effect of family function and relationship satisfaction on protection from PPD and psychological interventions were suggested to improve relationship functioning to protect mothers against PPD (Çankaya & Alan Dikmen, 2022). Also, a culturally oriented grounded theory approach in a qualitative study conducted by Tang et al. (2016) for the assessment of PPD and social support in China revealed that social support has an essential role in mitigating the likelihood of PPD. This is achieved by reducing stress and responsibility associated with childcare and household tasks, as well as promoting elevated levels of self-esteem and maternal confidence, all of which are facilitated by understanding and appreciation provided by social support networks (Tang et al., 2016). In addition, attending to fundamental needs and accomplishing everyday tasks can contribute to the normalization of women's experiences, allowing them to maintain their sense of identity amidst the significant changes that surround them (Negron et al., 2013). Moreover, accessible support from a partner, friend, or family slightly reduces the life stressors for mothers, which is identified as predictive of PPD (Reid & Taylor, 2015; Negron et al., 2013). Therefore, using paternity leave by partners to participate in childcare and actively support mothers is deemed an essential factor in reducing the incidence of PPD (Magistris et al.,2013).

Dennis and Ross (2006) conducted a longitudinal study using questionnaires examining women's perceptions of partner support and conflict in relation to the

development of postpartum depressive symptoms. The study underscored the significance of emotional support in providing mothers with a sense of acceptance, care, value, and understanding. Furthermore, some research findings suggest that active participation by partners in household tasks and infant care can serve as a protective factor against mothers feeling overwhelmed and help them better cope with new life situations (Dennis & Ross, 2006; Faisal-Cury et al., 2020). A pilot retrospective survey-based study by O'Neill et al. (2019) examines the pre-post changes in depression symptom scores. The intervention involved receiving social support from friends and significant others. The results revealed a significant correlation between having a support person and the change in depression scores, indicating the positive effect of social support in reducing depression among mothers (O'Neill et al., 2019).

Simhi et al. (2021), in a cross-sectional survey, assessed the role of health beliefs and social support as mediators in the connection between sociodemographic variables and treatment preferences for PPD and found the importance of raising awareness among the mother's support circles as they can be encouraging in receiving the treatment. Moreover, Tang et al. (2021), in a comparative correlational study examining partner support and parent support on PPD among first-time mothers, mentioned the positive impact of support from parents and partners on the low level of PPD. Also, in the grounded theory approach qualitative study conducted by Tang et al. (2016) in China, many mothers mentioned the significant role of their partner in emotional support in all phases of childbirth, transition, coping, and adaptation. Nevertheless, Goodman et al. (2014), in a longitudinal study using interviews examining maternal depression associated with fathers' involvement with their children, indicates that when the

depression condition is prolonged, the father's involvement declines because fathers consider PPD a short-term issue. When partners' perceptions shift to a long-term condition, they withdraw their support and involvement (Goodman et al., 2014). Therefore, a partner's failure to provide needed support can adversely affect mothers' mental health and depression symptoms. Consistent with previous research, Negron et al. (2013), in a randomized trial to examine the postpartum view of women and their experiences with social support following childbirth, revealed that mothers identified their partners and family members as primary sources of support after childbirth. However, it is mentioned by some participants in the Tang et al. (2016) study that mothers bring unmet desires and needs from their partners to their mothers, friends, or other support persons. Seeking support from different people might have drawbacks as each person holds their own specific beliefs, values, and understanding of the postpartum period and PPD that can affect the way they offer support (Tang et al., 2016). Support persons can directly impact women's mental health and their desire and preference for help-seeking for their mental health problems, as seen in the study by Magistris et al. (2013), who state that when fathers consider the upbringing of the children as only women's responsibility, a sense of blaming and incapability may be received by mothers from their partners when they cannot meet the criteria of a perfect mother due to PPD symptoms and side effects.

Another critical risk factor noted in a cross-sectional study that assessed the relationship between postnatal depression, sociodemographic factors, and levels of partner support is parental confidence (Saligheh et al., 2014). The less parental confidence, the higher the levels of PPD, so the capability to understand and cope with

baby care will decrease the risk of PPD. Therefore, it is vital to have a trustworthy support person without judgement or negative beliefs about delegating the mother's responsibilities and asking for help and assistance for their childcare (Saligheh et al., 2014). In addition, one of the indirect impacts of having a support person for PPD and, in particular, a close circle of friends is that it is more likely that the woman will be able to get involved in physical activities, which positively influences mood and mental health (Saligheh et al., 2014). A cohort study showed lower levels of postpartum depressive symptoms or reduced risk of PPD among women who were married or in a cohabiting relationship with their baby's father, in comparison to women who were separated from their partner or not in a relationship during the initial postpartum year (Honjo et al., 2018). However, despite that, the quality of the relationship with the partner is also decisive, as the findings from a study comparing antenatal mental health outcomes in single motherhood versus poor partner relationships indicate that being in a relationship with inadequate partner support poses a greater risk to antenatal mental health, which subsequently has a direct impact on postpartum mental health, surpassing the risk associated with being a single mother. As a result, it is strongly recommended that the quality of partner support be assessed, as well as the factors influencing it (Bilszta et al., 2008). In addition, in the cohort study conducted by Honjo et al. (2018) that examined the relationship between living with family members and the risk of PPD in Japan, it was discovered that residing with in-law parents increases the risk of PPD. However, the detrimental impact of living arrangements, such as living with parent(s) in law, may be mitigated by a high level of perceived support from the partner for childcare responsibilities (Honjo et al., 2018).

A prospective study examining the impact of partner relationship quality on PPD yielded compelling findings (Faisal-Cury et al., 2020). The study revealed that women's perceptions of a positive relationship with their partner, coupled with no reported decline in their sexual life following childbirth during the 6 to 8 months postpartum period, were associated with a reduced likelihood of experiencing persistent depressive symptoms at 12 to 15 months after delivery (Faisal-Cury et al., 2020). This association may be attributed to the notion that women in satisfying partnerships with enjoyable sexual experiences may possess greater resilience to face the challenges of the postpartum phase. Furthermore, the psychological and physical stress associated with infant care may have a comparatively lesser negative impact on mothers who can rely on the support of a healthy relationship with their partner (Faisal-Cury et al., 2020). Hence, assessing the beliefs and values held by partners in sexual relationships during the presence of PPD can provide valuable insights for promoting sexual awareness within couples. However, this approach may serve as an indirect means to mitigate the risk of PPD. In a randomized trial conducted by Negron et al. (2013), examining mothers' perspectives regarding their needs, expectations, and mobilization of support, various barriers to support mobilization were identified. These barriers included personal attitudes, cultural norms, perceived support expectations, availability of support, and the potential consequences on relationships with partners and family members (Negron et al.,2013). Therefore, a prerequisite for enhancing the existing support for mothers involves examining women's comprehension and assessment of their social network. Moreover, examining fathers' perceptions and sociological understanding of illness roles and depression in their partners is recommended for future studies by Goodman et al. (2014). In Tang et al.'s (2016) study, mothers and mothers-in-law are reported as an

informational source of support, although many women were reluctant to accept these strict and traditional supports. Women living with their in-laws report avoiding help-seeking to retain harmony in the family and not being demanding from the family's perspective (Tang et al., 2016). Social support should be emphasized as it is both a risk factor and a preventive or treatment factor in postpartum mothers (Della Corte et al., 2022). Partners' and family members' beliefs and values of PPD influence their support, so exploring these factors in women's support circles is essential. Also, providing psychoeducation for partners and families can increase their awareness and prepare them to help; it also helps to enhance the quality and accessibility of support (Negron et al., 2013). It is critical to provide the most impactful and tailored educational programs for the social circle of mothers, exploring their understanding of PPD and their beliefs and values about this mental health issue.

Stigma and Help-Seeking Behaviours

Timely help-seeking is crucial for effectively treating PPD, minimizing its associated adverse effects, and enhancing maternal and infant outcomes (Grissette et al., 2018). However, multiple studies have identified various barriers that hinder women from seeking help in a timely manner (Negron et al., 2013; Faisal-Cury et al., 2020; Goodman, 2009). Negative beliefs and societal stigma surrounding PPD hinder help-seeking behaviours among affected mothers (Branquinho et al., 2020). A qualitative meta-interpretive synthesis of experiences of PPD among marginalized women showed that in specific cultural contexts, the maternal role and societal expectations often overshadow the physical and emotional needs of the mother and consider mothers' needs of minor importance, so the conceptualization of PPD in diverse cultural contexts can

lead to feelings of embarrassment for women when it comes to openly discussing their symptoms and experiences of PPD (Maxwell et al., 2019). Women often seek emotional or instrumental support from their immediate social network. Research investigating women's perspectives on social support has identified various attitudinal barriers that hinder seeking emotional support, including feelings of pride, independence, embarrassment, and stigma associated with experiencing depressive symptoms (Negron et al., 2013). Moreover, women have concerns about potential perceptions of their maternal role if they seek help (Negron et al., 2013). Limited research attention has been devoted to exploring the attitudinal barriers to seeking instrumental support in the context of PPD despite the extensive literature on help-seeking and the stigma surrounding PPD. This gap highlights the need for further investigation into this area (Negron et al., 2013).

Inadequate social support and the experience of emotions such as fear, shame, and guilt have a detrimental effect on women's quality of life during the postpartum period (Alang & Fomotar, 2015). Women may encounter discomfort in seeking assistance for depression, sexual concerns, and relationship difficulties, which could lead them to avoid discussing these topics during perinatal visits. Moreover, healthcare professionals often hesitate to address matters related to sexuality, mental health, and relationship issues with their patients. This reluctance can stem from various barriers, including cultural factors, lack of recognition, and time constraints during clinical visits (Faisal-Cury et al., 2020). Grissette et al. (2018), in an article on identifying obstacles to seeking help among women with PPD, emphasize that when women first encounter PPD symptoms, they frequently rely on their male partners for support and guidance.

Nevertheless, male partners frequently expressed a lack of awareness regarding the signs and symptoms of PPD. Consequently, the partners' limited knowledge about PPD results in normalizing these symptoms as typical aspects of the postpartum period, disregarding the necessity for treatment. An unexpected outcome of this study was the discovery that women with strong support systems, healthy infants, and financial stability felt a sense of shame in acknowledging their symptoms of PPD. This feeling stemmed from believing that only single mothers, women with disabled infants, and those from lower socioeconomic backgrounds could experience PPD (Grissette et al., 2018). Family members and friends reinforced these beliefs by urging the women to focus on their blessings, as societal norms dictate that childbirth should be a joyful experience. Furthermore, women faced stigma for having a mental illness and for not meeting society's expectations of being a competent mother (Grissette et al., 2018). Researchers observed that women refrained from disclosing their PPD symptoms due to fear of judgement from their significant others, family, friends, and healthcare providers. Consequently, they chose to suffer silently rather than risk being perceived as inadequate mothers (Grissette et al., 2018). The stigma associated with mental illness posed a significant barrier for women seeking help, resulting in their reluctance to seek treatment for PPD.

The apprehension of being labelled as having a mental illness and the stigma surrounding therapy and antidepressant medication deterred women from seeking assistance (Grissette et al., 2018). These beliefs about PPD indicate a lack of knowledge and understanding about the condition in mothers and their support circle (Grissette et al., 2018). Hence, addressing and reducing the stigma and negative beliefs surrounding

PPD at a societal level is crucial, particularly within the mother's immediate social circle, which may include her partner, friends, and relatives (Grissette et al., 2018). Therefore, efforts to address these barriers and promote help-seeking are paramount. McLoughlin's (2013) literature review on the stigma surrounding postnatal depression highlights common themes identified in various studies across different sociocultural contexts. The review found that feelings of shame, guilt, fear, and the perception that PPD is linked to personal weakness or being a deficient mother were prevalent among the mothers examined. This stigmatization can worsen PPD symptoms and may originate from both the affected mothers themselves and the attitudes of others in their social environment (McLoughlin, 2013). In a focus group study conducted by Alfayumi-Zeadna et al. (2019) among Indigenous Bedouin women in Israel, barriers to PPD treatment were examined. Participants expressed a perception of PPD as a frightening illness with devastating consequences. These beliefs and perceptions act as barriers that may hinder women from receiving a diagnosis and prevent them from openly discussing their emotions, causing them to endure their suffering silently. Similar findings were observed among African Americans, where depressed mothers were believed to be stigmatized as "crazy" and feared losing custody of their children (Sampson et al., 2014). In this study, various family-level barriers to PPD treatment were identified. One significant barrier was the lack of support from husbands and families, encompassing involvement in newborn caregiving tasks, emotional support, and material assistance, which has been linked to lower PPD symptoms (Alfayumi-Zeadna et al., 2019). Husbands' lack of support often stemmed from their limited awareness of PPD symptoms. Participants in the study also expressed that their families frequently failed to comprehend their emotional difficulties, posing a substantial obstacle to seeking professional help. Although husbands may have

poor knowledge of depressive symptoms, they could still recognize changes in mood and behaviour. However, the lack of communication and appreciation from husbands can impede mood improvement and become a barrier to PPD treatment, especially considering that many of these women rely on their husbands' support to access professional care (Alfayumi-Zeadna et al., 2019).

Goodman (2009) conducted a descriptive study utilizing a questionnaire administered to a convenience sample of women recruited from obstetrics clinics. The study evaluated women's attitudes, preferences, and perceived obstacles to treatment for perinatal depression. The results revealed that most women needed assistance managing emotional challenges and PPD. Family or couple therapy emerged as a favoured treatment option, but the presence of stigma and negative beliefs within families hindered help-seeking for mental health treatment. Recognizing the barriers to seeking help for PPD is crucial for improving treatment rates and the overall well-being of new mothers. Time constraints were identified as a significant barrier, emphasizing the importance of support and understanding from partners and relatives in addressing this issue. Moreover, women expressed a preference for receiving mental health treatment within obstetric settings to avoid potential stigmatization associated with specialized mental health clinics (Goodman, 2009).

Sampson et al. (2018) conducted a descriptive qualitative study focusing on Latina immigrants to explore how cultural beliefs and contextual factors influence women's perceptions of PPD and their help-seeking behaviours. The findings of this study revealed that PPD is often viewed as a negative characteristic within Latino cultures, leading women to feel a sense of inadequacy and uselessness as wives or

mothers. Cultural beliefs instilled by mothers, sisters, aunts, and friends further

contribute to the normalization of PPD symptoms and the perception that it is a transient

phase that does not require treatment. In Latino culture, there is a strong belief among

relatives that depressive symptoms will naturally pass, regardless of their intensity. The

societal expectations surrounding the maternal role significantly hinder women's

willingness to seek help for PPD. Participants in the study expressed that if their

partners, relatives, and friends had a better understanding of PPD and its treatment, they

would feel more empowered to ask for assistance. It was also suggested that raising

awareness within families could help reduce the stigma associated with PPD (Sampson

et al., 2018).

A phenomenological study conducted in China examined the causes of PPD and

coping styles from the perspective of mothers. The findings revealed that culturally

specific beliefs about mental illnesses significantly influenced mothers' experience of

PPD and their inclination to seek help (Tang et al., 2021). In this study, mothers

predominantly employed self-help strategies, including seeking emotional support,

seeking assistance from others, and adopting positive thinking to cope with their PPD

symptoms. Seeking professional help was not commonly favoured as a coping strategy

among the participants (Tang et al., 2021). Moreover, Kantrowitz-Gordon (2013), in a

study assessing internet confessions of PPD, found that societal expectations of being a

"good mother" and the prevailing biomedical discourses often reinforce the perception

that depression is an individual issue, placing responsibility on the woman to maintain

her well-being. However, some women only sought help for their depression symptoms

once they recognized the impact it had on others, particularly their infants. In this study,

women found treatment for depression in primary care clinics out of a sense of responsibility toward their families and concerns about how their depression could negatively affect their relationships (Kantrowitz-Gordon, 2013). A cross-sectional study exploring the role of knowledge, attitudes, and propensity to seek assistance in the Portuguese population identified two potential facilitators of help-seeking: having a connection with someone who advocates seeking assistance or who has personally sought help (Branquinho et al., 2020). Furthermore, the study demonstrated that mental well-being might be perceived as a confidential matter that should not be openly discussed beyond the confines of the family or immediate circle, thereby discouraging women from seeking help (Branquinho et al., 2020). Comprehending the perceptions and understanding of individuals close to mothers concerning mental health issues emerges as a crucial aspect to evaluate in this study (Branquinho et al., 2020). On the other hand, the significance of mental health knowledge and understanding within the support network emerged in this investigation, playing a crucial role in facilitating women's appropriate utilization of professional assistance. Individuals within these networks can aid in early symptom identification, promote women's engagement in treatment, and seek professional support (Branquinho et al., 2020). These findings underline the value of educational initiatives and public awareness campaigns to enhance their understanding of PPD. Such endeavours are likely to foster positive attitudes toward PPD, increase intentions, and promote behaviours that endorse recommending professional help for PPD (Branquinho et al., 2020). Accordingly, enhancing comprehension entails exploring and assessing mothers' close circles' existing knowledge and understanding of PPD, mental health concerns, and help-seeking, which is essential for improving awareness and promoting effective interventions.

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A qualitative study in the United States explored the perspectives of low-income women with PPD, revealing that some women became aware of their depressive symptoms through the observations and opinions of their friends and family members. This highlights the significance of expanding mental health first aid training to include the public, particularly those within the immediate social circle of new mothers. Implementing mental health first aid training during the postpartum period aims to provide primary support to mothers with knowledge of PPD risk factors, the ability to recognize signs and symptoms of PPD and the development of a strategic plan to support women in need (Guy et al., 2014). Furthermore, in a cross-sectional study by Almutairi et al. (2017), the role of help-seeking behaviour and partner support in PPD among Saudi women was examined. The findings revealed that Saudi women primarily relied on their extended family members, spouses, parents, and relatives as their main sources of support, reflecting a cultural norm in their community. However, despite having a strong support network, these women were less likely to seek help for depression. Interestingly, they expressed greater trust in physicians and mental health professionals than those within their immediate social circle when seeking help and advice. So, the study emphasized the importance of focusing on modifiable factors that can alleviate postpartum stress and reduce depression. While depression is influenced by various demographic, psychosocial, financial, and lifestyle variables, the study suggests that researchers should prioritize factors that can be modified. In particular, improving help-seeking behaviour and fostering a perception of the spouse as a supportive partner were identified as malleable factors indirectly associated with depression, as observed in this study (Almutairi et al., 2017). In a correlational cross-sectional study investigating the association between postnatal depression and attitudes towards seeking help, findings

suggest that women with elevated levels of shame and guilt are more prone to experiencing symptoms of postnatal depression and expressing unfavourable attitudes towards seeking help. Additionally, mothers who reported heightened levels of shame expressed apprehension about potential reactions from others if they were to seek assistance (Dunford& Granger, 2017). From an alternative standpoint, limited information exists regarding the shame and guilt experienced by partners and its potential connections to depression and attitudes toward seeking help. Offering psycho-educational resources to partners, identified support persons, and family members of mothers might enhance their comprehension and identification of maternal sentiments of shame and guilt. Partners could also be crucial facilitators in promoting help-seeking and accessing social support, particularly when maternal shame acts as a barrier (Dunford & Granger, 2017). The identified need for further research to gain a deeper understanding of partners' perspectives, beliefs, and values regarding help-seeking for PPD is evident.

