THE UNIVERSITY OF CALGARY

"Postpartum Depression in Native Women"

by

Patricia A. Carruthers

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE

DEGREE OF MASTER OF ARTS

DEPARTMENT OF ANTHROPOLOGY

CALGARY, ALBERTA

SEPTEMBER, 1987

ISBN 0-315-37981-2

THE UNIVERSITY OF CALGARY

FACULTY OF GRADUATE STUDIES

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies for acceptance, a thesis entitled, "Postpartum Depression in Native Women," submitted by Patricia Carruthers in partial fulfillment of the requirements for the degree of Master of Arts.

Dr. U Fleising, Supervisor
Department of Anthropology

Dr. B. Medicine
Native Centre
Department of Anthropology

Dr. I. Al-Issa
Department of Psychology

1987. 09. 22

ABSTRACT

Native women are actively seeking answers to the dilemmas of contemporary life. Their roles are rapidly expanding but successful motherhood remains the primary goal.

The meager mental health research about North American Indian women finds the majority of their problems are related to depression. Shore and Manson (1983) report most depressed Native people are women between twenty and forty years of age.

Epidemiological studies show that non-Native women in their childbearing years are treated for affective illness at significantly higher rates than males during the same years. At least ten percent of women suffer a depression following childbirth which, in extreme case, results in suicide and/or infanticide.

There are no published studies of postpartum depressive disorders in North American Indian women. This study describes the postpartum experience for "Eagle" women, members of a Native society in southern Alberta.

Postpartum depression is not known to occur in this group, but depression at other times in Eagle women's lives is. I posit that sociocultural factors buffer Eagle women from depression in the postpartum.

ACKNOWLEDGEMENTS

Native women informed me of the importance of this research and directed the method of inquiry. Eagle women gave their time and answered my endless questions. Thank you all.

My thanks to Dr. U. Fleising and Dr. B. Medicine for their supervision, suggestions, and support. Thank you, belatedly, to Dr. I. Al-Issa who encouraged this study by stimulating my interest in women and psychopathology and cross-cultural issues in mental health.

Dr. J. Ryan was always interested in my progress and gave advice at a critical point. I do appreciate her timing.

DEDICATION

To Nancy, the quintessential informant.

TABLE OF CONTENTS

CHAPTER ONE

THE STUDY

INTRODUCTION

Pregnancy and the postpartum period require that women everywhere experience the physiological processes of pregnancy itself and childbirth. Mood changes in the days or weeks following childbirth have been recognized for thousands of years. Hippocrates linked postpartum mental disorders to lactation. (Herzog and Detre, 1976:229) Savage, in 1975, used the term "milk fever" to describe the dysphoric mood which appeared to coincide with the onset of lactation. (Yalom et al, 1968:16) Tomes have been written about postpartum psychological responses but the diagnosis and etiology of the syndome remain controversial topics.

Transient emotional disturbances following childbirth, frequently referred to as "postpartum blues" in both medical and popular literature, occur with such regularity they are considered normal and unworthy of serious study. (Yalom at al 1968) Women in the first few days postpartum are commonly sad, weepy emotionally labile, and restless. (Anthony, 1983:3) These symptoms are almost never treated and usually subside within a week or so.

Postpartum depression is a term applied to a more severe group of symptoms which also appear in the days or weeks immediately following childbirth. This syndrome is characterized by sadness, fatigue, apathy, low self-esteem, feelings of inadequacy, and the inability to cope with the demands of everyday life. Postpartum

depression occurs in 10-13% of new mothers in the Western world, the symptoms are unremitting, and severe cases may result in suicide and/or infanticide. (Anthony, 1983; Braverman and Roux, 1978; Cox at al, 1982; Kumar and Robson, 1978; Nilsson and Almgren, 1970; Pitt, 1968) There are very few reports of its incidence in non-Western or indigenous cultures.

THE RESEARCH GROUP

This study examines the postpartum emotional experience of a group of North American Indian/Native women who are members of the Eagle band, a fictitious name used to protect the identity of the participants. Some women in the study group expressed the desire to be identified as 'Indian', others preferred 'Native'. The terms will be used interchangeably and a social definition of Indian/Native will be applied to identify the women studied. Each participant is a woman who has a registered band number or is defined as Native/Indian by herself or her relatives. (Hendrie and Hanson, 1972:481) She was either born on the reserve where the study took place or she has "married in." That is, she is, or was at one time, married to a man who was born and resided on the reserve.

THE RESEARCH PROBLEM

There is scant research investigating the mental health status and needs of Canadian Native people in general; the mental health data for Canadian Native Women are all but absent. A U.S. study (Shore and

Manson, 1983) finds that thirty to forty percent of nonalcoholic psychiatric presentations by Native people relate to depressive disorders; the majority of depressed patients are women between twenty and forty years of age.

Jilek-Aall et al (1978), in a cross-cultural study of psychiatric patients from three western Canadian ethnic groups, found a remarkably high incidence of depressive mood among Indian women. 76% met the criteria for this symptom formation compared to 59% of Mennonite women and 50% of Doukobor women.

Reports of suicide, homicide, alcoholism, spousal abuse, and chid neglect are rampant in the existing North American Indian mental health literature. Each of these phenomenon can also be an indicator of depression. The incidence and tragic nature of these situations are ample motivation to pursue research in the area of depression and Native women. An investigation into the postpartum psychological experiences will contribute to the research void evident when attempts are made to assess the mental health requirements of these women.

THE HYPOTHESIS

Cox (1983, 1979) has found a similar incidence of postpartum depression in Scottish and Ugandan women. Women of Uganda, living in traditional, rural societies and delivering their infants at home are as likely to suffer depressive symptoms following childbirth as industrialized urban women in Edinburgh who deliver their infants in

modern hospitals. He suggests that biological factors may be the most important variable in the etiology of postpartum depression.

Stern and Kruckman (1983) and Tentoni and High (1980) believe that postpartum depression may be a culture-bound syndrome with a much higher incidence among Western that non-Westerm women. The lack of documentation of the syndrome in the anthropological/cross-cultural literature suggests to these authors there is little evidence of postpartum depression in less industrialized cultures where postpartum events are structured; there is instrumental support for new mothers; and there is social recognition of the role transition for new mothers.

This study proposes that new mothers in contemporary reserve society are 'immune' to those depressive symptoms so common to new mothers in non-Native, non-reserve society. The social and cultural traditions of Indian people on reserves during the immediate postpartum period buffer Indian women against postpartum depression. The sociocultural factors are presently unknown and require identification.

THE PEOPLE

The Eagle people live on reserve land near a southern Alberta city. Ranching and private business ventures are the primary economic bases of the reserve. Pow wows, rodeos, and traditional dancing competitions are important aspects of most Eagles' lives.

Informants report that alcohol is THE major mental health problem among the Eagles. All say that the abuse of alcohol negatively affects each and every family on that reserve at some point in the developmental cycle of the family.

Multi-generational living is common to many households; there is a marked housing shortage, often making it impossible for young adults to establish independent residences, even after marriage.

A recent residence pattern has emerged among young women. Albers and Medicine (1983) discuss natalocal residence patterns of young women on U.S. reservations. The term they apply to this pattern is "uterine" and they define it as the increasing tendency of daughters to remain in or near their natal homes following marriage. (1983:210) Probably the most important reason for the emergence of uterine living is the inability of young men to adequately support a wife and family. (ibid:210) This living arrangement is increasingly evident among Eagle young women. Several who have married men from nearby reserves have refused to leave their parental homes.

Many homes on the reserve are headed by Eagle woman. Cruikshank (1976) reports on this common residence pattern in northern Canada. She uses the term matrifocality "to designate a family consisting of a woman in the role of mother who assumes domestic headship in the absence of a regularly attached male in the role of husband-father, as well as her children and other members of her kin group." (1976:106)

The economic conditions in Cruikshank's study are similar to conditions within many Native societies in Canada and are certainly similar to those on the Eagle reserve. Native men must compete with non-native men for both jobs and Native women. (ibid:107) Most Native men lack the skills required to compete in the White job market; they have neither the education nor specialized training. Many employers remain reluctant to hire Natives because they are "unreliable." Native males most often have access to only a few low status, low paying jobs. Traditional skills once needed for successful hunting and trapping are no longer valued. Families frequently rely on government assistance.

Cruikshank argues that Native women have had to make fewer adjustments than men. (1976:108) Their roles still include child-bearing, child-rearing, and home-making; these activities have a measure of continuity with the past. Marriage and survival are no longer interdependent. A Native woman's survival is not only possible, but sometimes easier, if she is not permanently or legally attached to a Native man. As the author points out, matrifocality is not necessarily normative, but it is an adaptive response to a changing situation. (1976:119) For the time being, Eagle women find matrifocality a necessary residence pattern.

THE WOMEN STUDIED

Two groups of women participated in the research: women who were formally educated prior to 1962 and lived away from their

parental homes in boarding schools for much of the year, and women who were educated after 1962 and attended public or separate schools within the city. All now live on the reserve.

Eagle women are ambivalent about the latter group. City schools offer expanded educational opportunities for young people who must now, more than ever, compete in the dominant, non-Native society for jobs and advanced educational opportunities. On the other hand, many young people have lost knowledge of and interest in traditional culture and have been negatively influenced by what many Eagle women view as pitfalls of modern urban life (access to drugs, alcohol, video media, desire for fast vehicles, etc.).

The women in the research group are not very different from women the world over. They are employed as social workers, teachers, maids, waitresses, curators, and craftswomen. Additionally, they may be wives, daughters, mothers, and grandmothers all at the same time, struggling to meet the demands and fulfill the obligations of each role. They believe the present is stressful and challenging and the future is precarious and frightening for their people. Many are coping daily with the ravages of alcoholism, poverty, and physical violence.

The necessity of research into the mental health status and requirements of contemporary Indian women is obvious. They are attempting to devise coping methods which prepare them to manage "new" stressors; there must be knowledge about the cost of this adjustment. Manson at al (1985) report a gender-specific pattern of

depression among Natives they studied in the U.S.. There is a much greater frequency of depression in Native women than Native men and they hypothesize this increased frequency is related to women's attempts to cope with the increased psychosocial stresses on families that are intrinsic to cultural change. (1985:360) If postpartum depression is present at the same rate as other depressions in Native women, the threat to Native families is even greater.

CHAPTER TWO

LITERATURE REVIEW

DEPRESSION

Clinical depression is more than a feeling of sadness or a depressed mood. A person diagnosed as clinically depressed is experiencing changes of mood (crying, sadness, restlessness, apathy, and tiredness) accompanied by cognitive, somatic, and behavioral symptoms (sleep and appetite disturbances, weight loss or gain, social withdrawal, feelings of guilt, irritability, etc.). (Brown and Harris, 1978:23) Beck has described the central core of depression in terms of the self seeming worthless, the outer world meaningless, and the future hopeless. (ibid:22)

The literature reports a consistently higher incidence of depression among women than men, with the exception of a few nations such as Iraq, New Guinea, India, and Rhodesia. (Weissman and Klerman, 1977) In contrast to pre-World War II data where female depression is higher only at earlier ages, rates of depression are higher for women in all age groups, with a shift in the peak of elevated depression to a younger age. (Al-Issa, 1980:103)

Several explanations have been offered for gender differences in the epidemiology of depression. These include the possibility the trends are spurious because of artifacts produced by methods of reporting symptoms, or they are real because of biological susceptibility, psychosocial factors such as discrimination, or female-learned helplessness. (Weissman and Klerman, 1977:98) Weissman

and Klerman's comprehensive analysis of the literature concludes the preponderance is not spurious. Women do experience depression more than men and there is probably not one single factor that will account for this phenomenon.

POSTPARTUM DEPRESSION

Women are at increased risk for the development of depression in the postpartum period. (Hopkins et al, 1984:498) When depression is associated with pregnancy, it is more likely to have onset following delivery than at other stages of the childbearing process. (Paffenbarger, 1982:19) Researchers have attempted to differentiate the clinical features of postpartum depression and those of other depressions for more than a century. During the 1800s depressions following childbirth were considered quite distinct but depressions occurring during pregnancy were considered clinically indistinquishable from those unrelated to childbirth.

The earlier concept of a distinct syndrome gradually become unfashionable and today the descriptive term "postpartum depression" does not appear in the diagnostic nomenclature of DSM 111. The fact remains that women are at increased risk for the development of depression during the early weeks postpartum.

Postpartum depression is probably not a unitary entity. The physiology of the puerperium is not a cause in itself of any of the symptoms, but should be regarded as a contributory or triggering factor operating on an underlying predisposition. (Steiner, 1979:449)

There is little to distinguish this group of women from groups of women experiencing depression at other times, excepting the fact they have recently given birth. The continuity between postpartum and other depressions is apparent in the significant association between postpartum depressions and the numerous factors associated with all depressions. Because of this tendency to equate postpartum depressions with other depressions, little research was generated for many years. Recently there has been a resurgence of interest and the scientific literature is more visible. (Hopkins et al, 1984:498)

Hopkins et al (1984) believe the renewed interest is a result of several factors. First, the research of Brown and Harris (1978) indicates an association between stressful life events and psychiatric disorder. The postpartum period presents a unique opportunity to examine this relationship in the context of a clearly defined life event and the onset of a specific disorder. Second, the latest studies using standardized test measures reveal a relatively high incidence (up to 20%) of postpartum depression. (Cox, 1979, 1982; O'Hara, 1980; O'Hara et al, 1984; Paykel et al, 1980) Third, because women are increasingly active in the labor force, the effects of postpartum depression have obvious economic consequences. There is now greater motivation for primary prevention. Finally, early data suggest the disorder my affect both the infant and the mother-infant relationship. (Crnic et al, 1984; Field et al, 1985; Wrate et al, 1985)

INCIDENCE

Pitt's (1968) landmark study of postpartum depression found an incidence rate of about 11% within six weeks of delivery; these findings have since been confirmed by many investigators. This study will be described in detail because it is regarded as the main work against which other investigations are compared. (Kumar, 1982: 103)

A noteworthy feature of Pitt's research is that he was recording incidence (new cases) and not prevalence. All subjects showing an elevation of six or more points on his screening questionnaire when assessed on two occasions, the first around the twenty-eighth week of pregnancy and again six weeks postpartum, were interviewed as potentially suffering from postpartum depression. Pitt, unlike many researchers, lists the criteria he used to define cases:

1) Subjects should describe depressive symptoms.
2) These symptoms should have developed since delivery.
3) These symptoms should be unusual in their experience and, to some extent, disabling.
4) The symptoms should have persisted for more than two weeks.

Additionally, he administered the Hamilton Rating Scale for Depression. The mean Hamilton rating of depressives was ten points higher than for the rest of the sample. These results support the reliability of Pitt's scale.

Pitt's clinical account of depressed patients is classical in its description of postpartum depression:

It was after return home that depression was almost always evident, chiefly as tearfulness, despondency, feelings of inadequacy and inability to cope--particularly with the baby. ("Every other woman seems to be blooming.") Mood was often labile, and any diurnal variation took the form of greater distress in the evenings. Guilt was mainly confined to self-reproach over not loving or caring enough for the baby. Suicidal ideas were present only in women admitted to psychiatric hospital, and feelings of actual hopelessness were not frequent. Yet many felt quite changed from their usual selves, and most had never been depressed like this before.

Depression was almost invariably accompanied and sometimes overshadowed, by anxiety over the baby. Such anxiety was not justified by the babies' health; none was seriously ill, and most were thriving. Feeding worries were the commonest. Babies who would not sleep and kept crying were found hard to love, with consequent quilt and anxiety. Overt hostility to the child, though, was rare. Two mothers had great difficulty in accepting their babies as really theirs. A few, while able to satisfy their babies' physical needs, feared spoiling them. Multiparae tended to worry over the older childern's jealousy of the new arrival.

Anxiety was often manifest in hypochondriasis. Somatic symptoms abounded and formed the basis of fears of ill-health... .

Unusual irritability was common, sometimes adding to feelings of guilt. A few patients complained of impaired concentration and memory. Undue fatigue and ready exhaustion were frequent, so that mothers could hardly deal with their babies, let alone look after the rest of the family and cope with housework and shopping. Sometimes there was a lost of normal interests.

