

The Essential Meaning Structure of Postpartum Depression
A Qualitative Study

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Summary

Postpartum depression (PPD) is a fairly common yet often unidentified disorder which not only affects the mother, but may also have an adverse effect on the cognitive, emotional and social development of her baby. The nature of PPD and whether it may be qualitatively different from non-postpartum depression (NPPD) is still disputed. The main aim of this thesis is to explore the phenomenon of PPD from the first person perspective. In order to deepen our understanding of PPD we compare it with the phenomenon of NPPD. The methodological approach towards this aim is descriptive phenomenology as outlined by Giorgi. The participants are 4 PPD and 3 NPPD women who were interviewed in-depth two to three times about their experience of depression.

The findings of this thesis are presented in three separate papers. The first paper “Two ways of living through postpartum depression” presents two identified essential meaning structures of PPD: 1) The looming threatening world and 2) Loss of primordial my-ness. In “the looming threatening world” we describe how mothers after birth may experience themselves as anxiously thrown into an alienated and threatening world in which their inhibited body is perceived as an obstacle for their attunement to their baby. The baby becomes a catalyst for feelings of guilt and shame, and they tend to withdraw from others into loneliness. In “loss of primordial my-ness” we describe how a mother experiences a fundamental feeling of unreality and disconnection both in relation to self, the baby, and the social and material world. She experiences a basic loss of ownership of her own perceptions, feelings, thoughts and actions. In parallel, the world is perceived as unreal, colorless, strange, and robbed of its meaning. Unbearable anxiety accompanies this overwhelming feeling of depersonalization.

The second paper “Incest and postpartum depression intertwined” is a case study which explores how incest experiences in the past constrain perceptions, thoughts, emotions and actions in the present. We describe how the birth of a baby girl may re-actualize and throw a mother into a world of incest where she is overwhelmed by intruding fantasies of men who abuse her children. Constantly on guard, she actively seeks information about abuse of other children in the media, which in turn feeds her anxious vigilance and fantasies.

The third paper “Engulfed by an alienated and threatening body: The essential meaning structure of depression in women” describes the essential meaning structure of NPPD. We described how NPPD women initially feel entrapped in a personal mission that has gone awry. Experiencing her lack of personal resources to resolve the situation, the NPPD woman crumbles under the perceived disapproval of others. She doubts her own judgments and experiences others’ negative emotions almost as if they were her own. Excessive feelings of responsibility are coupled with strong feelings of shame and guilt, which lead her to overwork or over-involve herself. In the process she ignores her embodied emotions, which gradually become alienated and threatening and in which she is ultimately submerged.

This qualitative study suggests that the most striking difference between PPD and NPPD is that PPD mothers felt in essence disconnected and alienated from the world and others (the baby), and in the case of one mother, also in relation to self, whereas in NPPD the problem was rather an experienced heightened sensitivity to others’ distress or negative judgments. Thus, there may be a difference in the development of PPD and NPPD which seems to be centered around two opposites; heightened sensitivity versus disconnection. We conceptualized the alienation in PPD as existential depression and anxiety, and the increased sensitivity in NPPD as a more relational type of depression and anxiety.

List of papers

Paper I

Røseth, I., Binder, P-E., & Malt, U. F. (2011). Two ways of living through postpartum depression. *Journal of Phenomenological Psychology*, 42(2), 174-194.

Paper II

Røseth, I., Bongaardt, R., & Binder, P-E. (2011). Postpartum depression and incest intertwined: A case study. *International Journal of Health and Well-being*, 6: 7244.

Paper III

Røseth, I., Binder, P-E., & Malt, U. F. (2013). Engulfed by an alienated and threatening emotional body. The essential structure of depression in women. *Journal of Phenomenological Psychology*, 44(2), forthcoming.

Abbreviations

APA	American Psychological Association
CBT	Cognitive behavioral therapy
DSM-IV-TR text	Diagnostic and statistical manual of mental disorders 4 th edition, revision
DST	Dynamic systems theory
EPDS	Edinburgh postnatal depression scale
GHQ	General health questionnaire
HPA	Hypothalamic-pituitary-adrenal
ICD-10	International classification of diseases and related health problems, 10th revision
MDD	Major depressive disorder
NPPD	Non-postpartum depression
PPD	Postpartum depression
WHO	World Health Organization

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“I am not the outcome or meeting-point of numerous causal agencies which determine my bodily or psychological make-up. I cannot conceive myself as nothing but a bit of the world, a mere object of biological, psychological or sociological investigation. I cannot shut myself up within the realm of science. All my knowledge of the world, even my scientific knowledge, is gained from my own particular point of view, or from some experience of the world without which the symbols of science would be meaningless.”
(Merleau-Ponty, 1945/1962, p. viii)

1 Introduction

Giving birth to a child represents a moment in life where the body and existence are most intimately intertwined. Pregnancy and birth in themselves represent an extreme and existential transformation of the mother’s lived-subject-body-world; how she as subject-body exists in her lived world and is able to adjust to a world which is abruptly transformed by the presence of the all-encompassing vulnerable and helpless infant. How can we understand what happens when this existential period in a woman’s life, the postnatal period, coincides with the development of depression?

From a phenomenological perspective the self, body and world are inseparable. “To be ill, even with just a trivial illness, as much as with a mortal illness, means, above all, to experience things in a different way, to live in another, maybe hardly different, maybe completely different world” (Van den Berg, 1972, pp. 45). Van den Berg describes how we in illness perceive the world around us in different ways and that the way we perceive the world reflects our mode of existence. Thus, the patient’s perception of the world is a facet of his or her lived illness. Merleau-Ponty (1945/1962) states that the properties of consciousness and the world complement each other and are mutually dependent. The way we perceive the world depends on our consciousness. Not only are consciousness and the world inseparable, but our consciousness is also inseparable from our body, the body-subject (Merleau-Ponty, 1945/1962). Patients’ awareness of their embodied self is bound up with their awareness of the world. Hence, illness and disease are not something added on to a person who remains the same; rather they change everything; one’s sense of self, body, and the world one lives in.

Our mood plays an important part in how we constitute phenomena, how we experience our self, our body, and the world (Heidegger, 1927/1996). We do not experience emotions in isolation; rather emotions are the atmosphere or tone of our perceived world. Our emotional body is the medium through which we gain access to the world, providing both the possibilities and the constraints of our existence in the world.

Transitioning into motherhood can be said to represent an existential crisis that presents women with a number of challenges. Most mothers live through this transformational experience without succumbing to depression, but unfortunately for some mothers this is a time of despair. How can we best understand postpartum depression (PPD)? From a phenomenological viewpoint we first have to describe the phenomenon we seek to understand before we try to explain it. The fundamental presupposition is that we all share the same human existence and it follows that patients share certain essential characteristics that we can describe (Van den Berg, 1972, p. 52). Phenomenology does not offer definitions of psychiatric symptoms or an overview of syndromes; rather it offers insight into certain modes of being in this world. This dissertation is a phenomenological study of PPD which may add important dimensions to our understanding of the specifics of the existential crisis experienced by mothers who develop PPD.

To be able to fully understand PPD, we compare it with depression in women in general. We have therefore conducted a separate phenomenological study on non-postpartum depression (NPPD). This study of NPPD also provides valuable knowledge on depression in women that stands in its own right. However, in this dissertation it functions primarily as a tool to compare and sharpen our findings on PPD. A comparison of results was enabled by our use of the same phenomenological method for our studies of both PPD and NPPD.

1.1 Postpartum depression: The magnitude of the problem

Prevalence rates of PPD may vary according to definitions of PPD (major and/or minor depression, or simply depressive symptoms) and different methods of collecting data (self-report or diagnostic interviews). In Norway the prevalence of PPD (defined as Edinburgh Postnatal Depression Scale (EPDS) score ≥ 10) is reported to be from 8.9%

(Eberhard-Gran, Eskild, Tambs, Samuelsen, & Opjordsmoen, 2002) to 10% (Berle, Aarre, Mykletun, Dahl, & Holsten, 2003). Using the 28-item version of the General Health Questionnaire (GHQ-28), Skari et al. (2002) found the prevalence of clinically important depression (GHQ-28: depression subscale case score ≥ 2) at 4 days after delivery to be 6%, and only 1% 6 weeks after birth when controlling for the impact of giving birth to infants with serious malformations. This is a somewhat lower prevalence rate than the meta-analysis of 59 studies by O'Hara & Swain (1996), where the estimate was 13%. Here the method of assessment and period of time under assessment were found to affect prevalence rates. Also, studies using a wider window (e.g. the first eight weeks) usually reported higher prevalence rates than studies that used a narrower window (e.g. the first four weeks). An evidence report (a meta-analysis for the U.S. Department of Health and Human Services) showed a prevalence of major depression as defined by DSM-IV-TR (Diagnostic and statistical manual of mental disorders, 4th ed., text rev.; American Psychological Association, 1994) after delivery ranging from 1.0% to 5.9% at different times during the first postpartum year (Gavin et al., 2005). For both major and sub-threshold (minor) depression the prevalence rate ranged from 6.5% to 12.9% at different times during the first year postpartum, indicating that approximately half of the affected women experience a major depressive episode and half a minor depressive episode at any given time. PPD should be distinguished from postpartum blues and postpartum psychosis. Postpartum blues is the most common puerperal mood disturbance with estimates of prevalence ranging from 30% to 75% (O'Hara, Neunaber, & Zekoski, 1984). Postpartum psychosis is a rare condition with rates of 0.1-0.2% of all deliveries (Kendell, Chalmers, & Platz, 1987).

Some studies report that the prevalence of depression postpartum is no higher than at other times in a woman's life (Cox, Murray, & Chapman, 1993; Gotlib, Whiffen, Mount, Milne, & Cordy, 1989; O'Hara, Zekoski, Philipps, & Wright, 1990), suggesting no special link between childbirth and depression. Other studies, however, indicate an increased risk of depression in the postpartum period (Eberhard-Gran et al., 2002; Kumar & Robson, 1984; Vesga-Lopez et al., 2008; Watson, Elliott, Rugg, & Brough, 1984). One study suggests that primiparas have a three times higher risk of hospital admission for clinical depression (Munk-Olsen, Laursen, Pedersen, Mors, & Mortensen, 2006). Fatherhood was not associated with any increase. The study also indicates a natural dynamic process of selection into parenthood. These results are comparable to the results

of a study by Eberhard-Gran et al. (2002), who found that women choosing to be mothers tend to have good psychic health. In her study, postpartum women originally had a lower prevalence of depression compared to non-postpartum women. However, when controlling for known risk factors, postpartum women had a higher risk for clinical depression. In sum, there seems to be evidence that the postpartum period is a time with increased risk for depression in women. Unfortunately, many women suffering from PPD are not identified and do not seek professional help (Abrams, Dornig, & Curran, 2009; Sword, Busser, Ganann, McMillan, & Swinton, 2008).

Clinically significant PPD raises unique questions concerning parental function, mother-child interaction and the potential harm the mother's depression causes to the infant. Studies show that the sadness, irritability and social withdrawal that characterize depressed people have a negative effect on the mother-child dyad, and consequently on the emotional, cognitive and social development of the child (Forbes, Cohn, Allen, & Lewinsohn, 2004; Murray & Cooper, 1997; Reck et al., 2004; Whiffen & Gotlib, 1989). A recent review by Kingston, Tough, & Whitfield (2012) suggests that prenatal and postnatal depression may have different adverse effects on child development; prenatal depression negatively affects the cognitive, behavioral, and psychomotor development whereas PPD contributes negatively to cognitive and socio-emotional development.

Over the last two decades there has been an increasing focus on PPD, which has had a positive impact in a number of areas including the recognition of depression after birth and the fight for improved clinical services for women and their families (Cooper et al., 2007). Nevertheless, PPD is still presumed to be an under-diagnosed illness (Eberhard-Gran, Tambs, Opjordsmoen, Skrondal, & Eskild, 2003; Horowitz & Cousins, 2006; O'Hara & Swain, 1996). Despite an increasing amount of research on PPD, there is considerable confusion about the definition and even the existence of PPD as a unique disorder. Today, the prevailing view is that PPD is no different from depression occurring at other times in life, at least from a symptomatic point of view (Cooper et al., 2007; Murray & Cooper, 1997; Whiffen, 1991). Research gives conflicting results, however, and important questions remain regarding the scientific status of PPD.

2 What is postpartum depression?

In this chapter we describe prevailing understandings of PPD. We start by describing the diagnostic status of PPD and then present the biological, evolutionary, psychological and critical feminist perspectives.

2.1 PPD: a disorder?

In the DSM-IV-TR (APA, 2000) PPD is not defined as a separate diagnostic entity, but as a course specifier connected to the diagnostic category Major Depressive Disorder (MDD). MDD is defined as PPD if the onset is within 4 weeks post partum. ICD-10 (International classification of diseases and related health problems, 10th edition; World Health Organization, 2004) allows for diagnosing mental and behavioral disorders as puerperal if the onset is within 6 weeks after birth. Similarly to the DSM-IV system, mental disorders associated with the puerperium should be coded according to the presenting psychiatric disorder using a second code (O99.3). A Major Depressive Disorder is described as a cluster of symptoms including depressed or sad mood, marked loss of interest in virtually all activities, significant weight loss or gain, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or guilt, diminished ability to think or concentrate, and recurrent thoughts of death or suicide (APA, 1994). To satisfy the criteria for a major depressive disorder (DSM-IV-TR), 5 out of 9 criteria must be met over a period of at least 2 weeks and at least one of the symptoms must be depressed mood or markedly diminished interest or pleasure.

But does this cluster of symptoms give a satisfactory understanding of what PPD is? The idea that one can identify, separate and cluster symptoms is based on the theory of Thomas Sydenham (1624-1698) that nature is uniform and consistent, i.e. that different persons that get the same disease will have the same symptoms (Hofmann 2008). The classical psychometric view regards observed differences between individuals to be a function of an underlying variable. The syndrome of depression is thought to have multiple possible causes; psychological, psycho-social, hereditary, evolutionary and biological causes. DSM-IV-TR and ICD-10 do not claim to offer an explanation of what MDD or PPD is. It is rather portrayed as an atheoretical and value-free taxonomy of disorders (APA 2000; WHO, 2004). The classification system is claimed to be the end result of a collective enterprise governed by consensus and compromise (Agich 1994). It

is pragmatic in the sense that its main goal is to maintain diagnostic consistency, efficiency and inter-rater reliability to ensure that this enterprise is coherent with current knowledge on the diagnosis and treatment of mental disorders.