Experiences and Understanding of PPD

Understanding mothers' perceptions and experiences of PPD is essential for providing effective support and designing targeted interventions (Patel et al., 2013). The existing literature on PPD predominantly focuses on exploring the beliefs and understandings of mothers. At the same time, this study aims to address a noticeable gap in understanding the perspectives of partners, families, and other identified support persons. Following this is an overview of the literature on the understanding and experience of PPD, narrowing the focus to the specific gap.

A qualitative study focusing on low-income postpartum women identified cultural beliefs and societal expectations regarding motherhood as barriers to seeking

help for PPD (Sampson et al., 2014). The community emphasized self-sufficiency and hiding PPD symptoms, pressuring women to endure motherhood without showing weakness or mental illness. Despite disclosing their symptoms, some women were often dismissed or ridiculed (Sampson et al., 2014). Stigma and the perception of weakness hindered seeking professional help. These beliefs overshadowed women's recognition of their PPD symptoms and need for support. Viewing depression as a character flaw and associating PPD with extreme behaviours led women to downplay mild or moderate symptoms that could be treated early. Untreated symptoms could worsen with severe consequences (Sampson et al., 2014). Seeking help for PPD was challenging due to cultural beliefs and expectations of being a self-reliant and strong mother figure in Sampson et al.'s. (2014) study. Despite feeling overwhelmed, stressed, and angry with family members, participants felt unheard and feared being labelled crazy. Participants believed increasing community awareness and education would reduce the stigma surrounding PPD, encouraging more women to report their symptoms and seek help. Ultimately, they desired to be heard, understood, and free from the stigmatization associated with PPD (Sampson et al., 2014). So, addressing these cultural barriers is crucial for supporting women with PPD (Sampson et al., 2014). Also, a literature review conducted in Canada by Johnson et al. (2020) examined mothers' lived experience of PPD. The review identified key themes, including loss, help-seeking behaviours, support, and recovery, which shed light on the experience of PPD and its related mood disorders. These findings provide valuable insights into the complexities of PPD and can inform interventions and support strategies for affected mothers.

Hadfield and Wittkowski (2017) systematically reviewed qualitative literature on women's experiences of seeking psychological and psychosocial interventions for PPD. The review identified a significant barrier to seeking help for PPD: the negative self-perception and stigma associated with PPD. Women often internalized this stigma, expressing shame, embarrassment, and a sense of failure. They viewed themselves as weak and believed that experiencing PPD made them inadequate as mothers. Consequently, women hesitated to disclose their difficulties to professionals due to the fear of being labelled as a "bad mother" and the potential consequences, such as having their children taken away. These views about PPD and motherhood were influenced by idealized comparisons to "perfect mothers" and a desire to fit into societal norms of competent motherhood. The study highlights the need to address stigma and negative self-perceptions surrounding PPD to improve help-seeking and support for women experiencing PPD (Hadfield & Wittkowski, 2017). In their study, Hadfield and Wittkowski (2017) identified several barriers to accessing professional support for PPD. One significant barrier was the lack of knowledge among women about PPD, which affected their ability to recognize the symptoms. Additionally, the limited knowledge about PPD among relatives and spouses influenced how women perceived and understood their experiences. For example, some women believed that PPD was untreatable, particularly if there were no changes in their social circumstances. On the other hand, women believed that the symptoms of PPD would resolve on their own without the need for any intervention. These findings underscore the importance of addressing knowledge gaps and misconceptions surrounding PPD to improve access to appropriate support and treatment (Hadfield & Wittkowski, 2017).

A qualitative study conducted in England by Patel et al. (2013) explored the illness beliefs of mothers with PPD. The findings revealed that these mothers experienced internal struggles as they aimed to be good mothers but believed that having PPD implied they were inadequate as mothers. Help-seeking was delayed, primarily due to concerns about being perceived as a "bad mother" and fearing judgement from others. While the label of PND provided some relief by normalizing their experience, it was overshadowed by stigma. The study also highlighted those participants who held unique conceptualizations of PPD, often intertwining their illness with their sense of self. Their narratives regarding the origin and consequences of PPD were complex. The perceived stigma from others, combined with feelings of being a "bad mother" due to PPD, compounded the psychological distress experienced by these mothers. They sought understanding to address these issues but often encountered conflicting solutions, such as taking antidepressants to alleviate symptoms, which paradoxically reinforced their belief of being a "bad mother" (Patel et al., 2013). Mothers participating in Patel et al.'s (2013) study expressed lingering uncertainties about their future. Despite subjective improvements, they harboured doubts regarding their prognosis, the long-term use of antidepressants, and the potential for future episodes of depression. These concerns about future episodes were shared among the mothers in this study as well as in previous research. The experience of postnatal depression leads to a sense of loss, including loss of self or former identity, loss of relationships, loss of control, and the loss of meaningful time spent with their children (Patel et al., 2013).

Regarding literacy of PPD, a cross-sectional survey conducted among Indian mothers assessed their PPD literacy using a standardized questionnaire. The findings

revealed that only 50.7% of the postpartum mothers had sufficient knowledge about PPD. The study also found significant associations between PPD literacy and participants' age, income, and occupational status. These results emphasize the existence of specific gaps in PPD literacy that may hinder help-seeking behaviours among postpartum mothers. The findings highlight the urgent need to raise awareness about PPD and emphasize the importance of healthcare professionals actively promoting PPD literacy among perinatal women and their family members (Poreddi et al., 2021).

A systematic review appraised the literature on attitudes and perceptions of postpartum women, their families and healthcare providers surrounding PPD in Bangladesh, India, and Pakistan (Insan et al., 2022). This study revealed limited qualitative research on perceptions and attitudes of postpartum women along with key family members and emphasized further research in this area (Insan et al., 2022). Also, a systematic review of qualitative evidence explored the experiences of PPD among new parents (Holopainen & Hakulinen, 2019). The review primarily focused on mothers' experiences of PPD, with a limited representation of fathers' experiences in the included studies (Holopainen & Hakulinen, 2019). This systematic review highlights the need for more comprehensive investigations from the perspective of fathers, as their experiences were not extensively described in the available data (Holopainen & Hakulinen, 2019). Furthermore, in a qualitative phenomenological study conducted in the USA, the experiences of couples dealing with PPD were explored (O'Brien et al., 2019). The study revealed that couples anticipated challenges during the transition to parenthood but were unprepared for the experience of PPD. Despite receiving extensive education on self and infant care, they felt insufficiently informed about the risks of PPD and how it could

impact their relationship. Despite their efforts to support each other and accommodate the mother's treatment and recovery, the couple struggled with guilt and frustration, leading to changes in their relationship. They wanted to learn more about PPD and the anticipated changes in their relationship (O'Brien et al., 2019). The couples recognized the importance of providing space and support for each other's personal needs but acknowledged the complexity of this process. They highlighted the need for better prenatal education that addresses how relationships evolve after childbirth, improving communication between couples and equipping them with coping strategies for difficult emotions and PPD (O'Brien et al., 2019).

A cross-sectional study was conducted through social media among social support networks of postpartum women living in an area in Malaysia to assess their social knowledge level, attitudes and beliefs regarding PPD (Alsabi et al., 2022). This study reported that PPD awareness is poor among Malaysian adults and highlighted the need for education for family members to become familiar with this situation, pay attention to postpartum women and provide needed support for them (Alsabi et al., 2022). Moreover, a descriptive qualitative study designed by using semi-structured interviews examined the experiences of fathers whose partners suffer from PPD in the Asian milieu (Ng et al., 2021). The findings of this study highlighted the presence of struggles and the need for support in fathers whose partners suffer from PPD, which shows the importance of further investigations into their experience to provide the needed support.

A study by O'Brien (2019) that particularly assessed heterosexual couples' experiences of PPD found that in the context of the birth of a new child and the transition

to parenthood, couples experience significant changes in their established relationship dynamics. This transition is typically anticipated and embraced by couples. However, when the mother is diagnosed with PPD, additional challenges arise, necessitating adjustments and establishing new routines to accommodate her symptoms and facilitate her recovery (O'Brien, 2019). Coping with the mother's depression during early parenthood is a multifaceted process, and couples require tailored support that addresses their unique needs. Therefore, O'Brien (2019) states that it is important to recognize that PPD has various relational dimensions, as mothers and fathers collaboratively shape their early parenthood experiences and navigate the challenges associated with PP. The existing literature on PPD predominantly focuses on exploring the beliefs and understandings of mothers. At the same time, this study aims to address a noticeable gap in understanding the perspectives of partners, families, and other identified support persons. Following this is an overview of the literature on the understanding and experience of PPD, narrowing the focus to the specific gap covered by this research work.

Branquinho et al. (2019) conducted a cross-sectional internet survey of the general Portuguese population to examine knowledge and attitudes about PPD. The study emphasized the importance of high levels of knowledge among women's support circles for early identification and help-seeking. In addition, the findings revealed that male, older, and less educated participants had the lowest levels of PPD knowledge. Similarly, Poreddi et al. (2020) investigated the knowledge and attitudes of family members toward PPD in a cross-sectional survey. While positive attitudes and good levels of knowledge were observed, negative beliefs, stigma, and misconceptions were also present among

family members. Culturally sensitive research was recommended to address these negative stereotypes and stigmas associated with PPD. Sampson et al. (2021) employed qualitative descriptive research to explore PPD beliefs and experiences among low-income immigrant Latino mothers. The study identified various themes related to mothers' beliefs and experiences, highlighting the importance of acceptance and support from their families. Lack of awareness about the causes, types, and treatment of PPD led to negative and judgemental behaviours from families and partners. In a quantitative study, Lodha et al. (2022) assessed the understanding of perinatal depression between low-income mothers and families in India. The research revealed limited awareness due to mental health issues' general stigma. Additionally, the belief that pregnancy resolves problems between spouses or conflicts at home contributed to the perception that PPD is unlikely to occur during and after pregnancy in Indian society. These studies shed light on the knowledge, attitudes, beliefs, and cultural factors surrounding PPD, emphasizing the need for awareness, support, and interventions to address the complexities of PPD within different populations.

In a doctoral dissertation in the USA, Moseley (2022) employed a hermeneutic phenomenological qualitative approach to investigate the lived experience of men whose partners were diagnosed with PPD. Through in-depth interviews, the study aimed to uncover themes that reflect men's encounters with having a partner affected by PPD. The findings revealed that the participants faced emotional and physical challenges due to their partners' PPD. Nevertheless, they also reported experiencing positive aspects in the context of their partners' condition. Additionally, the study emphasized the significance of available support for men whose partners are affected by PPD, as it played a crucial

role in alleviating the distress they encountered (Moseley, 2022). Moreover, Meighan et al.'s (1999) phenomenological study in the USA examined the father's experience living with a partner with PPD. The study revealed that PPD significantly disrupted fathers' lives and their relationships with their wives. Fathers experienced fear, confusion, and deep concern for their spouses while feeling helpless in aiding their recovery from PPD. The inability to solve the problem resulted in frustration and anger. Most respondents reported making numerous sacrifices to maintain their family and relationship. Despite improvements in PPD symptoms over time, fathers were left facing an uncertain future with a spouse who seemed changed from their previous knowledge of them (Meighan et al., 1999). The study emphasized the need for support and educational interventions. However, this study is dated, and subsequent research primarily focuses on paternal depression rather than exploring the beliefs and values of partners dealing with PPD. Juntaruksa et al. (2017) conducted a cross-sectional survey in Thailand to compare the knowledge and attitudes of family members regarding PPD. Participants identified themselves as primary caregivers for postpartum women at home, emphasizing the importance of their knowledge in detecting early signs and symptoms of PPD to prevent severe complications. However, the study revealed that some participants lacked the knowledge to identify PPD, increasing the risks for affected women. Insufficient knowledge and negative attitudes toward PPD can lead to negative consequences at individual and family levels. Therefore, educating and providing sufficient knowledge to family members, including husbands and female relatives, is crucial regardless of depression (Juntaruksa et al., 2017). The study findings indicated that husbands and female relatives had similar levels of knowledge regarding the causes and risk factors of PPD, such as life crises, unplanned pregnancy, history of depression, and low-income

family relationships. However, some participants held misconceptions, associating PPD with ghost possession or sin. This highlights the existence of erroneous beliefs within Thai society about the causes of PPD. Family members displayed positive attitudes towards PPD, particularly husbands who exhibited greater acceptance and sympathy towards their wives. This positive attitude fostered a supportive and caring relationship between couples. However, nearly half of the participants reported that they would feel ashamed and keep a PPD diagnosis within the family, reflecting the presence of stigma surrounding PPD in Thai society (Juntaruksa et al., 2017).

Beestin et al. (2014) conducted an interpretative phenomenological analysis narrative study in the UK, investigating the impact of maternal postnatal depression on men and their fathering practices. The findings revealed that men perceived their partner's depression as resulting in significant physical and psychological maternal absence, fracturing the family unit and challenging their father-fathering ideological foundation. Factors such as unequal divisions of labour, unmet expectations, and preoccupation with their partner's depression diverted some men from their fathering role. On the other hand, some men adapted by accepting the loss of shared parenting and focusing on building an exclusive father-child relationship. The study highlights the profound impact of losing a close adult relationship on fathering experiences (Beestin et al., 2014). A descriptive phenomenological study conducted in the USA by Ierardi et al. (2019) explored the experiences of men whose partners had PPD. The participants shared their efforts to support and care for their families, their fears, anxieties, and physical responses, as well as the challenges of feeling isolated and uncertain about seeking help. They expressed the importance of being included in postpartum healthcare visits and

being part of the assessment and evaluation of their family's health. When they could not attend healthcare visits, the men often turned to the Internet for information about their partners' changes and PPD. The study emphasized the need to understand fathers' experiences and provide support interventions for families dealing with PPD, as depression affects the entire family. Further research and support initiatives were recommended to ensure families receive adequate support during this critical period (Ierardi et al., 2019).

A qualitative study in Sweden using interpretative phenomenological analysis explored the experiences of mothers and fathers regarding PPD and parental stress after childbirth (Johansson et al., 2020). Both parents experienced feelings of inadequacy, with fathers highlighting external demands and mothers emphasizing internal pressures as the main sources of stress. Difficulties during pregnancy or traumatic delivery contribute to PPD and anxiety in mothers, affecting fathers' well-being. Mothers had varied experiences with child healthcare support (Johansson et al., 2020). PPD had implications for the couple's relationships, leading to loneliness and relationship difficulties. Emotional issues and troubled upbringing in the parents' families of origin may contribute to their experiences. Comprehensive support and interventions are needed to address the impact of PPD on both parents (Johansson et al., 2020).

A qualitative thematic analysis explored how partners respond to PPD in the United States (Maxwell et al., 2022). The study highlighted that within a family unit, each person's thoughts, feelings, and actions are interconnected and influence other members (Maxwell et al., 2022). Partners in the study described various supportive behaviours, such as active listening to and understanding the experiences of new

mothers, reminding them of their worth and values, and encouraging them to seek professional assistance (Maxwell et al., 2022). One primary form of support mentioned by partners was simply "being there for her," which encompassed both emotional and instrumental assistance (Maxwell et al., 2022). The effectiveness of support varied among mothers, as each person perceived different actions as positive (Maxwell et al., 2022). Nonetheless, certain social and cultural factors influenced these preferences (Maxwell et al., 2022). Therefore, to design effective educational plans and support systems for partners, it is crucial to thoroughly examine their beliefs, values, and the cultural and social constructs that shape them (Maxwell et al., 2022).

Identified Gap in the Literature

The existing literature primarily focused on the experiences, knowledge, and understanding of PPD among mothers, with limited coverage of partners and relatives. Additionally, the knowledge and attitudes of partners and families are more extensively studied than beliefs and values. It is vital to differentiate between knowledge and beliefs as they have distinct conceptual meanings, with beliefs influenced by experiences and sociocultural factors, while knowledge pertains to literacy and awareness. Thus, a comprehensive exploration of the beliefs and values associated with PPD in the current literature was required. Moreover, most studies examined were conducted outside of Canada, highlighting the geographical gap this study aimed to address. This research stood out in terms of methodology and analytical lenses as it adopts a Feminist poststructural (FPS) lens to investigate partners' and relatives' beliefs and values. Using FPS allowed for examining how gendered and personal meanings of PPD were socially, culturally, and institutionally constructed and understood by partners and relatives. This

research also included all gender-type partners, identified support persons, and family members, which covered a unique aspect not covered by existing studies. By filling these gaps, this research could contribute to maternal mental health in Canada by assessing the beliefs and values of partners and relatives of mothers about PPD. The findings could inform healthcare providers in designing appropriate health service delivery to mitigate the negative consequences of PPD.

Chapter Three

Methodology

Feminist poststructuralism (FPS) served as the guiding theory and methodology throughout all stages of the research process (Weedon, 1996; Foucault, 1984). The subsequent section provides an overview of FPS, exploring its key concepts and highlighting its relevance as a viable approach to address the research questions. This chapter will also encompass various aspects of the study, including a description of the study setting, participant selection criteria, data collection procedures, data analysis methods, ethical considerations, and strategies used to ensure rigour and trustworthiness.