Anorexia, occasionally associated with nausea, was present with remarkable consistence. Sleep disturbance, over and above that inevitable with a new baby, was reported by a third of the patients, taking the form of getting off to sleep, and nightmares, more often than of early morning waking. (Pitt, 1968:1327-1328)

Most frequently cited studies align closely with Pitt's statistical findings on the incidence of postpartum depression. Nilsson and Almgren's (1970) important longitudinal Swedish survey of 152 women revealed a point prevalence of 10.7% of their sample. Unfortunately, these authors are not specific about their clinical criteria for depression.

Kumar and Robson (1978) studied a group of married women in central London. Their sample was confined to first pregnancies and skewed towards the middle class (older, well educated). They report an incidence of postpartum depression in 16% of their sample three months following delivery.

Watson et al (1984) conducted a prospective study in South London to complement Kumar and Robson's data. Their population was predominantly working class. The authors were looking for class differences, wondering if Kumar and Robson's sample may be more inclined to respond to pregnancy with a depressive reaction. Depression was identified in 12% of their sample in the sixth postpartum week.

Cox (1982, 1983) conducted separate studies of 105 Scottish and 183 Ugandan women. 13% of the Edinburgh sample and 10% of the Ugandan sample were found to have a depressive illness in the puerperiun. The author warns a comparison of the two samples should be made with extreme caution because of the considerable sociocultural differences. Nonetheless, he is surprised at the similar frequency of postpartum depression in the two groups of women.

NORMAL POSTPARTUM ADJUSTMENT

A prerequisite for understanding postpartum depression is a knowledge of normal postpartum adjustment. (Hopkins et al, 1984:499) Several studies document the profound physical, social, and psychological changes that accompany pregnancy, childbirth, and

the postpartum term. This developmental stage is marked by changes in the marital, family, and social relationships, and in daily routine.

Postpartum women frequently complain of physical discomfort as well as cognitive, affective, and somatic changes that can result from the physical stress of labor and delivery, the marked hormonal changes that accompany childbirth, the onset of lactation, and the effects of medication, fatigue, and the hospital environment. (ibid:449) They consistently report feelings of dysphoria, anxiety, irritability, emotional lability, tearfulness, and fatigue. Changes in appetite, sleep disturbance, and loss of sexual interest, common sequelae of childbirth, may also be confused with the vegetative symptoms of depression.

There is relative consensus on the nature of the changes that occur in the normal immediate postpartum period. Hopkins et al (1984) point out this research has been mainly descriptive and lacks methodological rigor. The authors advocate quantitative research, designed to describe normal postpartum adjustment to provide a set of baseline measures so that "abnormal reactions to childbirth can be distinguished from normal ones...studies that provide quantitative, normative data are needed to clarify the nature and extent of affective and somatic reactions immediately following delivery." (ibid:499)

EPIDEMIOLOGY

The relationship between demographic variables and postpartum depression have been examined in several epidemiological studies.

Despite much interest over the past two decades, these studies are not conclusive.

Epidemiological studies are concerned with frequency distributions of obstetric variables as possible determinants of postpartum mental illness. (Paffenbarger, 1982:20) "The epidemiological techniques [are] employed in a search for clues to a practical understanding of the disease by assessing the relative risks of developing a first mental illness in the presence and absence of certain obstetric variables and other circumstances of childbearing." (ibid:20) Clinical studies focus on individuals and a case-history approach; epidemiological studies look at larger numbers and calculate the risk of disease in the presence of a characteristic versus its risk in the absence of a characteristic. This relativity can suggest the relationship between the characteristic and the disease. Epidemiological information can be helpful to clinical activities.

Age

Numerous studies have compared the age distribution of postpartum depressives with nondepressed postpartum controls. Paffenbarger (1982) found the risk of postpartum psychiatric illness was 28% higher for older (>25 years) than for younger mothers during the first month following childbirth and 73% higher in the next five months after delivery. Paykel et al (1980) reported that women experiencing postpartum depression are significantly younger than nondepressed women. Kendell at al (1976) correlated age with

depression: either young or old primiparous mothers seem to be most vulnerable. Yalom et al (1968) found that age of first menses correlated more strongly with depression than age at first pregnancy. Obviously, there is no clear evidence of a high-risk age group of women who become depressed postpartum.

Marital Status

Paykel et al (1980) and Pitt (1968) found no association between marital status and postpartum depression but O'Hara (1980) reports a significant relationship between divorced status and depression following childbirth. Kendell et al (1976) determined a very high proportion of illegitimate births correlated with psychiatric symptoms. They reviewed 2,257 births in 1970 and concluded that women having illegitimate babes experienced a new episode of "psychiatric morbidity" in the first three months postpartum at twice the rate of non-illegitimate deliveries. The increasing divorce rate and the fact that more single women opt to have children may clarify these two variables in the near future.

Parity

Evidence about the relationship between parity and postpartum depression is inconsistent. Paykel et al (1980) and Nilsson and Almgren (1970) report an independence between the two variables. Pitt (1968) found more primiparous women suffer postpartum depression and Tod (1964) suggests an association between

postpartum depression and multiparity. Paffenbarger (1982) reports primiparae are at double risk during the first month postpartum when compared with multiparous women, but at 24% lower risk in the following five months. It is difficult, then, to determine the relative risk for developing postpartum depression following first, as opposed to second or third pregnancies, but evidence does suggest that after a first episode, there is a high probability of recurrence. (Hopkins et al, 1984:504)

Previous Psychiatric and Family History

Most studies report a relationship between previous nonpostpartum psychiatric history and postpartum depression. (Nilsson and Almgren, 1970; O'Hara, 1980; Paykel et al, 1980; Tod, 1964) Dalton (1971) and Pitt (1968) failed to find any such relationship. Paykel at al (1980) found postpartum blues more commonly occurred in women who developed full-blown postpartum depression than in women who did not become depressed.

Empirical information about the family history of women who experience postpartum depression is scarce. Nilsson and Almgren (1970) reported a relationship between the number of psychiatric symptoms postpartum and family history of emotional disorder. In a more recent study by Ballinger at al (1979), women with postpartum "problems" reported a higher incidence of "family disruption" in childhood than women without postpartum "problems."

Summary

A number of other variables have been tested for their relationship to postpartum depression including obstetrical complications (Dalton, 1971; Nilsson and Almgren, 1970; Paykel et al, 1980; Pitt, 1968), social class (Kendell et al 1976), housing conditions (Nilsson and Almgren, 1970; Paykel et al, 1980), educational level (Nilsson and Almgren, 1970), and immigrant status (Kendell et al, 1976). These studies report contradictory findings and, because they are assessing the relationship of many variables, some of the correlations reported may be due to chance. (Hopkins et al, 1984:505)

ETIOLOGY

Hypotheses of causation of postpartum depression are many and varied. "It is still a moot question to what degree the emotional changes experienced by the pregnant and postpartum woman have a physiological basis, or to what extent they are a reflection of sociocultural or psychodynamic stress." (Rosenbaum, 1984:145)

Physiological Considerations

Certainly, the homeostasis of the hypothalamic, endocrine, and autonomic nervous systems is disrupted during pregnancy and the postpartum period. These profound changes have prompted many researchers to postulate a biological basis for postpartum depression. (Cox, 1983, 1979; Dalton, 1980, 1971; Hamilton, 1962; Steiner, 1979) The results of research provide both direct and indirect

evidence to support the hypothesized biological involvement in the etiology of these symptoms. (Hopkins et al , 1984:505) As Steiner (1979:453) warns, though, we must bear in mind a very important concept when the physiology of postpartum depression is considered; it was alluded to earlier in this study. Postpartum depression is not a unitary phenomenon. The symptoms observed in the syndrome do occur at other times in one's life, do not necessarily occur each time the woman gives birth, do not occur in all women, and do occur in men. The physiology of the postpartum term is not a cause in itself of any of the symptoms.

Physiological Theories

The endocrine changes occurring before, during, and immediately after childbirth are unique in their magnitude, rapidity, and complexity of regulation. (Steiner, 1979:454) Again, an understanding of "normal" postpartum changes is essential before any link between hormones and postpartum depression can be made.

There is a precipitous fall in female reproductive hormone levels postpartum. Estrogen and progesterone increase tenfold during pregnancy through synthesis by the fetal placental unit. (Kruckman and Asmann-Finch, 1986:xviii) When the placenta is removed after delivery, there is an immediate and pronounced drop and, by three days postpartum, estrogen and progesterone levels have returned to prepartum status.

It has been reported repeatedly that onset of emotional symptoms on the third day postpartum correspond strikingly to third day postpartum hormonal changes, leading to investigations of hormonal involvement in postpartum depression. (Kruckman and Asmann-Finch, 1986:xvii) Two research approaches have been taken recently. First, hormonal events unique to the postpartum period were examined and data from both depressed and nondepressed postpartum women were compared. Second, those biological findings correlated with depression in general were examined in postpartum women to ascertain if the processes were similar or unique in the postpartum period.

Nott et al (1976) examined the hormone levels of twenty-seven women before and after delivery and concluded that women with the greatest drop in progesterone were more likely to rate themselves depressed within ten days of delivery. However, an attempt to correlate hormonal findings and clinical findings failed. The authors found no relationship between postpartum blues and levels of estrogen or progesterone, ratio of estrogen to progesterone, or in the rate of change of hormonal levels during pregnancy or the early postpartum period.

Handley et al (1977) and Stein et al (1976) found a relationship between a sudden drop in estrogen at childbirth and a decrease in tryptophan levels to be correlated with depression. Trytophan is the rate-limiting enzyme in the production of the central neurotransmitter, 5-HT, and there is increasing evidence of a

disturbance of 5-HT metabolism in all depressive illness. (Hopkins et al, 1984:506) Even Oakley (1980), a strident feminist and objector to physiological explanations for women's psychological distress, admits tryptophan metabolism may play a role in postpartum mood changes.

Norepinephrine, another neurotransmitter, has been examined in postpartum depression research. Treadway et al (1969) assessed norepinephrine levels in pregnant and postpartum women and in matched controls. They reported a decreased level of norepinephrine in pregnancy and the postpartum period and an inverse relationship between norepinephrine and depression during pregnancy. This association was not found during the postpartum period.

REM sleep patterns are also believed by some to play a role in postpartum depression. Karacan et al (1969) found evidence of an excessive decrease in the level of Stage 4 sleep in late pregnancy. They suggested a failure or delay in the rebound of this stage in the early postpartum period was a factor in postpartum depression.

Frank et al (1987) examined 52 women with recurrent depression to determine the differences between women with and without histories of pregnancy-related depressive episodes. The EEG-recorded sleep of the women with and without histories of pregnancy-related depression was distinguished by longer REM sleep time and more REM activity. The differences were accounted for almost entirely by women with histories only of postpartum depressive episodes.

Summary

There are other physiologic theories of postpartum depression but obviously, the status of all such theories is equivocal. Evidence of a direct link between hormonal levels and postpartum depression is weak. There have been some consistent findings associating changes in trytophan metabolism and postpartum psychological syndromes but these studies have a major flaw: samples have been confined to women suffering from postpartum blues. This makes it more difficult to generalize these findings to postpartum depression. (Hopkins et al, 1984:506)

Psychological Theories

Psychoanalytical Formulations

Many psychological theories of postpartum depression are couched in psychoanalytical terms. Freud's analysis of the role of reproduction in women's lives has greatly influenced the whole body of psychological literature on postpartum adjustment. (Oakley, 1980:67) Several aspects of Freud's thoughts on this subject have shaped the psychological constructs of women as mothers, particularly his view that having a baby is an expression of penis envy, and his interpretation of postpartum problems as overt manifestations of underlying personality defects. (ibid:67)

Psychoanalytical formulations of postpartum depression stress that the regression which occurs in all women during pregnancy

forces earlier conflicts to the surface, particularly in cases were there are inadequate maternal role models or there is a rejection of maternal role models. (Hopkins et al, 1984:506) Postpartum depression, then, results from unresolved conflicts about motherhood or the feminine role.

Grete Bibring, in "A study of the psychological processes in pregnancy and of the earliest mother-child relationship" (1961) observed that pregnant women were preoccupied with their relationship with their own mothers. (Saks, 1984:165) She says, "It is as if the attitudes in this relationship established as solutions of childhood experiences are abandoned and replaced by various new forms of identification with the mother." She argues that, in successful maturation, the women develop a useful identity with the mother as the prototype parental figure. (ibid:165) If there is conflict about identifying with the mother, this useful identification may not occur. Some women know they can become a different mother from their own, but one's own mother usually remains a predominant model. Additionally, Bibring says, it is hard for a mother to know how to invest in and bond with a baby if she has not been invested in and bonded with during her own development.

Many authors have written about women's relationships with their own mothers as being critical to their own emotional adjustment postpartum. However, they are only able to provide anecdotal clinical evidence; psychoanalytic theory suffers from a lack of empirical support. (Hopkins et al, 1984)

Developmental Theory

Again, Grete Bibring is one the most influential proponents of this theory. (Oakley, 1980:62) Very simply stated, pregnancy and childbirth are 'normal crises' in a woman's psychological development. The crises are an essential part of growth which must precede and prepare maturational integration.

Breen (1975) attempted to revitalize the developmental model by focusing on the changes in a woman's self-concept that occur with the onset of motherhood. The women she judged as least adjusted had difficulties with the split between ideal and reality. That is, they could not resolve the conflict they felt about the mothers they thought they were, as opposed to the mothers they thought they ought to be. The women who were able to see the ideological nature of the association between perfect and actual motherhood were likely to accept their own experiences in becoming mothers as valid.

This formulation for postpartum psychological problems suffers from difficulties similar to psychoanalytic theory: it derives from our (Western) cultural idealization of motherhood/femininity and it retains 'adjustment' as the defining characteristic of feminine women. (Oakley, 1980:65)

Personality and Attitudinal Theories

Tod (1964) found that each case (n=20) of postpartum depression in his large sample (n=300) was preceeded by anxiety

during pregnancy. His assessment of anxiety was based on subjective interviews during pregnancy and the immediate postpartum; pre- and postnatal interviews do not appear to be blind and independent. (Hopkins et al, 1984:507)

Meares et al (1976) conducted a more objective assessment of the anxiety variable. They used the Taylor Manifest Anxiety Scale and assessed postpartum depression with visual analogue rating scales and found the severity of postpartum mood changes correlated with the severity of anxiety scores during pregnancy. Dalton (1971) also found an association between anxiety measured in early pregnancy and postpartum depression. Grossman et al (1980) used the Trait Anxiety Scale to assess anxiety during the first trimester of pregnancy. They found that anxiety was highly correlated with self-reported depression at 2 months and 1 year postpartum in a nonclinical sample.

Hayworth at al (1980) were examining whether anxiety, hostility, and locus of control measured during pregnancy predicted postpartum depression. Both high anxiety and high hostility during pregnancy were positively correlated with depression. They also found a direct association between external locus of control and subsequent postpartum depression. The authors postulate that women who perceive themselves as less in control of their lives may show something like "learned helplessness", which has been posited as an etiological factor in depression. (Hopkins et al, 1984:507)

Negative maternal attitudes toward child rearing and the family have been associated with postpartum adjustment problems. (ibid:507)

Grossman et al (1980) suggest that less positive attitudes toward children and the maternal role are associated with less favorable adjustment to care taking and more self-reported depression.

Nilsson and Almgren (1970) found women who assessed themselves as more "masculine" reported more psychiatric symptoms in the postpartum period. "Masculine" women reported poor contact with their mothers during childhood and were less likely to see their partners as dominant in the relationship. Nilsson and Almgren interpreted this to mean their fathers were the major object of identification.

While isolating personality and attitudinal variables provides useful data, it would seem more effective to examine a number of clinically relevant variables simultaneously to determine if it is possible to predict postpartum depression.

Cognitive-Behavioral Models

Researchers have just begun to specifically address behavioral and cognitive issues relevant to postpartum depression. O'Hara et al (1982) conducted a prospective study to test whether particular cognitive-behavioral variables measured during pregnancy predicted postpartum depression. They examined such deficits as excessive monitoring of negative events; insufficient self-reward and excessive self-punishment; dysfunctional attributional styles characterized by internal, stable, and global attributions for success; dysfunctional beliefs as evidenced by negative cognitions about the self, the world,

and the future; and social skills deficits such as limited ability to elicit positive responses from others.