There are issues concerning these claims that need to be addressed to promote a deeper understanding of MDD as a diagnosis. After all, this classification system has an enormous impact on people's life, research, and the distribution of social welfare. The fact that a condition is considered as MDD only if it satisfies 5 out of 9 criteria implies that none of the criteria are necessary or sufficient for a specific person to have the disease. Thus, many different combinations of symptoms can satisfy the criteria for MDD and consequently also PPD. The combination of symptoms/criteria that satisfy the criteria of a diagnostic entity (an underlying syndrome) can only be reached by counting and proceeding logically. They are not seen as interrelated in making up a whole (Gestalt) that is qualitatively different from the mere sum of its parts (Kraus, 1994). Moreover, it is pointed out that the different symptoms in themselves do not differentiate successfully between essentially different psychiatric phenomena (Kraus, 1991; 2003). Expanding our understanding of this problem, Kraus (2003) argues that it is the reduction of psychiatric phenomena to consensual symptoms and criteria that makes the diagnostic entities too general and imprecise. But at the same time the preference for reliability pushes toward discreteness, i.e. the clear separation into different diagnoses. This preference for reliability is pressed forward at the expense of internal validity, as experiential phenomena are reduced to symptoms and criteria.

The statement has been made that our medical classification system is both evaluative and heavily theory laden (Agich, 1994). Agich argues that the DSM (APA, 2000) classification system reflects theoretical commitments through preferences regarding principles of causation, explanation, or relation. In accordance with this, Malt (1986) points out that the diagnostic system reflects cultural, historical, and social preferences and values and changes over time in accordance with these. The DSM, Agich proceeds to argue, favors the biological and/or evolutionary perspective. This may also be the case for the course specifier of PPD. For a depressive episode to be labeled postpartum, it must have occurred within 4-6 weeks after birth. This decision may be based on the theory that postpartum depression is mainly caused by hormonal dysregulation (physiological view) after birth. This hormonal dysregulation is again assumed to be connected to genetic susceptibility (ontological view) (Halbreich, 2005;

Jones & Cantwell, 2010). On this basis, one might assume that a preference for biological perspectives underlie the criteria for what type of depressions may be labeled as PPD.

2.2 Biological perspective

How can we best understand and describe postpartum depression (PPD)? In “A treatise on insanity and other disorders affecting the mind” from the early 19th century, James C. Prichard (1835) described puerperal mental disorders as an imbalance in the vascular system after pregnancy in susceptible women. “The conversions or successive changes in the temporary local determinations of blood which the constitution under such circumstances sustains and requires, appear sufficiently to account for the morbid susceptibility of the brain” (p. 312). Especially breastfeeding was thought to excite and exhaust the vascular system, which in turn caused melancholia. Since Prichard’s time the scientific understanding of PPD has undergone major changes, from a focus on the vascular system to specific hormonal changes after birth (Bloch et al., 2000; Bloch, Daly, & Rubinow, 2003; Bloch et al., 2005) and genetic susceptibility (Jones & Craddock, 2007; Mahon et al., 2009; Murphy-Eberenz et al., 2006). The focus, however, has very much remained on biological causes inside the body and it is assumed that such causes may differentiate PPD from other types of depressions.

Within this view, PPD is thought to be a real disease (a natural kind or real essence, in Locke’s terminology; Locke, 1975) whose underlying causes can be found, at least partly, in our biology. Susceptibility to changes in ovarian hormones is presently suggested to be one important trigger to PPD (Brummelte & Galea, 2009; Bloch et al., 2003; 2005). This vulnerability to PPD is assumed to be influenced by distinct familial-genetic factors (Maguire & Mody, 2008; Murphy-Eberenz et al., 2006) that are suggested to be different from those that predispose non-*puerperal* women to MDD (Cooper & Murray, 1995). Several studies have shown that certain genetic factors may reflect a susceptibility to PPD (Corwin, Kohen, Jarrett, & Stafford, 2010; Doornbos et al., 2009; Jones & Craddock, 2001; Kumar et al., 2007; Mahon et al., 2009; Mitchell et al., 2011; Murphy-Eberenz et al., 2006), and how psychiatric diseases (such as PPD) could be transmitted across generations (Franklin et al., 2010; Tarantino, Sullivan, & Meltzer-Brody, 2011). Different genetic factors have been identified (Doornbos et al., 2009; Jones & Craddock, 2007; Kumar et al., 2007) indicating various biological systems that may be

malfunctioning in women with PPD. This suggests that the genetic base for the PPD syndrome is complex in the sense that it does not exhibit Mendelian recessive or dominant inheritance that can be connected to one single genetic locus (Skuse, 2001). Accordingly, Skuse and others suggest that the focus should be on the latent genetic base for traits (endophenotypes) that may be related only indirectly to the classic disease symptoms listed in DSM-IV-TR (APA, 2000). Also, epigenetics, the interaction between the environment and gene expression, has been suggested as an explanation for how maternal care can have a persistent effect on the child's health into adulthood, and subsequently influence the child's maternal care for her own child.

A growing amount of research provides evidence for dysregulation of hormonal changes after birth in a subgroup of women associated with the development of PPD (Bloch et al., 2000; 2003; 2005; Brummelte & Galea, 2009; Jolley, Elmore, Barnard, & Carr, 2007). The hypothesis is that despite normal reproduction hormone levels, women with PPD may respond abnormally to these changes. The researchers therefore assume that it is a deviation from the normal biochemical brain activity, especially in the hypothalamic-pituitary-adrenal (HPA) axis, which is associated with PPD (see Brummelte & Galea, 2009; Jolley et al., 2007).

2.3 Evolutionary perspective

Evolutionary scientists, not focusing on the underlying genetic, hormonal and neurological causes, are more interested in how nature defines and deals with abnormality. Evolutionary perspectives are modern variations of a physiological theory of disease that is inspired by Darwin's evolutionary theory (Boorse, 1976). Boorse is one of the most ardent scientists in arguing for the evolutionary standpoint. In this view health and disease are defined according to what functions are typically found within members of a species. "But behind this conceptual framework of medical theory, a body of doctrine that describes the functioning of a healthy body, classifies various deviations from such functioning as diseases, predicts their behavior under various forms of treatment, etc. This theoretical corpus looks in every way continuous with theory in biology and the other natural sciences, and I believe it to be value-free" (Boorse 1976, p. 56).

According to evolutionary theory, judgments about health and disease can be objectively described in terms of nature. The strong claim is that these descriptions are value-free. What does evolutionary theory have to say about PPD? Hagen (1999; Hagen & Barrett, 2007) and other evolutionary researchers propose that PPD in some circumstances may be adaptive, as women should reduce or eliminate their investment in their children if the costs outweigh the benefits. PPD women are found to have fewer positive and more negative emotions towards their children, they are less responsive and sensitive to infant cues and some have thoughts of harming their children (Beck, 1996; 2002). Also, PPD is often associated with low social support, infant problems, and a history of psychiatric disease (O'Hara et al., 1984). Psychological pain (e.g. depression) is portrayed as a necessary motivation to take action to reduce the level of pain. One possible way is for the mothers to reduce or eliminate their interest in the children, consequently reducing their reproductive costs. Another assumption is that the depressive symptoms, especially in MDD, function as a threat to defect from the childrearing enterprise if the mother is not given more social support, although Hagen (1999) admits that there is little evidence for the latter hypothesis. Nesse (2000) and Nettle (2004), looking at NPPD depression, propose that depressive behavior can be perceived as taking shelter and staying out of danger, and they hypothesize that such behavior had higher benefits for survival for women than for men.

Depression is, however, often considered as a disadvantage for reproduction. The proposed answer from the alternative functionalist view is that depression might be the result of a mismatch between genetic variants of older evolutionary origin and the stress of modern society. Thus, what was adaptive in the past may not be adaptive in the present (Uher, 2009). A more general functionalist argument is that a high sensitivity to stress can lead to both negative and positive consequences depending on the environment. For example, to be highly sensitive to others' (the baby's) distress and needs is generally very positive for the health of the offspring under good or optimal circumstances, but the same sensitivity also makes women more sensitive to stress and negative life events (Oldehinkel & Bouma, 2011). In addition, other evolutionary brain adaptations, such as metacognition, may have some maladaptive side-effects, such as a high degree of self-reproach and ruminations (Gilbert, 2006). A high degree of neuroticism is thought to heighten social competitive and pro-social behavior until a certain point where the negative side-effects outweigh the benefits (Allen & Badcock, 2006).

2.3.1 Social evolutionary perspective

The attachment theory is the best known theory within the social evolutionary perspective. This theory proposes that the attachment between the infant and the attachment figure is necessary for the survival of the infant and successful reproduction (Bowlby, 1953; 1954). Because of the infant's long-term helplessness, its survival depends on the availability and resources of attachment figures. Favored attachment behavior that increases attachment figure-infant proximity and leads to greater protection of the child is thought to enhance gene survival (Cassidy, 1999). According to this theory, we are born with motivational, emotional and behavioral systems whose function is to keep attachment figures and infants in close contact to ensure that the infant receives appropriate protection, vital resources, and comfort (Gilbert, 2006). Attachment theory proposes that the infant through interaction with its caregivers adopts different strategies to ensure its protection. When an attachment figure is unable to establish a secure attachment with its infant, the infant will eventually suppress the initial anxiety and find less optimal ways of being with its attachment figure: it will adapt to ensure its survival. These attachment strategies serve as working models for the infant in its relation with significant others later in life, and may contribute to the development of depression (Fonagy, 1999; Fonagy, Gergely, & Target, 2007). Hence, attachment strategies which were functional in relation to a depressed, fearful or preoccupied parent may be less adaptive later in life, leaving the individual more vulnerable to depression. Thus, the child's socio-emotional and cognitive development is thought to be affected by early patterns of attachment. Attachment is believed to be active throughout the human lifespan, but the behaviors that maintain attachment to significant others are thought to change according to the different life stages (Ainsworth, 1991).

Daniel Stern's (1995) theory of mother-child interaction overlaps with and expands on attachment theory and research. (Here Stern's theory is positioned under the heading social evolutionary perspectives. However, we acknowledge that his theory is also informed by other perspectives such as phenomenology). In his book, *The Motherhood Constellation*, Stern (1995; 2004) proposes that new mothers enter a "motherhood constellation", a maternal readiness state, in which the mother's sense of self becomes largely organized around the presence of her baby, the baby's well-being,

and the connection between the mother and the baby. While in the motherhood constellation, the mother becomes preoccupied by the safety of her baby. According to Stern, the activation of the motherhood constellation also implies that any issue the new mother has concerning mothering and her own experiences of being mothered will simultaneously be activated. Therapy has to take into account this specific motherhood self-organization and how a disturbance, such as postpartum depression, is of necessity evident in the nonverbal interactions within the mother-child dyad (or father-mother-baby triad).

2.4 Psychological perspective

Within psychology, we have not been able to identify specific theories regarding the etiology of PPD. There are probably several reasons for this, but one possible reason is that psychological researchers view the psychological dimensions of postpartum depression as similar to depression in general. There are several different psychological theories of depression; however, within the scope of this thesis we cannot account for them all. It is pertinent here to describe three dominant psychological perspectives of depression as a contrast to the dominant biological and feminist cultural perspectives on postpartum depression, namely the cognitive information process, dynamic systems and the psychodynamic perspective.

2.4.1 The psychoanalytic model

The psychoanalytic theory was developed by Freud in the 1890s in Vienna. In 1917 Freud published the essay “Mourning and Melancholia” in which he identified two different responses to loss - mourning and melancholia. The latter represents a pathological holding on to, and internalizing of, the lost object. Sydney Blatt (1974; 1990; Blatt & Luyten, 2009ab; Luyten et al., 2007), one of the most prominent researchers within the psychodynamic tradition, categorized patients into two sub-types: introjective (self-critical) and anaclitic (dependent). According to Blatt, healthy development consists of a balance between needs for independence and needs for interpersonal relatedness, while pathology involves an over-emphasis on either dependence or independence and a defensive avoidance of the opposing need. In the anaclitic (dependency) personality type,

needs are over-focused and are overly invested in closeness, intimacy, nurturance, trust and approval seeking, while the introjective personality type is preoccupied with self-sufficiency, accomplishment, has rigid and often unrealistic standards, and high needs for freedom and autonomy. The former type of depression is presumed to be caused by a disruption in primary relations, while the latter type is thought to be caused by a harsh, punitive, and critical super ego. Anaclitic patients' coping strategies mostly involve avoidant defenses, such as withdrawal, denial and repression, to deal with conflict and stress, while introjective patients employ counteractive strategies, such as projection, rationalization, intellectualization, doing and undoing, reaction formation and overcompensation (Blatt, Quinlan, Pilkonis, & Shea, 1995). Anaclitic patients are preoccupied with threats to interpersonal relationships, whereas introjective patients are more concerned with defending and protecting a viable sense of self. Consequently, failures which disturb their sense of self are more depressogenic for introjective persons, whereas ruptures in significant relationships are more depressogenic for anaclitically oriented individuals.

Within the psychodynamic perspective, the transition to motherhood is thought to involve challenging issues related to a re-definition of self and other which could lead the mother into depression (Antonucci & Mikus, 1988; Belsky, 1991). Priel and Besser (1999) hypothesize that self-critical mothers are more vulnerable to depression because they are likely to become increasingly self-critical when facing motherhood. In addition, pregnancy and childcare are thought to compromise the self-critical woman's need for autonomy. Raphaël-Leff (2001) suggests that pregnancy and childbirth may confront the mother with unprocessed traumatic experiences from her past such as loss or mourning. He stresses the importance of internal working models in the postpartum period, which have their roots in early attachment experiences.

2.4.2 The cognitive behavioral model

The modern roots of cognitive behavioral therapy (CBT) can be traced to the development of behavior therapy in the 1920s, the development of cognitive therapy in the 1960s, and the subsequent merging of the two (Rachman, 1997). Aaron T. Beck and colleagues (1975; Beck, Rush, Shaw, & Emery, 1979) developed a cognitive model of depression where they suggested that depression is due to distortions in the patient's

perspective. Beck proposed three underlying concepts of depression: negative thoughts about one's self, one's world and one's future, distorted information processing such as arbitrary inference, selective abstractions, over-generalizations, etc., and recurrent negative depressive thinking. Cognitive scientists and therapists focus on cognitive schemas and processes as the determining factors in depression. The computer has been used as a model in the underlying cognitive theory of mind, and consequently many technical terms have been borrowed from computer science, e.g. information processing, operator, input, output, etc. (Røseth, 2000). Starting in the 1950s and continuing through the 1970s, Lazarus (1958; 1971) developed one of the first forms of broad spectrum cognitive behavioral therapy. In the 1980s and 1990s cognitive and behavioral techniques were merged into what is now commonly called cognitive behavioral therapy (CBT; Rachman, 1997). The criticism of the cognitive behavioral model is that it seems to focus on mechanical mental processes and overt behavior, both of which are assumed to be learned responses. It has also been criticized for being dehumanizing, much due to its standardized and mechanical techniques. The model's strengths lie in its capacity to describe "representational-hungry" phenomena, such as anticipation, memories, etc. However, it has not been applied specifically to PPD.