Feminist Post Structuralism

Feminist poststructuralism (FPS) can serve as a philosophical, theoretical, and methodological framework appropriate for a range of research areas. FPS can also be applied across various contexts and offers insights into personal, social, and institutional practices (Wijlen & Aston, 2019). Feminist theory, as proposed by Weedon (1996), highlights the need for a comprehensive theory that elucidates the mechanisms through which individuals oppress one another. This theory should explore conscious and unconscious emotions and thoughts, enabling us to interpret people's relationships and social interactions. FPS is a valuable tool for understanding why women sometimes prioritize their subjectivity in ways that disregard their needs and emotions. Moreover, poststructuralist ideas prompt us to ask probing questions that transcend superficial, culturally ingrained notions of reality, opening avenues for deeper exploration and understanding (Gavey, 2011). In other words, a poststructuralist perspective provides a

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deeper understanding of the complexities and contradictions that influence our perception of the world. When exploring our lives and the challenges we face, a feminist poststructuralist approach proves to be a helpful theoretical framework. Unlike rational models, it embraces the intricate and conflicting desires and motivations that shape our experiences (Gavey, 2011). Moreover, poststructuralist approaches emphasize the significance of diversity, fragmentation, and multiple perspectives (Cheek, 2000). These approaches primarily concentrate on investigating and examining texts, which are representations of reality. In the context of poststructuralist analysis, texts can encompass various forms, such as patient case notes, images, poems, procedures, conversations, artwork, or articles (Cheek, 2000). It should also be noted that the aim of post-structural research approaches is to delve into the significance of specific representations by exploring their origins, understanding their formation processes, and deciphering the messages they convey within their unique cultural and historical frameworks (Squier, 1993).

In contemporary contexts, feminist poststructuralism remains pertinent due to its inherent critique of existing power structures and ongoing deconstruction while offering guidance for transformative action (Aston, 2016; Weedon, 1987). As Weedon (1987) states, poststructuralism is inherently diverse, encompassing a variety of theoretical positions rather than having a fixed definition. However, all post-structural perspectives share a common focus on examining language, meaning, and subjectivity (Weedon, 1987). FPS offers a fresh perspective on knowledge, language, and subjectivity, enabling a transformative understanding of how people relate to language, cultural practices, and the material realities that shape our lives (Gavey, 2011). Feminist poststructuralism

provides a conceptual framework that informs feminist research and practice, aiming to deepen our understanding of individuals' experiences. It explores the intricate connections between language, subjectivity, social organization, and the institutions that shape power relations within everyday lives (Weedon, 1997). From a philosophical standpoint, FPS disrupts existing norms and challenges the status quo (Aston, 2016). It provides a valuable framework for exploring sensitive and often taboo topics within sociocultural contexts (Baxter, 2016). Additionally, FPS recognizes the complexity of the human experience, considering various factors such as race, class, age, ability, gender, sexual orientation, and religion (Weedon, 1996). Multiple truths can coexist within overlapping discourses, highlighting knowledge's contextual and subjective nature from an epistemological perspective (Ollivier, 2020).

The purpose of this study was to examine partners', identified support persons', and family members' understanding and experiences of PPD and how these experiences are socially and institutionally constructed through beliefs and values that may facilitate or create barriers to support mothers experiencing PPD. Through the utilization of an FPS approach, I conducted a qualitative study to delve into the intricate connections between the personal experiences of partners, identified support persons, and family members and the broader contexts that are socially and institutionally constructed. By employing this theoretical framework, I gained insights into how individual and societal beliefs, values, and practices were shaped by power relations and influenced by factors such as gender, class, and health (Kirk et al., 2014). To get a comprehensive understanding of how partners, identified support persons, or family members perceive PPD, it was imperative to critically examine and question the underlying structures of

key institutions such as family, health, medicine, media, and education. By deconstructing these systems, we delved deeper into the complexities of PPD and its multifaceted impact on partners', identified support persons', and family members' experiences and understanding within their cultural context. Furthermore, to explore the social meanings and beliefs in the study context, FPS matched the theoretical framework to analyze the construction of paternalistic structures and participants' positioning within them (Weedon, 1996). Drawing on feminist poststructuralism, this study investigated the social and institutional construction of participants' experiences across various subject positions, including gender, race, sexual orientation, class, socio-economic status, and culture (Aston, 2016). To use the FPS framework, we should first understand the concepts of FPS and the relation between these concepts (Weedon, 1996). Subsequently, the concepts of FPS, which help us foster a deeper understanding and analysis, will be explained.

Language and Meaning

Language plays a crucial role in all interactions, including therapeutic encounters. Through language, perceptions are formed, and relationships are defined. The words we choose and the way we communicate can shape how we perceive and understand one another, influencing the dynamics within therapeutic relationships (Aston et al., 2012). According to Weedon (1996), language is a crucial element in poststructuralism for analyzing social meanings and consciousness. Institutions and social groups produce meanings and languages that influence individuals to conform to societal norms and everyday ways of living. Our feelings, thoughts, experiences, and interpretations are shaped by our everyday language and the broader social and institutional language and

meanings surrounding us (Aston, 2016). As Baxter (2016) mentions, language does not simply reflect the world around us but actively constructs our understanding of reality. Poststructuralism, as a way of studying language, offers different perspectives that challenge traditional ways of thinking (Baxter, 2016). For example, instead of seeing language and identity as separate or fixed, poststructuralism suggests they are closely connected and constantly changing. In addition, it questions the usual categories and divisions in applied linguistics, such as how we view power, structures, and agency in the language (Baxter, 2016).

While using FPS to understand the meaning of language, we should be aware that language is a system of signs, including words, sounds, and visual images. These signs do not have inherent meanings; they acquire meanings through their relationships and differences with other signs (Baxter, 2016). Also, as Aston (2016) asserts, it is crucial to approach people's narratives without the need for "triangulation" or fact-checking, as individuals are the only ones who can authentically share their own experiences. However, Weedon (1996) emphasizes recognizing the construction of social meanings within sociocultural institutions and practices as it helps to understand power relations (Weedon, 1996). Aston (2016) also highlights the influential feminist concept "the personal is political," which has guided her research. This concept suggests that personal experiences are intertwined with broader social and institutional discourses. Experience encompasses personal, psychological, and emotional investments within an individual as a social agent (Aston, 2016).

Weedon (1996) considers language's role significant in shaping individuals' sense of self and subjectivity. Through the lens of FPS, it is understood that language and

discourses can have varying meanings across different cultures and are not fixed or inherent. So, while individual meanings are arbitrary, a pre-existing social agreement influences the language we learn and use. This structuralist language system significantly impacts shaping our identities, so language reflects and shapes our social reality (Baxter, 2016). The belief that language has fixed meanings restricts our thinking and may lead us to disregard experiences that do not align with the norm (Aston, 2016). Therefore, to fully explore the experiences of partners and relatives of PPD, it is crucial to move beyond predefined and limited meanings and languages considered the norm (Aston, 2016). We must also uncover the socially and personally constructed meanings associated with PPD. This entails setting aside preconceived notions of what is considered normal and delving into individuals' unique experiences and interpretations. So, we can better understand how social and institutional contexts shape these discourses using the FPS lens.

Beliefs and Values

Participants' beliefs, expressed during interviews, go beyond mere descriptions and reflect their opinions. Therefore, it is crucial to listen attentively to how they articulate their experiences and situations (Aston, 2016). By employing the FPS perspective, we can analyze participants' experiences in relation to their beliefs, values, and practices (Aston, 2016). This approach prevents us from imposing our assumptions and interpretations on their experiences (Wijlen & Aston, 2019). In addition, we should be aware of our own beliefs to prevent them from influencing our understanding of participants' beliefs. Aston (2016) found that focusing initially on participants' beliefs forces us to suspend our own beliefs as researchers. Aston (2016) considers a personal

perspective from the participant's view as a value. By interrupting their quotes, we can find what they value as individuals. We can also use "deconstruction" to reveal the power relations in discourses and among discourses and individuals and access to beliefs and values (Aston, 2016)

As mentioned in the literature in the previous chapter, the polarized partners' understanding of PPD often leads to shifting blame solely onto mothers. However, feminist poststructuralism offers a way to move beyond this limited perspective by acknowledging the existence of binary opposites (Aston et al., 2012). By employing discourse analysis, we can explore the complex relationships that contribute to the formation of these polarized views. It becomes evident that factors considered external to individuals are intricately connected through power relations, which can only be comprehended by exploring how personal beliefs and practices are influenced by societal beliefs and practices (Aston et al., 2012). For instance, through the lens of FPS, we examined how societal beliefs and values shaped and impacted the stigmatization and blame often directed toward PPD. After identifying beliefs and values, another vital step is understanding people's practices regarding their beliefs and values (Aston, 2016). For instance, we found through these concepts that a partner's beliefs about PPD include frustration about PPD; however, they also held values such as being committed and supportive; consequently, their practice about beliefs and values would be deciding to support their spouse.

Using discourse analysis as a tool, we can explore further into the topic and gain fresh insights that challenge the traditional understanding of binary opposites (Aston et al., 2012). It is also crucial to contextualize experiences within personal, relational,

social, institutional, and historical frameworks (Aston et al., 2012). By bringing these experiences to light and examining them through a feminist poststructuralist lens, especially those that are often overlooked or marginalized, we have the potential to question and transform harmful beliefs and practices that negatively impact individuals and society.

Relations of Power

Power is a key element within feminist poststructuralism, enabling a perspective that views interpersonal connections as dynamic and context-dependent (Aston et al., 2012). Questioning and challenging the notion of power as linear can lead to new ways of exploring and understanding relations (Aston et al., 2012). Essentially, power can be understood as a form of regulated communication or relationship where one person's actions have the potential to impact the actions of others. What characterizes a power relation is that it operates by shaping and influencing actions rather than directly and immediately exerting control over others. It acts upon existing actions or those that may arise in the present or future (Aston et al., 2012). Power cannot be simply understood as a linear and hierarchical action. To comprehend power relations, one must consider an individual's thoughts, emotions, responses, reactions, and interpretations, all influenced by personal, social, and institutional beliefs and practices (Aston et al., 2012). By bringing these experiences and understandings to the forefront and subjecting them to critical examination through a feminist poststructuralist framework, particularly those that are alternative, concealed, or marginalized, we have the opportunity to challenge and potentially transform harmful beliefs and practices that negatively impact both individuals and society as a whole (Aston et al., 2012).

Within the framework of social constructionism, seemingly neutral distinctions between concepts or ideas can be transformed into oppositional constructs (Aston et al., 2012). For instance, in the PPD understanding, a healthy mother may be considered "powerful," and a mother with PPD symptoms may be perceived as "powerless" in their close circle, which can lead to negative feelings in mothers (Aston et al., 2012). However, they were not literally powerless, even if they felt uncomfortable or oppressed. We recognized their potential to use their power differently (Kirk et al., 2014). It should also be noted that binary oppositions, such as man/woman, Black/White, doctor/patient, good/bad, or objective/subjective, are common examples. It is essential to recognize that these binary opposites create differences and assign distinct values to each side (Aston et al., 2012).

Aston (2016) asserts that to understand "power relations," we need to examine how social and institutional contexts influence interactions between individuals. We must assess how different discourses and people affect each other. Aston (2016) also considers the relationship of power as a mode of action that acts through other actions on others. Regarding PPD, for instance, having a baby is considered a happy and positive family experience. In contrast, PPD as a mental health issue during this period might cause power relations that impact how partners and relatives react to PPD.

Discourse Analysis, Subjectivity, and Agency

Foucault (1984) explains that language is always influenced by specific ways of thinking and speaking called discourses. These discourses compete and serve different interests and powers within institutions like law, government, media, education, and

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family. They shape our understanding of reality. In this way, language is not neutral but reflects society's politics and power relations (Baxter, 2016).

The concept of discourse lies at the heart of social constructionism and encompasses the cognitive framework through which we perceive and comprehend a subject, shaping our collective understanding and social construction of it (Aston et al., 2012). Discourse analysis is grounded in the idea that language is a system that creates meaning, shaped by both historical and social factors. Various types of texts, such as books, articles, newspaper reports, interviews, observations, or drawings, are embedded within specific discursive frameworks. These texts are not only shaped by the understandings derived from discourses but also contribute to the construction of understandings within those discursive frameworks (Cheek, 2000). Discursive analyses of texts go beyond mere descriptions or content analyses, instead taking a critical and reflective approach that transcends common-sense interpretations (Cheek, 2000). For feminist poststructuralist scholars, discourses serve as a lens through which they can define "reality" and explore how specific phenomena are socially constructed, emphasizing the role of language, practices, beliefs, and values (Aston et al., 2012). Moreover, from the perspective of Foucault (1984), discourses play a crucial role in recognizing, constructing, and regulating individual identities. The process of constructing identity occurs through the active participation of individuals who use language and are motivated to assume specific positions within various discourses (Baxter, 2016). At the same time, individuals are also subject to being positioned as subjects by the normative power embedded in these discourses (Baxter, 2016).

According to the poststructuralist perspective, individuals are constantly shaped by cultural forces and discursive practices. They occupy specific "subject positions" or ways of being that are approved and made available by the discourses present in their social context. If someone deviates from these expected discourses in their speech, actions, or behaviour, they may be stigmatized and labelled as different or outside of societal norms (Baxter, 2016). Acknowledging that the understanding of partners, identified support persons, and family members of PPD may deviate from societal stereotypes and norms can lead to fresh perspectives and discussions surrounding PPD. This recognition allows new understandings to emerge and alternative discourses to shape our understanding of PPD beyond traditional societal expectations (Aston et al., 2012). Also, FPS provides a valuable lens through which we can examine PPD in relation to the socially constructed values, beliefs, and practices of individuals, society, and institutions (Aston et al., 2012). For instance, the discourses surrounding PPD may vary between medical settings, such as hospitals, and personal, familial, or cultural contexts. Taking into account these different discourses is crucial for understanding the diverse perspectives and experiences of PPD. These multiple discourses shed light on the diverse perspectives and understandings of PPD, highlighting the complex nature of the phenomenon (Aston et al., 2012).

It is crucial when individuals share their personal stories, and it is important to listen to the content of their narrative, how they express themselves, and the emotions they convey. By doing so, we can understand how power relations and societal discourses impact their beliefs and behaviours (Aston et al., 2012). Discourse analysis also provides a valuable approach to understanding how people in the context perceive

and enact PPD. By examining the language and discourses used by individuals, we can gain insights into their shared understanding and practices surrounding PPD (Aston et al., 2012).

Subjectivity can be understood as a process of self-reflection and self-awareness that allows individuals to recognize their position and how it is shaped in the world (Weedon, 1987). Agency, on the other hand, refers to how individuals respond to this self-reflection, whether through transformation, challenge, resistance, acceptance, or adaptation (Weedon, 1987). While frustrations may arise from societal structures or norms, the agency plays a crucial role in feminist discourse by giving individuals the language and concepts to act according to their own choices and capacities. However, it is important to acknowledge that individuals' environments, cultures, past experiences, and sense of safety may influence their ability to exercise agency (Ollivier, 2022). Therefore, understanding the perspectives of individuals close to mothers and their beliefs about maternal agency, particularly in seeking help for mental health issues, is crucial in navigating cultural and familial stigmas.

Research Design

The following section outlines the research design and methodology employed in the study, which aimed to investigate the experience of partners, identified support persons, and family members regarding PPD. This qualitative study was conducted using the FPS framework. Subsequently, I provided an overview of the participant characteristics, including the sample size, recruitment process, and eligibility criteria. Additionally, I discussed the data sources and utilized the methods of data analysis that were employed and addressed the trustworthiness and ethical considerations in the study.

Sampling and Recruitment

It may become necessary to modify the chosen sampling method during a study. Nonetheless, it is crucial to plan the sampling strategy in advance to the best of our ability (Walby, 2015). In order to investigate the experience of partners, identified support persons, and family members on PPD, a specific group of individuals closely associated with the mothers were chosen as participants in this research study. Purposive sampling was used to select participants willing to openly share their experiences and perspectives on PPD. Multiple recruitment strategies were employed to achieve a diverse sample of partners, identified support persons and family members of mothers who have birthed or adopted a baby within 0-12 months. The primary method involved designing a recruitment poster (see Appendix A) using Microsoft PowerPoint. The poster provided information about the study and emphasized that participants receive a gift card as compensation for their time. In addition, interested individuals were directed to contact the researcher via telephone or email for further details.

While recruiting participants through social media can be cost-effective and efficient, it is essential to acknowledge that not all individuals may have regular internet access or the time to engage with social media during the postpartum period. Therefore, recruitment efforts included distributing posters in various locations and utilizing social media platforms such as mumsns.ca, Instagram, and Twitter. The posters were also placed in areas frequented by postpartum families, such as the IWK postpartum clinic, public libraries, obstetrics and gynecology clinics, and mental health clinics. The final decision on participant selection was made after a brief conversation with interested

individuals and asking them to fill out a pre-screen questionnaire (Appendix B) to assess if they met the inclusion criteria.

Eligibility Criteria

This study aimed to recruit partners, identified support persons, and family members who were identified as support persons by mothers who have given birth within the past 0-12 months and reside in Nova Scotia. Eligible participants were required to have the ability to speak and read English. Additionally, individuals had to be 18 years of age or older, and they provided consent to be audiotaped during the interview. The focus was on understanding the perspectives of partners, identified support persons, and family members to capture a range of experiences and insights related to PPD. Furthermore, the presence of a diagnosis of PPD or the presence of depressive symptoms was not considered a specific inclusion criterion for participants. However, during the recruitment process, information related to the presence of PPD or depressive symptoms was gathered for the purpose of data analysis. This helped to explore the potential influence of PPD or depressive symptoms on the experiences and perspectives of the participants involved in the study. Considering this aspect during data analysis, a more comprehensive understanding of the participants' experiences concerning PPD and depressive symptoms was achieved.

Data Collection

Sample Size

Creswell and Poth (2018) emphasize that qualitative research does not aim for generalization; therefore, large sample sizes are unnecessary. Instead, this study adopted

an in-depth perspective to explore partners', identified support persons', and family members' experiences, which required ample time and attention to detail. Vasileiou et al. (2018) highlight the importance of considering sample size and saturation parameters in previous methodological studies. Previous research utilizing the FPS framework has typically involved a sample size of six to ten participants (Joy et al., 2020; Mselle et al., 2017; MacConnell et al., 2013). This range allows for conducting sufficient interviews to thoroughly examine participants' experiences and conduct a rigorous study following trustworthy practices. Consequently, seven qualified participants were recruited for this study. Potential participants who expressed interest were contacted through email, phone calls, and text messages. Subsequent telephone conversations were conducted to provide detailed information about the study, address any inquiries, and confirm their interest in participation. In addition, a pre-screen questionnaire (Appendix B) was employed to assess participants' eligibility for the study. Once eligibility was established, a suitable time and location for the interview were offered in person, via Zoom, or by phone; all the participants preferred the Zoom platform for interviews. Enrollment of participants was contingent upon their provision of written or verbal informed consent (Appendix D), which was obtained at the time of the interview.