O'Hara et al (1982) administered the Beck Depression Inventory and a structured interview schedule to 170 women in their second trimester of pregnancy and 3 months postpartum. Results indicate the deficits in self-control, attributional style, and social skills, measured during pregnancy, are related to the level of postpartum depression.

Cutrona (1983) followed 85 primiparas from the third trimester of pregnancy through the second month postpartum. She assessed initial attributional style and causal attributions for a range of naturally occurring stressful events. The subjects were assessed for level of depression at three time points. Pregnancy scores on the Attributional Style Questionnaire predicted level of postpartum depression among women who were not depressed during pregnancy. Among women who were depressed during pregnancy, though, attributional style was not a significant predictor of postpartum depression but it significantly predicted speed of recovery from the depressive episode.

Interactional Models

Interpersonal factors such as family interaction, companionship, and marital problems have also been suggested as important in postpartum depression. (Kruckman and Asmann-Finch, 1986:xxii) Hostile or ambivalent mother-daughter relationships have been

discussed earlier in the psychoanalytic literature review. Bensel and Paxson (1977) found an interrelationship between mother-infant bonding problems and postpartum depression. Marital problems both before and after childbirth have been correlated with depression by Kumar and Robson (1980), Nilsson and Almgren (1970), and Watson et al (1984). Paykel et al (1980) found marital problems an important factor only in the presence of other stressful live events.

Kraus and Redman (1986) posit postpartum depression as an evolving interpersonal system. Postpartum depression is conceptualized by these authors as a "predictable developmental, family crisis, which occurs when the natural difficulties of childbirth are benignly mishandled." (ibid:63) They see unique problem-amplifying behaviors occurring with childbirth, agree that hormonal and other physiological changes can set off a vicious interpersonal cycle, but believe that for a full-blown postpartum depression to develop, the mother and others involved with her must deal with these transitory situations in a way that exacerbates them.

Kraus and Redman do not take a biological versus psychosocial position on the etiology of postpartum depression. They believe that social interaction, cognition, and neurohormonal physiology influence each other in a circular, feedback manner.

Social Origins of Postpartum Depression

The psychosocial factors of postpartum depression have, in the past decade, received more attention in a literature that previously

emphasized either biological or psychodynamic issues. (Rosenbaum, 1984:146) Probably the major impetus behind this recent attention is the famous 1978 study by Brown and Harris which finds the women most vulnerable to depression tend to have experienced "severe" life events in the recent past and that certain factors either in isolation or combination, enhance women's risk. (Kumar, 1982:109) The typical woman "at risk" is working class, with three or more children under the age of fourteen years and therefore not employed, with a non-confiding relationship with her husband, and lost her mother before 11 years of age. Brown and Harris's conclusion that women in their series showed "no evidence that childbirth and pregnancy as such are linked to depression" (1978:141) has been criticized by many. The series they refer to is a sample of 114 psychiatric in- and out-patients and not the community sample from whom the original profile of vulnerability factors was obtained. Their failure to find links between the incidence of depression and childbearing does not, then, necessarily imply that such links do not exist. (Kumar, 1982:111)

Since 1978, several studies have examined the role of social support and life events in postpartum depression. Results from these studies indicate that social support does have a significant impact on the stress-illness equation, either as a mediating or independent variable. (Hopkins et al, 1984:509) Social support appears to be particularly relevant for postpartum women who, because of the increased demands imposed by the birth of a child, might require more than usual emotional and instrumental support.

One aspect of social support, specifically a confiding relationship with husband, is identified as an important variable linking social support and depression. (Brown and Harris, 1978) This relationship seems to be particularly crucial for new mothers who, because they are relatively housebound and constantly responding to the demands of child care, may have difficulty obtaining adequate support from other members in their social network. (Crnic et al, 1983) Grossman et al (1980) found the quality of the marital relationship one of the strongest predictors of postpartum adaptation, especially for first-time mothers.

These studies indicate that women who are depressed in the postpartum period perceive their husbands as less supportive and report more marital difficulties than nondepressed women in the postpartum period. They do not, however, permit a good test of cause-effect relationships. (Hopkins et al, 1984:511) O'Hara et al (1983) found the depressed women in their study reported more frequent contact with other members of their social system than prior to delivery, illustrating the complexity of the relationships between social support, life stresses, and depression.

This research emphasizes the lack of clarity about "whether depressive affect influenced perceptions of social support in the face of additional stress, whether the decreased quality of social support in the face of additional stress increased vulnerability to depression, or whether the interaction between a high level of stress and depressive

affect led to the need for particularly high levels of social support." (Hopkins et al, 1984:511)

Anthropological Perspectives

It is clear that most of the research on postpartum depression has looked to biological and/or psychosocial etiologies. Little consideration has been given to the impact of cultural patterning of the postpartum period as an etiology in postpartum depression--factors like the structure and organization of the family and social group, role expectations of the new mother and other people significant to her, etc. (Stern and Kruckman, 1983:1028)

The period of conception through childbirth and the postpartum is everywhere differently segmented and defined structurally in terms of its behavioral, social, and experiential content. (Kruckman and Assman-Finch, 1986:xxiv) This patterning represents each society's "policies" about the importance of the perinatal period for the mother and child, the family, and the wider social system and reflects theories about the nature and implications of these events. (ibid:xxv) Interestingly, the anthropological literature reveals remarkably little evidence of the phenomenon identified in Western psychiatric diagnoses as postpartum depression. (Stern and Kruckman, 1983:1028) For example, researching the influence of native customs on childbearing in Nigeria, Kelly says, "Postpartum depressions are rare. This may be due to the postpartum customs of the Ibibio people." (1967:611) She suggests the social structure and postpartum rituals

play a role in prevention, especially the 2-3 month seclusion in the "fattening room."

A study by Hart (1965) in southeast Asia found "...no unusual anxieties or apprehensions in the postpartum period." (cited in Kruckman and Asman-Finch, 1986:xxv)

Stephenson et al (1979), following a review of the literature on Micronesia and interviews with 21 informants, hypothesize that postpartum depression is not common in Micronesia. (ibid:xxvi)

Pillsbury (1978), studying the postpartum period ("doing the month") in China, found no evidence of postpartum depression and emphasizes the importance of social support in the postpartum. Her observations of interactions in Chinese households in the first month postpartum gave the impression that "far more attention is lavished upon the mother, relative to the newborn infant, than in the U.S.. This extra attention their families and social networks show them while doing the month seems, in fact, to preclude Chinese women from experiencing postpartum depression as understood and so taken for granted by Americans--despite the fact that the same biological factors are operative for women in both cultural backgrounds." (ibid:18)

These data are complicated by the work of Davidson (1972) and Cox (1978; 1979; 1983). Davidson studied 43 Jamaican women and found them to have the highest levels of depression during pregnancy rather than the postpartum period. 26 (60.4%) also experienced emotional upset in the first 11 days postpartum. However, these

women were poor, had experienced multiple births, were living in a high unemployment area, and there was little institutionalized marriage or mandated financial or emotional support from the baby's father.

Cox compared large samples of Ugandan and Scottish women and found a surprisingly similar rate of postpartum depression. He uses this finding to argue against the 'colonial' hypothesis that an African woman is relatively unlikely to become depressed in the puerperium. (1983:25) Cox argues further that these data may even suggest sociocultural variables are less important than biological variables. (p.27) It is important to note that some of the Ugandan women "remembered their previous difficult deliveries. Some were even reminded of earlier stillbirths." (p.27) Additionally, many were co-wives, a situation fraught with difficulty according to the anthropological literature.

Before interpreting any of these findings, there are methodological caveats. (Stern and Kruckman, 1983:1033) First, until recently most anthropologists were male and cross-cultural postpartum depression was not given attention. Secondly, formal diagnostic testing and ethnographic field observations of postpartum emotional responses were lacking. Cross-cultural comparisons will be made more difficult in this area because of the confounding of behavioral and emotional criteria in the Western conceptualization of "depression." (ibid:1033)

Keeping these methodological problems in mind, the possibility remains that behaviors which are categorized as postpartum depression in Western cultures are not widely found cross-culturally and represent, in effect, a culture-bound syndrome. (Kruckman and Asmann-finch, 1986:xxviii) Stern and Kruckman propose that a relationship exists between the strategies typically employed cross-culturally in the postpartum period, which serve to mobilize social support to the new mother, and postpartum mental health. (1983:1036) Their hypothesis is that the negative outcomes of postpartum depression in the West derive from the relative lack of: 1) social structuring of postpartum events; 2) social recognition of a role transition for the new mother; and 3) instrumental assistance to the new mother. Conversely, clear cultural patterns of activities, explicit recognition of new social status, and assistance in fulfilling former role expectations and caring for the newborn may serve to mask or prevent negative emotional states postpartum.

Uzzell (1977) says it is important to investigate 'folk illnesses' or 'culture-bound syndromes' from a symbolic interactionist perspective: i.e. the costs and benefits of adopting the sick role in a particular social and cultural setting. Analyzing *susto*, Uzzell suggests that it may represent 'legitimate deviance' and that the label of folk illnesses are typically applied when other explanations have failed. The author's suggestion that *susto* presents a paradox in which withdrawal from interaction becomes a mechanism for maintaining interaction is even more interesting when considering postpartum depression. It may be

that postpartum depression is a form of legitimate social deviance resulting from perceptions of role helplessness and can be analyzed as a culture-bound illness. (Stern and Kruckman, 1983:1038)

Although there is some awareness in our (Western) culture that early postpartum weeks and months are a difficult time, this awareness does not seem to be among our explicit shared beliefs. (Brown, 1979:118) Our society does not designate the postpartum period as a unique time in the life of the mother and infant, nor do we accord the new mother special status with its accompanying social support. Postpartum ceremonies practiced in so many other cultures involve family members and neighbors, support the new mother, and often increase her social status, While there may be societal pressure to have children in Western society, the parental role itself is not highly valued; parenting is not considered a career. (Tentoni and High. 1980:247) New mothers know their society's values about childrearing. In our society, changes in the mother's attitude about herself are culturally induced, occur long before the infant's birth, and may be the precursors of later postpartum depression.

CONSEQUENCES OF POSTPARTUM DEPRESSION

The relationship between maternal depression and childhood disturbance has been the subject of several studies. Weissman et al (1972) found that 3/4 of children whose mothers had been hospitalized for depression showed emotional disturbance. Richman et al (1975) and Richman (1977) found an association between less

severely depressed mothers and behavioral disturbance in three year old children.

Two published prospective studies of postpartum depression and later child behavior report conflicting results. Uddenberg and Englesson (1978) examined the mental status of 69 Swedish women in the puerperium and four and one-half years later, when the child's behavior was also assessed. They found an association between postpartum 'mental disturbance' and the mother's tendency to describe her child in a negative way. Children of mothers who had a postpartum psychiatric disorder described their mothers more negatively than children of non-depressed mothers. In the second study, Ghodsian et al (1984) followed 131 women in London until their children were forty-two month of age. No relationship was found between maternal depression at four months postpartum and later child disturbance.

Wrate et al (1985), using data from Cox's (1982) study of postpartum depression in Edinburgh, re-examined the hypothesis that three year old children whose mothers had been depressed following their birth would show more behavioral difficulty than children of mothers not depressed at that time. 91 of the original 103 mothers were reinterviewed three years later to determine their present mental status and the Richman's Behavioral Screening Questionnaire was administered to assess their child's behavior. No relationship was found between prolonged postpartum depression and behavior disturbance in the child, but children whose mothers had brief

postpartum depressive episodes showed more disturbance than those with non-depressed mothers. Although the duration of symptoms was briefer for these mothers, they were more anxiously preoccupied with their baby. The results of this study suggest to the authors that a depressed mood in the postpartum may not invite an enduring effect on the interaction between mother and child, except when a depressed mother is excessively concerned with her child, or uncertain about her mothering.

Field et al (1985) found their sample of mothers suffering from postpartum depression expressed more punitive, controlling attitudes toward childrearing than the non-depressed mothers. The depressed group displayed less imitative behavior, played less, and were less emotionally responsive to their infants, The babies squirmed and fussed more than those of non-depressed mothers. "Whether the infant's depressed affect derives from their exposure to the depressed behavior modeled by their mothers or from minimal stimulation provided by their mothers is an empirical question." (ibid:1155)

Anthony's (1983) sample of mothers who were depressed during the postpartum period were concerned that they did not like their babies because they were fretful and "difficult." They expressed disappointment when the baby was not developing well but blamed themselves. When the baby refused to eat or sleep, they used stronger techniques than they felt was appropriate. They were unable to enjoy the baby "like other mothers" and believed the baby was disappointed in them and would not love them. "It is far too much of a burden for

the young child to have to deal with the mother's despair and despondency." (ibid:16)

Erikson (1968) has commented on the quality of the maternal relationship as being considerably related to the formation of the infant's trust in his/her environment. Among the most threatening hardships to the internal security of the infant are the chronicity or repetitiveness of physical or mental illness in the parents and the unpredictability of parental mood changes. (Reid and Morrison, 1983:37) The greatest danger comes from living with unrecognized or nonverbalized chronic depressive symptoms. (ibid:37)

The most severe consequences of postpartum depression are, of course, suicide and/or infanticide. Fortunately, both acts, in association with pregnancy, are rare but when they do occur, they do so in the postpartum at a higher rate than during pregnancy. (Rosenbaum, 1984:143)

TREATMENT OF POSTPARTUM DEPRESSION

Because postpartum depression affects a significant proportion of women, effective intervention strategies are required. Research that elucidates the course and duration of postpartum depression and provides the etiologically relevant data may assist in the development of appropriate, cost-effective intervention and prevention strategies. (Hopkins et al, 1984:512) For instance, if low levels of social support are consistently associated with postpartum depression in prospective studies, educational efforts prior to childbirth aimed at bolstering

social support should be implemented and empirically tested for effectiveness.

The same medications used to treat nonpostpartum depression appear to be effective in the treatment of postpartum depression. (Garvey and Tollefson, 1984:114) Standard tricyclic antidepressants and newer "second generation" antidepressants are commonly used. Plasma levels of several of the more common antidepressants are available and can be used to prescribe the most advantageous dosage, The disadvantage of antidepressant medications is that they are excreted in breast milk so mothers must discontinue breastfeeding.

Cognitive and interpersonal (marital) therapy may be helpful in certain situations. However, there are no substantive data to support the efficacy of many forms of psychotherapy in the treatment of depression. (Garvey and Tollefson, 1984:115)

PROGNOSIS

The prognosis for a single episode of postpartum depression is, with effective treatment/intervention strategies, good for that episode. But, women with a previous history of depressive episodes at other times in their lives have a 20-30% chance of postpartum depression; women who have experienced one postpartum depression have a high risk, variously reported to be 50-100%, of experiencing postpartum depression with subsequent pregnancies; and female relatives of women who have experienced postpartum depression may be at

increased risk. (Garvey and Tollefson, 1984:115) Familiarity with the personal histories of obstetrical patients is essential for prevention.

The period following childbirth is characterized by profound changes that have potential ramifications for the woman, her infant, and her marriage. Studies have not examined postpartum adjustment as a function of such factors as employment status or financial independence. Further investigation is necessary to provide insight on both predictive and preventive factors.

CHAPTER THREE

METHODOLOGY

INTRODUCTION

Many academic disciplines view the Western scientific method as the only valid and reliable way to approach knowledge and understanding. (Leininger, 1985:2) As Western researchers learn increasingly more about non-Western methods of knowledge acquisition, this belief that scientific knowledge is the only valid knowledge is being challenged as narrow and reductionistic. An active debate about the relative advantages of quantitative versus qualitative research methods has ensued.

Quantitative or "scientific" research methods focus on empirical (objective) analysis of discrete and preselected variables which have been derived as theoretical statements in order to determine causal and measurable relationships among the variables. (ibid:7) These methods come from the natural sciences and assume the social world can be studied with objective forms of measurement.