2.4.3 The dynamic systems theory

Dynamic systems theory (DST) in its modern conception can be traced back to the 1920s when von Bertalanffy (1972) argued against the standard atomistic view of science where the investigation of single parts and processes were thought to explain the whole. Similarly, within psychology, Gestalt psychology argued that psychological wholes are not reducible to elementary units such as punctual sensations and excitement in the retina (Agre, 1997). DST provides an alternative conceptual framework that emphasizes the interaction between organism and environment and stresses that individuals are highly integrated self-organizing systems (Kellert, 1993; Kelso, 1995). According to DST human behavior is constantly self-assembled anew from dynamic self-organizing interactions between multiple levels of organization (Røseth, 2000; Thelen & Smith, 1994). Thus, our personality traits, memories and anticipations are not seen as fixed structures or schemas somehow stored in our brain. Rather, our more stable personality traits and our memories and anticipations may be seen as involving internal control parameters that constrain our

ever changing selves. They represent more slowly developing systems on a larger time scale (Keijzer, 1997; Varela & Maturana, 1988).

Stolorow (2003; Stolorow & Atwood, 1997) and Greenberg and Watson (2006) have utilized the theory of dynamic systems as a guiding metaphor for the illustration of the fluid, context-sensitive, and yet structured and self-organizing nature of mental development. (We have placed these authors under DST; however, we acknowledge that they are also influenced by other theories and perspectives.) Stolorow and Atwood (1997) use DST to reject the “teleological conceptions of preordained end states toward which developmental trajectories are presumed to aim” (p. 339). They object to the description of mental phenomena as a product of isolated intrapsychic mechanisms and fixed intrapsychic structures (p. 339). More traditional psychoanalytic theories, like Blatt’s (1974; 1990) theory of anaclitic and introjective personality types, may easily present an image of a mind as an internally closed, static and mechanical system which is resistant to change. Stolorow stresses the importance of change and interpersonal dynamics to the extent that he calls his theoretical viewpoint a “no-person psychology” where mental phenomena are formed “at the interface of reciprocally interacting worlds of experience” (p. 339). Greenberg & Watson’s (2006) emotion-focused approach stresses that emotions are the creative and organizing principle in people’s lives. This approach portrays the self not as a constant structure, but as emerging in the moment and constantly changing. They propose that a “weak” or “bad” sense of self, associated with basic shame and fear, is the core of depression. Depression is thought to set in when emotional schematic memories of past feelings of abandonment, powerlessness, and humiliation are activated. The basic shame and fear thus function as an organizing principle in the continuing construction of the “bad” self. Subsequent treatment involves overcoming the fear of entering the maladaptive state and accessing the “bad” sense of self. The idea is that one cannot overcome a maladaptive state before one has faced it, making it possible to differentiate, elaborate on and symbolize it, and subsequently change. However, this theory has not been explicitly related to PPD.

2.5 Critical feminist perspective

Feminist standpoint theories emerged in the 1970s from Marxist feminist and feminist critical theoretical perspectives. Feminist researchers from within the sociological

(Nicolson, 1998; Oakley, 1981), and social psychological (e.g. Mauthner, 1999; Nicolson, 1998; Whiffen, 2004) perspectives criticize biomedical models for their taken for granted view of depression as a form of neurobiological, hormonal disturbance or as an intra-psychological phenomenon that can be understood without regard to the socio-cultural context (Gammell & Stoppard, 1999; Ussher, 2010). The wider structural conditions and constraints in which new mothers live are highlighted; PPD is linked to the cultural and socio-political context (Mauthner, 1999). These feminist perspectives share the standpoint that Western culture undervalues and naturalizes mothering practices and they focus on how these cultural frames, norms and values contribute to and aggregate difficulties brought on by the transition to motherhood. Feminist perspectives on PPD tend to explain PPD, and depression in women in general, as a natural reaction to role transition and stress (Mauthner, 1999; Whiffen, 1991).

Feminists often adopt a social constructivist theory of illness, where illness is perceived as culturally constructed, and not as a “natural kind”. Feminist researchers tend to be critical of the status quo in modern societies and often press for cultural change. In line with this theory, feminists often claim that cultural gender role expectations lead women into depression (Jack, 1991; Jack & Ali, 2010), or that normal female behavior is being pathologized and medicalized as part of the implicit power struggle of Western society (Ussher, 2010). In line with the latter argument, certain feminist researchers aim to show how women construct a self-understanding in terms of the biomedical model of diagnosis and treatment, self-help books, and women’s magazines (Brescoll & LaFrance, 2004; Gammell & Stoppard, 1999; LaFrance & Stoppard, 2007; Stoppard & Gammell, 2003). The radical feminist argument is that what is currently labeled as postpartum depression is in fact a normal response to motherhood and something that women should expect to suffer through (Nicolson, 1998; Oakley, 1981; Romito, 1990). This view has been criticized by more moderate feminists for describing motherhood in negative terms and for not acknowledging the difference between merely feeling low and being depressed (Mauthner, 1998). The radical feminist standpoint has also been criticized for valuing paid work outside the home more than motherhood (Nicolson, 1998; Oakley, 1981; Romito, 1990). Also, feminism can be criticized for being inherently political; their aim is not only to describe, but to fight for women’s rights and against what they consider to be inequality between men and women.

More generally, the social constructivist perspective often argues that women's experiences of PPD are unique and constantly changing, and subsequently that generalizations or fixities are undesirable and inappropriate in our attempt to understand a phenomenon.

2.6 Additional comments

The abundance of research on underlying genetic and biochemical causes of PPD reveals the strong position of the biological perspective in the field. It has been argued that the historical and contemporary tendency in research and the DSM-IV-TR (APA, 2000) and ICD-10 (WHO, 2004) diagnostic classification systems favor naturalistic and objective scientific perspectives (Agich, 1994; Hofmann, 2008; Kraus, 1991; 2003). Agich (1994) suggests that the preference for objectivity consequently devalues or renounces subjective experiential data and 'Gestalts'.

The biological and evolutionary perspectives analyze people from the outside, that is, from the objective third person perspective (it-perspective). Rollo May (1983) described this perspective as grounded in our "Umwelt", which is the world of natural law and includes biological processes, needs, drives and instincts. Many psychological theories, like psychoanalysis, cognitivism, behaviorism, as well as dynamic systems theories of the mind, are also conducted from the objective third person perspective. The cultural feminist perspective adds to this knowledge base by showing how we are culturally embedded, and how illnesses such as PPD may be socially constructed. This perspective is grounded in our "Mitwelt", i.e. the world of being with ones' own kind (May, 1983). We are complex organisms with a mind that is embodied, embedded, and which has genetic and cultural historicity beyond our own lives. However, the presented biological, functional, psychological and cultural perspectives do not sufficiently account for the subjective dimensions of postpartum depression, our "Eigenwelt", i.e. our relationship to ourselves.

3 What do we know?

Is there a qualitative difference between PPD and NPPD? Or is PPD just like any other depression but happens to be connected to giving birth to a child. In this section we will review previous research comparing PPD with NPPD.

3.1 Quantitative studies comparing PPD and NPPD

We conducted a literature search of studies that compared PPD with NPPD. We identified fourteen original studies. These consisted of five retrospective, case-control studies (Cooper et al., 2007; Dean & Kendell, 1981; Hendrick, Altshuler, Strouse, & Grosser, 2000; Katona, 1982; Wisner, Peindl, & Hanusa, 1994), five cross-sectional studies (Augusto, Kumar, Calheiros, Matos, & Figueiredo, 1996; Bernstein et al., 2008; Eberhard-Gran et al., 2003; Mott, Schiller, Richards, O'Hara, & Stuart, 2011; Nieland & Roger, 1997), and four prospective studies (Cooper, Campbell, Day, Kennerley, & Bond, 1988; O'Hara et al., 1990; Troutman & Cutrona, 1990; Whiffen & Gotlib, 1993). Eleven of these studies compared PPD directly with an NPPD group, whereas three studies compared PPD indirectly with data from separate studies on NPPD (Bernstein et al., 2008; Cooper et al., 1988; Mott, et al., 2011). The sample size of the PPD group in the case-control studies ranged between $N = 26$ and $N = 96$, and in the population based studies between $N = 95$ and $N = 483$.

Although all but one study reported differences in clinical symptoms, no consistent differences were reported. The inconsistencies may be explained partly due to different samples, but more importantly because of major differences in assessment methods (different psychiatric interviews, physician-rated scales and self-report questionnaires). None of the methods applied cover the whole spectrum of depressive symptomatology (e.g. melancholia, atypical depression, bipolar subtypes). In addition, differences in the definition of postpartum depression (e.g. 6 weeks, 6 months; 1 year) and variation in the types of depression addressed (e.g. major depression only; minor and major depression, symptom severity beyond a specific cut-off) preclude comparison across studies and possibilities for merging of findings. In our opinion, current quantitative studies are so diverse that consensus on the presence of differences in clinical presentation between PPD and NPPD or within the PPD group cannot be expected.

3.2 Qualitative studies on PPD and NPPD

We have been unable to identify a qualitative study that compared the lived experiences or meaning structures of PPD versus NPPD. We found however a substantial amount of qualitative studies on depression in women grounded in a social constructivist approach, e.g. critical feminist and discursive perspectives. These studies typically stress the role of cultural narratives (Mitwelt) concerning the female role (Ussher, 1992; 2010) or motherhood in the development and course of depression postpartum (Abrams & Curran, 2010; Amankwaa, 2003; Everingham, Heading, & Connor, 2006; Mauthner, 1998; 1999; Nahas & Amasheh, 1999; Nicolson, 1990; 1999). According to these studies, the common conception of the good mother raises unrealistic expectations, which subsequently clash with the reality of motherhood, leading the mother into depression (Berggren-Clive, 1998; Leung, Arthur, & Martinson, 2005; Mauthner, 1998; 1999; Nahas & Amasheh, 1999; Nicolson, 1990; 1999). Phenomenologically inspired studies on postpartum depression have identified various experiential themes, such as the loss of a former sense of self, autonomy and time, and the loss of former appearance, femininity, sexuality, occupational identity, support and control (Beck, 1992; 1996; Mason, Rice, & Records, 2005; Wood, Thomas, Droppleman, & Meighan, 1997). In one study by Beck (2002), the respondents used metaphors like “drowning”, “sinking deeper and deeper”, “spiraling down”, and “falling through the air” to describe their growing distress and feelings of being totally overwhelmed by the demands of the baby. “Spiraling through a series of emotions including feeling trapped, angry, panicked, and isolated” (Wood et al., 1997). Some studies describe ambivalent feelings and a lack of bonding with the baby (Beck, 1996; Sluckin, 1998). Other studies stress the significance of past life experience, e.g. abuse (Mason et al., 2005), lack of partner support (Mason et al., 2005), and guilt for being depressed and thus not being able to properly care for one’s child (Hall & Wittkowski, 2006).

Beck (2002) conducted a metasynthesis of 18 qualitative studies. There were only two criteria for inclusion in the metasynthesis: (a) The focus of the study was PPD, and (b) the research design was qualitative. The included studies employed widely different definitions of PPD (ranging from subjectively experienced stress to diagnosed MDD) and different timeframes for depression onset after birth (6 weeks to 12 months). The

metasynthesis revealed 4 overarching themes on the basis of the central concepts found to be essential by the researchers in the studies: (1) Incongruity between expectations and reality of motherhood, (2) spiraling downward, (3) pervasive loss, and (4) making gains. In Beck's metasynthesis, she portrayed the development of PPD as a downward spiral of depression beginning at various times during the postpartum period (first 12 months after birth). Many of the women in these studies were interpreted as having unrealistic expectations of motherhood, which were shattered by the reality of their own life as mothers. This in turn made them feel overwhelmed, perceiving themselves as failures as mothers, which consequently produced a terrible burden of guilt. Metasyntheses are important in the quest to make qualitative data from several studies more uniform in order to make a stronger claim for generalization of the results. However, it should be noted that metasyntheses analyze the researchers' analyses and not the patients' raw data and will thus reflect the perspectives and focus of the researchers who conducted the studies.

Qualitative studies on depression in women, not limited to PPD, have revealed that social isolation, feelings of loneliness, and concern about self in relation to others are central themes. Scattolon (2003) explored major themes in women's experiences of living with and managing depression. She found that women experienced depression as filled with feelings of isolation and aloneness, that they were unable to carry on as usual, and that they were "going on" for the sake of others. Rice et al. (2011) found that depressed women's difficulties with social interaction involved a lack of interest in others, that they were too emotionally overloaded to interact, that they feared being a burden, and that others would not understand them.

To our knowledge, there is a paucity of original studies on PPD aimed at describing the phenomenon as a whole (Gestalt). Rather, previous studies have identified important themes that women may experience, and seemed to focus more on what (the content) the women experienced than on how (the structure or form) the women experienced the phenomenon. Thus, they show more interest in the mothers and their lived experience than in the phenomenon, i.e. the essential meaning structure of PPD.

4 What is next? The departure point for this study

Despite a substantial amount of research, the connection between childbirth and depression is still unclear. One question that remains is whether there might be a qualitative difference between depressed postpartum and non-postpartum women in the way they perceive their lifeworld. Is there a difference in how PPD and NPPD women perceive their lived body, the other person, the world, and time? The question of ‘how’ these women deal with difficulties in their everyday life can perhaps give the most basic essential meaning structure of postpartum depression. Such essential meaning structures may aid the development of instruments that help identify early symptoms of depression, both in postpartum and non-postpartum women.

This dissertation presents studies that take heed of the coherence and integrity of these experiences. We will thus go beyond a description of essential themes or symptoms (see Section 3) and describe the essential meaning structure of both PPD and NPPD and interface the essential descriptions to reveal similarities and differences (Giorgi, 2009). Our claim is that phenomenology can offer a scientific analysis and description of various essential pathological modes of being.