Interviews

Conversations serve as a valuable source of knowledge about personal and social aspects of life (Brinkmann, 2014). In addition, interviews allow the researcher to obtain comprehensive data about a specific phenomenon (Barrett & Twycross, 2018). Also, when it comes to understanding the qualitative aspects of an experience, qualitative interviews are considered the most appropriate method of inquiry (Brinkmann, 2014).

The primary goal of qualitative research interviews is to uncover participants' lived experiences and understand their meaning (Brinkmann & Kvale, 2015). Additionally, as Barrett and Twycross (2018) noted, verbal interview responses provide a structured framework and give the researcher more control over the process. Furthermore, Aston (2016) asserts that open-ended and feeling questions in semi-structured interviews help us to explore individuals' experiences more profoundly. Questions in this study regarding the experience of partners, identified support persons, and family members of mothers regarding PPD were focused on their beliefs and values.

As this study aimed to examine the experiences of partners, identified support persons, and family members, the data collection process was through audio recording and handwritten field notes of one-on-one interviews that were conducted using a semi-structured research guide comprised of open-ended questions. Developing a meticulously designed semi-structured interview guide, which avoids leading participants and provides gentle nudges or guidance only when necessary, significantly enhances the credibility and reliability of the semi-structured interview as an effective qualitative research approach (Kallio et al., 2016). Therefore, these interviews were guided by a semi-structured interview guide (Appendix D) and aimed to facilitate a comprehensive exploration of participants' understanding and experiences related to PPD. For data collection in this study, feminist researchers strived for a "horizontal relationship" between themselves and the participants, aiming for equality and mutual respect (Gillis & Jackson, 2002). To avoid not receiving adequate data, Creswell and Poth (2018) emphasized providing a comfortable environment to decrease the challenges caused by the shyness of participants. In line with this approach, the interviews were conducted in a

conversational and non-hierarchical manner, fostering open dialogue and collaborative engagement. To prioritize participants' comfort and minimize external pressures, semi-structured interviews were offered in a private room at the Dalhousie University campus or via Zoom or phone, depending on their preferences. This approach ensured a conducive environment and effectively controlled potential undue environmental influence. We also considered a sensible time limit and space between questions to provide comfort and an ideal situation to talk and share with participants (Creswell & Poth, 2018). Before starting the interview, the researcher explained the study's purposes and impacts, the time the interviews would take, the participants' rights to quit the study, and obtained consent forms from interviewees (Creswell & Poth, 2018). In addition, to avoid bias and indirect influence on the participant's responses, the researcher was aware of leading questions or non-verbal signals (Barrett &Twycross, 2018). Following participant consent, all interviews were audio-recorded and transcribed verbatim by the researcher. Detailed notes were also taken during the interviews to capture additional contextual information. The transcripts were carefully stripped of identifying details and replaced with pseudonyms to ensure confidentiality. Additionally, the researcher promptly transcribed each interview and transferred relevant field notes to prevent forgetting crucial details of the interview.

Reflexivity

Reflexivity, as described by Gillis and Jackson (2002), involves critical thinking and reflection while analyzing the interaction between the researcher and the data. According to Creswell and Poth (2018), reflexivity is a characteristic of high-quality qualitative research. The researcher, functioning as the research instrument, impacts the

research findings (Dodgson, 2019). Therefore, reflexivity plays a crucial role in acknowledging the researcher's position within the research context (Creswell & Poth, 2018). In addition, the researcher must be aware of potential biases, beliefs, and values they may bring to the study (Creswell & Poth, 2018).

In this study, reflexivity was crucial in acknowledging my background and potential biases. I have been married for six years but do not have personal experience with childbirth or PPD as a woman in her late twenties; I hold a unique perspective as someone who intends to have children, and PPD has been my concern for years. PPD has been both a personal interest and a professional concern for me during my clinical work as a nurse with postpartum patients. I have been interested in the mental health of mothers during the postpartum period. Additionally, in my home country of Iran, there are negative cultural beliefs surrounding mental health issues, and I have consistently advocated against these beliefs. It is essential to acknowledge that my strong interest in and awareness of these negative beliefs and values may or may not have introduced a potential bias in the analysis of this study. Therefore, my supervisors and committee members provided attentive supervision during the data analysis process to mitigate this potential bias. On the other hand, my experience and knowledge regarding postpartum mental health issues contributed to interpreting and analyzing concepts and beliefs that could be unfamiliar to someone without these experiences. These past experiences would shape the data's findings, conclusions, and interpretations. Also, to ensure reflexivity, I engaged in reflective journaling through notes and memos to situate and organize my thoughts throughout the interviews and data analysis.

Data Analysis

The audio recordings were transcribed in a private study room at Dalhousie University or a private room in the researcher's home and then analyzed using steps of Aston's (2016) guide to using FPS informed by discourse analysis. The analysis process involved several steps. Firstly, I thoroughly reviewed the transcripts, extracting quotations that addressed critical issues (Aston, 2016). These quotations were attributed to the participants' beliefs, values, and practices. Subsequently, I focused on identifying the social and institutional discourses that emerged from the participants' words and meanings, providing insights into the PPD problem. These discourses sometimes were evident within the quotes, while in other cases, interpretation was necessary (Aston, 2016). Throughout the analysis, I explored the interconnectedness of these discourses and their impact on the participants, paying particular attention to potential conflicts or tensions. Additionally, I examined the power dynamics experienced by the participants, known as the "relations of power" (Aston, 2016). Finally, I incorporated the participants' subjectivity, considering how they positioned themselves as partners, men, women, any other genders, or family members. Furthermore, I explored their agency, examining how they respond to and engage with the discourses, either by conforming to them or challenging them (Aston, 2016).

By following the steps, I gained insight into the participants' expressions of their beliefs, values, and practices within social and institutional discourses. Employing the FPS allowed me to adopt a distinct perspective on the participants' experiences and critically examine oppressive elements. It is important to note that FPS does not aim to assign blame to institutions or solely challenge oppression; instead, its primary purpose

is to uncover how individuals either accept or challenge prevailing ideas and to employ analysis to identify potential avenues for transformative change (Aston, 2016).

Trustworthiness and Rigor

Qualitative researchers can assess the trustworthiness of their data using five key principles: credibility, transferability, dependability, confirmability, and authenticity (Bradshaw et al., 2017; Creswell & Poth, 2018). These principles serve as indicators of the quality of the findings in a qualitative study. To enhance the credibility of this study, I actively engaged with the participants and considered external influences (Stahl & King, 2020). Furthermore, I prioritized establishing a trusting relationship with the participants and ensuring the accuracy of the data by incorporating the repetition of quotes in the interviews (Bradshaw et al., 2017). Regarding confirmability, I employed direct quotations from the participants, provided descriptions of their demographics, and maintained a reflective journal with notes (Bradshaw et al., 2017). To ensure dependability, I documented the steps I used and any changes that occurred throughout the study, and utilized and adhered to the principles of poststructuralism (Bradshaw et al., 2017; Stahl & King, 2020). Additionally, to address transferability, I intended to implement purposeful sampling, include detailed descriptions, and conduct in-depth interviews to enhance the applicability of the data to other settings, contexts, and groups (Bradshaw et al., 2017). In order to maintain the authenticity and credibility of this research, the analysis process was undertaken in a collaborative partnership with my supervisor, Dr Megan Aston, who possesses extensive expertise in FPS and discourse analysis (Creswell & Poth, 2018). Moreover, this research study cannot be generalized to

a broader population. However, readers would be encouraged to establish connections between various aspects of the study and their personal experiences with PPD.

Ethical Considerations

The researcher must pay attention to ethical issues during the different phases of a qualitative study in order to identify and address them (Creswell & Poth, 2018). As this study is part of a master's thesis at Dalhousie University, I obtained the university's approval before starting the study implementation. The IWK health center's ethics approval was obtained for this study, which is acceptable for Dalhousie University. This research study focused on the experiences of partners, identified support persons, and family members regarding PPD, which encompassed sensitive topics related to mental health and depression. The process of obtaining free, informed, and ongoing consent was followed to ensure ethical considerations. To ensure voluntary participation and to prevent any external pressures, I carefully assessed the participants' intent to participate. I provided participants with detailed information about the study's purpose, time commitment, eligibility criteria, their rights to withdraw from the study, and the potential risks and benefits associated with their participation. After that, ample time was given for participants to ask their potential questions regarding the study. To document their consent, each participant signed a consent form before starting the interview, confirming their agreement to participate in the research study. Moreover, as the researcher, I acknowledged and respected the diverse cultural, religious, gender, and other differences among the participants (Creswell & Poth, 2018).

During the data collection phase, I aimed to create a comfortable interview environment, minimizing disruptions that may hinder participants' openness and

willingness to share personal and sensitive feelings and experiences (Creswell & Poth, 2018). The interviews were recorded in audio format and transcribed verbatim by the researcher. The data consisting of electronic consent forms, electronic transcriptions of the interviews, field notes, and audio recordings of the interviews are stored on Dalhousie's online secure system called OneDrive in a password-locked laptop computer, and a copy of these files is stored in flash memory. The flash memory and all hard copy data are stored in a locked cabinet in my supervisor's office at Dalhousie University, secured by a lock. As soon as audio recordings of the interviews were uploaded to my computer, the audio files were deleted from the digital recorder. In compliance with Dalhousie University and IWK REB guidelines, all data will be destroyed within five years of the date of my final thesis defence.

The findings were accurately and truthfully reported, adhering to the ethical principle of avoiding disclosing harmful information to participants (Creswell & Poth, 2018). Multiple points of view and contrary findings are published, enhancing the transparency and credibility of the research. The participants' privacy is treated as a top priority, and while complete anonymity cannot be guaranteed, any personal information or potential identifiers are kept confidential. To maintain confidentiality, pseudonyms were assigned to participants, and any identifying information was removed while transcribing audio files. In the dissemination phase, participants who expressed interest in receiving the study results, as indicated in the consent form, were provided with copies of the report. This study also aimed to ensure transparency and fulfill the commitment to share the findings with relevant stakeholders. Additionally,

acknowledgment of the research funders and beneficiaries is included in the final report

(Creswell & Poth, 2018).

Chapter Four

Findings

I will describe this study's findings and interview interpretations in this chapter. The purpose of this study was to explore the experiences, including beliefs and values of partners, identified support persons, and family members of mothers with babies aged 0-12 months regarding Postpartum Depression (PPD) using a Feminist Post-Structuralist lens (FPS). Although the study's recruitment criteria were open to individuals of any gender identity, all the participants who ultimately took part in the study referred to the person they were supporting as "mother" and used the pronouns "she/her." Furthermore, all the mothers referred to in this study gave birth to their babies within 0-12 months of the date of the interviews. The study addressed the following research questions: 1) What are the experiences of partners, identified support persons and family members regarding PPD? 2) How are their experiences socially and institutionally constructed?

To elaborate on the findings' context, we have done seven interviews overall, including two partners, three sisters, one brother, and one friend of postpartum mothers who identified themselves as the mother's main support person. Seven semi-structured interviews with open-ended questions were conducted for approximately one hour each, with participants discussing their experiences of PPD in detail. All the participants were older than 18 years old, residents of Nova Scotia, and varied in gender and race. Based on discussions among interviews, they were mainly Nova Scotian Black or African American Black, and one of them referred to her race as White. Five participants mentioned English as their second language, but two confirmed that English is their first language. Interviews were transcribed word for word after the interviews, and analysis

was done using the FPS lens. All participants' names have been changed to participants' numbers to ensure confidentiality. Participant 1 (sister) was the support person for her older sister after giving birth; her sister's husband supported the postpartum mother as well, but she was the main support person. She identified her race as African Nova Scotian. Participant 2 (partner), who mentioned his race as African Black, was supporting his wife after the birth of their first child himself; their families were aware of the PPD situation and were following up on how they were going through this, but there was no direct support from them. Participant 3 (partner) stated he was African and was born and raised in Nova Scotia. He supported his wife with minor and occasional support from his wife's sister. However, he did not reveal this issue with his own family, which will be discussed in the following section. Participant 4 (sister) mentioned her race as Black American and has been the primary source of support for her older sister, who lost her partner before giving birth. Participant 5 (brother), who was an undergraduate student at university and identified his race as African American, supported his older sister while her husband was preoccupied with work and was often unavailable. Participant 6 (friend) identified her race as White Canadian. She was born and raised in Nova Scotia and was the main support person of her friend as her family members were absent. The mother's husband was frequently away for work during the postpartum period. Participant 7 (sister) mentioned they were from an African Nova Scotian family. She was the main support person for her younger sister, with minor help from her sister's husband and other siblings. Each participant had a unique experience with PPD as a support person; however, some similar themes and discourses emerged after analyzing the interviews. Most of the participants demonstrated a belief that there were people with negative and judgemental beliefs about PPD and mental health issues, which exhibited a discourse of

stigma and taboo surrounding PPD and mental health issues. Participants identified PPD as a family issue and emphasized the importance of partners' and family persons' roles in supporting postpartum mothers. Participants also shared their beliefs about what they thought a mother should be, including a discourse that perpetuated happy, perfect, and normal mothers. Participants also noted the lack of knowledge and awareness as dominant issues they encountered as support persons. The findings were categorized into four main identified themes: 1) Challenge the Meaning of Normal Mother, 2) Navigating Judgements about Mental Health, 3) A Family Affair: PPD No One's and Everyone's Business, and 4) Valuing Knowledge and Awareness of PPD. Each theme is described and analyzed in detail, supported by quotations from participants' experiences.

Theme one: Challenge the Meaning of Normal Mother

The meaning of being a postpartum mother has been socially constructed through a mothering discourse incorporating the ideas of being normal or a good mother. This meaning shifts and changes from person to person and culture to culture. Labelling mothers as good, bad, normal or abnormal can have adverse effects on their mental health. It may lead to constant comparisons to other mothers, resulting in feelings of guilt and depression if they feel they are not experiencing mothering the way they are 'supposed to.' This study's participants discussed their perspectives on the meaning of being a mother based on their personal or cultural beliefs. A discourse of happy and normal mothers appeared when participants were describing the PPD symptoms in mothers. Participants believed mothers naturally tend to be happy and care for their babies. Most of the participants mentioned PPD symptoms as not being normal, and they were shocked that after delivering the baby, the mother was not happy and excited and

doing all the baby's care herself. All participants negotiated the normal and abnormal meaning of mothering in the context of PPD. When participants were asked how a normal or good mother must be, they believed a normal mother should be happy and excited to have their own baby. For instance, participant 3 (partner) valued when a mother cared for their baby and worked hard to ensure everything was okay and used his own mother's behaviour as an example:

> When I was a child, my mom used to make sure we woke up in time to prepare for school, we got the meal on time, and we prayed together. She worked hard to make sure we were okay. That is what mothers do.

Participant 3 (partner) expressed his confusion about not finding his wife excited after birth. This is an excellent example of how his confusion had been created through a binary understanding of motherhood and how he was oppressed by his expectation of mothering being natural for a mother, which made him confused: "She was very excited about getting pregnant and being a mother, but at the same time, after the birth, she was depressed, and the whole situation was confusing." He also noted: "She was afraid of not being a good mother to her child. So that leads to depression." This participant was challenged by the discourse of a normal and happy mother and was feeling confused; his wife was not presenting as a normal mother that had been socially constructed, and he also believed his wife was depressed due to her fear of not being able to be a good mother. Participant 3 (partner) was initially affected by the binary meaning around motherhood. Then, he navigated the relation of power by challenging the discourse of the normal mother by stating: "I did not have a negative thought. I know

maybe it is normal to have that feeling and to be afraid. It was normal, so I just tried to be supportive."

Participant 1 (sister) also explained how she and her sister's husband were feeling depressed when they found out the mother was not happy after delivering the baby. This shows how the binary meaning of motherhood affected them and how they were challenged by the belief behind the discourse of a happy and normal mother, so when they could not meet their expectations of how a mother naturally should be, this depressed them. Participant 1 (sister) noted: "She felt really down, and it was depressing on our own side because I felt she was happy about the pregnancy and delivering the baby, but later she started giving us attitudes, and she had a lot of mood swings." Participant 7 (sister) was surprised that her sister was not happy after giving birth while they were happy in the family. This is an example of questioning the meaning that comes with the discourse of the normal mother and being surprised that it is different from what they are experiencing with a postpartum mother: "She has given birth, and everyone was happy, but then, she did not share the same joy that we did. I was like, come on, what is going on?"

Participant 6 (friend) also manifested being surprised at not seeing a happy and excited postpartum mother and valued being excited, happy, and having a strong bond with the baby in postpartum mothers. This participant was surprised because her expectations of how a mother must be remained unmet, and she was challenged by the binary meaning of motherhood. Participant 6 (friend) noted: "Right after she delivered the baby, she did not want to hold her child. She was so detached from her baby. She did not have that excitement that mothers should have when they give birth to a child." She

added, "I was very surprised because there was a baby there, and we have all looked forward to having it for the past nine months. I feel like all mothers should be happy having a child, but then she was sad." This participant did not see her friend enjoying motherhood as perpetuated by the dominant socially constructed discourse on motherhood. Instead, she was surprised to see that her friend was not happy and excited. Because participant 6 (friend) believed a mother must be happy and close to the baby, he put this belief into practice and reminded her friend of her behaviour during her previous postpartum period and mentioned how mothers should be after giving birth; she noted: "I told her this is how mothers do after giving birth. This is their actual reaction, and I even had to refer back to when she had her first child; I told her this was not how she was reacting." The majority of the participants held the belief that mothers naturally possess an innate ability to care for their babies. They considered it abnormal when this did not happen, for example, in the case of a mother suffering from PPD. Participants also valued and thought it was in a mother's nature to address all their baby's needs and develop a strong bond with the baby. Regarding this, Participant 2 (partner) stated that he was concerned about his partner's and newborn's bonding as he was doing most of the baby's care. He was struggling with the belief that a normal mother should naturally be able to care for their baby and was therefore concerned that his wife was not doing the baby's care, and this felt abnormal to him. Participant 2 (partner) stated: "Anytime I am around, I am actually the one bathing the baby, preparing the baby, putting her in her diapers, and feeding the baby when she is having pain in the nipples to breastfeed the baby." Participant 5 (brother) also believed that mothers should be able to take care of babies themselves and having a Nanny to help with the baby's care was abnormal; he noted: "She was not always with the baby. The baby was always in the Cuddle chair. I

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have always been the one very close to the baby, and we had a Nanny to help. That is quite abnormal." Participant 5 (brother) was affected by the belief that all the baby's care should be done by the mother. He navigated the relation of power made by the binary meaning around motherhood in a way that he accepted the discourse of the normal mother and believed his sister's behaviour was abnormal as a mother.