"Two primary 'hard' quantitative methods prevail...experiment and survey." (Goldenberg, 1987:59) Both are "hard" in that they are centrally concerned with demonstrable reliability and careful quantitative measurement throughout; their emphasis on reliability leads to careful operational definitions of terms and considerable emphasis on identifying and measuring the independent effects of each variable present; and they can be replicated fairly easily, at least in modified replications. The emphasis is on control of variables and

picking apart the intricately woven complex of attitudes, values and structural circumstances that produces a given behavior. (ibid:59) Quantitative measures are precise, parsimonious, and can be quickly aggregated for analysis; quantitative reports are usually presented with standardized tables in a succinct, systematic manner. (Leininger, 1985:8)

Qualitative research methods are the techniques of observing, documenting, and interpreting attributes, patterns, characteristics, and meanings of specific contextual features of the phenomenon under study. (ibid:5) These studies tend to be exploratory in nature and provide descriptive information about the topic. (Tripp-Reimer, 1985:179) Qualitative research methods are appropriate when the investigator does not have a comprehensive knowledge of the study topic, and particularly appropriate when the investigator does not know the relevant questions to be asked or the range of responses likely to be elicited. (ibid:179)

The goal of qualitative research is to document, as completely as possible, the totality of the research matter from the studied group's perspective. This includes the identification, study, and analysis of subjective and objective data in order to know and understand the internal and external worlds of people. (Leininger, 1985:5)

Current arguments aside, qualitative and quantitative research may not be opposing methodologies. Each has advantages and limitations and they may, in fact, provide complementary data sets which together give a more complete picture. (Tripp-Reimer,

1985:179) Qualitative research findings can benefit quantitative studies by giving meaning to statistical and numerical findings. Conversely, quantitative methods play an important role in verifying or establishing facts from the qualitative data.

INITIAL RESEARCH PLAN

The initial goal of this study was to discover, using standardized measurements, the incidence of postpartum depression in a population of Alberta Indian women. The Beck Depression Inventory and the Zung Self-rating Depression Scale, both reliable and validated cross-culturally, were to be administered to women from two different tribal groups during pregnancy and again within the first postpartum trimester. I planned to include descriptive data, derived from personal interviews with postpartum women, about the postpartum period. Finally, I wished to make the results of the study known and, in conjunction with Indian women, identify postpartum problems and formulate effective prevention and/or intervention techniques.

Two groups of female Native students in two post-secondary educational institutions agreed to test the instruments. Both self-assessment scales were completed anonymously. Immediately following, I asked for feedback on the relevance and comprehension of the questions.

Approximately 30 women completed the scales; none reported difficulty with understanding and most were aware of the relevance of the questions to the diagnosis of depression. Many of the women had

heard of postpartum depression and many verbalized support of the study in general.

However, it was rapidly apparent that this method of obtaining data would provide an incomplete picture of the postpartum experience for Native women. Most of the student population were mothers and they informed me that they had never been invited to discuss the psychosocial aspects of pregnancy, childbirth, and the postpartum period with a researcher. They warned I would have trouble recruiting a large enough sample, the travel distance between the reserves was too great, and I would frequently confront missed appointments due to transportation problems of the subjects. The students were vocal in their criticisms of the scales; a simple checklist, they said, could not begin to describe these experiences for Indian women. This group, then, determined the focus, direction, and methodology of the study. I did not use the self-rating scales again and sought a more meaningful (for the women and for me) research method. This development should not have come as a surprise. Clark (1978) cautions, "Ignorance of cultural differences can indeed pose serious problems in diagnosis and treatment, for without such knowledge we will alienate the individual and run the risk of making recommendations that will be ignored. Only if the cultural dimensions are considered, can we claim we are practicing holistic or comprehensive health care." (p.vii)

I based my initial approach to the study on the assumption that cross-cultural differences are quantitative rather than qualitative, and

that pan-cultural similarities in mental illness outweighed cross-cultural differences. This kind of research represents an etic strategy *par excellence.* (Draguns, 1984:41) Standardized instruments of appraisal, exemplified by symptom rating scales, have outstripped the application of other means of appraisal in cross-cultural research, resulting in an imbalance toward etic conceptualization of disorder, emphasizing worldwide similarities and deemphasizing differences. The etic basis has gone hand in hand with an inadvertent neglect of phenomenology of, and subjective reactions to, disturbed experiences. (ibid:50-51)

THE ALTERNATE PLAN

Several observers and evaluators of cross-cultural psychiatric research (Draguns, 1977, 1982; Marsella, 1978, 1979; Kleinman, 1977) agree that the emic approach in the study of abnormal responses has, thus far, not been given a fair chance. Nonetheless, this is the approach I wanted to take. If I could identify and document the thoughts, beliefs, meanings, world views, values, and general characteristics of life events, relationships, and ceremonies of a limited number of Indian women, I could learn the unique features of pregnancy and the postpartum experience for this group of women at least and, maybe, glean some common threads about this time for all North American Indian women.

I decided to use what Leininger (1984) calls a culturological interview. The critical challenge to work with people of another

culture, Leininger says, is to discover ways to assess, communicate, know, understand, and work with clients effectively. (p.111) Interviewing and assessing cultural lifestyle is an area that goes beyond an individual focus to group cultural behaviors, cultural systems, language systems, institutional values and norms, and diverse environmental forces. Focus on "culturological data will provided some entirely new assessment and therapy modes for mental health personnel." (ibid:111)

Culturologically based interviews prevent cultural impositions and unnecessary cultural stresses and conflicts. (Leininger, 1984; Spradley, 1982) Intentionally or unintentionally, professionals often impose their values. The professional who uses culturally based knowledge in interviews can prevent unnecessary stresses and conflicts. She will be able to value, use, and promote cultural accomodation, preservation, and repatterning according to the needs of the group. (Leininger, 1984:112) Entering the emic or local view, and understanding the world view, values, and referent groups provide new insights for professional growth. Finally, culturological interviews tend to promote new lines of systematic inquiry with different theoretical postures. (ibid:113) "Comparative insights about human deviations, life problems, and struggling to maintain oneself are a few of the areas to be described, explained or predicted. A variety of theories with testable hypotheses are emerging from interviews with clients or families of different cultures and leading to new and major

theories about health diversity and the universality of human behavior." (ibid:113)

The Culturological Interview

Leininger (1984) offers the following guidelines and principles in conducting a culturological interview:

1) When feasible, conduct the interview in the individual's natural setting, such as his or her home or workplace.
2) At the beginning, identify yourself, the nature and focus of the interview and the general areas of interest or plans for the interview.
3) Use the interviewee's native language. If this is not possible, then you should use a reliable interpreter.
4) Use a small pad to record a few key words or phrases as well as nonverbal observations.
5) Interview in an open, friendly, and respectful manner.
6) Throughout the interview, maintain an active listening and observing role with the interviewee, and a reflective attitude about what is presented.
7) Maintain a learning attitude; learn from the interviewee and do not assume to be the "expert."
8) Let the interviewee guide the interview, sharing what he or she is comfortable discussing. The interviewer takes cues from the interviewee, except occasionally to clarify, validate, or direct inquiries about ideas or to open a new domain of inquiry.

9) Since the culturological interview primarily seeks to identify behavioral and health life-styles through identification of cultural values, beliefs and practices, the interviewer should let the interviewee know this focus.
10) Clarify the past or current role of the interviewee to determine his or her activities, role, and function in the culture.
11) During the interview, the interviewer needs to be aware of his or her own verbal and nonverbal responses.
12) At the end of an interview, the interviewer should express appreciation to the interviewee for sharing information.

Many of these principles will be familiar to the experienced interviewer. I attempted at all times to adhere to them, with slight modifications. For instance, in addition to a written record, I utilized a tape recorder during most of the interviews. It was not necessary to use the interviewees' native language; all were fluent in English. Additionally, I repeatedly clarified the purpose and use of interview data and assured interviewees of confidentiality.

Entrance Strategies

The first prepatory step was a search of relevant literature. This procedure is sometimes questioned in fieldwork because of the potential for selective perception. ((Evaneshko, 1985:137) Prior readings may lead to biased observations of only those data that confirm preconceived notions. On the other hand, becoming as well informed as possible about the community is a very successful

entrance strategy. Accurate knowledge of the culture and history of the reserve, I believe, influenced interviewees to take the study seriously and eased my entry.

I decided to limit the study to one reserve and based my selection on distance from the city and the access of a faculty advisor to that particular reserve. The community offered a representative sample with the necessary characteristics of income, age, and health knowledge.

I wanted to conduct lengthy interviews with as many women in all age groups as possible and began by going to the reserve on my own and introducing myself and my research project to a very public female elder. She was given information about the educational institution, the purpose of the study, how it would be conducted, when it would be completed, the part the women's community would play in the study, and the time commitment required from interviewees. She was interested and receptive, offering herself as a key informant and referring me to another woman who would subsequently introduce me to other potential informants.

The Informants

I wanted to use a small number of informants in order to obtain in-depth perceptions of pregnancy, childbirth, and the postpartum period. The key informants represented some variation in age, occupation, education, and tribal origin. I used primarily unstructured interviews and observation-participation. These techniques allow the

researcher to focus on a comparatively limited domain of inquiry, using a minimal number of data collection methods with a small number of informants during a relatively brief period of time. (Wenger, 1985:289)

Because many Native groups feel they have been "overstudied," I was hesitant to approach women I had not met through other women on the reserve. Also, the distance and mistrust of the women was obvious on initial contact. I chose the key informants, then, as a result of my access to them, as well as their knowledge about the domain of study. Selection of the informants rests on the identification of persons who are representative of the culture and who show potential to reveal substantive data. (Leininger, 1985:47) It was fascinating to discover I was repeatedly being referred to the same key informants by community members; I interpreted this to mean I was talking to the "right" people. General informants were women with whom I was in brief, or group, contact.

Key Informants

Nancy

Nancy is a separated 62 year old Eagle woman who has 7 children and 20 grandchildren. She must be considered the key informant of the key informants because she made herself available to me for over fifty hours during a seven month period. Nancy decided early in our relationship to describe all aspects of being a woman on the Eagle reserve as completely and accurately as possible. She

explained and explained issues to me, even though I often sought clarification about the same thing over several visits. As time went on, it was clear to me there was nothing I could not ask Nancy about; her perceptions were both articulate and complex. Other informants repeatedly, though unknowingly, validated her information about life as an Eagle woman.

Sara

Sara is 26 years old, an Eagle, married, and has one infant child. She was employed in a busy, demanding job until a few months ago and agreed to work with me because she believes that she, and many of her female peers, are at risk for depression "just because of the way things are here...we are all trapped."

Sonya

Sonya is a 55 year old married mother of eight and grandmother of five. She "married in" to the Eagle reserve as a young woman and believes this situation leads to its own difficulties and perspectives. Sonya thought this study was extremely important to the mental health of young mothers and, because of her high public profile, took it upon herself to introduce me to several of these young women. She was at all times encouraging and active in her recruitment of new informants.

Rachel

Rachel is about 72 years old. She is widowed, has five children, and "too many grandchildren and great grandchildren to count." I spent less time with Rachel than the three preceding women, but her

information is relevant and astute. She is open and concise, and has some very definite opinions about the life and status of Eagle women. Rachel, too, was born and raised on the Eagle reserve.

General Informants

Layla

Layla is married to an Eagle man and has three small children. Her contributions to the data are especially interesting because she is a member of a very different indigenous group.

Marcia

Marcia has also "married in." She is in her mid-thirties, has three children, and came to the Eagle reserve as a bride at eighteen years of age. She has retained many traditions from her band of origin and is something of an expert on the ritual and spiritual history of this band.

Dawna

Dawna, too, has "married in" to the Eagle people but she and her husband spent several years away obtaining post-secondary education. They have recently returned to the reserve with their three children. When I met Dawna, she was eight weeks postpartum.

Martha

Martha is a middle aged widow with eight children and "many" grandchildren. She is from another province but has a professional job and has worked at it for so many years that she has accumulated a vast store of knowledge about Eagle people.

These descriptions of informants do not include all the women who contributed data to the study, but the remainder will remain anonymous either because the contact with them was very brief; or they were not comfortable discussing certain issues; or the information was included by one of the identified informants. As well, there are numerous potential informants who were not engaged in the study due to time constraints and the inability of some to see me at a convenient and reasonably private location on the reserve.

ETHICAL CONSIDERATIONS

North American Indians are reluctant to have researchers, especially social science researchers, in their midst; too often the people's needs have been secondary to the researcher's wants. (Rynkiewich and Spradley, 1967:2) Many believe the relationship between social scientists and Indians was unethical with social scientists exploiting Indians for their own professional gain. (Cohen, 1976:84) Today Indians often ask, "What good is this study to us?" They have been studied innumerable times and rarely do they see the results or conclusions of the studies.

Not only can researchers not harm people but, I believe, they should leave a contribution to the study group. I asked a group of women to share with me some of the most intimate details of their lives. This information must be of some value to Eagle women at the very least and, optimally, to all North American Indian people. In an attempt to attain this goal, I am returning to the Eagle reserve with a

written account of my research findings to share with the informants and anyone else who may be interested.

Confidentiality

I have tried to keep the identity of my informants confidential. Spradley says researchers have a responsibility to safeguard the rights, interests, and sensitivities of informants. (1979:36) Protecting informants goes beyond changing names, places and other identifying features; "informants must have the protection of saying things 'off the record' which never find their way into the [researchr's] field notes." (ibid:36) In one or two instances, this protection will be given in the written study.

I have used pseudonyms for all names and places but there remains the possibility that some informants could be identified. I discussed this with each of the women on several occasions. Those who felt this too great a threat were excluded from the study.

Consent

All participants, including the two groups of students, in the study signed one of two consent form, I wrote and, of course, used the tape recorder, in the presence of the key informants. Because I usually met with general informants in groups, I left the recording until later. All notes and tapes will be destroyed upon completion of the written report. Throughout the research process, I repeatedly asked for permission to continue interviewing.

Leaving the Reserve

I have formalized my departure and thanked all informants, checking for outstanding concerns and clarifying the use of my data. I will return to review the themes I collected, documented, and abstracted from the women. If they affirm what is accurate and inaccurate, I will be somewhat assured of the reliability of the data. "...truth becomes sustained once identified and presented in a meaningful way to strangers, and it becomes the major criterion for internal and external validity for qualitative research." (Wenger, 1985:302)

LIMITATIONS OF METHODOLOGY

The limitations of qualitative methods generally apply to this study. The findings are imprecise and subjective. There is no measurement of variables so no causal and measurable relationships can be established. This lack of "hard" or objective measurements means no internal or external validity factors can be applied to the data.

There is an assumption that quantitative methodologies will allow the researcher to predict the subsequent occurrence of phenomena. (Carter, 1985:30) Extensions of this idea include allowances for prescribed actions to produce or control the desired outcomes. True prediction is probably not possible but quantitative methods do allow forecasting. That is, they allow the probabilistic

estimation of the likelihood that an event will occur. Forecasts cannot be made from the methods used in this study.

Probably the greatest limitation of this study is its lack of generalizability. (Tripp-Reimer, 1985:193) The data cannot be taken as representative of indigenous groups in general, or even of North American Indian groups. They describe the experiences of some Eagle women only. Hopefully, these very limitations will stimulate further research in an area that is essential to the understanding of mental health needs for other groups of non-Western women.

CHAPTER FOUR

THE DATA

EAGLE WOMEN TODAY

Prior to 1951 Eagle women, like all Native women in Canada, could not vote nor participate in band matters or land negotiations. Today, they are involved in political and economic spheres and, often, head households of up to four generations. Many work outside the home, some holding important administrative and management positions. Eagle women are social workers, teachers, bus drivers, curators, therapists, and recreation planners. Both old and young who are not employed outside the home make traditional crafts for sale at a variety of outlets on the reserve or in the city.

Eagle Women assume the primary roles in childcare and home maintenance. The increased availability of housing has given some younger families greater autonomy and privacy but many cannot sustain themselves economically for the early years after marriage. Hence, the extended family pattern of living is still quite common.

During my months of fieldwork several public figures and celebrities visited the Eagle reserve. This is a time of heightened activity for women when they work long into the night completing food and entertainment preparations. They are frequently given very little warning of the pending visit, yet believe it is necessary to provide a multicourse meal and prepare children and other band members to present traditional dancing and drumming.