4.1 The phenomenological perspective

The word phenomenon originates from the Greek word “phainomenon” meaning to ‘show itself’ (Heidegger, 1927/1996). One task of phenomenological philosophy is to discover essences based upon a direct description of our experience as it is, without projecting theories of its psychological origin and the causal explanations of biology, sociology and history (Merleau-Ponty, 1945/1962). Phenomenological philosophy originated with Husserl (1913/1962) and was developed further by Merleau-Ponty (1945/1962) among others. Husserl (1913/1962) opposed both relativism (psychologism, sociologism, and historicism) and rationalism (logicism). He claimed that psychologism leads to relativism and irrationalism because it implicitly describes the thoughts and principles of the mind as only the result of external causes (automatic conditioning), thus holding the position that truth cannot be found (relativism). Through a radical reflection (the phenomenological reduction), Husserl sought to transform the automatic conditioning into a conscious conditioning of the mind.

“By a truly radical reflection, which reveals the prejudices established in us by the external environment, he [Husserl] attempts to transform this automatic conditioning into a conscious conditioning. But he never denies that it exists and that it is constantly at work.” (Merleau-Ponty, 1964, p.48-49)

Merleau-Ponty (1947/1964) described Husserl’s phenomenological reduction (the epoché) as motivated as follows: “From the mere fact that he desires not only to exist but to exist with an understanding of what he does, it follows that he must suspend the affirmations which are implied in the given facts of his life.” (p. 49). At the same time Merleau-Ponty stressed that to suspend these affirmations is not the same as “to deny them and even less to deny the link which binds us to the physical, social, and cultural world. It is on the contrary to see this link, to become conscious of it. (p. 49)

Through suspending the affirmations of the existence of reality (the epoché) and thereby adopting the phenomenological attitude, Husserl (1913/1962) studied the essential structures of consciousness. In the course of his phenomenological studies he found that many acts of consciousness demonstrate that consciousness is conscious of something; it is intentional. It is directed towards an immanent object (e.g. memories, fantasies or hallucinations) or a transcendent object (an object in the physical world). Husserl (1913/1962) pointed out that all phenomena are a product of both the intentional act (noesis) and the intended object (noema), thus phenomena are in essence relational and context dependent. Giorgi (2009) points out that the term intentional act is better understood as actualization rather than activity: “consciousness makes objects come present. It actualizes presences” (p. 105). Moreover, from a phenomenological perspective our emotions and our body are inseparable (which we will refer to as the “emotional body”) and our emotions permeate our world (Merleau-Ponty, 1945/1962; Toombs, 2001). Emotions are described as a certain action readiness or bodily engagement with the world. In our natural attitude towards the world, however, we by default take the existence of things for granted and treat them as objects largely independent of our own perception and embodied emotions. This tendency to be Cartesian dualists can easily be understood because our lived bodies, by which we are given access to the world, are largely invisible for us (Leder, 1990).

In his seminal book “Phenomenology of Perception”, Merleau-Ponty (1945/1962) stressed that “phenomenology is the study of essences”, but he equally stressed that phenomenology puts essences back into existence (p. vii). It is a philosophy in which the understanding of man and the world is based on their ‘facticity’ in a world that is ‘already there’ before we start to describe and reflect on it, and all the efforts of this philosophy “are concentrated upon re-achieving a direct and primitive contact with the world, and endowing that contact with a philosophical status” (p. vii). Essences belong to our everyday world, and are not added or constructed by the researcher. In this study we use the phenomenological method to describe individual subjectivity. Phenomenological essences are the most invariant meanings that account for the empirical variances in the data. Phenomenological essences are “the structural invariance within variance, that which gives shape and coherence to the variance” (p. 29). Thus, phenomenology attempts to show how an experience, although individual and singular for one person, may also be shared and generalized.

Phenomenology opens up to the study of bodily experience, the interpersonal context of lived happenings, the temporal dimension of what we live through, and self as the centre of all that takes place within the lifeworld. Husserl’s philosophical program formed the anchor for Giorgi’s (1970; 2009) endeavor to formulate a psychological phenomenological research approach. Giorgi’s approach is the method used in the three phenomenological studies in this dissertation. Phenomenology does not try to explain illness, rather it seeks to describe and illuminate inherent complex meaning structures that are constituted in the interface between our intentional consciousness and the world. From a phenomenological point of view, Kraus (1994; 2003) argues that intuitively grasping a psychopathological Gestalt already has an important role to play for our classification system, only in an immanent and pre-scientific way. This intuitive grasping of a Gestalt has been described as the “*praecox feeling*” that experienced clinicians have before diagnosing patients. Another concept that captures the mode of presence of phenomena is physiognomy (Cloonan, 2005). The phenomenological method aims at a scientific study of this ‘grasp of the whole’, the experiential Gestalt. It has as its main focus the very experience that precedes and enables our theories and scientific endeavor.

The phenomenological claim is that consciousness with its “irreal” objects (which do not exist as real objects in nature) does not obey the laws of natural science, and that it therefore should be studied through human science. When we deal with experiential

phenomena, such as the experience of being depressed, we first and foremost deal with an idiographic and unique experience. However, this unique experience also possesses more general and essential properties. These essences are not understood as universal, but as contingent essences that pertain to their cultural and causal context. Earlier phenomenologists like Husserl, Merleau-Ponty, Van den Berg, Sartre and others give important insights that have the potential to enrich and move forward modern psychiatry and psychology. They conducted painstaking phenomenological analyses of the essential structures of consciousness that provide the philosophical and epistemological fundament of the different phenomenological perspectives.

4.2 Aims

The main objective of the current study is a phenomenological exploration of the essential meaning structure of postpartum depression through the lived experience of women. In order to deepen our understanding of postpartum depression, we separately explore the meaning of depression in women outside the postpartum period, and then compare the two phenomena to reveal differences and similarities. The aim of this phenomenological study is to describe the phenomenon, i.e. the essential meaning structures of postpartum and non-postpartum depression. In doing so, we move beyond the idiosyncratic meanings towards the implicit, more general meanings that encompass the different experiences of a number of women. Further, we intend to reflect on these essential meaning structures in the context of the phenomenological thinking of Husserl, Heidegger, Sartre and others, and discuss our findings in relation to the contemporary theoretical and empirical context of (postpartum) depression research.

5 Method

5.1. Phenomenological study

This qualitative study was grounded in descriptive phenomenology (Giorgi, 1970, 1985, 2009). The epistemological frame is Husserlian phenomenology with the aim of contributing to a deeper and broader understanding of PPD and NPPD and the similarities and differences between them. Phenomenology is not limited to the description of idiosyncratic experiences; it is designed to reveal the implicit meaning structure of the phenomenon.

“A phenomenology, therefore, has a double purpose. It will gather together all the concrete experiences of man which are found in history - not only those of knowledge but also those of life and of civilization. But at the same time it must discover in this unrolling of facts a spontaneous order, a meaning, an intrinsic truth, an orientation of such a kind that the different events do not appear as mere succession.” (Merleau-Ponty, 1964, p. 52)

5.1.1 Interviews

The phenomenological researcher begins with collecting detailed descriptions of concrete experiences of the phenomenon as experienced by others. It is important that the descriptions are concrete and not more general and abstract narratives which lack the complexities of pre-reflective experience.

In our studies we chose to use in-depth interviews. The participants were interviewed two to three times, with each interview lasting from 45 to 90 minutes. The interviews were performed at a venue chosen by the participant, six preferring to be interviewed in the researcher's office while one woman preferred her own home. Before each interview we spent time to establish rapport with the participant before the recorder was put on. At the beginning of the interview we invoked the phenomenon, provided some orientation, but did not direct the participant to any specific topic. Through our questions we sought clarification or requested elaboration on specific experiences that were pertinent to the phenomenon, i.e. the development and experience of PPD and NPPD. Each interview was transcribed verbatim. Interviews provide the researcher with

the possibility of obtaining very rich data about the phenomenon (Kvale, 1996). The advantage of being both a therapist and a researcher has been noted by both Kvale and Finlay (2009a). As a therapist the interviewer is trained in creating a safe context for the interview in which to gain access to the participants' experiences.

A potential pitfall with the interview as a method is that the researcher may not be able to create a secure environment. There is a danger that the researcher is too preoccupied with her own experiences or preunderstandings during the interview to create an emotional attunement to the participant's lived meanings. One result of this lack of attunement may be that the researcher will tend to pose leading questions in order to get the participant to say certain things that the researcher is looking for (Giorgi, 2009). Following Husserl (1913/1962), an important part of the research process is to bracket one's prior knowledge about the phenomenon, meaning that the researcher performs the phenomenological reduction.

5.1.2 The phenomenological reduction

Husserl developed a phenomenological method that involves putting aside, or "bracketing", theoretical and practical preconceptions and assumptions about the phenomenon to be studied. Within the natural attitude, received views can be helpful. It is transferring the natural attitude to the phenomenological attitude that is erroneous (Husserl, 1913/1962; Merleau-Ponty, 1945/1962). The second main meaning of the phenomenological reduction is to withhold the existential claim, meaning that we suspend belief in the existence or "reality" of that which is under investigation. Facts are reduced to phenomenal presences. Hence the term reduction, which in this context does not mean to diminish but to restore or return something to a more primordial mode (Applebaum, 2004). In the case of a question such as "Are the depressed mother's feelings about the world justified?" Husserl would put it aside to focus instead upon the appearance to consciousness. The human subject can describe how she experiences what presents itself to consciousness - perceptions, thoughts, emotions, desires, etc.

5.1.3 Selection of subjects

5.1.3.1 PPD participants

We included only the mothers who satisfied the diagnostic criteria for major depression (MDD) according to the diagnostic and statistical manual of mental disorders, DSM-IV-TR (APA, 2000), and whose depression developed within three weeks after birth. All new mothers in any part of Norway routinely come into contact with the local health care clinics at two weeks postpartum. For ten months in one municipality, local health care nurses invited all new mothers who could read and write Norwegian to take part in the study. In this period 464 babies were born. A total of 305 mothers gave written consent to join the study and completed the Edinburgh Postnatal Depression Scale, EPDS (Cox, Holden, & Sagovsky, 1987), at two and six weeks postpartum. The EPDS forms were coded, enclosed in envelopes and sent directly to the researcher, who then contacted by phone those women scoring ≥ 13 within two weeks of the first score above cut-off for additional EPDS assessment. 21 women scored over cut-off at either 2 or 6 weeks postpartum and were further evaluated. Of these 21 women, only 6 had an MDD that developed within three weeks. One of these chose not to join the study and two were excluded due to short duration of depression (less than 3 weeks) and uncertainty regarding diagnostic status. In parallel, we also unsystematically recruited mothers from two psychiatric outpatient clinics. One mother was referred and recruited from one of the outpatient clinics.

Our final selection consisted of four women, two of whom also met the criteria for melancholic depression (ICD-10 terminology: somatic syndrome; WHO, 2004). Three women had normal deliveries, while one had a cesarean section. Two mothers were primiparous and two were multiparous; of the latter one gave birth to twins and one had given birth twice. Three of the women had no prior psychiatric history, while one woman had suffered clinical depression and anxiety earlier in life. At the time of the interview only one of the women was receiving psychotherapy. She also took medication for her depression. The age of the women at interview was between 20-45 years. All were cohabiting with or married to the father of the newborn.

We judged the descriptions of the participants to be large enough to provide rich and diverse data on the phenomenon and small enough to enable detailed and sophisticated analysis. Giorgi (2009) claims that descriptions are adequate if they contain

sufficient depth and detail to reveal new psychological knowledge about the phenomenon (Giorgi, 2009).

5.1.3.2 NPPD participants

We unsystematically recruited women from two psychiatric outpatient clinics and from two local GP practices in two Norwegian municipalities. Eligible women were asked to participate in the study by their GP or therapist. Women who agreed to participate were contacted for further assessment. They were excluded if they were pregnant or had given birth to a baby within the last year. We included only women who satisfied the diagnostic criteria for major depression according to the diagnostic and statistical manual of mental disorders, DSM-IV-TR (APA, 2000).

After the recruitment and inclusion of three women with diverse and rich descriptions of NPPD, we determined that we had sufficient data for a descriptive phenomenological method. We had thus made a purposive selection to ensure that we could get rich data on the phenomenon (Polkinghorne, 2005). All three women satisfied the criteria of MDD and one of them also met the criteria for melancholic depression (DSM-IV-TR criteria; APA, 2000). Two of the women had no children, while one had a preschool child. Two of the women had no prior psychiatric history, while the third had experienced a previous depressive episode. At the time of the interview one of the women was receiving psychotherapy and taking medication for her depression. Their age was between 20-45 years. All were in relationships, but only one was living with her partner.

5.1.4 Data analysis

We analyzed the interviews using Giorgi's descriptive phenomenological method (1970; 2009). We started by adopting the phenomenological attitude: bracketing our preconceptions about the phenomenon and withholding the existential claim. Within the phenomenological attitude, we analyzed the interviews in four logical steps: First we read the whole transcript of each interview several times to get a sense of the whole. Secondly, for each interview we divided the transcript into meaning units by being sensitive to and marking shifts in the psychological meaning of what was said. Thirdly, we transformed each meaning unit into psychologically sensitive language, where the more general

meaning was identified by imaginative variation. During imaginative variation we probed the descriptions, trying out different levels of categorizations and thereby finding invariant meanings that can encompass facts from several individuals. In our analysis we read between the lines and teased out the coherence between explicit and implicit meanings in the descriptions. In the fourth and final step we synthesized the transformed meaning units of all the descriptions by the participants into an essential structure. For the sake of analysis, this essential structure can be separated into essential constituents. It is important to note that these constituents are highly interrelated and can only be fully understood as part of a whole Gestalt.

5.2 A phenomenological case study

During the research process we were intrigued by the intertwining of the incest experience with postpartum depression in one of the participants, i.e. how her incest experience in very significant ways formed her present perceptions, thoughts, feelings, and anticipations of the future. From the perspective of a clinical psychologist, we found her story of critical importance for our knowledge of the possible implications of incest postpartum. But we also wanted to find out whether her description provided more general knowledge of how trauma in the past may haunt us in the present and future. Thus, by going deep into the complex and intertwined experiences of one well chosen case, we hoped to find more general knowledge, indeed an eidetic structure.

The works of Merleau-Ponty, Minkowski, Van den Berg and Freud are based on a number of well chosen case studies. They picked pathological cases which functioned to render the familiar unfamiliar (Romdenh-Romluc, 2011). Within traditional natural science, qualitative research and case studies in particular have been considered useful only for generating hypotheses that later may be tested systematically with a large number of cases. In this view, case studies cannot in themselves provide generalizable knowledge. Flyvbjerg (2006) argues that this view is based on fundamental misunderstandings and claims that case studies indeed can generate general knowledge, albeit not statistical generalizations. He claims that delving deeply into the intricate patterns of one case can give important insight into more general patterns and that critical cases may also be used to test hypotheses. Kvale (1996) suggests two reasons why significant knowledge from one case may reveal knowledge generalizable to larger groups. Firstly, quantitatively each

case may contain a large number of concrete descriptions of the phenomenon. Secondly, qualitatively, the focus on one single case enables the researcher to describe in detail consistent and recurrent patterns in the relationship between the individual and the situation.