Participant 5 (brother) also believed the definition of a "good" and "normal" mother was to be happy and able to interact with their baby through play, breastfeeding and holding:

> From my perspective, a good mother should be happy to have her baby, hold her child, breastfeed her child, and play with the child. That is how a good mother should be. There were these moments when I walked into her room, and then she was crying. She felt really sad. The baby was distant from her. A normal mother should be playing with the baby, but that was not what she was doing.

He believed a mother naturally should play with the baby and have a strong bond. He put this belief into practice by reminding his sister how a normal or good mother should be: "I walked up to her like a junior brother. I tried talking to her, trying to encourage her. I also try to remind her of how our mother raised us." Participant 5 (brother) articulated how different he found his sister's behaviour as a mother from their mother's behaviour: "I saw or heard her cry, and the bonding between her and the baby was not there." He added: "My mom told me a story of how she was happy to have me and how she was glad she was always next to me, then comparing that to how my sister is to her child and it is abnormal." He strongly valued a mother's happiness and closeness to the baby and believed that mothers are naturally happy and tend to be close

to their baby; otherwise, this would be considered abnormal: "Every mother should be close to her child. A mother should be happy." This is an example of how the brother of a postpartum mother was influenced by the dominant social discourse of what it meant to be a 'normal mother.' Their mother had told him about her happiness of being a mother and he believed a mother should be naturally happy. This belief created a binary opposite of mothers being normal and not normal.

Additionally, Participant 7 (sister) believed mothers should be naturally happy and they want to do all the baby care themselves: "Normal mothers would want to do the care to baby, they want to embrace the child. So, a normal mother would be happy to have the baby." This participant accepted the beliefs around motherhood that were perpetuated from the social discourse that normalizes happy mothers who are naturally close to their babies and do all the baby's care. She put this belief into practice and stated: "I told her, do not worry, everything is going to be fine. There is definitely something wrong. I am going to figure it out and fix it. There is nothing that cannot be fixed." This shows how this participant was affected by the binary meaning of motherhood and accepted the belief that when a mother is not happy and close to their baby, and it is abnormal to experience distance from one's baby and unhappiness. Constructing the experience of being unhappy as abnormal creates a difficult situation whereby people do not know how to help mothers who are unhappy because it is part of a hidden discourse on mental health. The dominant happy mothering discourse perpetuates more power than a discourse on mental health. This will be further addressed in subsequent themes.

Summary

The majority of participants in this study spoke about how they believed the postpartum mother they were supporting was experiencing something abnormal. All participants believed that there was a normal way to be a mother, which entailed feeling happy and excited, as well as forming a strong bond with the newborn. Understanding how the social discourse of 'normal' and 'happy' mothering strongly impacted all participants is important. All participants struggled with the binary meaning around motherhood made from the discourse of the normal and happy mother, and they navigated the relation of power in different ways. The dichotomy of normal and abnormal was an important issue to deconstruct further to understand how the participants negotiated relations of power. All participants negotiated the normal and abnormal meaning of mothering within the context of PPD. For some, it made them feel concerned, confused, depressed, and unsure. These feelings that many participants clearly articulated demonstrate a site of struggle that needed to be questioned and challenged throughout their journeys with postpartum mothers. This led to changes in their behaviour as a support person and in their willingness to seek help when dealing with postpartum mothers experiencing symptoms of PPD. This will be discussed later in other themes.

Theme two: Navigating Judgements about Mental Health

Judgemental attitudes and stigma toward mental health issues can impact the support persons, their responses, and their willingness to seek help for PPD. A significant theme evolved from this study's data regarding judgemental attitudes towards PPD. These attitudes stemmed from participants' and others' personal beliefs and values. It

was evident that a discourse of stigma or taboo was constructed from sociocultural contexts and impacted the way participants sought help, which directly impacted the mothers they were supporting. Consequently, participants said they obtained less information about PPD as a mental health issue as it carried a dominant discourse of being a taboo subject in society, where people do not talk about it enough. This demonstrated how help-seeking behaviours from participants brought about less direct talking about PPD and delayed support for mothers.

Participants in this study highlighted their beliefs about the existence of negative beliefs and judgemental views around mental health issues while they were sharing their experiences about PPD. Participants believed the judgemental views were prevalent among themselves, people close to mothers, and within society, and this stemmed from a lack of awareness about PPD. Participants valued not having a judgemental view and tried to understand the experiences of postpartum mothers even when it was hard to understand. Participants responded to judgement by isolating themselves and the postpartum mothers, raising awareness about PPD, seeking support from specific individuals, and avoiding disclosing PPD to some other individuals. Participant 4 (sister) strongly valued understanding postpartum mothers unconditionally. However, she found it difficult to understand her sister's postpartum experience at times. Before she learned about PPD, she viewed it as abnormal, revealing the presence of judgemental views in her beliefs. She also believed that if she shared her sister's situation with someone, they would consider the sister as crazy: "I was looking at it as abnormal and crazy. I felt like if I tell someone what she is going through, the person would look at it as crazy!" This demonstrates how the stigma that is perpetuated in society gives the discourse of mental

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health issues a dominant meaning of a taboo subject. This participant was affected by this discourse, feeling unable to seek support or discuss her sister's PPD due to fear of judgement. Additionally, her limited knowledge about PPD contributed to her own judgemental beliefs, making it challenging for her to challenge the oppressive discourse. However, she then explained that after getting knowledge of what was going on with her sister, she was able to question and challenge what PPD meant to her and her sister:

> You just have to put yourself in her shoes, and I would say pretend you understand to make her feel good. I really do not know how it feels. Even when I pretend to act as I know, deep down, I know that I do not feel the same pain she feels.

She valued understanding postpartum mothers and showed her practice for this value by saying, "Putting yourself in her shoes." Participant 4 (sister) used her agency and negotiated the power relations that had been constructed through oppressive judgements about mental health issues. After earning a deeper understanding of PPD through her own experiences, she came to strongly believe that judgemental views were rooted in a lack of knowledge about mental health issues in general:

> People who do not know anything about it have judgemental feelings about people with mental health issues. In my family, they are aware now because of my sister, but in my community, if you try to talk to them about mental health, they are not willing to listen because they feel like it is abnormal.

This participant's experience clearly showed the dominant discourse of mental health as a taboo subject. Participant 4 (sister) explained how her sister's husband's

family reacted to her mental health issue as a subject that was not acceptable or tolerable. They avoided any contact with her and decided to abandon her. Labelling people who are suffering from mental health issues can also be seen in this quote where the husband's family labelled the mother as crazy:

> From her husband's family. They did not want her to be around anything associated with her because they felt like she was going crazy. The husband's family judged her and did not want to stay around us.

This participant's experiences depicted the social discourse of stigma and taboo around mental health issues, which oppressed her to the point that led to isolation and a preference to stay at home to avoid being judged. Participant 4 (sister) also declared an experience with her sister at a grocery mall in their neighbourhood that shows how judgement can feel oppressive and can lead to isolation. She said:

> She was not saying anything; she was just crying, and a lot of people passed by, and they were like, what is going on? They saw us as crazy. There were a lot of eyes on us. Their facial expressions would make you know that they were judging. So, a lot of people in the community look at mental health patients as crazy. They find it weird to accept that this person is actually having a mental breakdown.

This shows that this participant was aware of the social discourse regarding mental health issues as a taboo subject, and she was feeling judged and labelled for the way people were staring at her sister. She also acknowledged that people found it weird to accept a person who was just going through a mental health breakdown, which depicts

the discourse of abnormality and taboos regarding mental health issues. There was a binary meaning attached to mental health issues that was both normal and abnormal. Her feelings and thoughts demonstrate that she was internally struggling with and challenging a dominant discourse that was being perpetuated by others' reactions. This struggle indicates the extent to which she felt oppressed by a dominant social belief of judgemental and social views about mental health issues. This then led her to be more isolated and to avoid seeing people. Participant 4 (sister) mentioned:

> Since the incident at the mall, she just gets fingers pointing when we go out to show that we are the ones with that experience. Sometimes, I feel like I do not want to go out anymore because it is so much when you are out, and I feel like they are staring or pointing at you.

Since Participant 4 (sister) had witnessed judgement from strangers in the community as well as her sister's in-laws, she was hesitant to disclose her sister's situation to her friends, as there could be rejection and judgemental behaviours from them. She stated: "I felt uncomfortable at first because I thought my friends would distance themselves from me. I thought they would push me aside. Maybe they cannot be associated with someone who has a family with this kind of issue." She had this fear of being rejected or judged as the dominant discourse around mental health had created a binary of meaning, including healthy and happy versus depressed and mentally ill. This social discourse constructed the meaning that a mental illness would be judged, and people would not be willing to deal with it or recognize it; this discourse had been socially constructed over time through social beliefs and values. This discourse created fear of judgement when one was seen as different, not normal and mentally ill.

Participant 4 (sister) believed people from the community were not willing to talk about mental health topics in general. She found this perspective upsetting and recognized that it was not helpful; therefore, she decided to use her agency to challenge and overcome the oppressive relation of power she was experiencing and talk about the mental health issue her sister was struggling with to increase awareness: "I talked about how they [friends] should not discriminate people with this type of issue. Make them feel love, make them feel comfortable because they are humans like all of them."

The discourse of stigma and taboo regarding mental health issues emerged as seen through participants' beliefs, values, and practices. The majority of participants initially intended to share this issue only with people close to them, probably due to feeling uncomfortable and oppressed by the stigma around this subject. Many participants, however, sought help from others in different ways that will be addressed later. Participant 7 (sister) acknowledged the existence of judgemental views regarding mental health but had not personally encountered them as she chose not to share her experiences with many people. This shows how she was oppressed by the negative belief around the discourse of mental health issues as a taboo subject and how she used her agency, accepted this belief, and decided not to reveal this issue to others. This highlights how the fear of judgemental attitudes can hinder open discussions about mental health issues that may lead to isolation and silence:

I am definitely sure there are others out there that have those kinds of discrimination against people with mental health issues. I did not really talk about my sister's problem much. I did not actually feel the need to talk about it with

others because she already had the support she needed. We did not talk about it

outside because I saw that some people had negative comments about it.

 Similarly, participant 6 (friend) believed that although there were people with

judgemental views, she believed close friends and family would not be judgemental. She

chose to only disclose information about her friend's PPD to their close circle of friends.

While she did not experience judgement from friends, she decided not to disclose this

information outside of family and friends:

Some persons have some judgemental thoughts when it comes to mental health

issues. I did not see any judgemental views because the whole thing was not fully

disclosed to everyone, and not everyone knew about it, so this was just friends

and family. And they never gave any judgemental look or talk.

This participant believed that people outside the close circle of friends could be

judgemental. Therefore, she navigated the potential judgement about PPD by using her

agency. She protected her friend by ensuring she did not disclose that she had PPD

beyond the circle of friends. These are examples of how participants used their agency to

think about how the judgement was present within and outside certain circles of people.

So, they decided to only disclose to a small and close circle of people to avoid

judgemental views. This choice and practice can be seen to be a way of navigating

relations of power associated with a discourse that perpetuates PPD, a mental health

issue, in a negative and judgemental manner. In other words, PPD is a taboo subject.

The fear of judgement also affected how support persons sought help. For

example, one participant only felt comfortable discussing this issue with a therapist who

was also a family member. Participant 5 (brother) expressed that it would have been hard to reach out to a therapist who was a stranger and was thankful they had the privilege of having a therapist who was also a family member. This demonstrates how the discourse of mental health and therapy has been constructed through a discourse that places the meaning of secrecy and shame on PPD. We can observe how participant 5 (brother) experienced the relation of power that was created through a dominant discourse of mental health issues as taboo. He had to navigate the feelings and social beliefs about mental health issues that had been created by a dominant and very visible discourse. He used his agency to negotiate the relations of power that felt oppressive to him and accepted the discourse of mental health issues as a taboo subject. Foucault would write that institutions and discourses cannot do things to people. It is people who react to the social beliefs that are dominant thinking, and their reaction is the way they navigate relations of power by challenging or accepting certain social ideas about PPD. Participant 5 (brother) stated:

> I do believe people have judgemental views about mental health issues, especially people who she does not keep in touch with closely. She would not feel comfortable disclosing her situation to her friends that she is not close to them because they would have a judgemental view of that.

Participant 5 (brother) also believed talking about PPD, even with his cousin, the therapist, was hard for him as he was worried about his cousin's perceptions and reactions. He had a fear of being judged by his cousin, which depicts how he was oppressed by the negative meaning from the discourse of mental health issues and

accepted it. This was probably due to how he felt about a dominant social discourse of stigma and taboo around mental health issues. Participant 5 (brother) noted:

> My cousin, who is a therapist, tends to be very close to us. At first, it was quite hard for me to explain her situation to him and for him to understand it. It was hard for me because I never knew how my cousin would have perceived that, as people have different views about these things. I also did not know if he was going to be willing to assist. It would be very difficult for her to talk to a therapist who is not a close family member.

Some participants believed these judgemental views may not always be from strangers, and people in a close circle of mothers might also have those judgemental views, which can negatively impact mothers. This belief may stem from negative personal and cultural beliefs about mental health issues that the participant has experienced. Participant 6 (friend) stated:

> Aside from strangers, I feel like close friends or close people sometimes give judgemental looks and talk, too. So, it is not just strangers. I feel like it is going to have a very negative impact if their support persons and husbands take this negatively.

The participants expressed their concerns that their friends or family members may share dominant social beliefs about PPD. Participant 5 (brother) also expressed difficulty in explaining his sister's mental health issues to their cousin, as we discussed above. Not knowing how to talk about mental health can feel paralyzing and isolating. This silencing and isolation created a discourse where people were unsure, nervous, and

did not know what others thought because most people did not talk about it due to society's dominant beliefs and values. However, participants recognized the fact that their close friends and family members might be more accepting and understanding and may not judge them. This fear of being judged and the idea behind the dominant discourse of stigma and taboo around mental health issues oppressed some participants, and they navigated the relation of power in a way that showed their practice of not sharing PPD issues even with people in their close circle. However, some participants did talk about PPD in 'small circles' in private because they needed support. This is a way to challenge the dominant discourse on mental health that creates mental health issues as a taboo subject. They used their agency to push back, seek help, and talk to people. The support people of mothers with PPD were brave as they challenged social beliefs and discourses. They found ways to help.

Participant 3 (partner), who was supporting his wife, believed PPD was not an issue you could solve alone and valued help-seeking, especially from family. He involved one of his friends and his sister and subsequently decided not to disclose any more information about his wife's PPD to anyone else or family members:

> It is not something you can solve on your own. I did not really involve the family that much. I just asked my mom if she had such an experience before, and she did not bother asking me more questions. I did not tell her this is what my wife is going through, so she never knew my wife was going through that. It was just my wife, my friend, and her sister.

This can be considered as an instance of how he used his agency first to ask a question to figure out his mother's beliefs and values about PPD. Then, when he felt the

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possible judgemental and negative beliefs around PPD, he navigated the relation of power and did not share this with his family. However, he found his friend and his wife's sister with fewer judgemental beliefs. This practice can be considered as a way of navigating relations of power associated with a discourse that maintains mental health issues in a negative and judgemental approach as a taboo subject. Moreover, when he was asked why he did not share this with his family, he mentioned possible judgemental views from people in his Black culture. This demonstrates how he used his agency to negotiate the relations of power, encountering judgemental beliefs around mental health issues. Sometimes, he accepted it, and sometimes, he challenged it. Participant 3 (partner) noted:

> People judge; they do not want to know what really happened. They judge you because you are having some mental issues. So, I am a Black person, and we have a different culture. My mother might think differently about her, so I did not want my family to see her in some other way. No, I did not just want to go to my family. I was just being logical. I did not even know how my family would take it and how my mom precisely would take it. I did not just want to escalate our situation. I knew it could be a little bit challenging for her to cope with that.

This participant was aware of the social discourse regarding mental health issues and the belief that it can be difficult for people to talk about and cope with mental health issues because it is seen to be 'abnormal.' He also briefly indicated that his Black culture impacted the way he chose to speak or not speak about PPD. The dichotomy between normal and abnormal mental health creates a situation where people need to choose which belief they are going to agree with, challenge, or ignore. He knew his mother

might react poorly. Therefore, while he was aware of this social meaning, he struggled with how to negotiate the binary meaning of PPD, and he chose, at this time, not to challenge the ideas within this discourse about mental health and not have a conversation with his mother. The power of the discourse can be seen in his struggle. Feeling like he could not talk about it with his mother is an example of how he may have felt oppressed by a dominant social belief about mental health issues. He did express that he believed people should be able to talk about PPD and have their family and friends support and value this; however, he was not able to express it at this time.

Summary

Some participants used the word 'abnormal' when referring to PPD symptoms, while others described how PPD was invisible because people did not want to acknowledge or talk about PPD. The binary that is created is based on two different discourses. One discourse creates negative meanings about mental health issues that perpetuate PPD as 'abnormal' and a taboo topic to talk about. The other discourse perpetuates the meaning of mothering as happy and free from any mental health difficulties. This discourse is socially constructed to be dominant and therefore 'normal'. When participants use the term 'abnormal' to describe PPD, it immediately positions PPD as a mental health discourse in opposition or in a binary with a 'normal' and happy experience of mothering free from PPD. The word 'normal' is problematic, and all participants in this study challenged the meaning of mothering and how PPD is understood and addressed by themselves, friends, and family members. This theme demonstrates how the dominant discourse of negative and judgemental views around mental health issues reveals the idea of mental health issues as a taboo subject. The

dichotomy between normal and abnormal mental health made participants choose which belief they were going to agree with, challenge, or ignore. All the participants were aware of the social discourse regarding mental health and the belief that it can be difficult to talk about PPD or share what they were going through with PPD as PPD was associated with a taboo meaning in certain social discourses. All participants were aware of the mental health social discourse that had constructed judgemental beliefs towards mothers experiencing PPD, which could be from others or was ingrained in their personal beliefs and values. The majority of the participants felt that judgement arose from a lack of awareness about PPD. Based on their personal values, participants used their agency and negotiated relations of power in different ways. Some challenged, some ignored, and some accepted the status quo and uniquely expressed their practice. Participants reacted to judgement in different ways by isolating themselves and the mothers, increasing awareness about PPD for themselves and others, and avoiding disclosing this issue to certain people. We must have awareness regarding the social discourses around mental health issues and consider the ways individuals would navigate the relations of power stemming from these discourses and how they can affect a person's help-seeking and mental health improvement.