All Eagle women I spoke with are very well informed politically. Many of our discussions were about band, provincial, federal, and even world politics. They are opinionated and analytical. Conversations are full of realism and, not infrequently, cynicism and humor. For, example, two of the old women informed me that people who are found not guilty of murder due to insanity are making a joke of the legal system. "Everyone knows when they have killed someone and nobody should get off with that defense."

Many Eagle women are alone; several are widows, others are separated, and others have never married or lived with a man. I was often told, "Our worlds are our families." Women spend a great deal of time together participating in household tasks like canning, cooking, and beading. In fact, it is unusual to see or meet with a woman alone. Daughters spend time with mothers, grandmothers, and aunts. These women are familiar and, obviously, comfortable with each other because there is little or no evidence of editing or hiding information in the presence of relatives.

Gossip and feuding abound on the reserve. Intimate details of people's lives are common knowledge. I was told on many occasions when I voiced concern about the visibility of my visits that it did not matter, everyone knew who I talked to and what we talked about anyway. Feuds persist over many years and extend to several generations within what is called "feuding families." Feuds are invariably around political and economic issues and are not readily resolved. One feud of long duration involves two families, each with

many members. Both are active in band politics and, I am told, the family who can get the most members out to vote holds the political power for that elected term. This situation has, apparently, been going on for several years. Another feud revolves around the rental of land to "whites." One band member receives a considerable sum of money from a man in the city. He is often accused of greed and "selling out" to non-reserve people.

Most women feel strongly that their employment is not for individual, or even family, gain. Nancy said, "I'm working for my people, not myself. This is my contribution; I feel I'm really doing something for them when I come to work." Many others expressed the desire to contribute something to the Eagle people as a whole through their work. When Sara had to terminate her employment she felt the was "letting down the whole reserve." Similarly, Dawna was not interested in applying her postgraduate education to a job off the reserve. "What would be the point?"

Old Women

An old Eagle woman is anyone beyond her sixtieth birthday. They act, advise, and lecture *carte blanche* and this is not restricted to their own families! Nancy's son, who rarely takes a drink, had imbibed one evening and she threatened to "jump on his head or drum all day in his room tomorrow." She sent someone to bring him home and scolded him soundly for his behavior. Rachel is frequently overheard lecturing her grandchildren for buying "junk" at the store,

referring to toys or candy. I observed Martha reprimanding her daughter-in-law for visiting with a friend too long and neglecting her responsibilities at home.

Old women promote all kinds of traditional behavior. I was told a very, very old woman chastised Nancy for speaking English to her. This same old woman was not beyond reading the tabloid papers from cover to cover, however, and freely admitted to an addiction to the soap operas. Rachel often expressed concern about the young women being too interested in "white" things. "They go to the store for nothing and almost every day too. They forget they're Indian, their traditional values." Nancy, as well, thinks the young women on the reserve are moving too fast, changing for the sake of change. "Old people don't change; they remember who they are."

Nancy was instrumental in the resolution of a conflict at her place of employment. She decided to tell the young employees "straight out what they're doing wrong." She told them that lying and backstabbing were not Indian practices and encouraged them to speak out to their boss and help him to understand their discontent. She reminded them they were part of a small reserve, they all had to work together or the divisions among the people would destroy them all.

To a group of women Nancy said, "You're all young, you're all women, you're going to get hurt very often. You need to come to the old people. Don't think we don't know anything. We have something to offer, to share. Come and ask us." She believes the young are often shy about approaching the old and understands this but is always

assuring them that the old women are only too glad to share their knowledge. In conversation with a young chief and his friend she said, "Don't run around in circles, catch your breath, don't hurt someone, slow down, sit awhile and talk with the old people. We've seen the old way, we've seen the change. You have not, you've only lived with the change." The two young men nodded and, later, heeded her advice.

Respect for the old is evident in public aspects of Eagle society. The elders lead in ceremonial dancing, say the prayers at celebrations, and address visitors. They have their own organization and meeting place where others attend only at their invitation. They participate in band affairs and the chief and council appear to make few decisions before obtaining input from them. All women I spoke with told me that elders' opinions are considered more than all others in the administration and execution of band matters.

Motherhood and Grandmotherhood

"The job for an Indian woman, beyond anything else, is to be a mother." (Nancy, 1987) Motherhood is revered even today by the Eagles. Sara related that by the time one had been married for a year the pressure to have the first child is mounting and, again, pressure is freely exerted by all old women, whether or not they are relatives of the young woman.

Children are welcomed by the community without undue regard for the mother's "circumstances." This means that even children born to very young, unmarried women are blessings. The grandparents will

just raise it as their own. Nancy believes her children are her support system and sees this as a major difference between Eagle women and men. "We are different, we have our children."

I did not meet a single woman who refuted this notion nor was I able to elicit a single instance of children being unwelcome, although several young women confided that their own mothers and grandmothers would not have been impressed with them having a child out of wedlock. Nevertheless, this is not an uncommon occurrence and the grandparents do indeed assume responsibility, the degree of which seems to depend primarily on the age and maturity of the mother.

Without exception, women discuss the achievements of their children and grandchildren endlessly. I learned of academic awards, goals scored, dancing competitions won, and new words spoken on each visit. Grandmothers take great delight in telling stories 'out of the mouths of babes' and usually find the misadventures of their grandchildren extremely humorous. This does not include circumstances like poor grades, poor school attendance, or any situation related to alcohol. Three motor vehicle accidents occurred while I was doing fieldwork. Two teenagers were killed and one young mother was crippled. All involved alcohol and there was an intense community mourning evident for days following each accident.

Eagle Women and Eagle Men

The ideal (and traditional) relationship between Eagle women and men is complementary. There are, historically, very clear role delineations and, for most Eagle women, this is the way things should be. With few exceptions, though, this is not the way things are. Eagle women feel overburdened and uncompensated for the extensions of role which are occurring for women in all societies. They articulate and manage the resulting dissonance between men and women in a number of ways.

Sonya is employed weekdays plus takes night classes. She felt she was falling behind in household chores and requested that her nineteen year old son wash up his own dishes on the evenings she attended classes. His response was, "I'm not a girl" and his mother was appalled. She expressed surprise and hurt that her son would think the task demeaning and meant only for females.

I attended a group meeting one evening and five of six women brought their children. When I asked about this I was told that men won't babysit. Women, though, believe babysitting provides tremendous relief for mothers. On several occasions, Sonya's children and their spouses went away for the weekend. She and her remaining daughters provided childcare for the absent parents and she explained that she felt this was the most helpful service she could offer. Similarly, Nancy is always aware when one of her children requires "a break" and she assists with babysitting, meals, or housework.

Several women told me that men are not perceived as important in childrearing. One stated that men are usually temporary in women's lives anyway, so the entire responsibility for children rests with women. This opinion, while fairly common, is certainly not the rule among Eagle people. I learned of several men who were involved in every aspect of childcare including babysitting, feedings, and changing diapers. Sara agrees that some men do this willingly but most, even if they help at home, will not be seen doing these things publicly. She thinks the definitions of maleness and male roles account for the private versus public behavior.

Nancy is proud of her sons as husbands and fathers and believes she has influenced them more than their father. One day, their father was observing an interaction between one of his sons and his wife. He commented, "That woman gets everything done for her." Nancy rushed to her daughter-in-law's defense and said, "She deserves it." She told me later she is pleased when she sees her boys behaving differently than their father and uncles. "We don't like the way most of our boys treat our girls; it is never the other way around."

It is not unheard of for men to assume complete responsibility for "women's work." Nancy tells a story of an old Eagle man whose wife had severe arthritis: "It didn't matter where you met him, at the grocery store or anywhere on the reserve, he was always in a hurry. He always left us by saying he had to get home and cook or clean for the old lady because she could not be left alone for long. He did everything for a long time."

A common punishment for men's indiscretions is to withhold "women's work." Sara was angry with her husband one evening prior to a trip. She did not iron or pack his clothes for him and he immediately knew she was displeased. "I let him do it all himself and he asked me what I was mad at." Other women reported they did not cook supper or wash their husband's clothes when they were angry. It is common to hear, "I just left and went to my mom's" when stories are being relayed about marital discord.

"Marrying In"

Again, there is more than one version of what happens to women when they "marry in" to the Eagle reserve. Women who are very involved with their daughters tend to take their daughters-in-law as their own. For example, Sonya was told by her mother when she left her reserve that she was on her own. Her mother-in-law did not put herself out to welcome Sonya and rarely assisted her once the babies arrived. She remembers this time now and vows never to treat her daughters-in-law as she was treated. She assists all of her children and their spouses in any way she can. It is rare for a weekend to pass without her entertaining one or several of her children and their families.

Similarly, Nancy is very close to her daughters and has made every effort to know and care for her daughters-in-law in the same way. Each interaction I observed with her sons' wives was warm and helpful. They, in turn, were concerned for, and respectful to, her.

When she relates women's concerns, she speaks of her daughters-in-law as frequently as she does of her daughters. There was not a single occasion, over many hours of interaction, that Nancy verbalized even a veiled criticism of her sons' wives, although one is quite distant and aloof from the family.

Marcia, who several years ago "married in" from a reserve many miles away, advises, "naturally, when you first arrive you are lonely and afraid. I just sat back and observed for a long time. I didn't want to push so I just waited until I felt comfortable. That worked for me." Marcia found it helpful to learn as much as she could about Eagle customs and attempt to contrast them with her own childhood experiences.

I was occasionally told that "marrying in" was difficult. Sara, who is an Eagle, says the knowledge of this difficulty is what has stopped several of her friends from leaving the Eagle reserve to live with their husbands. "They see what it's like for girls who come here and they're not going to go through that." On the other hand, she thinks "marrying in" may have its advantages: "At least if I had done that I would have somewhere else to go. I could go to my family miles away." After a statement like this, which Sara makes often, she shrugs, shakes her head, and says, "Oh well, it's too late for thinking like that now."

STRESS AND COPING TECHNIQUES

Eagle women in stressful situations suffer under a siege mentality. This is expressed in a number of ways. Sara feels this the most frequently of all the women I talked with. Her sense of being "trapped" is, at times, overwhelming and she can talk of little else. When she attempts to find her way out of her painful predicament, she comments, "I have nowhere to run. For me, there is no escape. I really am trapped on the Eagle reserve."

This perceived need for an escape is valid and real. Women know no other life; a move is even more terrifying then remaining trapped. Men, too, belong on the reserve and can no more leave than their partners. Yet, when things have reached crisis proportions, it is the women who must go from the reserve. This fact is clearly illustrated by a young mother of four who has been battered by her husband for years. One day, the eldest daughter was severely beaten along with her mother. The mother knew their lives were in danger and they had to protect themselves. She was not safe anywhere on the reserve and had to move to an emergency shelter in the city where she stayed for many months. Her husband remained on the reserve.

Eagle women know it is necessary for non-Indian women to hide from violent husbands. They also believe that women's shelters are excellent refuges but they are frustrated as well. Nancy, again acting as spokeswoman, put it the most aptly. She said, "It's not that they're not good; they are. It's just that Indian men should not ever beat their wives and Indian women should always stay on their own reserves,

even when things are very bad." The shock of leaving at such a critical time is horrendous and Nancy believes the recovery may be hindered somewhat because of the move away from those who are so important to the woman.

Alcohol Abuse

Each and every informant relays story after story of the ravages of alcohol abuse on the Eagle reserve. All agree that it affects every family on the reserve at some time. Some are devastated by it and never free themselves. Others have successfully conquered alcoholism, but the family scars remain.

Nancy lived with an alcoholic husband for more than twenty years. She tells a familiar story of poverty, abuse, neglect, and loneliness. Her grocery money was stolen and livestock were sold so her husband could purchase liquor. Finally, when her youngest child was fourteen, Nancy took her and left her home. She, too, had to live in the city for more than a year, waiting until it was "safe" enough to return. She reports she was filled with bitterness and hatred. She could not even take the sacrament at church because she felt her attitude was not that of a true Christian. Nancy's doctor put her on a highly addictive minor tranquillizer while she was separating from her husband. Her son and daughter-in-law took them away and flushed them down the toilet, telling her she didn't need to take them anymore. She was able to stop using them but says it was extremely difficult.

Sara estimates over half of her female peers exist in relationships with alcoholic, abusive men. The stories are all very similar and so are the coping mechanisms. There are frequent separations when women return to their natal homes, reconciling with their husbands after he has "sobered up." Or, women join their husbands in lengthy drinking episodes and leave children in the care of grandparents, an outcome that informants find extremely difficult to discuss. I did not meet any women with a history of alcohol abuse but was told they do exist and it is about this group that informants express their greatest fears. "If mothers drink, the children have no life." (Nancy, 1987)

Most divorces in Eagle society are a result of alcoholism. Sara thinks the divorce rate would be a lot higher if "wives were braver and could find some way of getting out." She initially moves to her mother's home when her husband and his friends party but she returns the next day and "kicks them all out and makes [my husband] clean up the mess." Sara often wonders why she returns but, at the time of my fieldwork, could see no option even though her family of origin encouraged her to leave her marriage and begin a new life. She does not want to return to her natal home because her family is so negative about her husband and she doesn't believe that she is able to financially support herself if she were to attend school or move to the city.

Depression

Eagle women identify depression in women as a grave concern. Sonya thought about this issue a great deal and felt an urgent need to find methods of helping young women, in particular, cope. Again, informants knew a great deal about depression and were able to clearly articulate the syndrome from both a personal and cultural perspective.

Without exception, each depressive episode I was told about was precipitated by a major loss in the woman's life. Nancy, for example, endured numerous stresses and hardships throughout the years of marriage and childrearing. She is, however, certain that she suffered what is called a depression only once and that was a few years ago following the death of her mother. She believed she had truly lost her mind. "I felt drunk. I'd look at people who came to visit after she died and I'd see them but it didn't matter that they came and I didn't know who came to see me. You can't describe the emptiness; I have never lost any children or grandchildren. I used to look for her in a crowd and every night I would wake up twice at the times I used to take her to the bathroom."

Nancy described her mother's "visits" for several months following her death. Finally, one night in a hotel room in the U.S., a close and respected family friend told Nancy her mother had come on the trip with them because she felt she had to protect her. He told Nancy "to let her go, let your mother go to rest, you're holding her back." Nancy complied with his wishes and her mother's "visits" were terminated. These symptoms lasted for more than six months and she

now advises others that it will take a very long time before they feel well again. She still becomes tearful when she tells me of this, even though her mother has been dead for several years now.

Sara believes she is experiencing depressive symptoms as she comes to terms with the fact that her marriage is probably not going to succeed. She is unable to eat, sleeps every chance she gets, and feels very detached from everyone. "I don't care about anything; I feel just flat; I don't respond the way I should. The other day [my baby] put the truck into gear and it started rolling away. I just sat there for a long time before I did anything. I slowly leaned over and put on the brake but I didn't feel as if I cared." Her voice is quiet and lacking in emotion as relates this information.

In some cases, the loss is not so tangible. Sonya thinks the reason depression is so prevalent among women is that after they marry, they feel a loss of freedom and support. They are sometimes alone in their homes for years and years, rarely going out and seeing only their children. This is especially true for women who have "married in" or who have lost their female relatives through death, moving, or constant inebriation. Nancy, too, sees this isolation as the prime precipitant of depression in women. She thinks "men do not want to talk to people, to open up, to talk about their experiences. Women are different, they need this, it is their major support."

Suicide

Suicide is rare among Eagle women. Nancy says it is because women are "taught in their upbringing, amongst our own people, that it is wrong." Even if it came to mind as a way out, she says, one could not do it because of her children. One woman did successfully suicide in the past few years and her two little girls "want their mother even now. Each time one of them goes out to play she says her mom was out there with her. She needs her mom to comfort her and that is why women cannot kill themselves."

Eagle women voice pride in their low suicide rate compared to many other reserves. Nancy is extremely concerned about the reported frequency of suicide on surrounding reserves and hopes suicide is never perceived as an acceptable coping mechanism by Eagle people.

Sara, too, discussed the suicide rate on a neighboring reserve. She is horrified by the apparent calmness with which news of another suicide is received by these people. "Everyone talks about it but nobody seems surprised or upset. If that was the [Eagle] reserve, everyone would be trying to find out why and how to stop it from happening again."