Our case was chosen because it was especially rich and detailed, giving unique access to the lived intertwinement of incest and postpartum depression. We strove to illuminate the complex, implicit, and contextualized meaning structure through one mother's experience.

5.3 Ethics

The participants received information about the study both verbally and in writing. They were assured confidentiality and any information in the transcribed interviews that might reveal any person's identity has been changed or removed. The participants gave their informed consent both verbally and in writing to take part in the research project. They were informed of their right to withdraw from the study at any chosen time without stating a reason. The Norwegian Regional Committee for Medical Research Ethics had approved the study beforehand (No. S-08247a).

6 Findings

6.1 Paper I: “Two ways of living through postpartum depression”

In Paper I we identified and discussed two essential meaning structures: the looming threatening world and the loss of primordial my-ness.

6.1.1 The looming threatening world

In the essential meaning structure “the looming threatening world” we present and discuss PPD as entering a looming threatening world. Crumbling under a world perceived as dangerous, the mother fears for her baby’s safety. She is tormented by a painful feeling of insecurity and anxiety that infiltrates normal everyday activities. Her anxiety is nourished by her own emotional past and present; however, she is mostly unaware of this process. The lived body manifests itself as an obstacle by its heaviness and lack of energy. She feels out of touch with the world, the baby, and other people. Painfully aware of this alienation, she tries to convince herself rationally of her love for the baby. Being unable to live up to her own expectations regarding love and care for her baby makes her vulnerable to the gaze of others. She feels guilt because she perceives her mothering skills as inadequate, and she feels shame because she perceives herself as inferior or bad. She transforms her experience of time into guilt for missed opportunities for loving and caring for her baby. She also grieves her baby’s loss of a loving caring mother. Anxiety or strong feelings of guilt and shame make the woman conceal her true thoughts and feelings and withdraw from social others. Although desperately in need of help to care for the baby, she often interprets support as a confirmation of her failure as a mother. In constraining herself by isolation she feels ambivalent. She fears social situations, but at the same time she feels terribly lonely, and thus longs for good social relations which she hopes can relieve her pain.

Within this essential meaning structure, we identified six constituents: 1) The vulnerable baby and the threatening world; 2) perforated, anxious self and motherhood; 3) the lived body as a heavy physical obstacle and a mother’s attunement; 4) the baby as a catalyst for guilt, shame and remorse; 5) ambivalence concerning practical support and positive feedback; 6) withdrawal from others and loneliness.

6.1.2 Loss of primordial my-ness

PPD can alter the basic feeling of my-ness. After the birth, the mother experiences sudden and repetitive lapses into intense feelings of unreality and disconnection both in regard to self, the baby, and the social and material world. In experiencing a distorted sense of basic my-ness, or primordial self-awareness, she loses her fundamental sense of owning her perceptions, emotions, thoughts and actions. Rationally she knows that they belong to her, but she is unable to feel it. Unbearable anxiety precedes and accompanies this overwhelming feeling of depersonalization and alienation. Fundamentally cut off from her normal self, she perceives the world as colorless, strange, alien, and robbed of its meaning. She relentlessly ruminates on why this has happened to her. She despairs over being trapped, never able to escape this alienation and regain her normal self. Within this essential meaning structure, we identified three constituents: 1) unreal world and others; 2) unreal self; and 3) unbearable anxiety.

6.2 Paper II: “Postpartum depression and incest intertwined: A case study”

The contextualized meaning structure of study II revealed the structural intertwining of incest and postpartum depression through a particular case. For “Nina”, PPD means to be thrown into a world full of men who abuse children. Before giving birth she could keep traumatic memories of incest at the fringe of her daily life consciousness. After giving birth she is overwhelmed by an anxious vigilance and intruding fantasies of men who abuse children. Her fantasies merge with recollections of her incest experiences. This intertwined Gestalt of memories, fantasies and experiences is so painful that she hardly ever succeeds in keeping it out of her consciousness, and as a consequence it has an enormous impact on her daily life; it alters her perceptions, thoughts and emotions, i.e. her entire mode of existence. Overwhelmed, Nina succumbs into fatigue and sadness. Yet childhood sexual abuse (CSA) experiences of unknown people interest and attract her. She actively seeks out information about CSA, which in turn feeds her anxious vigilance and fantasies.

Within this contextualized meaning structure we revealed three constituents; 1) from maintaining distance to overwhelming closeness; 2) the attraction of the world of abuse; and 3) difficulty separating self from baby.

6.3 Paper III: “Engulfed by an alienated and threatening emotional body: The essential structure of depression in women”

The essence of Study III showed that NPPD in women is experienced as ultimately being engulfed by an alienated and threatening emotional body. A mission, initially embarked on with hope and emotional investment, has backfired and is now experienced as a major source of distress that the woman feels unable to abandon. Feeling trapped in this negative situation over an extended period of time, she finds herself lacking the necessary personal resources to resolve the situation. She is strongly affected by the perceived disapproval of others concerning her situation, which throws her into ambivalence, doubt and excessive worry. She experiences others’ feelings and judgments almost as if they were her own, temporarily invalidating or subordinating her own feelings and judgments. Feelings of excessive responsibility are coupled with feelings of shame and guilt which can be traced back to negative experiences in her past. Despite the experience of hopelessness about changing the distressing situation, she feels deeply responsible for the emotional well-being of others. Her mission is to succeed in her goal, to satisfy others’ demands and to relieve her intense feelings of shame and guilt. However, this is achieved by ignoring and suppressing distressing and negative embodied emotions. Consequently these suppressed emotions grow awry and are experienced as forced down upon her in increasingly unexpected and frightening ways; there are feelings of sickness, fatigue, sadness, panic attacks or inner restlessness, which also deprive her of sleep. Gradually she becomes less able to fulfill the responsibilities that she has claimed or accepted, thus adding to her burden of shame and guilt. Deep inside the feeling of unfairness about her situation frustrates her and negatively affects her relationship with others, which again produces more feelings of guilt. Eventually she experiences a breakdown as she is forcefully submerged in her emotional body.

For the sake of further analysis the above essential meaning structure is delineated into six constituents: 1) Entrapment in a mission; 2) Engulfed by others’ pain and negative judgment; 3) The present constraint of past guilt and shame; 4) Ignoring

embodied emotions; 5) Anger and feelings of injustice; 6) Becoming submerged in a threatening alienated emotional body: The breaking point.

7 Discussion of methodological issues

Research findings should be trustworthy and evaluated within the framework of the epistemological assumptions that underpin the procedures used to generate the findings (Stige, Malterud, & Midtgarden, 2009). Accordingly the methodological ideals of validity and reliability, so pertinent to quantitative research, may need to be considered when applied to phenomenological research.

7.1 Trustworthiness in phenomenology

Giorgi (2002) argues that quantitative research is based on empirical philosophy in which two epistemological assumptions underpin validity: 1) All knowledge must be based on perceptual experience, and 2) knowledge must be of the event “in-itself” (p. 5). From within this perspective, Giorgi argues, the apprehension of the subject is intrinsically distorting. In quantitative studies, the credibility of a study depends on the quality of instrument construction, while in phenomenological studies the researcher is part of the method. Furthermore, whereas in quantitative research reliability and validity are viewed as separate issues, in phenomenological research they are encompassed by broader terms such as credibility, rigor, and trustworthiness (Kvale, 1996). As a result, the methodological quality of qualitative research is often approached by addressing subjectivity, reflexivity, and social interaction in the interview process. Thus, within qualitative research, to validate is perhaps best understood as to reflexively investigate, check, question, and theorize about the nature of the phenomenon (Kvale, 1996).

There have been several more or less successful attempts to generate an integrative checklist to assess the methodological quality of qualitative research across different qualitative methods from different scientific perspectives (e.g. Elliott, Fischer, & Rennie, 1999; Malterud, 2001; Stige et al., 2009). For example, the checklist provided by Elliot et al (1999) includes criteria such as explicitly stating one’s perspective, situating the sample, grounding findings with quotes from the data, different types of credibility checks, coherence and resonating with readers. The danger in generating and advocating such checklists is that they may favor one qualitative method at the cost of others. Also, some of these checklists (e.g. Elliot et al., 1999) seem to lean on quantitative ideals when they advocate the need for many participants to be able to generalize, or triangulation of methods as a credibility check of findings. Stige et al. (2009) proposed seven general

themes (EPICURE) indicative of quality; this is conceivably the most integrative of these guidelines/checklists as it permits different methodologies to place more weight on certain themes and less on others. In my view it is appropriate to allow different scientific perspectives to define scientific quality from within their own epistemological frameworks. However, two particular criteria seem more generally applicable across different qualitative methods: to explicitly state one's perspective and to be methodologically coherent. Methodological coherence is especially important when considering the validity of findings; the research question and methodological steps are to be coherent with the proclaimed scientific perspective (Morse, Barrett, Mayan, Olson, & Spiers, 2002).

In Husserlian phenomenology, one does not seek to eliminate, but to clarify, the role of subjectivity. Phenomenology aims to understand the conditions under which valid or correct knowledge can be obtained. We may overimpose our subjectivity on, or be less present to, the phenomenon and thus present distorted findings. Thus, what matters is how the researcher is present to the phenomenon under study (Giorgi, 2002). "There is only knowledge for a human subject who apprehends it" (Giorgi, 2002, p. 9); it is impossible for us to know things in themselves. This proposition raises the question of how we can gain access to the conscious experience of others. Husserl (1913/1962) answers this by assuming that consciousness has certain shared essential structural features which on the individual level are varied and idiosyncratic (see the section "Essential meaning structures versus themes or idiographic descriptions" below).

Husserl developed a phenomenological method that involves putting aside, or "bracketing", theoretical and practical preconceptions and assumptions about the phenomenon under study. Bracketing is an important methodical step that we have explained in the method section and which we will discuss in further detail later. Following Husserl (1913/1962), we utilized bracketing to ensure that our analysis was true to the phenomenon under study. In our analysis of the data we followed the rigorous methodological steps developed by Giorgi (2009) to ensure that the whole description was analyzed in a manner that could be repeated by other phenomenologists from within the same perspective. Also, quotes from the interviews clarify and illustrate the analysis to the reader or other researchers.

One implication of using qualitative methods is that one cannot make statistical generalizations based on the results. However, one can claim to make what Kvale (1996) has termed analytical generalizations. An analytical generalization is a reasoned judgment of whether and how the findings of one study could be used to understand what may happen in another situation. In this thesis the results have been lifted by eidetic reduction from the particular and idiographic to a more general and essential level (Giorgi, 2009) which makes it reasonable to assume that the findings will be useful for our understanding of PPD and NPPD women in other situations. Furthermore, we will critically discuss our research in the light of available theories on (postpartum) depression that are relevant for our findings. Also, the usefulness and transferability of our findings has been and will be critically evaluated by ourselves, the researchers, and by the readers, such as peer-reviewers, other researchers and clinicians (Kvale, 1996). Thus, in our research we strive for knowledge that is general, systematic, critical, and methodical as defined by Giorgi (2009).

The issues of validity, reliability, credibility, trustworthiness and transferability are tightly interwoven with the theory of science and epistemology. Research has to be evaluated from within the perspective and research paradigm in which it is designed and conducted. Also within phenomenology there are disagreements about how we can have access to knowledge. Questions such as “is all description necessarily interpretation?”, “is bracketing possible or even desirable?” or “do essences exist?” involve pertinent issues regarding the conceptions of subjectivity and scientific trustworthiness or rigor. These issues are frequently discussed, especially in the form of a polemic between interpretive and descriptive phenomenology. We will address this polemic in the next section.

7.2 Descriptive versus interpretive phenomenology

Today, there exist many researchers with widely different research methods and techniques who call their research phenomenological. All phenomenologists agree that phenomenological research deals with subjective experience, but there is a continuous debate about the researcher’s stance in the research process, about whether the focus of research should be on essential meaning structures or on themes and idiographic

descriptions, and regarding what methodological criteria, if any, should be applied in the research process. A major part of this debate concerns whether phenomenology is best understood as a critical modernist (descriptive phenomenology) or a constructivist (interpretive phenomenology) view of science.

Interpretive phenomenologists, mainly inspired by Heidegger (1927/1996) and Gadamer (1991) tend to focus on the relation of the individual to his lifeworld and contend that people are inevitably and fundamentally influenced by the world they live in. Interpretation is understood to be rooted in the fore-structure of projection of Dasein, and since this fore-structure precedes our reflective understanding of the world, understanding is always interpretation. In interpretive phenomenology interpretation is often understood to apply in a broad and undifferentiating manner to all forms of knowledge and to correspond to the claim that all knowledge is constructed (Applebaum, 2011; 2012). Applebaum points out that from the hermeneutic perspective “research is not so much meaning-discovery as it is meaning-making, a creative enterprise engaged in collaboratively with research participants (2012, p.9). Thus we can develop a plausible but contingent line of meaning attribution for a phenomenon, but never argue for its exclusivity. Other plausible accounts could also be given. From this perspective the modernist project of the Enlightenment is considered outdated and naive, and the interpretive or social constructive stance is, implicitly or directly, presented as the only right answer. However, descriptive phenomenology is also presented as a viable alternative to objectivistic mainstream science, without simultaneously embracing constructivism (Giorgi, 1992; 2009).

Both Husserl (1913/1962) and Giorgi (2009) acknowledge that the phenomenological psychological approach is perspectival; it adopts a particular point of view which is constitutive; the researcher constitutes the research process. However, to acknowledge consciousness or science as constitutive is not identical to believing that consciousness constructs its objects, nor that science necessarily alters its objects in grasping them scientifically (Applebaum, 2012). The researcher grasps a phenomenon from a certain perspective, acknowledging that there are other possible perspectives that can be described. Husserlian phenomenologists employ a narrow definition of interpretation in their research, where they believe in a meaningful distinction between description and interpretation, which is ignored in over-simplistic claims such as “all knowledge is interpretation” or that “all description is interpretation” (Applebaum, 2012;

Giorgi, 1992). Descriptive phenomenology involves the belief that we can, from within a given perspective, describe whatever presents itself to consciousness, however incomplete and ambiguous it may be. Unlike interpretive phenomenology, descriptive phenomenology does not strive for the best interpretation of this incompleteness and ambiguity; it seeks to describe this incompleteness and ambiguity as it is given to consciousness.