Theme three: A family affair: PPD No One's and Everyone's Business

The popular proverb *'It takes a village to raise a baby'* represents the importance of the support persons and people around mothers to raise the baby. The postpartum period comes with many responsibilities and challenges, and mothers require support from their close circle. This need can be even more serious when it comes to issues like PPD or other mental health issues. All the participants in this study mentioned PPD as a

family issue, and they strongly believed people in a close circle of mothers should be involved in coping with this issue. PPD has been socially constructed to be an invisible individual matter; however, all participants spoke about how PPD affected not only the mothers but also partners, family, friends and even society. Participants acknowledged that they could not provide sufficient support on their own, so they reached out to their family, friends and mothers' partners for assistance. Asking for help was mainly from people from the close circle of mothers, which demonstrates the dominant discourse around mental health as a taboo subject which comes with judgements and negative beliefs. Participants also highly emphasized that partners' support was the most crucial form of support. Many participants said everybody should care about this issue as it is our problem and not only the mothers' problem; Participant 3 (partner) stated: "When it affects an individual, it affects family and society. So, some people say it is not our business, but it will be our business at some point." This participant believed some people were not willing to address mental health issues and help individuals suffering from these issues because they believed it was not their business. In contrast, he believed mental health was everyone's business and affected all people in the family. This dichotomy creates a problematic opposition of meaning and raises the question, 'Whose business is PPD'? Is it no one's business or everyone's business? Presently, all participants in this study recognized that the dominant social discourse on PPD perpetuated the idea that mental health was not the business of society and needed to be hidden because it made people feel uncomfortable, and the outcome of this was that those with mental health issues were judged. We can see how the relation of power between different meanings created this binary opposite that all participants questioned and challenged. Participants demonstrated the importance of questioning the dominant

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discourse that encourages people to keep mental health issues hidden. They believed that PPD was everyone's business.

Participant 5 (brother) valued support from family for mothers as he believed his sister would not be able to overcome PPD by herself and the family support would give her a feeling of love and connection, which would make everything easy for her:

In my sister's case, she was not able to solve the problem herself. So, I would say families should be willing to assist and provide support to mothers who are experiencing postpartum depression. The mother would feel loved, relieved, happy, and connected. And this connection makes everything quite easy for her.

Participant 6 (friend) highlighted the importance of family support and believed that while the mother was receiving some support from her family, it was not enough. So, she had to step in as her support person. She recognized the importance of constant support for her friend, and when the family was not available for the mother, she believed alternative support from friends would help the postpartum mother. Participant 6 (friend) said:

She did get family support, but maybe not how she wanted it. Maybe she needed all of them right there at that time, but then they did not seem like they would be available. Well, then, she did get it from friends. She did get it from me.

Participant 2 (partner) also valued support from their family and their help in making decisions and supporting his wife when he was not available. He put this value into practice and asked for help then mentioned that this support helped him cope better. He stated:

I believe that the family would help make decisions and think of available solutions to the problem. I had to ask her sister to come so that when I was at work, her sister would be around to help her, and with her sister's help, I could cope with it.

He also believed PPD was a problem that concerns everybody: "We shared it with our family. It was a problem that concerned everybody, so we had to involve them."

Another participant, participant 7 (sister), also believed that PPD was a family problem and that all the family members should bring their knowledge and ideas to solve the problem:

It is not only the mother's problem; it is the family's problem, and they should come and support it. Everyone should chip in their knowledge and ideas. So, I feel like it is when a mother will pass postpartum depression.

Participant 4 (sister), who was the main support person for her sister, valued having more people and more family support as she believed it would make this experience easier to handle for her as a support person. She believed most of the pressure was on her, and if there were more family members available, this experience would have been easier for her:

I was the only one that stayed with her. The rest of my siblings and my mom just came occasionally, checked her and then went. It was just me. So, the pressure was more on me. This is best if most or all of the family know how to handle and care for a postpartum mother, as it would not be easy on one person. At least if

we were two or three together, we might have been able to bring her out of this depression easier.

 Family support was a value for this person to the extent that she showed her practice by trying to involve the family members in the care of her sister. "So, I gave credit to my other siblings and my mom to speak to her."

All participants acknowledged the importance of having a group of support persons. They believed this would decrease the pressure on one main support person and make it easier to help the mother. They valued this support from family members or friends, probably due to their awareness of the social discourse of judgemental views around PPD. Based on what we discussed in the previous theme, they believed this support should be mainly from a close circle of friends and family. It was evident that they were aware of the socially constructed binary meaning of normal and abnormal around PPD. This construction influenced their practices that considered support from family and friends to be the best available support for the postpartum mother as they believed strangers like therapists or support groups would have judgemental views that might negatively affect mothers.

Partners' support was valued by most of the participants, as they believed that lack of support from the partner would be one cause of PPD based on what they experienced. Participant 3 (partner) highlighted his responsibilities as a husband and father: "It is my family and my responsibility. I know my dad took care of his own family. It is my turn to take care of my family. We are sharing everything."

Participant 5 (brother) also justified the importance of the partners' support for the fact that the husband was the one who put the mother in this situation, which he means by this situation was having a baby: "I feel she was missing the husband cause the husband is the person who put her in this situation. He is the one to whom she gave birth to his child, so why is he not much around? "He also used his mother's postpartum experience as an instance to show the importance of the partner's support; he believed that because she had support from the partner, family and friends, PPD had not happened:

> In my family, postpartum depression was not the case because my mother was very close to me based on what she told me….and my father was always by her side. Then she also had family members and friends; She had major support.

Partner's support was an essential value for participant 5 (brother) as he put this value into practice and tried talking to other people and asking them to talk to her sister's husband to make sure he would come for a visit; he also mentioned it was a cultural value for them:

> When I told my mom about it, she communicated with her husband, asking him questions about why he was away and why the wife was only there. The husband was giving us reasons for work, but she ensured that he returned home to visit his wife. In our culture, once the wife gives birth, the partner must be with her and spend some time with her.

Participants believed the main and most important support person of postpartum mothers were their partners. They valued the partners' presence with the mother and held

the belief that a lack of support from partners can lead to PPD. As participant 5 mentioned, the husband was the person who put her in this situation and should be with her. This demonstrates that the PPD situation comes with a meaning of a burden that should be shared between the persons who created the baby. This meaning may stem from the dominant discourse of mental health and the negative beliefs and values that come with this discourse. Most of the participants believed both husband and wife should suffer from this unpleasant situation. This means the postpartum couple should take this suffering and burden together, and mothers should not suffer alone and must have their partners' support

There were also instances of lack of support from partners among participants' experiences. Participant 6 (friend) believed her friend's husband intended to be around for support, but then the work obligations dragged him away: "He said, I will do my best to be around the times I can, but then work was always there dragging him away. He was trying to show up when he could. He does his best." She valued the partners' support and believed the partners were the right people to bring comfort to mothers in the postpartum period. She also admitted that this lack of support had a negative effect on the mother:

> I think this affected her a lot because she needed that support from him as he is her husband. I feel like the support from partners is very important because those are the right people to be able to comfort them during this period.

Participant 6 (friend) also assumed that the PPD situation would be better for her friend if the husband's support were adequate. She valued support from partners to help mothers recover from PPD faster: "If my friend's husband were around at that time, she was going through it better. I am sure she would have been able to escape the situation

quickly." She valued a partner's support and believed that enough support would help the mother recover better. Because the partner's support was not available, she brought more support from their close friends as an alternative support:

> I told the husband and her I would need your permission because I had to tell them first before disclosing a family issue to others. So, since the therapist said we should get support, I needed to tell our close friends, and then the husband fully supported it.

It should be noted that while she was aware of the social belief that mental health issues were a taboo subject and should be hidden, she also challenged this belief and asked the postpartum mother and her husband to disclose this to their friends and ask for support as she held a value in having support. Participant 4 (sister) had a similar experience where her sister, who had PPD, did not have her partner's support at all during the postpartum period. She believed not having the husband by her sister's side made the postpartum period a tough time for her:

> When she had the child and her husband was no longer with her, it became more of a problem. Dealing with a newborn baby without your husband and nobody to support. It was a very tough time for her. Taking care of the baby while her husband was dead, and she looked at her stomach, and then she said that my husband was not even here with me to assist me through this journey.

She valued the partner's support and believed her other siblings did not go through all these issues as they had their partner's support and were experiencing the postpartum period in an easier way:

She was the first one because she lost her husband, and nobody was supporting her from her husband's family. For my other siblings who have given birth, we did not have to go through all of this, and I did not have to go and stay with them. I guess maybe they just knew how to manage it well and did not need help because my other siblings had their partners with them. So, it was easier.

She believed that her sister did not have the support of her husband, and this made her situation worse. She believed the lack of her partner's support was one of the causes of her sister's developing PPD. She also challenged the belief mentioned in previous themes that taking care of a baby or managing the postpartum situation is only the mother's responsibility, and she considered this a shared responsibility between partners.

Summary

Although PPD has been socially constructed to be an invisible individual matter, all the participants believed mental health issues are not only a problem for the person who is suffering, but they are also the partners', families', friends', and even society's problem as they will affect a broad range of people. This belief challenges the dominant discourse around mental health as a taboo subject, which is considered a subject that should not be discussed comfortably, should remain hidden and should be solved only by the person who is suffering from it. Most of the participants also mentioned that it was challenging to support postpartum mothers alone, so they asked for support from family, friends, and partners. Some of the participants challenged the idea of PPD as a taboo subject. They used their agency and showed the practice of sharing and disclosing PPD issues with other persons to ask for more help and support, and they believed lack of

support would lead to PPD or make the situation worse. Participants highly valued support from partners and individuals within the mother's inner circle, indicating a belief that those outside this circle are more likely to hold judgemental views.

Theme Four: Valuing Knowledge and Awareness of PPD

Participants in this study emphasized the significance of having prior knowledge about PPD and openly discussing it. They explained how this awareness could impact their experiences and timely help-seeking behaviours. They mentioned that with adequate awareness and talking about PPD, they would understand postpartum mothers better and support them more effectively. They also mentioned that they could support and handle the situation more quickly and efficiently with prior awareness and if mothers had openly discussed their issues. Lack of awareness had been socially constructed through an oppressive normalizing discourse of mental health. The awareness was not adequate, probably because there were not enough people talking about PPD because of a dominant discourse of mental health as a taboo subject.

Participants initially relied on mothers to tell them what was wrong but realized mothers were unable to do this because of their depression and their similar lack of knowledge. Participant 5 (brother) believed that if his sister was aware of what she was going through and how it should be handled, it could be resolved more easily, and this shows he valued the postpartum mother having awareness of PPD herself. He believed it was hard for him as a support person to figure out the reason behind the symptoms his sister was showing. This shows the significance of increasing awareness both in mothers and the people in their close circle who would be considered as their support persons. Lack of awareness and inadequate talking sometimes merged with participants'

experience with PPD and made the situation harder for them. The dominant mental health discourse perpetuates beliefs and values that are constructed as taboo. Subsequently, it is difficult to get information as people do not talk about PPD in everyday conversations. Because mental health has been socially constructed as abnormal, it is spoken about differently in society and families, and has predominantly been kept private and hidden. Participant 5 (brother) said, "If she had an idea of what she was experiencing, what she was going through, and how this could be resolved, then that would be easier, but she just gave me the various symptoms she had." He valued knowledge and awareness as equipment and good preparation to handle PPD, which shows the need for talking more about PPD and providing enough educational preparedness for postpartum families even before giving birth and during pregnancy. Participant 5 (brother) mentioned: "Knowledge is very important because it gets one well-equipped, gets one well prepared. If my sister had this knowledge prior to the situation, it would have been quite much easier for me as a support person." He also valued partners having prior knowledge of PPD because if they knew about this, they would make themselves more available and provide support for the mothers. He believed that lack of knowledge can lead to a lack of support at some point: "If the husband be the person who knows about this, he is going to make himself more available to provide the support."

Many participants mentioned lack of knowledge as a hurdle for identifying the issue and asking for help, resulting in more difficult times and a waste of energy for them. Participant 7 (sister) believed she would help her sister differently if she had prior knowledge. Sometimes, she could not decide what she should do:

I feel like I would have been able to help my sister in a different way as

sometimes I did not know what to do. So, I feel like if I had fair knowledge about

it, I would have been knowledgeable on what and what not to do because the

more knowledge you have about these things, the better.

Most of the participants believed that awareness was low about PPD, and not

only the mothers but the partners and the whole family should know about PPD and how

to handle it. One participant also mentioned that the more knowledge she gained, the

more her judgemental views about her sister decreased, and subsequently, this could also

affect judgemental views to a broader extent in the society. Participant 4 (sister) stated:

"When I found out about postpartum depression, I had to speak to myself and put her

own emotions first, her own feelings first before mine. If I had prior knowledge, I would

obviously not react the way I did".

The social discourse of mental health, with the idea and belief of mental health

issues as a taboo subject, caused this lack of awareness. When a subject is socially

accepted as taboo, people tend to hide it and not talk about it, so less talking can bring

about a lack of knowledge and awareness in society. People can feel oppressed by the

belief that PPD is a taboo subject, and this contributes to not talking about it and hiding

it, which then leads to a lack of knowledge and awareness about PPD. This can affect

timely help-seeking or mental health improvement. Participant 6 (friend) valued

awareness about PPD, and she challenged the belief of PPD as a taboo subject and used

her agency to put this value into practice and tried to talk about it and increase

awareness:

I think the awareness is kind of low, and not many people know about this. I feel more mothers should be aware of this whole thing and how to deal with it. I feel like it is something everyone should know about. I talked about it here and there.

She also mentioned the lack of knowledge of her friend's partner and valued increasing awareness among partners and families:

The husband was sad for his wife but did not know what to do; he said, "I wish I could just take off this burden from her and make it go away." It would be nice if the husbands and their families could be aware of what is called postpartum depression. So, I feel like it is going to be very good if they can be made aware of everything that's happening."

Moreover, participant 4 (sister) valued not neglecting postpartum mothers and believed that a support person's awareness would prevent mothers from feeling neglected: "It is very important that you be aware so you would know how to handle the situation very well with care. So, the person with the issue with postpartum depression would not feel neglected or left out." As she values increasing knowledge and awareness around PPD, she challenged the status quo and used her agency to put her value into practice by trying to increase knowledge by explaining it to people: "We have been trying to reach out and have some sessions with people in the community, so we explained what this is and how to handle it."

Participant 2 (partner) recognized himself as 'short-sighted' and did not know what to do or who to ask. This information may have been 'hidden' because the dominant social discourse on mental health is that people are ashamed to talk about mental health.

He was questioning the status quo and saying that if there had been more obvious information and he did not have to dig for it, it would have been easier for himself and his wife. They would not have had to struggle as long as they did. The dominant discourse impacted them negatively:

> I did not know what to do in the first place. I did not do anything to be specific other than to be as caring as her husband and support her, trying to understand what was going on. Before going to the therapist, I was curious, but I did not do anything as I was short-sighted. I did not know where to ask or from whom to ask until I was able to have the courage to ask my friend when he came around.

He believed he was short-sighted and was not doing anything but caring for his wife for a while, and then he got the courage to ask his friend about this. So, to talk about PPD, he needed to have courage, and probably it was challenging for him. The dominant discourse of mental health had negatively affected him, making it hard for him to talk about it comfortably. He also believed more information would result in less overwhelming and exhausting feelings and fewer problems in their relationship. This may be because PPD has been unknown, and he found it hard to understand it, so supporting a person who is suffering from an unknown thing was exhausting for him. This highlighted the importance of having awareness and knowledge and showed the impact that PPD had on them:

> If I had more information beforehand, I think it could not have overwhelmed me. I would not have been exhausted. I think I could have gone to the right channel, sought help at the right channel, and then made sure my wife was okay within a few months.

Participant 2 (partner) also believed PPD was challenging for him because it was a new experience, and he had no idea of what initiated this situation; he valued having more knowledge to be able to help his wife, so he talked to his wife and communicated with her to get more information. Many participants referred to mothers in the first place to get information on what was going on and how they could help, and this depicts the importance of mothers' awareness and knowledge of PPD:

Because it was all new to me, when something is new to you, it can be challenging. Without knowing what initiates something, it is difficult to seek a solution. So, I need to know more, so I should talk to my wife.

Participants believed early help-seeking and easier managing of PPD symptoms would be possible if the mother was able to tell them what she was going through. This can stem from a lack of awareness as well as having limited knowledge about PPD and mental health issues; they were expecting mothers to tell them what was happening, what PPD was, and even what they should do to help.

Similarly, participant 3 (partner) expressed a deep belief in the importance of discussing difficult situations and finding the root cause. He recognized that it took time and consistent effort to figure out the reasons behind his wife's PPD symptoms. This shows that talking about PPD was hard for his wife, possibly due to the discourse of the negative and taboo meaning of mental health issues. He was hoping they could work together to navigate this difficult issue by having open and honest conversations with his wife; however, this demonstrates how having limited knowledge and awareness impacted their ability to discuss PPD.

Many of the participants had a lack of awareness about how PPD or mental health issues affected the mothers, such as their level of energy. Most participants were expecting mothers who were struggling with PPD to tell them what was going on. This shows an expectation that people who are suffering from mental health issues can and should talk about it. This expectation depicts how limited knowledge about PPD significantly affects how one can support a mother experiencing PPD. This lack of knowledge and awareness can stem from the dominant discourse around mental health issues as a subject that should not be discussed and is socially constructed as taboo. In other words, there was not enough talking about PPD in general and in society, and that is why there was a lack of awareness:

> I had to ask her what was going on, and sometimes, she would not answer me or say anything. It was difficult because she could not even tell me what was going on, so it took a lot of our time and consistency to find out what the bloody cause of that was. I need to talk to my wife to find out the cause of it so we can get through the situation.

Participant 4 (sister) also believed she could better understand what was happening and how to help by having open conversations with her sister. She believed that their PPD experience would be different if they could simply have meaningful conversations. It appears that her understanding and awareness of PPD symptoms were quite limited, and she was not aware of how PPD may affect the mother in a way that she may not be able to talk about her issue. The idea behind the social discourse of mental health as a taboo subject also influenced her. She navigated the relation of power in a way that used her agency. She did not ask for information from a healthcare provider in

the initial phases, maybe because she wanted to hide this issue from others as she believed people would have a judgemental view of mental health issues and may label them as crazy, which is mentioned in previous themes:

> I was thinking that if she were talking, if she communicated with me, it would have been a lot easier for me. She was not talking; she was not communicating. So, I just had to observe and then take the next action. It would have been different if she was talking. I would have understood that this was happening and what was going on with her.