Prevention

Sonya thinks the way to prevent depression and suicide among women is to give them back the support systems they have lost. She firmly believes in mothers' groups and attempts to promote them on

the reserve. She encourages the "happy and healthy" young women to learn about the plight of their peers and become involved in programs to help them. Sonya sees female bonding as the only way to provide support and decrease isolation in a reserve setting. She becomes frustrated and upset when young women do not attend programs established for them and tries many different ways to engage them.

Nancy is a believer in women's support groups as well, but especially in cases of alcohol abuse and physically abusive relationships. She says, "If Al-Anon and those kinds of things were around when I was a young woman, I would have gone and it would have helped. I would have left much sooner."

Treatment

I asked what kinds of treatment are effective for women in times of crisis. The first people women should approach are the elders. Young women can tell them what is troubling them and seek advice. A white psychiatrist or therapist can be helpful too, but only those that know and like Indians.

Traditional healers continue to play an important role in treatment of the emotionally upset. Nancy went to a medicine man and asked him to help one of her daughters. She took him many gifts and felt comforted with the knowledge that he would be assisting in her daughter's treatment.

Another of Nancy's daughters was successfully treated in an urban detoxification centre. Both mother and daughter believe this

program was very beneficial to the daughter's recovery. Another young woman on the reserve has never remained in a treatment program "so she never gets better." (Nancy, 1987) There is considerable onus on the Native patient or client to assume some responsibility for her recovery. "Nobody can help if she doesn't want help." (Nancy, 1987)

MENSTRUATION, PREGNANCY, AND CHILDBIRTH

Female puberty ceremonies and rituals associated with pregnancy and childbirth have all but disappeared for Eagle women. Nancy was born in a tent with old Eagle women as attendants; babies today are born in large city hospitals with doctors, nurses, and sometimes, fathers present. Pregnant women attend prenatal classes and immunization clinics for their infants. They know how important maternal health is to the delivery of a healthy, thriving baby. Nevertheless, fetal alcohol syndrome is present in a large enough number of newborns to frighten the women I talked with.

Husbands have just begun to involve themselves in prenatal classes and childbirth. Nancy's and Sonya's sons have attended classes and been present at the births of their babies. Nancy says that, unlike white society, it has not been an expectation of Indian men to comfort and assist their wives during pregnancy and delivery. "We get less attention from our husbands. We're not pampered like you; we're more tolerant and accepting. The younger women expect more now and the men see white men doing things in the hospital; they learn."

Mothers and grandmothers worry about their "girls" when they have babies even though they are relieved there are hospitals and technological interventions to decrease the risk to the new mother and baby. "When a woman has a baby, she's putting her life on the line, she's in danger." (Nancy, 1986) Again, Nancy expresses pride in her own sons, "I'm so glad my boys know this and look after their wives and their babies."

It is rare for new mothers to come home from the hospital to an empty house. Each of the older women I talked with said they were there when their daughters and daughters-in-law came back to the reserve with their new infants. Nancy says, "Everyone needs care and support when they come home, especially when you have two or three others. When I had my (fourth baby), it was so hard. It's nice to have a new baby but there is so much work. My mom was always there for me. Now, I can't do much but I'm there too."

When I questioned about special treatment afforded the pregnant woman, Martha related a humorous incident about her first pregnancy. It was very late in the pregnancy and she attended a dance on the reserve with her husband. She was far too big and awkward to dance but "he was having a great time. I just sat there and stared to cry and the old women went and got him and made him take me home. That was the end of his fun!" Martha laughed frequently as she told her story and, at the end, the young women joined in the laughter. Her daughter-in-law clapped her hands with delight and there was verbal approval for Martha's "solution" to her problem.

Eagle women are extremely concerned about new mothers on their own. Sonya's attempts to establish support systems and groups for them attests to the awareness and concern on the part of older women. Each time I introduced this study, there was a general murmur of assent from mothers and grandmothers. They always responded with a statement like, "Yes, we need to know that to help our young mothers." But, childcare and transportation prove insurmountable problems and, invariably, those that attend the planned group meetings are the women who would be the helpers rather than the helpees. A great deal of discussion continues about how best to reach and maintain contact with isolated mothers.

Taboos

Some traditional taboos are still practiced among Eagle women. They eat no organ meats during pregnancy because of a belief that the infant's face may be blotched or marked in some way. Pregnant women must avoid stepping over ropes or electrical cords to prevent the umbilical cord from wrapping around the infant's neck. If one's husband is a hunter, he must not kill a female animal during his wife's pregnancy or he risks causing harm to his infant. New mothers should not visit the sick for several weeks postpartum or the ailing person will become sicker. I observed marked upset in Nancy when a sick old woman was visited by her postpartum granddaughter. She verbalized her anxiety to the old woman's family and the new mother was asked to leave.

The most powerful and strictly adhered to taboo centres around the traditional sacred bundles. Menstruating women cannot ever be in the presence of bundles and this applies to all women from all cultures. Old women enforce this taboo, especially in May and October of each year when the beaver bundles are opened. Nancy voices concern and disapproval about the presence of bundles in various museums throughout the country. She warns, "something is going to happen." She informs curators of her beliefs and says all bundles should be returned to the appropriate families to be cared for as they should. Nancy becomes angry when she sees sacred objects in museums and is tempted to take them; "they seem to call to me to pick them up and take them home." Even though she is postmenopausal she will not appear in the same room as sacred bundles unless she has smudged herself with sweetgrass and sage and has an offering to leave.

Birth Control

Birth control is not widely practiced among Eagle women, sometimes because of religious beliefs but most often because it is simply not right to interfere with nature. Sonya, for example, does not approve of even her married children planning their families. Nancy says, "In my time, if I was going to have another baby, I would accept it. No matter what the conditions, we are still sorry when there is a miscarriage. I'm always referring back to what my mom told me. She said, 'those seven children will always be your friends.' Even my

daughters-in-law are my friends. I knew [my seventh] was going to be my last and she was so special."

Nancy knows of traditional medicines used by some groups of Indian women to either prevent conception or terminate a pregnancy but she says these have never been available to Eagle women. Sara reports that several of her peers use contraceptive methods but none tell their mothers or grandmothers. "They would make a big deal of it and they would never understand. Having babies is so important here. I don't know why but it is. I don't care; I'm not having a bunch of kids until I see if [my husband] is going to settle down and show me he's ready to be a good parent."

Permanent contraception (usually tubal ligation) seems to be more acceptable to old women. At least three of Nancy's daughters and daughters-in-law have chosen this method of family planning, but only after they have had three or four children. It is important to mention that the older women are not completely rigid about family planning. They do understand the differences in economics between the past and present, as well as young women's desire for careers. Still, it would be exaggerating to say they approve.

Adoption and Foster Care

Adoption and foster care are uncommon on the Eagle reserve. Nancy points out that social services on the reserve are recent and prior to these services, women relied on sisters or other female relatives to care for their children if necessary. Today, babies are

rarely surrendered for adoption; relatives still take them as their own. She says the Eagles don't like Indian children to be taken and placed in white homes. "Some are good but if children have to be taken away from parents, they should keep them in their natural environment among their own people. I think they should be left here, or at least in a Native environment. They will look at whites who look after them and think, 'Who are my mom and dad? Who are my grandparents? These people are not like me'."

Nancy is bitter about her eldest brother and his wife who were both alcoholic. Their children were in foster homes for over six years. "She wouldn't leave them with us because we're family; she'd rather leave them with strangers. They're all back here now, they're all right."

In a present day case of adoption, the child was placed with relatives. Friends and family of the adoptive couple have supported them with copious gifts, childcare, and complete involvement of the child in their lives. He is pampered and given more attention than any baby I met on the reserve. The adoptive parents brag and tell story after story of his antics; this child is believed to be special and is treated as such.

Postpartum Blues/Depression

Layla says postpartum depression is not known among Eagle women. "It is a white illness and only white women suffer it." She thinks vulnerability may have something to do with living in cities and

being away from relatives. A postsecondary student who was raised on the reserve said she had never heard of postpartum depression until she went to college and began to socialize with Caucasian women. A Native academic has never seen postpartum depression in any Native group she has studied. A physician working on another reserve has never heard a Native woman complain of postpartum blues or postpartum depression.

One Eagle woman told me she cried the entire third postpartum day following the birth of her first child. Interestingly, she was working at a demanding job and residing in the city when this baby was born. This was the only firsthand account of sad or overwhelming feelings in the immediate postpartum period. Two other reported incidents could be related to a postpartum psychiatric illness. The first was told to me by another postsecondary student who remembered an infant she had cared for just prior to leaving her reserve for university. The child had frequent bruises and when the student asked the mother about the marks, she appeared disinterested and denied knowing where they came from. The student recalled being puzzled and concerned by the mother's response and later heard the baby had been removed from the mother's care.

The second reported incident concerns an Eagle woman who was described as being "odd" for several years prior to the birth of her first child. When I explored the meaning of the word "odd," I was told this woman used to laugh to herself and speak aloud in response to no

apparent stimuli. The behavior would appear and disappear at irregular intervals and appeared a few days following childbirth. As soon as the baby's maternal grandmother noticed her daughter's behavior, she took over the care of the baby and the mother "was never trusted to look after her baby by herself." (reported by several women, 1986)

Nancy was never told about postpartum blues or depression by her mother but by the time her girls were having babies, she knew to watch them for symptoms. She cannot remember who told her about the possible emotional disorders following childbirth but she recalls being vigilant with one daughter and one daughter-in-law, for very different reasons. She justifies her vigilance with the following explanation: "[My daughter] was in a very troubled marriage and I knew she would get no support from her husband whenever she came home with a new baby so I was with her and watched her all the time. [My daughter-in-law] has a good marriage but she was not raised on a reserve and her mother is far away. I was so worried about her when she came home with her first baby and I'm very glad I was there. She cried a lot and was too scared to even hold the baby. You know, I have seen postpartum blues, haven't I? [My daughter-in-law] had them with her first, didn't she?"

I asked Nancy for more details about her daughter-in-law and she replied, "I helped her a lot. I told her to go to a movie or go to a hockey game. She would go but she worried about her baby all time

she was gone. She has four children now and it never happened again so I think I was helpful to her. My concern is my grandchildren."

I repeatedly commented on the difficult circumstances under which many older women had their babies. I knew their husbands were often absent or inebriated and the living conditions were less than adequate. Martha said her babies actually "buffered" her from depression; "I loved to cuddle them and each one gave me more and more comfort. Without them, I would have been depressed." Layla, too, reports this comfort and "buffering" effect of childbirth. She feels more fulfilled and self-confident with each baby. In fact, she says, she is less prone to depression in the months postpartum than at other times of her life.

Nancy, as she often does, offers the final comment on postpartum depression. "I lived in the same yard as my mom. Why would I ever be depressed when I came home with a new baby? I didn't care if [my husband] was there; my mom was. And, you know, the only time I really got depressed was when I lost her, not him."

CHAPTER FIVE

ANALYSIS OF DATA

INTRODUCTION

Qualitative findings are far more difficult to analyze than quantitative types of research data. (Leininger, 1985:67) There is no electronic or mechanical means to handle qualitative data. It is necessary to preserve volumes concerning meanings, attributes, values, world view, and structural and other components that characterize human styles and, in the final analysis, interpret, summarize, and report these findings to others. The researcher is also responsible for identifying and explicating the explanatory and predictive powers of qualitative research methods. This requires considerable creativity and attentiveness to the original purposes of the study. (ibid:67)

The primary question this study poses is whether sociocultural buffers supersede physiological factors to render a specific group of women "immune" to postpartum depression. Secondarily, it seeks to identify the buffers, predict what may happen to this group should these buffers be absent, and anticipate when this absence is most likely to occur. Finally, the study requires an application component; what use can the study group make of the data presented and what future research avenues should be taken?

WOMEN'S ROLES AND WOMEN'S POWER

The persistence of traditional values in contemporary times provides a source of power for Eagle women in their own society, despite the relative powerlessness of Indian people in North American society today. (Kidwell, 1979:114) They are not, and probably never have been , passive drudges or beasts of burden. The necessity of their roles, and the respect accorded them, continues today.

The status of Eagle women within their community is based on different cultural values than those of typical middle class Western women. The communally oriented culture and the enduring extended family structure give a different definition to the roles of women than do the nuclear family orientation and the technological aspects of the dominant culture. (ibid:114) What has frequently been overlooked in discussion of all Indian women's roles is the power that is inherent in traditional female roles due to the importance of bearing children and maintaining homes. The persistence of these roles through the processes of acculturation gives significant meaning to contemporary Eagle women.

In Eagle society, the child is highly valued and occupies a central place within the family. The historical role of biological necessity has determined Eagle women's function in a very real sense. "The luxury of choosing to have children or not to have children cannot exist in a group where the survival of the group's identity depends upon the production of children." (ibid:115) The comparatively high birth rate

among the Eagles attests to the persistence of this belief among the people.

The role of extended family in the raising of children relieves the mother of the burden of being sole female role-model and disciplinarian. Presence of relatives who assume responsibility for training children gives women more freedom to pursue other interests. (ibid:119) Grandparents, especially, serve as teachers and role-models for their grandchildren.

Once an Eagle woman has married and had children, and particularly grandchildren, she has validated her position in the eyes of Eagle society. She is respected because of that position, and this respect gives her a further role in her culture. She is a truly productive and active member in it. This flexibility of roles stands her in good stead in managing the processes of acculturation, processes which have drastically affected male roles. Males do not have this same continuity or flexibility of roles. Drastic changes have been forced on Indian people over a long period of time through the historical patterns of intervention by government and religious organizations in the affairs of Indian communities. (ibid:114) These changes have, in most cases, undermined the male role. For instance, his contributions from hunting expeditions are rarely possible or required. The female roles of mother and keeper of the home have persisted and provided a strain of continuity in Indian cultures throughout times of pressures towards acculturation.

The values and attitudes that have been part of women's roles in the past persist in contemporary Eagle society. The positive actions of children still reflect on her credit as wife and mother. If she has to, or wishes to, pursue employment in the dominant society, she still plays an important role in her own society. "She is still a bearer of culture and identity of her people, and in this role there is still power." (ibid:120)

THE LIFE CYCLE OF AN EAGLE WOMAN

The prestige in motherhood for Eagle women is magnified in grandmotherhood. Aging is a positive experience for these women; many of their rewards are delayed and they know this. This knowledge helps them to cope with the stress of today; it will be lessened in old age. Their society's support of, and respect for, motherhood/grandmotherhood promotes self-esteem and assures most of their worth. Their duties persist throughout their lives but prestige increases as women age.

Women anticipate the prestige they gain through aging. As grandmothers, they receive the same recognition as they did as mothers except they are accorded even more respect. They experience the same joy from their grandchildren's achievements as they did from their children's and they are still looked to for assistance from grandchildren to attain their goals. Old women feel truly useful and worthwhile. They are at liberty to advise and encourage, younger people come to them for help, and they are

depended upon for political and economic support. One of the most therapeutic cultural factors in Nancy's recovery from the loss of her mother several years ago was her vision of assuming her mother's role. She had to fill it; her people expected this and depended on her to do so.

Because older women are aware of the increased prestige that comes with age, they are motivated to see younger women through the "bad times." These difficult times can span a considerable number of years. They may last from a few months after the birth of the first child, when the celebrations are over, to the maturity of the youngest child. Old women are willing to create and continue the powerful female network that successfully buffers young women from isolation, dissonant relationships with men, and the negative consequences of unemployment and alcohol abuse. Thus, young women are protected from the situations which Eagle women believe trigger depressive reactions in their group.

FEMALE NETWORKS

The generational and peer bonding among Eagle women build a social network which provides support and diminishes hardships. A familiar coping strategy for women is to return to their family of orientation and seek comfort from mothers, grandmothers, sisters, and aunts. Most acknowledge that there are negative aspects to extended family involvement (expectations, intrusions, etc.) but the positive consequences obviously outweigh these, as indicated by the

recent emergence of a natalocal residence pattern among younger women.