In the following sections we present some of the discussions between interpretive and descriptive phenomenologists; 1) phenomenological reduction and reflexivity; 2) essential meaning structures versus idiographic descriptions; 3) detailed methodological steps versus integrative (eclectic) flexibility.

7.2.1 Phenomenological reduction and reflexivity

Recent proponents of the interpretive phenomenological approach argue for a greater focus on the constructive and relational aspect of the research process in itself; among these Finlay (2010) is prominent. We may note that there are other interpretive researchers that operate in a similar manner to the steps in Giorgi's method and that the difference between them lies mostly in their epistemology.

Finlay (2002; 2005; 2010), argues for a reflexive phenomenology and proposes that research data does not 'speak for itself' but is co-constructed in the researcher/co-researcher encounter (Finlay uses the term co-researcher to underscore the participants active role in knowledge creation). She stresses that the researcher should stay in reflexive contact with her own sensations, emotions, thoughts and fantasies while being open to, and staying with, the other in empathy. Finlay claims that the relational dynamics (both conscious and unconscious) between researcher and co-researchers should be emphasized and explored in phenomenological research (Finlay & Gough, 2003). Subsequently the data analysis focuses not only on the description given by the co-researcher, but also on the emergent dynamics of the research relationship as reflected on by the researcher. She explains that her relational approach employs theoretical concepts from existential phenomenological philosophy, Gestalt theory, relational psychoanalysis, and intersubjectivity theory.

Giorgi (2010) generally opposes this application of different theories to the Husserlian phenomenological stance, in which the researcher should refrain from applying theory (the phenomenological reduction). Also, Giorgi claims that the struggle for the understanding that knowledge is a mutual product emerging from the interview

situation is not original as it is already implied in the concept of intentionality and is the foundation of any scientific enterprise. Giorgi (2010) further states that the argument for co-construction of meaning in the research situation overlooks the fact that the researcher's role is not the same as that of the participant. The phenomenological reduction implies both withholding the existential claim and bracketing one's preconception of the phenomenon at hand (as we have explained earlier in the method section). Thus phenomenological researchers seek to minimize their presence to enable a full focus on the participant's experience. This does not imply that the researcher should become a tabula rasa ("blank slate"), but that she or he can put theories and preconceptions about the specific phenomenon 'out of play' in order to be open to the way the phenomenon presents itself to the researcher's consciousness. In therapy one employs interpretative guesses about what is going on, but in research such prompts could redirect what the person was intending to say, and thus confound his or her original perspective.

7.2.2 Essential meaning structures versus themes or idiographic descriptions

Phenomenologists differ in what they believe should be the focus for research: interpretive researchers often seek to describe lived experience articulated in idiographic descriptions of cases, with themes of a varying degree of generality, whereas descriptive researchers seek more invariant meaning structures through the phenomenological reduction and imaginative variation (Giorgi, 2011). Interpretive phenomenologists often accentuate the richness and diversity of the data and tend to resist the articulation into more general structures (Giorgi, 1992).

The aim of descriptive phenomenological psychology is to explicate the general meaning structure(s) and their relationship to the individual and idiographic experiential objects. This process is often referred to as the eidetic reduction. The descriptive scientist seeks to articulate the more integral knowledge that lies implicit in the descriptions. Through reflective inquiry the researcher seeks to uncover and clarify implicit and partly concealed meaning that lies in the medium range between particularity and universality. One seeks to tease out the unified meaning and describe it precisely as it presents itself to consciousness. This description of the general meaning structure is not a substitute for variety, but is a means of accounting for it (Giorgi, 2009; 2010). Giorgi stresses that

descriptive phenomenology seeks to describe “variations of an identical meaning and not variations as opposed to unity”. Essential identical meanings are called constituents to indicate that they are integrated into the essential meaning structure. All of the themes and idiographic meanings discovered by the interpretive approach form an integral part of these constituents and can be referred to. In order to facilitate access to the unified meaning, or general meaning structure, one employs free imaginative variation and seeks diverse descriptions of the phenomenon under investigation (Giorgi, 2009). A closely similar approach is lifeworld phenomenology (Dahlberg & Halling, 2001). The underlying assumption of these perspectives is that our intentional relation with the world has certain shared characteristics that we can describe.

Descriptive phenomenology has been criticized for being a realist modernist project where there is a belief in fixed and static immutable properties, i.e. essences that can be described. Phenomenologists claim that this is a fundamental misunderstanding, since phenomenology describes essences as relational, dynamic, fluid and ambiguous (Giorgi, 2009). In fact, phenomenological philosophy initially evolved as an alternative and a critique of modern natural human science. Phenomenology opposes the idea that we can have objective knowledge of the world in itself, and argues that all knowledge has to go through consciousness. According to both Husserl (1913/1962) and Giorgi (2009), knowledge does not represent fixed, universally true and complete meanings. Knowledge is always incomplete and dependent on the researcher’s perspective. However, Giorgi proposes that “meanings can be objectively understood even if they are subjectively established” (p. 80). Note that Giorgi uses the term objective to convey the idea that meanings can be intersubjectively identified.

7.2.3 Systematic procedures versus methodological eclecticism

In our two main studies where we sought to describe the essential meaning structures of PPD and NPPD (paper I and III), we followed Giorgi’s (2009) method step by step. In our case study, however, we chose to use a single case to explicate the intertwining of incest and postpartum depression. Thus, here we diverged from Giorgi’s method in which he recommends that at least three participants should be included. Giorgi claims that the researcher ideally needs more than one, and preferably three to four participants, to achieve a sufficient number of variations in order to draw out the invariant meaning. To

use his method on only one participant in order to arrive at an essential structure draws heavily on imaginative variation, as it is more difficult to separate the idiographic from the more general knowledge. Our discussion of the existing theories on the topic indicates that our findings are useful for understanding PPD mothers with childhood traumas. In addition the usefulness and transferability of these findings have already been and will be evaluated by peer reviewers, researchers and clinicians.

Some concern has been raised about the use of specified steps when conducting qualitative research as it poses a danger of valuing the steps more than reflecting on the methodology used (Giorgi, 2009). Cheek (2008) worries that the emphasis on methodological steps may reduce qualitative methods to a mechanical employment of a set of data collection techniques and that the steps thus become synonymous with the qualitative method. This poses a real threat; there are examples of the employment of certain phenomenological steps, without making evident any knowledge of, or reflection on, the philosophy that shapes the way a particular method is considered. Several phenomenologists (e.g. Finlay, 2009a; Smith & Eatough, 2007) argue for a flexible and eclectic use of methodological steps.

It is clear that any method can be abused, also Giorgi's (2009) descriptive phenomenological method, but this is not an argument for not applying one. Having no methodological steps poses a greater threat. It may support the idea that 'anything goes' and that phenomenology is a personal rather than an intersubjective and scientific enterprise (Giorgi, 2011; 2010). A description of the methodological steps used in a study renders research more transparent, enabling others to critically examine the research and if desired perform similar studies. Without a clear and specific method this becomes impossible. Qualitative research is sometimes presented as an individualistic personal enterprise where one is free to conduct research in any way that fits the individual researcher best (e.g. Finlay, 2009b). Giorgi (2010; 2009) and others (Norlyk & Harder, 2010) argue against this open and flexible version of phenomenology and claim that certain criteria need to be followed in order for the research to qualify both as science and phenomenology. Giorgi (2010) claims that if qualitative research methods are presented as so open to improvisation that they are not capable of producing systematic knowledge, i.e. an interrelated, coherent body of knowledge, they do not qualify as science.

7.3 Additional comments

Phenomenological philosophy has contributed two methods to the human sciences: an interpretive and a descriptive method. The interpretive method requires the researcher to come up with a meaning to account for the data (Applebaum, 2011). The descriptive method requires the researcher to tease out and articulate meanings that are already in the data. Some interpretive approaches consider the research process as a collaborative creative enterprise jointly constructed by the researcher and research participants. Descriptive phenomenology is based on the belief that we can, from within a given perspective, describe whatever presents itself to consciousness, however incomplete and ambiguous it may be. Subsequently some interpretive phenomenological researchers argue for a greater focus on the constructive and relational aspect of the research process in itself, whereas the descriptive phenomenological researcher seeks to minimize his or her presence to enable a full focus on the participant's experience. Interpretive researchers often seek to describe lived experience articulated in idiographic descriptions of cases or themes of varying degrees of generality, as opposed to descriptive researchers, who seek to describe a more general and invariant meaning structure, i.e. the phenomenon. Interpretive phenomenologists tend to present research as a personal enterprise where one should be free to conduct research in any way that fits the individual researcher best (e.g. Finlay, 2009b; Van Manen, 1990), whereas Giorgi (2010; 2009) and others (Norlyk & Harder, 2010) argue against this open and flexible version of phenomenology and claim that there are certain criteria that need to be followed in order for the research to qualify both as science and phenomenology.

The researcher's choice of method in qualitative research is not arbitrary; it has strong connections, implicitly or explicitly, to the philosophy of science. The method that one adopts carries assumptions about epistemology, theories regarding what type of knowledge we can possibly have about ourselves, others, and the world. We will not argue for one right or one wrong way of performing scientific, especially phenomenological, research, but we agree with Giorgi (2010), Norlyk and Harder (2010) that researchers should clearly state the philosophical perspectives that constrain and give meaning to the method and specify the methodological steps used.

8 Discussion of results

The overall aim of our research is to explore the phenomenon of postpartum depression from a phenomenological perspective. In this section we will first discuss separately the most essential findings of our studies on PPD and NPPD in Papers I, II and III. In the articles we have discussed the essential constituents in the different meaning structures as they are interconnected to a whole. Here we will discuss the various aspects of this whole that are pertinent to our understanding of the phenomenon. Secondly, throughout the discussion we will use theories that are pertinent to and may elaborate on our findings. Thirdly, in order to illuminate and sharpen our findings on PPD and NPPD further, we compare the different essential meaning structures, emphasizing differences and similarities.

8.1 Paper I: “Two ways of living through postpartum depression”

In Paper I we present and discuss two different essential meaning structures: 1) “The looming threatening world” and 2) “The loss of primordial my-ness”.

8.1.1 The looming threatening world

The first essential structure encompassed three women. The most striking finding in our phenomenological exploration of PPD is the sudden alienation and desynchronization experienced by mothers in relation to their world. The exploration of this essential meaning structure underscores the experienced vulnerability and anxiety experienced by depressed mothers. The perceived vulnerability of the baby catalyzes the change in the lived world for the mothers. They fear that they might not be able to protect their baby from the perceived dangerous world. When succumbing to depression the mothers experienced a sudden change in their lived world from a familiar atmosphere into a looming sense of ‘unhomelikeness’ and danger. We found that the mothers feel anxious, vulnerable and powerless in their perceived dangerous and obstructive world.



Table 1: PPD, Structure 2, development:

This finding is supported by other studies that found mothers often to be troubled by excessive worry or anxiety (Phillips, Sharpe, Matthey, & Charles, 2009; Ross, Gilbert Evans, Sellers, & Romach, 2003). Also, Phillips et al. (2009) found that even though the mothers' symptoms of anxiety do not qualify for an anxiety diagnosis, 10.8% experience what they called maternally focused worry which was experienced as equally debilitating.

We explored how these frightening and deeply disturbing experiences can be described as an existential crisis where the previously familiar world is suddenly rendered alien and unpredictable. All the habitual routines that gave a feeling of being at home, both in the world and in oneself, have been wiped away by the birth of the baby, resulting in an existential anxiety where the mother feels vulnerable and wide open to attacks at any moment. Although the focus of the external threat is the baby and not the mother, the death of the baby would mean the death of motherhood which is now central to her self and her being. It is revealed to her how little she can take for granted and how vulnerable the baby and she are in relation to the perceived threats from the environment.

To deepen our understanding of the mothers' anxiety in the face of this looming and threatening world, we enriched the descriptions with the thinking of Kierkegaard,

Sartre, Heidegger, and Tillich. According to Kierkegaard (1844/1981) and Sartre (1956) anxiety is the natural reaction when we are faced with the abyss of freedom. Freedom is experienced when our habitual and pre-reflective ways of dealing with the world disintegrate and we are faced with nothingness. Sartre stated that human beings are not things, but essentially emptiness (no-thing). We exist and in the process we create ourselves. However, we strive to have substance; to act as if we were a fixed set of being. Sartre stresses that we subsequently are fundamentally responsible for the projects that we choose to engage in. This realization is deeply anxiety provoking and may lead to what Sartre calls inauthentic preoccupation with projects. Similarly, Heidegger (1927/1996) described anxiety as the result of the encounter with our own fundamental isolation in the world. This realization is brought about by the inevitability of our own death, but also by existential death which is experienced in frustrations, disappointments and losses. Tillich (1952) distinguished between existential and neurotic anxiety. Existential anxiety concerns our inevitable finiteness, namely death. Our own insufficiency and possible failure reveal to us that we are mortal and open up the horizon of our death. Tillich saw neurotic anxiety as a cover for the real existential predicament that we all face. Neurotic anxiety is described as the result of one's inability to live courageously despite existential anxiety. Thus, one escapes into neurosis and ceases to develop in order to avoid the inevitable terror of freedom and one's own death. "Neurosis is the way of avoiding nonbeing by avoiding being" (Tillich, 1952, p. 66). It should be noted that others, such as Heidegger and Sartre, used the term existential anxiety to also include what Tillich called neurotic anxiety. Thus these concepts may have different meanings when used by other scientists and philosophers.

In the discussion of the looming threatening world we explored how transitioning into motherhood can be understood as a process where we strive to adjust and gain access to a 'new' world. Merleau-Ponty (1945/1962) described how we inhabit and integrate our world and how our body extends itself through our familiar objects; they become integrated in our self. Lang (1984), building on Merleau-Ponty's thinking, portrays the disruption of our familiar world as a transition where one is introduced to a new access to the world. He uses the door as a metaphor to illustrate the difference between a habituated and familiar world in contrast to an alien, unfamiliar world. If we stand in front of a house belonging to strangers, as opposed to the inviting and benevolent transparent door of our own house, the door represents a solid obstacle. It is a barrier which appears closed to our

entering, a massive object that demands attention for its own sake. The depressed mothers' experience of the looming threatening world can be understood as an unresolved transition where the once familiar world has lost its original meaning and where they stand before the door of a new world but feel rejected and threatened and experience themselves as unable to cross the threshold. The world which once was lived as an extension of self is now perceived as representing obstacles making movement in the world difficult. Subsequently the mothers are unable to acquire a new access to the world. This disturbance in spatialization (feeling disconnected) is concomitant with a disturbance in temporalization (desynchronization) where they no longer seem to be directed towards a future but rather locked in the past. The depressed mothers are stuck in limbo, temporarily unable either to go back to the world as it was or to enter the new hidden world that looms ahead. According to Lang, our practical projects and desires (our future) are curtailed as we are denied access through the door, and we become obsessed by it; we sit by the door and occupy it. This metaphor illustrates the mothers' preoccupation with the looming dangers in the world; at the same time as they fear this world, they feel drawn to it.