This participant also believed her sister was showing her emotions like crying and being depressed, but she was not talking, so there was no communication; this shows the importance of verbal communication, but at the same time, it shows how hard it is for people to talk about mental health issues. This means her sister was also oppressed by the idea that mental health should be hidden, and there may be judgemental views from people about it, so she showed her practice by just showing emotions and not talking about it directly. Also, it is predictable that if people are not comfortable talking about a certain topic, then there will not be enough awareness about it as well. So, participant 4 (sister) was not able to understand her sister's situation only by observing her sister's emotions, as her knowledge and awareness of PPD were limited. "There are times that instead of communicating, my sister cries instead of talking and saying oh, this is what is going on. There was no communicating."

We found out from the experience of participant 3 (sister) how her practice changed before and after acquiring knowledge of PPD. Participant 4 (sister) believed PPD was new and shocking for her in the early stages as she did not have any prior

knowledge of it, so she could not understand why her sister was showing those symptoms; her practice was ignoring the mother's feelings and putting her own feelings first. She believed that after acquiring knowledge of PPD, she had to speak to herself and put the mother's feelings and emotions first. Knowledge about PPD and lack of knowledge significantly impact relationships between mothers and people in their close circle. Social beliefs and values about PPD that are socially constructed through discourses influence people's relationships if they take on the social beliefs and values. This was damaging to participants in this study until they gained knowledge. They knew to question and seek out more knowledge that enabled them to challenge the status quo, challenge their lack of knowledge, challenge silence, and challenge the dominant discourse of mental health. This demonstrates how they negotiated power and, ultimately, gained control of their situation and helped the mothers and themselves. Participant 4 (sister) mentioned:

It was shocking to me. What is that with my sister? It was new to me. I really did not know how to handle it, and at the time, I ignored how she was feeling and just, you know, basically thought about my own feelings. It almost caused problems for us because I could not understand her. But when I found out about the postpartum depression, I had to speak to myself and put her emotions first before mine. If I had prior knowledge, obviously, I would not react the way I reacted.

Many participants mentioned a noticeable difference between knowing some information from the Internet and the actual knowledge they got after experiencing it. Participant 5 (brother) believed he had abstract knowledge. Still, the knowledge he got

from his experience gave him a broader view and made him able to educate other people about this, which shows he valued more tangible and relatable knowledge. This is an example of how information about mental health and PPD on the Internet may not make sense to those experiencing PPD, as well as to the support persons. This may stem from a mental health discourse that perpetuates PPD as a taboo subject, and therefore, there is not enough direct and tangible information about mental health issues available due to the negative effects of this discourse. Participant 5 (brother) noted:

Initially, I had an abstract knowledge about all symptoms of postpartum depression, but based on my experiences, I can broadly educate people on postpartum depression as now I have full knowledge about the symptoms. I also have a basic knowledge of how to handle the situation as a support person. There's this thing that we gain knowledge from experience, so prior to the situation, I would not say I had very good knowledge, but after my experience, I have a vast knowledge.

Participant 3 (partner) believed there was a difference between hearing about PPD and being involved in it in real life. What is obvious from the participants' experiences here is that maybe there was some information exchanged about PPD, but it had not been concrete enough to prepare them to identify and handle PPD early enough:

It is not about being heard but about being involved in it. What I mean is that it was a new thing for me because I had never been involved in such a situation before. I have heard of it and read about it, but I believe if I had known about it, I would have sought help prior. I did not know what was going on. So, I think it is important to get an awareness so in case it happened, you would know.

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Summary

All the participants highly valued the importance of prior awareness about PPD for both mothers and partners. They believed that this awareness would help in identifying and managing PPD more effectively. All the participants believed having prior knowledge and awareness of PPD and talking openly about it were essential factors in the early identification of PPD and seeking help. Lack of awareness had been socially constructed through an oppressive normalizing discourse of mental health. A lack of awareness and knowledge was identified in many participants; some of them called themselves short-sighted, and some of them explained how their understanding of PPD had changed after acquiring knowledge about it. This lack of knowledge and awareness can stem from not having enough talking and education about PPD.

Most of the participants expressed the belief that there was not enough talking about PPD, and openly talking about it may result in negative judgement toward mothers. They demonstrated this belief by only sharing their experience with PPD with people in close circles around mothers. Some even believed these judgemental views could be present among those closest to the mothers. This could be because they were negatively influenced by the belief that PPD is a taboo subject, and talking about it was not comfortable and easy for them. This may stem from mental health as a hidden social discourse where there is not enough talking about PPD due to being a taboo subject and fear of judgemental views. A possible source of information for many participants would be a healthcare professional who would 'look for certain things' or ask certain questions. However, most of them did not refer to these sources in the initial days and struggled to determine the problem. This may again be because talking about mental health issues is

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not easy, and they did not feel comfortable sharing this with anybody. So, support persons are put in certain situations and become caretakers. Also, there is much pressure on them, and they need to connect and communicate in a certain way.

Most of the participants valued that mothers talked about what they were experiencing and explained what they were going through, believing it would make the PPD experience easier for them as support persons and that they could provide better help. This is a vivid example of their limited understanding of PPD and its effects on postpartum mothers. Raising awareness among mothers is crucial. However, mothers experiencing mental health issues may struggle to express their feelings due to the impact of PPD. This underscores the importance of increasing awareness among support persons. It is essential to recognize that mothers may become aware of what is happening to them but struggle to discuss it due to the impact of PPD on their mood and energy. Additionally, many participants emphasized the significance of spreading knowledge about PPD to a broader audience, including family members and individuals in society. Participants explained that even the information on the Internet was not tangible enough to help based on one of the participants' experiences. This reveals that the discourse of mental health issues affected this negatively and depicts how the discourse of mental health and the ideas and beliefs that come with it influence social constructions and limit awareness and knowledge.

Chapter Five

Discussion

This research was conducted to understand the experiences, including beliefs and values of partners, identified support persons, and family members of mothers with babies aged 0-12 months regarding postpartum depression (PPD). I studied how the support persons perceived PPD as a mental health issue that mothers may encounter, their beliefs and values regarding this, and how these beliefs and values were personally, socially, and institutionally constructed. I also explored the practices that stemmed from these beliefs and values. The following research questions were addressed throughout the study: 1) What are the experiences of partners, identified support persons and family members regarding PPD? 2) How are their experiences socially and institutionally constructed?

Across interviews with seven study participants, study objectives were achieved, and four themes evolved, which are discussed in detail in the findings chapter: 1) Challenge the Meaning of Normal Mother, 2) Navigating judgements about Mental Health, 3) A Family Affair: PPD No One's and Everyone's Business, and 4) Valuing Knowledge and Awareness of PPD. Using an FPS lens and discourse analysis, I examined how the dominant discourses affected participants' experiences, values, and beliefs, how they related to their positions, how they used their agency, and what their practices were. This chapter will concentrate on placing the findings within the current and relevant literature and offering recommendations for practice, education, research, and policy. The research goals were achieved by analyzing participant

experiences and language and by exploring how participants navigated and negotiated power. The primary study results are outlined below.

First, all participants accepted, in complex and diverse ways, the discourse of motherhood that perpetuated normal and happy experiences by mothers. This then influenced their reactions as they were surprised that mothers were not excited or happy about their mothering experiences. They tried to remind mothers how a normal mother should be. Second, participants believed there were judgemental views about mental health issues and PPD in themselves and people around postpartum mothers, which could affect mothers' and support persons' help-seeking behaviour. This belief revealed how participants were affected by the social discourse of mental health and the beliefs and values around it that consider mental health as a negative and taboo subject. Third, participants valued having support from family and friends and held a belief that PPD is a family/society issue and not only an individual issue. Finally, awareness about PPD and having prior knowledge of PPD were highly valued by all the participants, and they believed these two factors would help in early help-seeking and having an easier PPD experience. Lack of awareness instances articulated by participants revealed how the dominant social discourse of mental health negatively affected individuals and social constructions.

Challenge the Meaning of Normal Mother

In previous decades, mothers were primarily responsible for housework and childcare in Western families (Schmidt et al., 2023). Women were often considered "good" for investing their time and energy in caring for their children (Schmidt et al., 2023). The concept of a "good" or "normal" mother has existed in society for a long

time, and people use this definition to demonstrate how they believe a good or normal mother should be. The societal notion of an ideal mother in Western cultures dictates that women must always prioritize their children's needs over their own, being constantly available and tending to their children's needs without much external support and doing so effortlessly and willingly (Read et al., 2012). Mothers sometimes struggle to achieve the ideal definition of a "good mother" as defined by society (Lupton, 2000). While motherhood is often called "the most important job in the world," and a happy baby means a happy mother, the prevailing view of good motherhood is more nuanced. A good mother is seen as consistently loving, patient, and supportive of her children while acknowledging that she may occasionally lose her temper and require support from others (Pedersen, 2016). Participants in this study negotiated the normal and abnormal meaning of mothering in the context of PPD. A binary meaning had been created between a discourse of the normal happy mother and a discourse perpetuating mental health as abnormal. Participants felt concerned, confused, depressed and unsure, which shows a site of struggle that needed to be questioned and challenged throughout their journeys with postpartum mothers. Most of the participants considered PPD symptoms as not being normal, and they believed the postpartum mother they were supporting was experiencing something abnormal as they were affected by the beliefs behind the discourse of happy mothers. They were surprised, confused, or depressed to see mothers unhappy and not excited after giving birth, and all participants believed a normal mother should be happy and excited. In our study, participants valued the importance of mothers providing the baby's care, considering it their primary responsibility. They believed the lack of providing this care or having a nanny was abnormal. Furthermore, they saw these actions as indicative of inadequate bonding between the mother and the newborn.

The discourse around motherhood and the meanings of good and normal mothers generates different aspects of postpartum mothers' lives. Participants identified a happy mother who breastfeeds and holds the baby as an example of a good mother. Some participants used examples of how their own mothers spent lots of time with them and compared them with the postpartum mothers they were supporting to remind the mothers how they should behave as good mothers. This shows how the participants were aware of the beliefs and values around the discourse of normal and abnormal motherhood and how they negotiated the relation of power, and the acceptance of this discourse was evident in their beliefs, values, and practices.

Understanding how the social discourse of 'normal' mothering affected all participants is crucial. The dichotomy of normal and abnormal was an important issue to deconstruct further to understand how the participants negotiated power relations. The way support persons were affected by the beliefs and values around the dominant discourse of motherhood had a significant effect on understanding PPD, what the mothers were going through, and their help-seeking and supportive behaviours. Mothers often strive to embody motherhood in a manner that aligns with the societal expectation of being "fit" or "right," as well as how it is depicted in the media (Devereux et al., 2023). This prevents mothers from expressing and sharing their true experiences as mothers, as their voices are suppressed, muted, and devalued by power structures (Devereux et al., 2023). A quantitative study was conducted using an open-ended online survey among one hundred thirty-six mothers recruited through calls on social media in the USA, revealing that they experienced a significant burden in portraying motherhood flawlessly online and offline (DeGroot & Vik, 2021). This pressure led them to project a

positive self-image, refrain from sharing their challenges, and only discuss positive experiences online, creating the perception of living dual lives - one public and one private. Additionally, the survey highlighted that certain social constructs surrounding motherhood can harm mothers (DeGroot & Vik, 2021). Consequently, these beliefs and values mentioned by all the participants in our study can lead to considering PPD symptoms negatively as it is against what is considered normal and neglecting or delaying seeking help for PPD because people see this subject as a taboo and not a normal situation.

Navigating Judgements about Mental Health

Individuals with mental health disorders are often labelled and stigmatized by society due to their behaviour and appearance, which are considered to deviate from the norms of society (Ibrahim et al., 2019). The participants in Cogan et al's (2023) qualitative study using semi-structured interviews in Scotland, UK, widely recognized and often internalized the stereotypes and negative beliefs about mental health, viewing it as a form of weakness and something shameful. Stigma causes society to view individuals with mental health issues as undesirable, leading to their exclusion. A cross-sectional study using a Depression Literacy Questionnaire has shown that stigma is a significant deterrent to seeking mental help in various populations (Ibrahim et al., 2019). In our study, the discourse of stigma and taboo around mental health issues is evident in participants' beliefs, values, and practices. All participants in this study were aware of the mental health social discourse that had constructed judgemental beliefs towards mothers experiencing PPD. These attitudes may stem from others or be instilled in their personal

beliefs and values. Most of the participants believed that judgement stems from a lack of awareness about PPD from themselves or others.

The stigma surrounding mental health makes it challenging to view individuals with mental illness as equals, leading to the misconception that seeking help or attending therapy could devalue a person (Koutra et al., 2023). Mental health issues are often stigmatized in various cultures to the extent that talking about them at home is discouraged (McSpadden, 2022). Seeking professional psychological help is frequently perceived as a challenge to one's self-esteem and is often interpreted as a sign of weakness and admission of failure. In a descriptive cross-sectional research study that was conducted to assess mental health help-seeking attitudes in Iran, the majority of older adults exhibited a negative attitude toward seeking mental health assistance (Mirzaei-Alavijeh et al., 2024). The stigma and taboo surrounding mental health issues may be rooted in sociocultural factors and can significantly influence mothers' willingness to seek help. These critical attitudes do not just affect mothers; they also have a noticeable impact on those around them. The stigma surrounding mental illness in Asian communities is often linked to the concept of "losing face," particularly for the family members of individuals dealing with mental health issues (Ibrahim et al., 2019). Some of our participants expressed their fear of being abandoned or judged by their friends because of being a family member of a person who is suffering from a mental health issue, and some of them experienced judgement from others towards the mothers with PPD. However, while judgemental beliefs around mental health discourse created feelings of oppression for them, they used their agency and navigated the relation of power in different ways, such as isolating themselves and the mothers, increasing their

awareness about PPD, seeking support from specific individuals, and avoiding disclosing issues to certain people. All participants intended to only ask for help from their close persons, likely because they felt burdened by the stigma associated with mental health issues. For instance, they only shared PPD issues with the people who were close to them and even sought therapist help only from that circle that may find it less or non-judgemental. All of them of them used their agency. They negotiated the relation of power in various ways. Some raised questions, some sought out support from others, and others tried to increase public awareness by talking about it. This shows how help-seeking behaviours can be affected by the dominant discourse of mental health that hinders individuals from sharing their mental health issues with others and asking for help.

It should also be mentioned that the judgemental views are not limited to strangers; even people in a mother's inner circle may hold negative opinions, which can significantly impact mothers. These beliefs may originate from personal and cultural stigmas surrounding mental health. Some participants hesitated to share their PPD issues with their close circle due to concerns about their reactions and judgemental views toward postpartum mothers.

A Family Affair: PPD No One's and Everyone's Business

The postpartum period brings numerous responsibilities and challenges, making support from their inner circle essential for mothers. Insufficient social support has been linked to a higher likelihood of experiencing symptoms of common mental disorders, such as depression, in postpartum mothers (Kay et al., 2024). Family members' involvement is crucial in reducing depression (Huang et al., 2021). Interventions focused

on improving family function should be prioritized in efforts to decrease the occurrence of depression in mothers (Huang et al., 2021). PPD has been socially constructed to be an invisible individual issue. Participants in this study believed PPD was not only an individual issue but was also an issue for family, partners, friends, and society. PPD was considered a family issue by all participants, and they had a strong belief that individuals within a close-knit community of mothers should be actively engaged in addressing this issue. Participants emphasized the significance of having a network of supportive individuals rather than relying on just one person. This approach reduces the burden on a single support person and facilitates better assistance for the mother. Mothers with strong social support are more likely to experience improved mental, psychological, and emotional health than those without (Bedaso et al., 2021). The participants in this study were aware of the stigma and judgement surrounding mental health issues and challenged the dominant discourse around mental health, used their agency, and sought support from various resources to improve the mothers' postpartum mental health.

The effects of illness on health and well-being reach beyond the individuals who are directly affected, extending to their family members (Lee et al., 2022). All participants emphasized the impact of PPD, highlighting its effects on not just the mothers but also their entire families and society at large. Many participants stressed the collective responsibility in addressing this issue, stating that it is a societal concern rather than solely the burden of the mothers. The well-being of pregnant mothers is significantly influenced by family-related factors, particularly their relationships with family members, including their partners (Hu et al., 2019). All participants believed that the partners were the most crucial source of support for postpartum mothers. They

emphasized the importance of the partners' presence with the mother and expressed the belief that a lack of support from partners could contribute to PPD.

While it is widely recognized that active support from a partner is crucial for the mental health of pregnant women, support from extended family members also holds significant importance (Hu et al., 2019). Participants strongly valued being around mothers and supporting them as much as possible, and they tried to involve family and friends in supporting mothers.

Valuing Knowledge and Awareness of PPD

Knowledge and awareness are crucial factors that can significantly influence people's responses and choices while dealing with a significant issue like PPD, which can impact both individuals and families. The lack of normalization, as well as the stigma surrounding mental health issues in society, is evident (González Sanguino et al., 2023). Lack of awareness had been socially constructed through an oppressive normalizing discourse of mental health. Participants in this study recognized that they lacked knowledge about PPD and wished they had known about PPD prenatally. The lack of knowledge and awareness about PPD may result from insufficient talking and education on the topic. The majority of participants believed that there was a significant lack of open communication about PPD, fearing that openly discussing it may lead to negative judgement of mothers. This belief was evident as participants tended to share their PPD experiences only with individuals in close circles around the mothers; some of them even concealed this issue from people in their close circle. Many participants sought information from a healthcare professional who would observe certain indicators or ask specific questions. However, they did not reach out to these resources initially and

found it difficult and uncomfortable to talk about it. Not talking about mental health because it is an uncomfortable issue and there is fear of judgement, continues to perpetuate the social construction of PPD as a taboo subject. People with mental illness often face negative perceptions and mistreatment in their communities. These attitudes can lead to fear, shame, and embarrassment, which can be significant barriers to seeking help (Davies et al., 2022).

Talking about PPD was hard for postpartum mothers in this study because of the dominant discourse of mental health and the stigma and negative beliefs around it. Participants initially relied on mothers to tell them what was wrong but realized mothers were unable to do this because of their depression and their similar lack of knowledge. This depicts their limited understanding of PPD and its effects on postpartum mothers. Despite the importance of raising awareness among mothers, mothers experiencing mental health issues may struggle to express their feelings due to the impact of PPD. Postpartum mothers may realize what they are going through but find it challenging to talk about it due to the influence of PPD on their emotions and energy. This highlights the significance of raising awareness among support individuals.