The extensive literature describing the extent and importance of female bonding among oppressed women (Charlton,1984; Cruikshank, 1976; Sims-Wood,1980; Stack,1974; Staples,1973) emphasizes how essential it is to the mental health of this population. Occasionally, the linkage is not possible among Eagle women. Unlike Black women in American ghettos, Eagle women cannot physically remove themselves from troubled relationships to form the powerful matrifocal communities so common there. Unemployed, abusive Eagle men do not leave their homes and, as one woman said, "Sometimes we have to wait until the men die." In cases like this, women may spend many years isolated from the support of the female community.

POSTPARTUM DEPPRESSION

Postpartum depression is not known to afflict Eagle women. A return to the scientific literature on the buffering hypothesis may help to clarify the absence of the syndrome in this group. Stern and Kruckman suggest there may be basic components which provide the necessary social support and which cushion or prevent postpartum depression, regardless of whether its etiology is biological, psychological, or social. (1983:1039) These include the structuring of a distinct postpartum time period; protective measures reflecting the presumed vulnerability of the new mother; mandated rest; assistance

in tasks from relatives; and social recognition (through rituals and gifts) of the new social status of the mother.

Eagle culture provides for most, if not all, of these components. For approximately the first six weeks postpartum, the new mother is considered more tired and fragile. She is given advice and assistance with home and child care, discouraged from contact with the sick, and encouraged to rest frequently during the day. One can even speculate that the pattern of gossip on the Eagle reserve is positive for postpartum women. Everyone knows of the birth and new mothers are the centre of attention at public events and her infant is lavished with gifts. The baby may be given a traditional Eagle name, an event which calls for special ceremony and more gifts. If she is fortunate, assistance from relatives continues for months or years following childbirth.

Brown and Harris (1978) identify a particular aspect of social support, specifically a confiding relationship with the husband, as an important variable linking social support and postpartum depression. The specific aspect of social support for Eagle women appears to be a confiding relationship with female relatives, especially mothers. In both cases of postpartum blues reported here, the new mothers did not have the required physical proximity to their own mothers to obtain instrumental and emotional support. While it cannot be even hinted these women were depressed in the postpartum, it is important to note they are the only ones who reported any symptoms of anxiety or sadness. Nancy's response to her mother's death

powerfully demonstrates what can happen when a woman's most significant support is absent.

Certain Eagle husbands cannot be ignored when evaluating social support. There are three or four young couples on the reserve who others identify as "ideal couples with ideal marriages." The husbands in these marriages are described as considerate and helpful; they babysit, do housework, do not drink, and are permanently employed. The wives, not surprisingly, do not verbalize the common feeling of entrapment or needing to escape and all view pregnancy and motherhood as joyous events in their lives. Additionally, each of these women has an intimate bond with her mother or mother-in-law.

DEPRESSION

Depression is known to Eagle women at other stages in their lives. The scientific literature reports an unusually high incidence of depression among Indian women during childbearing and childrearing years. Eagle women concur this is true for them as well. The most frequently cited (by Eagle women) cause of depression is isolation, not just as a result of a poor marriage or dependent children or transportation problems, but because of the institutional entrapment of the reserve. It is a closed system within an open society. If women do not have the required and traditional social support on the reserve, they are truly isolated.

Manson et al (1985) classify depressive symptoms into eight different categories of problems: 1) appetite change, 2) abnormal

sleeping patterns, 3) fatigue, 4) psychomotor retardation or agitation, 5) marked disinterest in sex, 6) a low sense of self-worth, 7) disoriented thought processes, and 8) suicidal ideation. Eagle women include each of these symptoms in their identification of depressive illness, pointing out they would only know about a marked disinterest in sex and suicidal ideation if the depressed person trusted her confidante implicitly. The confidante would never ask about these two issues. Some symptoms, such as low sense of self-worth and fatigue, might be assumed by observing drinking behavior or undernourished, poorly clad children.

Sara's reported symptoms of disrupted sleep, poor appetite, decreased energy, and apathy correspond to Western criteria for depressive illness. Nancy's symptoms of loss of awareness of her environment, spiritual visits from her mother, and tearfulness many years following her mother's death correspond more with a Western diagnosis of unresolved grief.

Eagle women often identify a depressive episode following the death of a loved one. Normal grief after such a loss occurs within the life cycle of most Eagle women and there are mourning mechanisms in place within Eagle society. Wakes, ceremonies on the anniversary of the death, and religious beliefs all assist in the resolution of normal grief. However, it appears that if the person lost is the woman's major social support, the risk of what Eagle women term depression is increased.

Eagle women view themselves as non-functional if they are depressed; they are unable to fulfill their roles as mothers. Emotionally healthy mothers raise healthy children. If mothers are rendered incapable, through depression, of raising healthy children, Eagle families are disrupted and mothers have failed to sustain Eagle culture for their children. The greatest fear of Eagle women is that the high rate of depression may eventually destroy Eagle culture completely. If children see their parents unable to cope, they will assume that traditional mechanisms are ineffective, eventually abandon them, and seek their solutions from the dominant society.

A synthesis of the stages of an Eagle woman's life may make clear this analysis of the depressive experience. The immediate postpartum weeks are filled with excitement, celebration, and attentiveness for the new mother, not just within her family, but within the entire community. Female relatives assist with home and child care, the new mother is rarely alone, and all community members acknowledge the mother and infant when they appear publicly. Over the next several years, however, many babies may be born to a woman; female relatives return to careers, become ill, or die; and the ravages of alcoholism and/or poverty exact their toll. Some women are imprisoned in their homes without adult female support or contact for many years.

Eagle women believe undiagnosed and untreated cases of depression are fairly common on their reserve. Jilek-Aall et al (1978:482) hypothesize these depressive behaviors represent an anomic depression secondary to acculturation pressures. The

traditional social patterns have broken down and these women are alone without knowledge of the resources available to them. Caring and involved Eagle women articulate this problem clearly but are uncertain about how to proceed with assistance.

THE SOCIOCULTURAL BUFFERS

The specific factors which buffer women from postpartum depression can now be identified. The cultural ideology surrounding motherhood and children is clear. The biological capacity of women to bear children is recognized as the major determinant for the continuation of the Eagle people. Children are a constant reminder of the life cycle of a people and are carefully nurtured to maturity. A new mother with a new infant synthesizes this ideology in a concrete way so the elevated status and recognition afforded the new mother almost certainly buffers her from depressive symptoms.

The belief that the new mother is tired and in need of protection from routine duties results in the formation of a work force of female relatives to assure she gets her rest and has help with her day-to-day chores. This network of female family members provides a cocoon for the new mother within which she is able to regain her strength and assume her duties gradually.

These features of Eagle society protect a new mother from isolation and loss of self-worth. She feels important and knows she has achieved the major goal for an Eagle woman. She has become a mother.

A CRITIQUE OF THE BUFFERING HYPOTHESIS

Research on the buffering role of social support has received a great deal of attention because of its implications for preventive intervention. (Thoits, 1982:155) It seems more realistic to try to improve and strengthen supports than to reduce the exposure to stressors. This appears particularly true for Native women where the probability of reducing stresses is very low indeed, at least in the short term.

There is evidence that social support can buffer the impact of life changes but there are several problems with the empirical literature that require resolution. First, conceptualizations and operationalizations of support are inadequate. As a result, the specific aspects of therapeutic support cannot be identified. Second, the direct and interactional effects of life change and social support may be inadvertently confounded; life events may alter the support available to individuals, and support may decrease the likelihood of events occurring. This confounding may bias study results in favor of the buffering hypothesis. Finally, the theoretical relationships between life events, social support, and psychological disturbances have not been clearly delineated.

The effectiveness of social support in the presence of life events may be different for the postpartum period than for other times in a woman's life. One interpretation of the lack of congruence between the possible effects of stressful life events on postpartum depression is

that individuals in a woman's social network may be especially attuned to postpartum difficulties. (O'Hara, 1986:572) The salience of stress in childbirth and the postpartum may be greater than the salience of other stressful life events, resulting in increased levels of support for postpartum women. A career task for Eagle women responsible for health and social services, then, is the ability to identify stressful life events for women at times other than the postpartum and elicit increased levels of support from available social network members.

SUMMARY

These data clearly demonstrate the conditional nature of postpartum depression. Eagle women are buffered from depression at a point in time when Western research says they are the most vulnerable. Their hormones are undergoing the same turmoil as other postpartum women; some are old, some are young; some are having their first baby, some have other children at home; some are married, some are not; some live in crowded living quarters, some have their own homes; and some have supportive marital relationships, many have not. Yet, they do not experience the depression following childbirth that is evident in 10-13% of Western, and at least one tribe of Ugandan, women.

Traditional Eagle beliefs and practices protect women in the postpartum period. There is little guilt experienced as a result of childbirth outside of marriage. Children belong to Eagle society more than they do to an individual Eagle family. New mothers are

recognized, nurtured, and assisted, rallying a strong social support system of female kin. Depression is not evoked in the postpartum by the very events that evoke depression at other times in Eagle women's lives (husband's alcohol abuse, poverty, dissonant marital relationships, etc.).

The results of this study diametrically oppose Dr. Cox's (1983:27) argument. Sociocultural factors are more important than physiological variables in the etiology of postpartum depression in Eagle women.

APPLICATION OF THE DATA

The Eagle data support what female Native post-secondary students told me when I commenced this study. Postpartum depression is not widely known in Native societies but depression at other times in Native women's lives is. The important question now would appear to be: can Native women expand the buffers that protect mothers in the postpartum to women at other times of their lives?

When Eagle women are not part of a powerful and protective social network, they are not buffered from depression. Indian women sometimes turn to professional counselors to counter stress or deal with depression. (Medicine, 1982:7) They frequently feel the therapist's lack of awareness of cultural differences has limited the usefulness of therapy. Eagle women, too, rely on resources off the reserve, most often women's emergency shelters and psychiatric clinics in city hospitals. While these programs are helpful to some

extent, they wish to identify specific needs of Eagle women and design programs specific to their needs.

Medicine suggests that peer counseling (narrating similar experiences) may be a valuable therapeutic tool for Indian women. (1982:7) McDonald (1975), a psychologist, also reports the positive results of group psychotherapy with Indian women, even though he is male and Caucasian. The retention of Indian cultural traits, even in urban settings, helps women to move securely in both worlds. "The ability to maintain a dual role rests on the self-image of the Indian woman, a self-image enhanced by strong connections to her own heritage." (Medicine, 1982:7) Fictive kinship bonds and women's networks are being established to provide support; these may prove especially beneficial in cases of isolated Eagle women.

The *Indian Mental Health Research Formulation* (1985) is a survey undertaken by the First Nations Confederacy to reflect the mental health concerns and perceived needs of Indians of Manitoba. It, like any similar undertaking in Alberta is sure to do, revealed the marked inadequacy of the provincial and federal health systems in providing mental health services to Indians. It must be a flexible system, allowing for the different needs of different areas. Tribal councils and Indian mental health workers were included from the inception of the survey.

Depression was rated as the major category of concern, not entirely the clinical syndrome of individual depression as would be recognized psychiatrically, but a more widespread reaction to a

number of factors that lead to what the survey termed a "community depression." (p.62) It recommends urgent intervention and training of indigenous health workers to begin to confront the problems. This recommendation probably applies to reserves throughout the country, certainly it does to the Eagle reserve.

Eagle women must develop coping mechanisms within the reserve and the need is urgent. The parameters of depression must be dealt with. If role complementarity is the ideal, the responsibility falls to mothers and grandmothers to make the ideal a reality. Males must be taught from early childhood how to establish complementary relationships with females and how to be positive role models for their children. Like Nancy, all Eagle mothers must want their sons to be better husbands and fathers than the previous generation of males.

The consequences for children of neglecting or drinking mothers must be confronted, no matter how difficult. If it is true that neglectful and drunk parents produce neglectful and drunk children, the cycle must be broken.

FUTURE RESEARCH NEEDS

The erosion of the extended family system through increased mobility, alcoholism, or death may be the major factor in decreased social support and increased rates of all depressions. Telles (1982), in a study of low-income Hispanic women in the U.S., found the longer the duration in the U.S. and the greater the level of acculturation, the

more psychological postpartum complications were in evidence. Eagle women may not remain "immune" to post partum depression forever.

It is essential to know if only Eagle women are protected from postpartum depression or does this protection extend to other Native women living on reserves. Large numbers of Native families are living off reserves, resulting in the loss of social support systems. Do urban Native women experience postpartum depression? Do women belonging to other indigenous groups?

Very little is known about depressive syndromes on non-Western women. Obviously, a great deal more research is required.

BIBLIOGRAPHY

Albers, P. and Medicine, B. (1983). *The Hidden Half.* U.S.A.: University Press of America.

Al-Issa, I. (1980). *The Psychopathology of Women.* U.S.A.: Prentice-Hall, Inc..

Anthony, J.E. (1983). "An overview of the effects of maternal depression on the infant and child." In H. Morrison (Ed.), *Children of Depressed Parents.* U.S.A.: Grune & Stratton, Inc.

Ballinger, B., Buckley, D.E., Naylor, G.J., and Stansfield, D.A. (1979). "Emotional disturbances following childbirth: Clinical findings and urinary excretion of cyclic AMP." *Psychological Medicine, 9,* 293-300.

Bensel, R.W. and Paxson, C.L. (1977). "Child abuse following postpartum separation." *Journal of Pediatrics, 90 (3),* 490-491.

Blackman, M. (1982). *During My Time.* U.S.A.: University of Washington Press.

Bourguignon, E. (1979). *Psychological Anthropology.* U.S.A.: Holt, Rinehart, and Winston.

Braverman, J. and Roux, J.F. (1978). "Screening for the patient at risk for postpartum depression." *Obstetrics and Gynecology, Vol. 52, No.6,* 731-736.

Breen, D. (1975). *The Birth of a First Child.* London: Tavistock Publications.

Brim, J.A. and Spain, D.H. (1974). *Research Design in Anthropology.* U.S.A.: Holt, Rinehart, and Winston.

Brown, G.W. and Harris, T. (1978). *Social Origins of Depression.* U.S.A.: The Free Press.

Brown, W.A. (1979). *Psychological Care During Pregnancy and the Postpartum Period.* U.S.A.: Raven Press.

Carter, M.A. (1985). "The philosophical dimensions of qualitative nursing science research." In M. Leininger (Ed.), *Qualitative Research Methods in Nursing.* U.S.A.: Grune & Stratton, Inc.

Charlton, S.E. (1984). *Women in Third World Development.* U.S.A.: Westview Press.

Clark, A. (1978). *Culture, Childbearing, and Health Professionals.* U.S.A.: F.A. Davis.

Cohen, F. (1976). "The American Indian movement and the anthropologist: issues and implications of consent." In M. Rynkiewich and J. Spradley (Eds.), *Ethics and Anthropology.* U.S.A.: John Wiley & Sons, Inc..

Cox, J.L. (1978). 'Some socio-cultural determinants of psychiatric morbidity associated with childbearing." In M. Sandler (Ed.), *Mental Illness in Pregnancy and the Puerperium.* London: Oxford University Press.

Cox, J.L. (1979). "Amakiro: A Ugandan puerperal psychosis." *Social Psychiatry, 14,* 49-52.

Cox, J.L. (1979). "Psychiatric morbidity and pregnancy: a controlled study of 263 semi-rural Ugandan women." *British Journal of Psychiatry, 134,* 401-405.

Cox, J.L., Connor, Y., and Kendell, R.E. (1982). "Prospective study of the psychiatric disorders of childbirth." *British Journal of Psychiatry, 140,* 111-117.

Cox, J.L. (1983). "Postnatal depression : a comparison of African and Scottish women." *British Journal of Psychiatry, 18,* 25-28.

Crnic, K., Greenberg, M., Robinson, N., and Ragozin, A. (1984). "Maternal stress and social support: effects on the mother-infant relationship from birth to eighteen months." *American Journal of Orthopsychiatry, 54 (2),* 224-235.

Cruikshank, J. (1976). "Matrifocal families in the Canadian north." In K. Ishwaran (Ed.), *The Canadian Family.* Canada: Holt, Rinehart and Winston of Canada, Limited.

Cutrona, C. (1983). "Causal attributions and perinatal depression." *Journal of Abnormal Psychology, 92 (2),* 161-172.