We described in Paper I how the mothers, when faced with this looming and dangerous world, experience a shift in how their body relates to the world. Their body which earlier resembled more a transparent medium through which they gained access to the world has become more like a physical object which obstructs them in its heaviness. Their obtrusive body was experienced as inhibiting their attunement to their baby. Subsequently, the desynchronization in depression and anxiety in PPD is experienced through the disturbance in the mothers' sophisticated attunement to the baby's embodied communication and needs. The communication between the mother and baby, which Stern (1995) characterizes as rhythmic and melodic interaction and mutual resonance, is disturbed and the mother feels unable to fully integrate the vulnerable baby in herself; the lived synchrony with the baby and others is disturbed. This is often verbalized as caring for the baby in a mechanical way, experiencing this as difficult and straining. Instead of the mother moving in the world dynamically with the baby, the infant presents as an obstacle to gain access to the world. Often the mother tries to solve problems analytically when relating to the baby in the world, as opposed to experiencing the world as inviting her and the baby to inter-engage in a certain manner.

8.1.2 Loss of primordial my-ness

The second essential meaning structure “Loss of primordial my-ness” in Paper I represents a significantly more radical and fundamental feeling of disconnection than Structure 1 (the looming and threatening world). This essential meaning structure is based on the description of the case of only one woman. We find that experiencing a loss of my-ness involves feeling that one no longer exists as oneself in the world. One’s perceptions, thoughts and actions are experienced as alien, as not belonging to oneself; one has lost oneself. The depressed mother described herself as an absent person, as a walking shadow. We revealed how the mother’s lack of primordial sense of agency for basic perceptions, feelings and thoughts created a vast abyss between her, the baby and the environment. She felt fundamentally cut off from others and the real world. Her newborn baby, her husband and the house they lived in felt equally unreal and as belonging to someone else. The mother’s loss of primordial my-ness and her fundamental disconnection from the world were connected to an extreme form of anxiety, in which suicide was felt as a last option to escape.

Minkowski (1970, p. 334) described a partly similar type of depression, “ambivalent depression”, which he analyzed as a disturbance in lived time. Minkowski pointed out that in this type of depression the dynamic integration of past, present, and future is lacking. The past is experienced as static memories and no longer felt to be the dynamic source of the present. Likewise the future is experienced as isolated visions of what will happen, not as vitally bursting forth from the present. Minkowski claimed that the patients suffering from ambivalent depression fail to unite these dimensions of time, which, he said, in reality cannot be separated at all.

Our analysis reveals that the experienced increasing disconnection from the body and world is synonymous with the sense of loss of self. The world loses meaning for the mother, it loses its ‘expressive force’ (Merleau-Ponty, 1945/1962, p. 342), and reciprocally she loses her sense of self. How we perceive others mirrors our mode of consciousness, i.e. how we exist in this world. Minkowski (1933/1970) proposed that a disturbance in the experience of achievement in the world (which he terms “ambient becoming”) could also easily lead to a feeling of perturbation in our relations with the environment. The morbid dualism between the patient and his world as seen in the patient’s functional incapacity to reach others is connected to a disturbance in his lived time, or “ambient becoming”. As Minkowski wrote, “I reach the ambient world through

my activity; the act or the work which it produces detaches itself from the ego and becomes inserted in the non-ego the moment that it is completed, while it nevertheless remains the ego's" (p. 347).

Minkowski (1933/1970) understood the ambivalent depression as an endogenous depression, different from e.g. reactive depression. According to Tellenbach (1961/1980), the endogenous aspect does not only refer to the rhythmic relationship between the somatic and psychic spheres, but also to our relationship with the world, i.e. our normal tendency to adjust and synchronize our biorhythm to the rhythm of the world. In melancholy this harmonious relationship with the world is broken (In Ambrosini, Stanghellini, & Langer, 2011).

8.2 Paper II: “A case study of a mother’s intertwining experiences with incest and postpartum depression”

In Paper II, we explored the contextualized meaning structure “Incest and postpartum depression intertwined”. We described how incest in the mother’s childhood may form and constrain her whole existence after giving birth to a baby girl and how it in fundamental ways affects her perception of and relation to events and persons in everyday life. Thus, we find that disturbance of lived time is of essential importance for our understanding of postpartum depression.

Husserl’s phenomenological description of time perception enriched our understanding of how we live time, how we can experience a coherent self and that things and events endure over time (Van Gelder, 1999). An event is perceived to have endurance because of the triple structure of consciousness: retention (an intentional awareness of past events), primal impression (an intentional awareness of what is happening now), and protention (an intentional awareness of future states). Retentions and protentions are not conceived of as representations, but rather as aspects of direct experience, as an intentional directedness. In addition to this basic lived duration, we also have memories of past events and anticipate future events. Heidegger (1927/1996) describes how the past, present and future are highly interconnected and that the past and future are a part of the

current phase of consciousness. Heidegger stresses that we approach the future on the basis of our past, and that the past and the future form the present.

This phenomenological description clarifies how our participants' past informs their anxiety about the future and how, being depressed, they live and grieve this future in the present (see Figure 2).

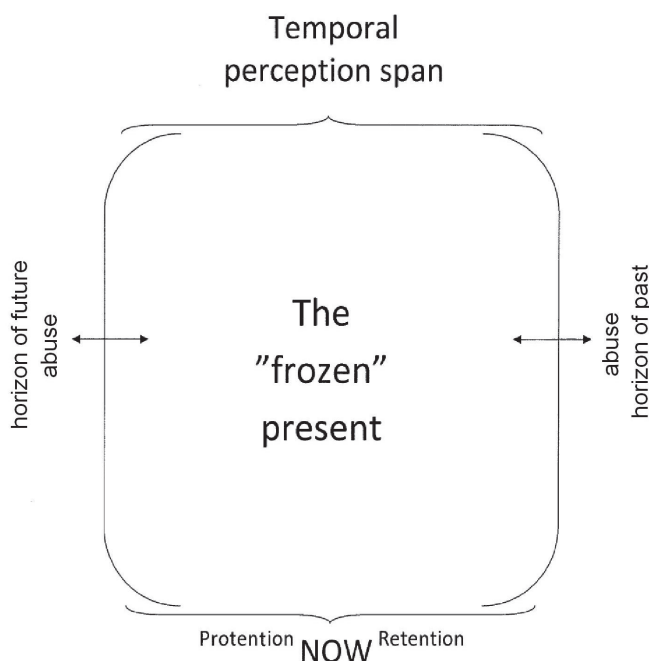


Figure 2: The frozen present

Our case study describes in detail how incest in one's childhood may form one's whole existence. It affects in fundamental ways how one perceives events and people in everyday life. It is not only the content of one's feelings and thoughts, but the very structure of one's perceptions and anticipations that is affected. The object-horizon structure of our consciousness described by Merleau-Ponty (1945/1962) clarifies how events from the past can lie in the horizon of our consciousness and yet color our whole existence. Merleau-Ponty made extensive use of Gestalt psychology to deepen his understanding of our perception of the world. In his object-horizon structure, our perceptions, thoughts, and feelings fluctuate from being in focus to lying at the fringe of the experiential horizon. The meaning of our conscious focus is dependent on, and

sensitive to, its horizon. Merleau-Ponty explains how new perceptions and emotions may replace the old ones, but that the underlying and implicit structure of the experience may still remain the same. The case study illustrates that we are not normally unconscious of an earlier trauma, but choose not to address it directly. As Merleau-Ponty (1945/1962) describes “Forgetfulness is ... an act; I keep the memory at an arm’s length, as I look past a person whom I do not wish to see” (p. 162). New events, such as the birth of a baby girl, may change and reorganize our perception of the world where earlier traumatic memories may once again dominate in our attempt to create meaning. Stolorow & Atwood (1997) put forth the idea of a dynamic unconscious which involves affective states that have been defensively aborted or walled off and in which the boundary between the conscious and unconscious is fluid and ever shifting, depending on the changing context.

In Paper II we explored how PPD for one mother who has experienced incest involved the repeated re-experience of the incest through the anticipated future of her children. The results of our case study show that not only may PPD women repeat traumas by anticipation, they may also actively seek information of others’ traumas through the media, etc. We explored different scientific understandings of this compulsion to repeat the predicaments of our past. From a psychoanalytic perspective, this re-entry into a world of abuse may be interpreted as the unconscious need to master a trauma and the unresolved unconscious conflicts by wanting unconsciously to go through the same situation, hoping turn the bad object (i.e. the incestuous father) into a good object (Fairbain, 1986). Instead of basing our approach on unconscious conflicts and goals, we prefer a phenomenological and dynamic systems theoretical interpretation. We found that the traumatic or negative ‘memories’ that dominated the participant’s life were not conceptualized as representational, but rather lived “as a manner of being and with a certain degree of generality” (Merleau-Ponty, 1945/1962, p. 83).

We explored how depression intertwines with anxiety. The mother dreaded the anticipated future abuse of her children. In anxiety we live in expectation of an anticipated dreaded world that closes in on us from the future (Minkowski, 1970). Minkowski stresses that expectation is a suspension of activity, which for him is equal to “life itself”, and therefore implies intense anxiety (p. 88). Because we cannot bear to stay in anguish over time, we must engage in action. In anxious depression we may act in an attempt to reduce overwhelming anguish when we seek information about what we fear.

But unfortunately, the action of seeking information often does not overcome our uncertainty; instead it feeds and colors the expectation, creating more intense anguish. Our anguish-creating actions stall time and curtail our future, which Minkowski described as an important aspect of depression. We described how anxiety and depression can be two sides of the same coin. We can understand the mother's dread (anxiety) and grievance (depression) of the future as inauthentically dealing with her traumatic past. Our description of lived time in depression revealed that the past, present, and future are highly interwoven, and determine each other in intricate ways.

8.3 Paper III: "Engulfed by an alienated and threatening body: The essential structure of depression in women"

In Paper III, we present and discuss the essential meaning structure of NPPD. We describe how the women in our study felt entrapped in a personal mission that had gone awry and become a major source of distress. Feeling that they lacked the personal resources to resolve the problematic situation, they were strongly affected by the perceived negative emotions and thoughts of others (see Figure 3). Scheler (1912/1970) and Minkowski (1933/1970) describe our sensitivity to others' emotions and sympathy as a vital contact with our fellows that is rooted in the living body and not a product of analytic inference (a construction) of a detached free-floating mind (Scheler, 1912/1970, p.10). Empathy is vital because it enables us to understand and anticipate the behavior of others. It denotes a fundamental positive ability to come into contact with and to get to know other human beings. However, as our analysis revealed, when the emotional pain involved in empathy is unbearable, the focus changes from care for the other to one's own painful feelings. The ability to separate negative feelings that belong to self from negative feelings that belong to others is compromised (Scheler, 1912/1970). The basic human power of sensitivity has flipped over and become a weak point. This increased sensitivity to others' emotions and judgments, combined with a high degree of self-criticism, led the women to neglect or ignore their own emotional bodies which they perceived as obstacles in their fight to succeed in their mission. Over time they became gradually more alienated from an increasingly threatening emotional body. Eventually they became engulfed by it and broke down into depression. This reveals some of the complexity of our empathic

relations with others and how empathy may flip over into emotional distress and depression.

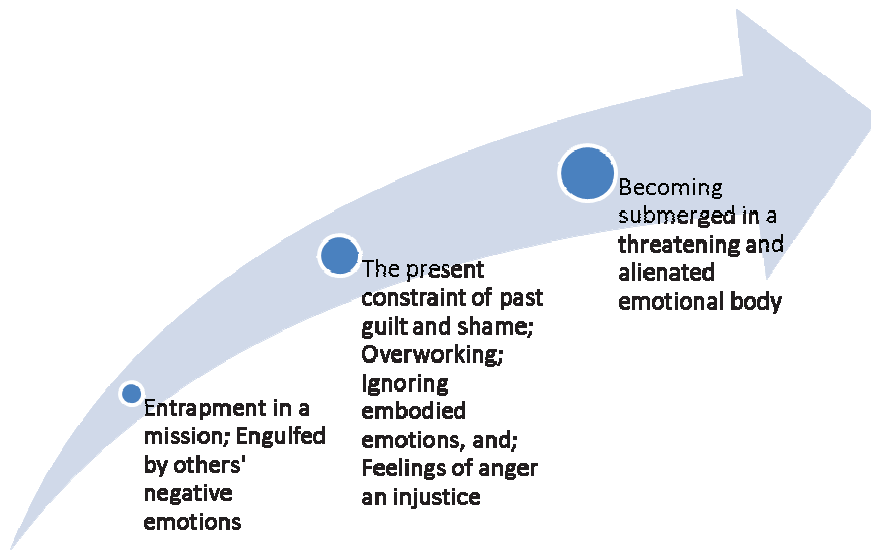


Figure 3: NPPD development

The depressed NPPD women in Paper III often perceived others as critical and condemning, and they ascribed these feelings as belonging to others and not to their own particular way of relating to the world (mood). In order to relieve their excessive feelings of guilt, they worked hard to make amends and to gain others' approval. Consequently, as our analysis revealed, they suffered from the negativity that they themselves had assigned to the other. The mental states of others vicariously felt by our participants may be said to be at least partially imagined, but nevertheless felt very real to them. Their perception of the critical other is pre-reflectively co-created by their consciousness (the intentional act of consciousness) and the perceived other (the object of consciousness). We implied that the distinction between self-centered and other-centered focus, which is often considered to represent different types of depression, is meaningless in this context because how we perceive others (interpersonal sensitivity to other's negative emotions) reflects how we perceive ourselves (self-criticism). Thus these two dimensions are intimately connected; they are inextricable aspects of being in the world.

The NPPD women in our study were troubled by a core shame, a deep feeling of being a 'bad' or 'weak' person. They also felt excessively guilty for imagined or real transgressions. Shame and guilt have been proposed as the core of depression and the creative and organizing principle in people's lives (Greenberg & Watson, 2006). The shame and guilt experienced by the women with NPPD made them engage in repetitive and critical examinations, so-called ruminations, of themselves, their actions and others' feelings and judgments towards them. The extreme feeling of guilt was coupled with a feeling of excessive responsibility which made the women overwork or emotionally over-involve themselves to the extent that they surpassed their own resources.