Protective factors against the stigma in its various forms include knowing someone with a mental health problem, engaging in open discussions about it, and having a higher level of education (González Sanguino et al., 2023). Most of the participants in this study highlighted the importance of having proper and prior awareness. They mentioned they could support and handle the situation more quickly and effectively with prior awareness. Many participants highlighted the lack of awareness about PPD as a significant obstacle in seeking help, leading to more

challenges and wasted energy. They believed that not only mothers but also partners, families, and society should be educated about PPD. Participants also mentioned that increased information about PPD would reduce overwhelming feelings and relationship problems. This underlines the significance of raising awareness and understanding the impact of PPD.

Participants also expressed that the online information available on PPD was not concrete enough to provide helpful support based on their own experience. This depicts how the discourse of mental health issues affected this negatively and led to insufficient information available for postpartum families. It also reveals how the discourse of mental health and the ideas and beliefs that come with it influence social constructions and limit awareness and knowledge.

Strengths and Limitations

This study was able to delve into the experiences, encompassing beliefs and values, of partners, identified support persons, and family members of postpartum mothers concerning PPD. By gathering and analyzing data, we were able to address the two research questions posed in this study: 1) What are the experiences of partners, identified support persons and family members regarding PPD? 2) How are their experiences socially and institutionally constructed? This study presented information on how individuals supporting postpartum mothers perceive PPD and what their beliefs and values are concerning this issue.

This study also revealed how these beliefs and values influence the way support is provided to postpartum mothers by their support persons and how they seek help for

PPD, addressing an identified gap in the literature. I created a secure and welcoming environment for participants to share their experiences. Being a young woman with a deep concern for the postpartum period, my knowledge of mental health issues, particularly PPD, and available support resources allowed for natural and comfortable conversations. My role as a young female nurse dedicated to addressing PPD and mental health issues might have influenced my understanding of the results. It is possible that my personal passion and perspectives on PPD and mental health could have unconsciously influenced the interviews and analysis. To minimize this bias, I consulted with my supervisor as I conducted rigorous data analysis, accompanied by continuous reflection on my personal values, beliefs, and practices. This study primarily included participants who identified themselves as Black or White, with most participants being Black. Interestingly, the majority of participants identified themselves as Black, which makes it unique, as our experience in Nova Scotia has been that most studies end up recruiting predominantly white participants when there is an open call. Without prompting, participants who identified themselves as Black briefly highlighted how their beliefs and values were influenced by their Black culture. Including personal subjectivities is an important concept in FPS and brings a particular depth and richness to the findings. While there were moments where participants spoke about their culture, it must be noted that these experiences cannot be generalized. The small sample size in this study enabled me to do an in-depth analysis and better understand participants' experiences. At the same time, it hindered me from transferring findings to various positions, such as culture, sexuality, gender, race, or abilities. Future studies could build upon findings from this study and use methodologies that support more focus on race, gender, sexuality, and/or abilities. Also, the study's geographical limitation—all

participants were from Nova Scotia, Canada—may have contributed to the limited

diversity of views obtained.

Recommendations

Practice

Healthcare professionals working with postpartum families need to recognize the

obstacles to seeking help for PPD, including lack of awareness, judgemental attitudes,

and normal motherhood expectations. Addressing and minimizing these barriers will

empower postpartum mothers and their support persons to communicate more openly

about their challenges. It is essential to acknowledge the difficulty of discussing PPD, as

this can lead to concealment and lack of identification, resulting in unaddressed and

untreated issues. Creating a safe environment within families, communities, and the

healthcare system as part of postpartum support can empower families to openly discuss

their concerns and challenges. Discussing PPD and mental health issues during the

prenatal and postpartum period is recommended to be included in the care plan or

provided as part of discharge education. Also, providing families with information about

potential resources for addressing mental health concerns could make it easier for them

to seek assistance. Participants in this study mentioned that although information had

been available, it had not been sufficiently tangible and helpful. This shows that

healthcare providers must go beyond simply imparting information when educating

families. They should ensure that postpartum families understand the stigma and

judgement surrounding PPD and acknowledge the difficulty mothers, family members,

and support people may face in discussing and seeking help for it. It's important to

inform them about accessible avenues for seeking help and to strongly encourage them to

address this issue, emphasizing its negative impact on both the mothers and the entire family. Healthcare providers are also able to provide support to families by acknowledging the stigma and unease surrounding discussions about PPD and by assisting them in locating secure environments for discussing PPD and mental health. Healthcare providers should make sure that postpartum families see PPD not just as an individual problem but as a family and societal issue. It's also important to highlight the significance of the role of support persons and partners in addressing this issue. This way, healthcare providers can be part of shifting the mental health discourse, which may help support people and mothers to feel less isolated.

It is also essential to provide postpartum families with clear, concise, and tangible information at the time of discharge, considering that they may be overwhelmed due to receiving multiple pieces of information and the challenges and responsibilities of the postpartum period. It is recommended that the healthcare team provide education to the postpartum family in a way that they have a bright view of the possibility of PPD for mothers, so they must be aware of that and check mothers' mental health situation. Also, support persons should have a distinct idea of possible symptoms they may encounter and how and where they can ask for help. This approach may help identify postpartum mental health issues earlier, enabling individuals to seek appropriate assistance in a timely manner. It is also crucial for those who support postpartum families to recognize the effects of PPD on the entire family, not just the mothers, and to provide care and support for everyone involved. Moreover, it is vital to consider the support of family and friends in the care and support plan for postpartum mothers and involve them in the care plan. Here are some suggestions for healthcare providers and nurses who offer

postpartum care: 1. Be mindful when defining what is normal and abnormal for mothers, as this can influence a mother's comfort in seeking help for their issues. 2. Be aware of stigmas surrounding mental health issues and PPD while providing care for postpartum families. 3. Provide thorough, clear, concise, and tangible education on PPD and mental health issues after birth, including information on where families can seek help, and allow adequate time for families to ask questions and voice concerns.

Education and policy

Healthcare students who could be participating in postpartum care for families in the future need to understand the obstacles to seeking help and be trained on how to facilitate and raise awareness about this as part of their future role. They should be educated, aware, and prepared to provide the best possible care for these families. Expanding efforts to improve overall understanding and awareness of mental health within postpartum families and society as a whole can help lessen the potential to overlook PPD cases and lessen its negative impact on families and mothers. There is a need for policies and strategic plans within interdisciplinary teams such as those in the healthcare, media, and education systems to promote discussion about postpartum mental health issues. The objective is to enhance awareness, normalize these discussions, reduce fear of judgement, and make support options more visible and accessible to individuals.

Research

Future research should delve deeper into the experiences of support persons from diverse positions in relation to PPD. In light of the limitations of this study, future research should explore the experiences of other intersecting identities, such as race,

culture, gender, sexuality, ability, and geographical location, and investigate how these factors might influence their perception of PPD. Also, further examination of the potential impact of providing timely, non-judgemental care on postpartum families affected by PPD should be a focus of future research.

Knowledge Translation

The study results should be translated to ensure that the findings reach those who can benefit from them or take action to benefit the study population. Following the study's conclusion, I will compile a community report to present the findings. This report will be shared with study participants who expressed interest in receiving the study results, and they are encouraged to share it with anyone they choose. I will also create a concise one-page summary and posters of the study and distribute these to the IWK postpartum care center. Additionally, I plan to contact the IWK postpartum care center and propose the idea of organizing educational workshops for healthcare professionals. This way, we can share our research findings and contribute to enhancing the quality of care for PPD. The study findings will not only be shared through an informal community report but also translated into manuscript formats for submission to peer-reviewed journals. The study results will also be disseminated at conferences to reach a broad audience of researchers.

Conclusion

The existing literature has focused on the experiences of mothers with PPD, leaving a gap in the understanding of the experiences of partners, family members, and support persons. This area has not yet been fully explored and studied. This study makes

a unique contribution to the literature by examining the experiences of partners' family members and identifying support persons. In-depth interviews provided extensive data that was analyzed using FPS.

Four themes were revealed through the data analysis phase, depicting how participants accepted normal and abnormal discourses around motherhood. They were also affected by a dominant discourse of mental health, which revealed the belief around it as a stigma and taboo subject and navigated relations of power in different ways based on their personal values and beliefs. Participants were also aware of judgemental views around PPD, and how it negatively affected their help-seeking behaviours. PPD was mentioned as a family and societal issue and not only a personal issue by participants, and they valued increasing awareness and talking about this issue more at different levels of society.

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Flyer

IWK Health

DALHOUSIE UNIVERSITY
Inspiring Minds

We Are Seeking Participants From Postpartum Families to Talk About Postpartum Depression

Study Details:

If you are a partner, family member or support person of a postpartum mother, we want to hear your thoughts and experiences regarding postpartum depression. The postpartum mother that you are supporting may or may not have experienced postpartum depression. We are seeking to interview 6-10 participants, and participants will receive a gift card as a thank-you for their time and collaboration.

Eligibility:

✓ 18 years of age or older

✓ Being a partner, identified support person or family member of a mother who has given birth to a baby in the last 12 months

✓ Currently living in Nova Scotia

✓ Able to read and speak English

Contact us for more info

Masoumeh Gholampour
✉ Ms584931@dal.ca
📞 9029894435

Appendix B

Pre-screen questionnaire

Thank you for your interest in taking part in our research study. We are currently conducting a study to gain insights into the experiences of individuals who are partners, identified support persons or family members of mothers who have delivered a baby within the last 12 months. Now that you have more information about the study, we would like to know if you are still interested in participating. If you are, we will proceed to the next section. If not, we sincerely appreciate your time and interest.

Before you can participate in the study, we need to conduct a pre-screening process. This involves asking you a few questions to determine your eligibility. The pre-screening will only take a few minutes of your time. Rest assured that your responses will be kept confidential.

Do you have any questions at this point? Please feel free to ask. (Answer any questions)

I start to ask questions as below:

Are you a resident of Nova Scotia? [Yes/No]

Are you 18 years of age or older? [Yes/No]

Are you a partner, identified support person, or family member of a mother who has delivered a baby within the past 12 months? [Yes/No]

Thank you for taking the time to answer these pre-screening questions. If you are eligible and still interested in participating, we can schedule a time for the review of the informed

consent process and the interview. If you are not eligible, we sincerely thank you for your interest and time.

IWK Health

Information and Consent Form

Research Title: HOW PARTNERS, IDENTIFIED SUPPORT PERSONS, AND
FAMILY MEMBERS UNDERSTAND POSTPARTUM DEPRESSION, USING A
FEMINIST POST-STRUCTURALIST LENS

Researcher:

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Funding:

This study is unfunded.

Introduction:

You are invited to participate in a research study named above conducted by Masoumeh Gholampour, a Master of Science in Nursing student at Dalhousie University. This form provides all the information you need to decide whether or not you want to participate in the study. Before you decide if you want to participate, you must understand the purpose of the study, the risks, the benefits, and what you will be asked to do. Please note that participation in this study is completely voluntary; you may decide not to take part, or you may withdraw from the study at any time up to one week after the interview. This will not affect the care you or your family members receive from the IWK Health Centre or any other health facility in any way. I (Masoumeh Gholampour) will be available to answer any possible questions. Thank you for considering participating in this research study.

Why are the researchers doing the study?

Having a baby can be an important experience in a person's life, but it can also come with many challenges and concerns, such as postpartum depression. Mothers often turn to partners, family members, friends, other mothers, and healthcare providers as their main source of support during the postpartum period. However, very few studies have examined the experiences of partners, support persons, and other family members and their understanding of postpartum depression. Therefore, we propose to examine their understandings about postpartum depression. Your answers to interview questions will

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provide valuable information that will help us to understand better how to best support mothers and families who experience postpartum depression.

How will the researchers do the study?

The study aims to recruit partners, support persons, and family members of mothers who have given birth within the past 0-12 months and live in Nova Scotia. Data will be collected in person, online, or by phone interviews. The researcher aims to interview eight to ten participants. During the interviews, participants will be invited to share their experiences and/or points of view about postpartum depression.

What will I be asked to do?

As part of this research study, you will participate in an interview the student researcher will conduct. The interview will involve an open discussion and will be recorded so that we can make sure we get all the information right. You can choose where you would like to have the interview - in a study room at Dalhousie University, online, or by phone. The interview is expected to last approximately 60 minutes. During the interview, the interviewer will encourage you to share your knowledge, understanding and/or experiences related to postpartum depression. Please note that all audio recordings will be transcribed word for word by the researcher to make sure we capture your answers correctly. Your name, age, gender, and relationship with the mother will be asked. However, your name will remain confidential and will be replaced with a participant number.

What are the burdens, harms, and potential harms?

The potential risks linked to participating in this study are minimal. However, during the interview, if you feel upset, stressed, or anxious talking about issues related to the research questions, you can stop the interview at any time to take a break or end the interview. We will also recommend seeking support from a healthcare professional you trust and feel comfortable speaking with to follow up. We can also provide you with a telephone number for support resources available at the IWK Health Centre. There is always a risk of potential privacy breaches, and sufficient assurance will be dedicated to protecting your personal information.

What are the possible benefits?

Although you may not see immediate benefits from participating in the interview, it can be valuable to have a meaningful conversation and share ideas with the researcher. We hope this study's results will help improve health care services for new parents during the postpartum period.

What alternatives to participation do I have?

There is no obligation for you to participate in this study. After speaking to the researcher before the interview begins, during the interview, or one week after the interview, you can leave the study. Leaving the study will not affect the care you or your family members will receive from any healthcare providers in any way. However, if you wish to help with the research, you can share information about the study with your friends and family members who might be interested and eligible to participate.

Can I withdraw from the study?

You don't have to participate in this study if you don't want to. You can leave the study at any time up to one week after the interview. After this time, we will not be able to remove your data from the analysis. When you withdraw, your data will be removed, destroyed, and not used in the study. The decision to participate or not is entirely up to you, and it will not impact any healthcare services you receive.

Will the study cost me anything, and if so, how will I be reimbursed?

This study will not cost you anything, and we can schedule the interview at a time that works best for you. Also, as an expression of our gratitude for your valuable time and participation, we would like to offer you a $25 gift card. This is just a small way to say thank you for contributing to the study.

Are there any conflicts of interest?

There are no actual perceived or potential conflicts of interest (including financial conflicts) by the researchers and/or the institutions.

What about possible profit from the commercialization of the study results?

The results of this study will not be commercialized.

How will I be informed of the study results?

When the study is complete, most likely within a year, we will post the results on www.mumsns.ca.

Please notify me when the results are posted. Yes___   No___

Provide your email address/phone number _____.

How will my privacy be protected?

We will prioritize the confidentiality and privacy of all information collected during this study. All data collected during the interviews, your consent form, and demographic information will be saved in Dalhousie's online secure system called OneDrive, and any paper copies will be kept in a locked cabinet in Dr Megan Aston's office at Dalhousie University and will be destroyed 5 years after the completion of the study. To ensure confidentiality, all names will be removed when the audio tapes are transcribed word for word. Any other identifying information will also be removed. Only the researcher and her supervisor, Dr. Megan Aston, can access the original audio recordings and written transcripts. Before other research committee members access the data, names and identifying information will be removed. It is important to note that no names or identifiable information will be used in any publications resulting from this study. However, the IWK REB Audit Committee may have access to study records for examining purposes. We will take all necessary steps to keep your participation in this study private and anonymous. If you tell us about any child abuse or neglect, we must tell the related authorities by law. We will keep your personal information and participation in this study safe and follow all the legal and ethical rules.

What if I have study questions or problems?

We are happy to talk with you about any questions or concerns you may have about your participation in this research study. Please feel free to reach out to Masoumeh Gholampour (at 902 989 4435 or ms584931@dal.ca) [or Megan Aston (at Megan.Aston@dal.ca)].

What are my Research Rights?

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project. In no way does this waive your legal rights nor release the investigator(s), sponsors, or involved institution(s) from their legal and professional responsibilities. If you become ill or injured as a direct result of participating in the study, necessary medical treatment will be available at no additional cost to you. You are free to withdraw from the study at any time without jeopardizing the health care you are entitled to receive. If you have any questions at any time during or after the study about research in general, you may contact Research & Innovation Advancement at IWK Health at (902) 470-7879, Monday to Friday between 8:00 a.m. and 4:00 p.m.

Signature Page

Study Title: HOW PARTNERS, IDENTIFIED SUPPORT PERSONS, AND FAMILY MEMBERS UNDERSTAND POSTPARTUM DEPRESSION, USING A FEMINIST POST-STRUCTURALIST LENS

Participant INITIALS:

Participant Consent

Please answer the following questions:

I have read or had read to me this information and consent form. Yes__   No__

I have had the chance to ask questions which have been answered to my satisfaction before signing my name. Yes__ No__

I understand the nature of the study. Yes__   No__

I am aware that the interview will be audio-recorded. Yes__   No__

I understand the potential risks. Yes__   No__

I understand that I have the right to withdraw from the study one week after the interview without affecting my care in any way. Yes__   No __

I have received a copy of the Information and Consent Form for future reference. Yes__ No__

I freely agree to participate in this research study. Yes__ No__

Would you like to receive information about the research results? Yes__ No__

Name of Participant: (Print)

Participant Signature:

Date: Time:

STATEMENT BY THE PERSON PROVIDING INFORMATION ON THE STUDY

I have explained the nature and demands of the research study and judged that the participant named above understands the nature and demands of the study.

Name: (Print)

Signature: Position:

Date: Time:

STATEMENT BY THE PERSON OBTAINING THE CONSENT

I have explained the nature of the consent process to the participants and judge that they understand that participation is voluntary and that they may withdraw at any time from participating.

Name (Print)

Signature: Position:

Date: Time:

Appendix D

Semi-Structured Interview Guide

1. The postpartum period represents a significant and transformative phase in the

    lives of new parents and families. During this time, mothers face diverse

    challenges, demands, unique needs, and concerns. As someone who has a close

    relationship with a postpartum mother, what specific issues, needs, concerns, and

    challenges have you encountered?

2. Can you tell me a bit about what you know about postpartum depression in

    general and in your partner or family?

3. Have your partner/mother you are her experienced Postpartum depression?

    If yes, how has that experience been?

    If not, how do you think postpartum depression happens in your family?

4. How do you see this issue personally? What were /or should be your roles and

    responsibilities in case of happening this issue?

5. In your opinion, what would help your family to cope better with postpartum

    depression? And what do you think about asking for professional help for that?