Dalton, K. (1971). "Prospective study into puerperal depression." *British Journal of Psychiatry, 118,* 689-692.

Dalton, K. (1980). *Depression and Childbirth.* Oxford: Oxford University Press.

Davidson, J.R. (1972). "Postpartum mood change in Jamaican women: a description and discussion on its significance." *British Journal of Psychiatry, 121 (565),* 659-663.

Doran, C. (1972). "Attitudes of 30 American Indian women toward birth control." *Health Service Reports, 87 (7),* 658-664.

Draguns, J.G. (1977). "Advances in cross-cultural psychiatric assessment." *Transcultural Psychiatric Research Review, 14,* 125-143.

Draguns, J.G. (1982). "Methodology in cross-cultural psychopathology." In I. Al-Issa (Ed.), *Culture and Psychopathology.* U.S.A.: University Park Press.

Draguns, J.G. (1984). "Assessing mental health and disorder across cultures." In P. Pedersen, N. Sartorius, and A. Marsella (Eds.), *Mental Health Services: The Cross-Cultural Context.* U.S.A.: Sage Publications, Inc.

Erikson, E. (1968). *Identity, Youth, and Crisis.* New York: Norton.

Evaneshko, E. (1985). "Entree strategies for nursing field research studies." In M. Leininger (Ed.), *Qualtitative Research Methods in Nursing.* U.S.A.: Grune & Stratton, Inc..

Field, T., Sandberg, D., Garcia, R., Vega-Lahr, N., Goldstein, S., and Guy, L. (1985). "Pregnancy problems, postpartum depression, and early mother-infant interactions." *Developmental Psychology, Vol.21, No.6,* 1152-1156.

Fischler, R.S. (1985). "Child abuse and neglect in American Indian communities." *Child Abuse and Neglect, Vol.9,* 95-106.

Frank, E., Kupfer, D., Jacob, M., Blumenthal, S., and Jarrett, D. (1987). "Pregnancy-related affective episodes among women with recurrent depression." *American Journal of Psychiatry, 144 (3),* 288-293.

Garvey, M. and Tollefson, G. (1984). "Postpartum Depression." *Journal of Reproductive Medicine, 29,* 113-116.

Ghodsian, M., Zajicek, E., and Wolkind, S. "A longitudinal study of maternal depression and child behavior problems." (1984). *Journal of Child Psychology and Psychiatry, 25*, 91-109.

Goldenberg, S. (1987). *Thinking Sociologically.* U.S.A.: Wadsworth, Inc..

Grossman, F., Eichler, L., and Winickoff, S. (1980). *Pregnancy, Birth, and Parenthood.* U.S.A.: Jossey-Bass.

Hamilton, J. (1962). *Postpartum Psychiatric Problems.* U.S.A.: The C.V. Mosby Company.

Handley, S., Dunn, T., Baker, J., Cockshott, C., and Gould, S. (1977). "Mood changes in the puerperium, and plasma trytophan and cortisol concentrations." *British Medical Journal, 2*, 18-22.

Hayworth, J., Little, C., Carter, S., Raptopoulos, P., Priest, R., and Sandler, N. (1980). "A predictive study of postpartum depression: some predisposing characteristics." *British Journal of Medical Psychology, 53*, 161-167.

Hendrie, H. and Hanson, D. (1972). "A comparative study of the psychiatric care of Indians and Metis." *American Journal of Orthopsychiatry, 42 (3)*, 480-489.

Herzog, A. and Detre, T. (1976). "Psychotic reactions associated with childbirth." *Diseases of the Nervous System, 37*, 229-235.

Honigman, J. (1965). "Social disintegration in five northern Canadian communities." *Canadian Review of Sociology, Vol. 2*, 199-214.

Hopkins, J., Marcus, M., and Campbell, S. (1984). "Postpartum depression: a critical review." *Psychological Bulletin, Vol. 95, No. 3*, 498-515.

Indian Mental Health Research Formulation. (1985). Manitoba: First Nations Confederacy.

Jilek-aall, L., Jilek, W., and Flynn, F. (1978). "Sex role, culture, and psychopathology: a comparative study of three ethnic groups in western Canada." *Journal of Psychological Anthropology, Vol.1 (4)*, 473-488.

Jordan, B. (1983). *Birth in Four Cultures.* Canada: Eden Press.

Karacan, I., Williams, R., Hursh, C., McCauley, M. and Heine, M. (1969). "Some implications of the sleep patterns of pregnancy for postpartum emotional disturbances." *British Journal of Psychiatry, 115*, 929-935.

Kelly, J. (1967). "The influence of native customs on obstetrics in Nigeria." *Obstetrics and Gynecology, 30*, 608-612.

Kendell, R, Wainwright, S., Hailey, A., and Shannon, B. (1976). The influence of childbirth on psychiatric mortality." *Psychological Medicine, 6 (2)*, 297-302.

Kendell, R., McGuire, R., Connor, Y., and Cox, J. (1981). "Mood changes in the first three weeks after childbirth." *Journal of Affective Disorders, 3*, 317-326.

Kendell, R., Rennie, D., Clarke, J., and Dean, C. (1981). "The social and obstetric correlates of psychiatric admission in the puerperium." *Psychological Medicine, 11*, 341-350.

Kendell, R., Mackenzie, W., West, C., McGuire, R., and Cox, J. (1984). "Day-to-day mood changes after childbirth: further data." *British Journal of Psychiatry, 145*, 620-625.

Kidwell, C.S. (1979). "The power of women in three American Indian societies." *Journal of Ethnic Studies, 6 (3)*, 113-121.

Kleinman, A. (1977). "Depression, somatization, and the 'new cross-cultural psychiatry'." *Social Science and Medicine, 11*, 3-9.

Kraus. M, and Redman, E. (1986). "Postpartum depression: an interactional view." *Journal of Marriage and Family Therapy, 12(1)*, 63-74.

Kruckman, l. and Asmann-Finch, C. (1986). *Postpartum Depression: A Research Guide and International Bibliography.* U.S.A.: Garland Publishing, Inc..

Kumar, R. and Robson, K. (1978). "Neurotic disturbances during pregnancy and the puerperium: preliminary report of a prospective survey of 119 primiparae." In M. Sandler (Ed.), *Mental Illness in Pregnancy and the Puerperium.* London: Oxford University Press.

Kumar, R. (1982). "Neurotic disorders in childbearing women" In I. Brockington and R. Kumar (Eds.), *Motherhood and Mental Illness.* Great Britain: Academic Press.

Leininger, M. (1984). "Transcultural interviewing and health assessment." In P. Pedersen, N. Sartorius, and A. Marsella (Eds.), *Mental Health Services: The Cross-cultural Context.* U.S.A.: Sage Publications, Inc..

Leininger, M. (1985). "Nature, rationale, and importance of qualitative research methods in nursing." In M. Leininger (Ed.), *Qualitative Research Methods in Nursing.* U.S.A.: Grune & Stratton, Inc..

Levy, J. and Kunitz, S. (1971). "Indian reservations, anomie, and social pathologies." *Southwestern Journal of Anthropology, 27 (2),* 97-128.

Manson, S., Shore, J., and Bloom, J. (1985). "The depressive experience in American Indian communities: a challenge for psychiatric theory and diagnosis." In A. Kleinman and B. Good (Eds.), *Culture and Depression.* Berkley: University of California Press.

Marsella, A.J. (1978). "Thoughts on cross-cultural studies on the epidemiology of depression." *Culture, Medicine, and Psychiatry, 2,* 343-357.

Marsella, A.J. (1979) "Cross-cultural studies of mental disorders." In A.J. Marsella, R.G. Tharp, and T.J. Ciborowski (Eds.), *Perspectives on Cross-Cultural Psychology.* New York: Academic.

McDonald, T. (1975). "Group psychotherapy with Native American women." *International Journal of Group Psychotherapy, 25 (4),* 410-420.

Meares, R., Grimwade, J., and Wood, C. (1976). "A possible relationship between anxiety in pregnancy and puerperal depression." *Journal of Psychosomatic Research, 20,* 605-610.

Medicine, B. (1982). "Native American women look at mental health. *Plains Woman, Vol. 6, No. 4,* 7.

Nilsson, A., and Almgren, P. (1970). "Paranatal emotional adjustment: a prospective study of 165 women." *Acta Psychiatrica Scandinavia Supplement, 220,* 65-141.

Nott, P., Franklin, M., Armitage, C., and Gelder, M. (1976). "Hormonal changes and mood in the puerperium." *British Journal of Psychiatry, 128,* 379-383.

Nott, P. and Cutts, S. (1982). "Validation of the 30-item general health questionnaire in postpartum women." *Psychological Medicine, 12*, 409-413.

Oakley, A. (1980). *Women Confined--Towards a Sociology of Childbirth.* U.S.A.: Schocken Books.

O'Hara, M., Rehm, L., and Campbell, S. (1982). "Predicting depressive symptomatology: cognitive-behavioral models and postpartum depression." *Journal of Abnormal Psychology, Vol. 91, No. 6*, 457-461.

O'Hara, M., Rehm, L., and Campbell, S. (1983). "Postpartum depression: a role for social network and life stress variables." *Journal of Nervous and Mental Disorders, Vol. 171 (4)*, 336-341.

O'Hara, M., Neunaber, D., and Zekoski, E. (1984). "Prospective study of postpartum depression: prevalence, course, and predictive factors." *Journal of Abnormal Psychology, Vol. 93 (2)*, 158-171.

O'Hara, M. (1986), "Social support, life events, and depression during pregnancy and the puerperium." *Archives of General Psychiatry, Vol. 43*, 569-573.

Paffenbarger, R,S. (1982). "Epidemiological aspects of mental illness associated with childbearing." In I. Brockington and R. Kumar (Eds.), *Motherhood and Mental Illness.* Great Britain: St. Edmundsbury Press.

Paykel, E., Emms, E., Fletcher, J., and Rassaby, E. (1980). "Life events and social support in puerperal depression." *British Journal of Psychiatry, 136*, 339-346.

Pillsbury, B.L.K. (1978). "'Doing the month': confinement and convalescence of Chinese women after childbirth." *Social Science and Medicine, Vol. 12B*, 11-22.

Pitt, B. (1968). "'Atypical' depression following childbirth." *British Journal of Psychiatry, 114*, 1325-1335.

Reid, W.H. and Morrison, H.L. (1983). "Risk factors in children of depressed parents." In H. Morrison (Ed.), *Children of Depressed Parents: Risk, Identification, and Intervention.* U.S.A.: Grune & Stratton, Inc..

Richman, N., Stevenson, J., and Graham, P. (1975). "Prevalence of behavioral problems in three year old children: an epidemiological study in a London borough." *Journal of Child Psychology and Psychiatry, 17,* 75-78.

Richman, N. (1977). "Behavioral problems in pre-school children: family and social factors." *British Journal of Psychiatry, 131,* 523-527.

Robinson, G.E. and Stewart. D.E. (1986). "Postpartum Psychiatric Disorders." *Canadian Medical Association Journal, Vol. 134,* 31-36.

Robinson, S. and Young, J. (1982). "Screening for depression and anxiety in the post-natal period: acceptance or rejection of a subsequent treatment offer." *Australian and New Zealand Journal of Psychiatry, 16 (47),* 47-51.

Rogers, S.C. (1975). "Female forms of power and the myth of male dominance: model of female/male interaction in peasant society." *American Ethnologist, 2,* 727-756.

Rosenbaum, M.B. (1984). "Psychological issues in pregnancy." In G. Kleiner and W. Marcus Greston (Eds.), *Suicide in Pregnancy.* U.S.A.: John Wright PSG Inc..

Roy, A. "Vulnerability factors and depression in women." (1978). *British Journal of Psychiatry, 133,* 106-110.

Saks, B. (1984). "Postpartum Mental Illness." In G. Kleiner and W. Marcus Greston (Eds.), *Suicide in Pregnancy.* U.S.A.: John Wright PSG Inc..

Saks, B., Frank, J., Lowe, T., Berman, W., Naftolin, F., and Cohen, D. (1985). "Depressed mood during pregnancy and the puerperium: clinical recognition and implications for clinical practice." *American Journal of Psychiatry, 142:6,* 728-731.

Shore, J. and Manson, S. (1983). "American Indian psychiatric and social problems." *Transcultural Psychiatric Research Review, Vol. xx (3),*159-180.

Sims-Wood, J. (1980). *The Progress of Afro American Women.* U.S.A.: Greenwood Press.

Spradley, J. (1979). *The Ethnographic Interview.* U.S.A.: Holt, Rinehart and Winston.

Spradley, J. (1982). *Readings in Community Health Nursing* (2nd ed.). Boston: Little, Brown.

Stack, C. (1974). *All Our Kin.* New York: Harper & Rowe.

Staples, R. (1973). *The Black Woman in America.* U.S.A.: Nelson-Hall.

Stein, G., Milton, F., Bebbington, P., Wood, K., and Coppen, A. (1976). "Relationship between mood disturbance and free and total plasma trytophan in postpartum women." *British Medical Journal, 2,* 457.

Steiner, M. (1979). "Psychobiology of Mental Disorders Associated with Childbearing." *Acta Psychiatrica Scandinavia, 60,* 449-464.

Stein, G. and Kruckman, L. (1983). "Multi-disciplinary perspectives on post-partum depression: an anthropological critique." *Social Science and Medicine, Vol. 17 (15),* 1027-1041.

Telles, C. (1982). "Psychological and physiological adaptation to pregnancy and childbirth in low-income Hispanic women. " DISS. ABSTR. Boston University.

Tentoni, S. and High, K. "Culturally induced postpartum depression." *Journal of Obstetrical, Gynecological, and Neonatal Nursing, 9 (4),* 246-249.

Thoits, P. (1982). "Conceptual, methodological, and theoretical problems in studying social support as a buffer against life stress." *Journal of Health and Social Behavior, Vol. 23,* 145-159.

Tod, E. (1964). "Puerperal depression: a prospective epidemiological study." *Lancet, ii,* 1264-1266.

Treadway, C., Kane, F., Jarrahi-Zadeh, A., and Lipton, M. (1969). "A psychoendocrine study of pregnancy and puerperium." *American Journal of Psychiatry, 125 (10),* 1380-1386.

Trimble, J., Manson, S., Dinges, N., and Medicine, B. (1984). "American Indian concepts of mental health: reflections and directions." In P.Pedersen, N. Sartorius, and A. Marsella (Eds.), *Mental Health Services: The Cross-Cultural Context.* U.S.A.: Sage Publications, Inc..

Tripp-Reimer, T. (1985). "Combining qualitative and quantitative research methodologies." In M. Leininger (Ed.), *Qualitative Research Methods in Nursing.* U.S.A.: Grune & Straton, Inc..

Uddenberg, N. and Englesson, I. (1978). "Prognosis of post-partum mental disturbance: a prospective study of primiparous women and their four and a half year old children." *Acta Psychiatrica Scandinavia, 1958,* 201-212.

Uzzell, D. (1977). "Susto revisited: illness as a strategic role." In D. Landy (Ed.), *Culture, Disease, and Healing.* U.S.A.: Macmillan.

Watson, J., Elliot, S., Rugg, A., and Brough, D. (1984). "Psychiatric disorder in pregnancy and the first postnatal year." *British Journal of Psychiatry, 144,* 453-462.

Weissman, M., Paykel E., and Klerman, G. (1972). "The depressed woman as mother." *Social Psychiatry, 7,* 98-108.

Weissman, M. and Klerman, G. (1977). "Sex differences and the epidemiology of depression." *Archives of General Psychiatry, 34,* 98-111.

Wenger, A. (1985). "Learning to do a mini ethnohistory research study: a doctoral student's experience." In M. Leininger (Ed.), *Qualitative Research Methods in Nursing.* U.S.A.: Grune & Straton, Inc..

Wrate, R., Rooney, A., Thomas, J., and Cox, J. (1985). "Postnatal depression and child development--a three-year follow-up study." *British Journal of Psychiatry, 146,* 622-627.

Yalom, I., Lunde, T., Moos, R., and Hamburg, D. (1968). "'Postpartum Blues' Syndrome." *Archives of General Psychiatry, 18,* 16-27.