Shame is differentiated from guilt; shame involves devaluing the self as weak or bad in the eyes of the other, whereas in guilt it is only one's behavior that is devalued (Lynd, 1961). When tormented by guilt we suffer feelings of regret and responsibility. In shame we feel self-conscious and suddenly exposed and bared to the penetrating critical gaze of ourselves and others (Sartre, 1939/1962). Shame involves a feeling of estrangement from our lived bodies and social others, and subsequently a suspension of immersion in a world full of projects. We suggested that the women in our study tried to shrink shame to manageable proportions through assuming themselves to be guilty, and subsequently tried to make amends (Connor, 2001). One result of turning shame into guilt may be excessive overworking or over-involvement as described by the women in our study.

In Paper III, we described how the NPPD women in our study felt trapped and powerless in their current situation and how they after an intensive but futile struggle to change their predicament became overwhelmed and submerged in their alienated and threatening emotional body. Sartre (1939/1962) pointed out that when our possibility to change the world through pragmatic action is blocked, we may try to change the world by "magic". Sartre explains that in order to change the world, we may pre-reflectively try to change ourselves either by minimizing or exaggerating the difficulty of the world. Our study revealed how the women in our study experienced periods of anxiety, such as panic attacks and massive death anxiety. They seemed to exaggerate the difficulty in the world and perceive the world as unjust and hostile because it demanded too much of them. Sartre interprets this as a non-reflective abandonment of responsibility because it

eventually puts them in a state where no further action is possible. In addition to periods with massive anxiety, they had periods with feelings of emptiness and numbness, in which their world was perceived as devoid of meaning. Sartre describes this as an act of self-protection against the unbearable by turning away from the world and thereby taking away its significance.

8.4 Comparing PPD and NPPD

In this section we aim to compare the three essential meaning structures: “The looming threatening world”, “Loss of primordial my-ness”, and “Engulfed by an alienated and threatening emotional body”. When analyzing the descriptions of PPD and NPPD women, we did not use the basic constituents of one essential meaning structure as a model for the other essential meaning structures. Thus, when comparing the three structures, we had to rephrase the constituents to describe the same dimensions. Here we use Van den Berg’s (1972) delineation of lived experience into lived world, lived others, lived self, lived body and lived time to position and compare the constituents (see Figure 4).

Figure 4: Comparing PPD and NPPD

	PPD: “The looming threatening world”	NPPD: “Engulfed by an alienated and threatening emotional body”	PPD: “Loss of primordial my-ness”
Lived world	The looming threatening world	Cruel and unjust world	Unreal world
Lived others (including baby)	Lack of attunement to baby; The baby as a catalyst for feelings of guilt, shame and remorse; Ambivalence concerning practical support and positive feedback, and; Withdrawal from others and loneliness	Engulfed by others’ negative emotions; Anger and feeling of injustice, and; Excessive feelings of guilt and shame	Unreal others
Lived self	Perforated, anxious self and; Bad or weak mother	Bad or weak self	Unreal self
Lived body	The lived body as a heavy, limited obstacle	Ignoring embodied emotions which leads to; Becoming submerged in a threatening and alienated emotional body	Unreal body
Lived time	The present constraint of past negative experiences	The present constraint of past guilt and shame	Lack of dynamic integration between past, future and present

When comparing three different phenomenological meaning structures, it is vital to identify and describe what gives the different constituents their meaning. Keeping this focus in mind, to dissect and discuss the constituents independently as if they were objective and independent symptoms could easily lead to a faulty understanding of the phenomenon. It is important to note that a difference in meaning structure is not a statistical and formal difference, and should not be treated as such. Van den Berg (1972) stressed that the different lived dimensions should be considered as unitary, i.e. as different aspects of a whole. A change in our lived emotional body will also mean a change in our lived world. Following a phenomenological rationale, we discuss the overarching differences that have an impact on all constituents and are considered to be the most meaningful.

8.4.1 Similarities

All the women but one (loss of my-ness) in our three studies experienced profound shame and guilt. For the PPD women in the first structure (the looming threatening world) in Paper I, shame was mostly experienced when they felt exposed as bad mothers in social situations, whereas they had a constant feeling of guilt because they perceived themselves unable to provide good enough care for the baby (lived self). When experiencing shame they condemned themselves through the perceived critical eyes of the other (lived others). The second essential structure (loss of my-ness) in Paper I reveals that if the alienation and disconnection are too profound, the woman/mother finds herself incapable of feeling any guilt or shame. The NPPD women in Paper III were mostly troubled by a core shame. In their descriptions this core shame was verbalized as a deep feeling of being a ‘bad’ or ‘weak’ person (lived self). Hence, the feelings of shame and guilt in both the PPD meaning structure (the looming threatening world) and the NPPD meaning structure (engulfed by an alienated and threatening emotional body) imply that both the PPD (Structure 1) and NPPD women felt that they were bad or weak people (lived self) and that others viewed them critically (lived others).

The PPD (Structure 1) women and the NPPD women revealed similarities with respect to how they lived time. For both essential meaning structures, negative experiences in the past, either trauma or former shame and guilt, form and restrict their emotions, thoughts and actions in the present and their anticipations of the future. Hence

the traumatic past has a dominant negative position. However, as our case study revealed, difficulties in past life re-emerge, not primarily as representational memories, but as a manner of being in the world.

8.4.2 How do they differ?

When comparing PPD (Structure 1) “the looming threatening world” with NPPD “engulfed by an alienated and threatening emotional body”, the most striking and meaningful difference is that for the PPD women the development of depression starts with the troubling experience that their whole world (lived world) is shaken. It is as if the very ground underneath their feet has been agitated. Their world has suddenly changed and has become more threatening and alienated. They feel more insecure and anxious (lived self). The everyday actions which they used to perform naturally and with ease now fill them with troubling insecurity and anxiety. The perceived threat from the world is experienced as directed towards their baby, and they question their own ability protect it.

The essence of NPPD reveals a rather different and more gradual onset of depression. The women experience themselves as trapped in a personal mission in which they overwork or over-involve themselves. They are highly sensitive to others’ distress (lived others) and restricted by feelings of guilt and shame (lived self) from the past, which make them neglect and ignore their own needs. They describe depression as a gradually developing relational disturbance.

PPD is experienced at a basic existential level; from the onset of the depression the women’s whole lived world has an alien and threatening atmosphere. Svenaeus (1999) refers to this as the feeling of uncanniness, of not feeling at home in the world. We can describe this difference between PPD and NPPD as a difference in their experienced nearness or distance to the world. The PPD women felt from the start in essence disconnected from the baby and the world, whereas NPPD women described themselves as being essentially infiltrated with others and the world. This is exemplified in the PPD women’s experience of the troubling feeling of detachment from their baby compared to the NPPD women’s experience of being wide open to the negative feelings of others and to some degree feeling others’ emotions as their own. However, the fact that the NPPD women experienced themselves as almost infected by others’ thoughts and emotions does

not necessarily imply that these feelings and thoughts belonged to the other. Our analysis revealed that the women had a tendency to interpret others' emotions on the basis of their past negative experiences. Thus, the experiences of being infiltrated with others' emotions or feeling disconnected from them do not necessarily equate to differences in attunement to the world.

Parallel to the difference in their lived world, there is a meaningful difference in how the PPD (Structure 1) and the NPPD women in our study describe their lived body. Here it is important to note that the lived body is not limited to the body as the object for consciousness, but refers to the emotional body as a means by which we relate to the world, "rather than a perception of the one in isolation from the other" (Ratcliffe, 2008). Whereas the PPD women experience their emotional bodies as an obstacle, limiting them in caring for and attuning to the baby, the NPPD women describe that they actively ignore and subsequently become increasingly alienated from their emotional bodies. The act of ignoring their own needs has detrimental effects over time; eventually the NPPD women reach a point where they become engulfed by their distressed embodied emotions; subsequently they too experience themselves essentially disconnected from others and the world.

The essential meaning structure "loss of primordial my-ness" (Structure 2, PPD) is similar to "the looming threatening world" (Structure 1, PPD) in the sense that both can be described as a disconnection from others (lived others) and the world (lived world). However, "loss of primordial my-ness" is experienced as a much more fundamental disconnection and includes the distinct experience of de-personalization that is not described in "the looming threatening world". In this essential meaning structure the mother experiences a loss of ownership of her own perceptions, emotions, thoughts and actions in a most basic way. This basic disturbance of self has been described as a disturbance in lived time which involves a loss of the dynamic integration of past, present and future (Tellenbach, 1961/1980). On the other hand, in both "the looming threatening world" and "engulfed by an alienated and threatening body" the dynamic integration of past, present and future is not lost. However, it may be disturbed in the sense that the past has a strong negative impact on the present and the future.

8.4.3 How can we understand these differences?

8.4.3.1 Differences: Theoretical perspectives

How then, can we understand the difference between PPD and NPPD? In the next section we will discuss these differences in terms of the understandings of depression from the various prevailing perspectives pertinent to our findings. Of all the different perspectives presented in Chapter 2, we will limit the discussion of our findings to the following theories that, we feel, can illuminate differences between the three essential meaning structures: Evolutionary, psychoanalytic, critical feminist and phenomenological perspectives.

Evolutionary perspectives

Evolutionary perspectives on depression, not limited to PPD, stress that entrapment, excessive interpersonal sensitivity, and neuroticism are highly associated with depression and anxiety (Gilbert, Gilbert, & Irons, 2004; Gilbert, 2006). From an evolutionary perspective, interpersonal sensitivity is essential for understanding as well as predicting others' behavior and thereby ensuring the survival and well-being of offspring. Also, a high degree of neuroticism may motivate the individual to engage in intensive work to avoid negative results, which in non-resolvable situations may lead to exhaustion and depression. Interpersonal sensitivity and neuroticism in moderate levels may be adaptive, but these personality traits may also have unfortunate side-effects, such as being overly sensitive to and preoccupied by others and self-critical thinking (Gilbert et al., 2004; Gilbert, 2006). The NPPD women in our study felt entrapped in a negative situation over a prolonged period of time and described a combination of excessive interpersonal sensitivity and self-critical thinking, which they tried to resolve by overworking or over-involvement. Hence, our findings indicate that the essential structure in NPPD fits in well with the general evolutionary theory of depression and anxiety, but how does this theory account for PPD?

One could hypothesize that the mothers in our study initially were highly sensitive to the baby's distress and needs, and that this sensitivity made them especially vulnerable to stressful life events in the postpartum period which led to depression (Oldehinkel & Bouma, 2011). But the mothers in our study did not describe stressful life events in the

postpartum period, that is, besides giving birth and their experienced depression. Neither did they describe an increased sensitivity to the baby. Rather, they experienced a sense of disconnection from the baby and the world. It is conceivable, however, that the mothers' increased sensitivity around the birth and in the postpartum period made them more vulnerable to their traumatic memories of stressful life events in the past. This in turn may have disconnected them from the present and their baby. How the past can become re-actualized in the present and the anticipated future was explored in our case study.

Another hypothesis within social evolutionary perspectives is that the mothers' own attachment strategies which may have been adaptive to their own dysfunctional parent may be less adaptive later in life, leaving the individual more vulnerable to depression (Ainsworth, 1991; Fonagy, 1999; Gilbert, 2006). Also, an increased degree of metacognition is hypothesized to have maladaptive side-effects, such as a high degree of self-reproach and ruminations (Allen & Badcock, 2006; Gilbert, 2006). According to this hypothesis women who have an increased metacognitive ability may have an increased risk of depression both postpartum and non-postpartum. Thus, this line of reasoning does not account satisfactorily for the difference between PPD and NPPD. One evolutionary theory that proposes an explanation for the feeling of disconnection in depressed mothers has been put forth by Hagen (1999). According to this theory the feeling of disconnection is equal to a reduction in the mother's investment in the offspring when the costs of caring for the child outweigh the benefits. PPD functions as a motivator both to take action to reduce the pain and also to seek social support. However, the PPD women in our study were very ambivalent to seeking the support of others and had a strong tendency to conceal their feelings from others. Thus, although Hagen's theory may account for certain important aspects of the PPD women's experiences, other aspects would seem to contradict it.

Stern's (1995) mother-child interaction theory and his description of important themes involved in the motherhood constellation may explain why women in the postpartum period may experience depression differently. (Although Stern here is placed within the social evolutionary perspective, it should be noted that Stern's theory also is influenced by other perspectives.) Stern proposes that women at a certain time during pregnancy and in the postpartum period enter the motherhood constellation, which encompasses four essential themes: 1) the life-growth theme, which concerns the mother's ability to maintain the life and growth of the baby; 2) the primary relatedness

theme, which refers to the mother's ability emotionally to engage with the baby in an authentic manner, and assure the baby's psychic development; 3) the identity reorganization theme, which concerns her ability to transform her self-identity, and 4) the supporting matrix theme, regarding her ability to create and permit the necessary support systems. The mothers in our study felt the world to be full of potential dangers for their baby and they questioned their ability to protect it from these dangers. Hence, the life-growth theme is of primary importance in the essential meaning structure of PPD. The second theme, primary relatedness, is also prominent for the mothers in our study, where they to various degrees feel unable to authentically attune to their baby. Rather, they felt desynchronized from it. The third theme, identity reorganization, was present in the mothers' highly self-critical thinking regarding their own capabilities as mothers. Some of the women also had problems in feeling like mothers, and reported feeling more like an aunt to the baby. They thus reported some difficulty in transforming their self-identity to include motherhood. The fourth theme was also present; they felt reluctant to ask others for practical support. Stern notes that the motherhood constellation involves an openness to unconscious representations and processes that at other times are often ignored. Stern's theory of the motherhood constellation may provide an understanding of why the consciousness of the PPD mothers in our study is centered on the baby and why they experience the world as essentially more dangerous than the NPPD mothers. But we found that it does not fully account for why the PPD mothers experience a sense of disconnection, whereas the NPPD women feel essentially infiltrated with others' feelings and thoughts, and neither does it account for the existential aspects of PPD.

Psychoanalytic perspectives

The depressed mothers' strong tendency to be overly concerned with the baby's safety can from within a psychoanalytic perspective be interpreted as a defense mechanism: If aggressive impulses towards the baby are anxiety provoking, the ego tries to undo or conceal (reaction formation) these thoughts by excessively worrying about the baby's safety or by the mother pulling herself together to do the practical care for the baby (Blatt & Luyten, 2009b; Luyten et al., 2007). Thus, even though the mothers in our study did not report anger issues in relation to the baby, they could be seen to undo, conceal or repress their anger. They did tend to rationalize their perceived lack of attachment and

tried to convince themselves that their practical care for the baby and their anxiety for its safety proved their love. Blatt and Luyten (Luyten et al., 2007; Blatt & Luyten, 2009b) propose that the above defense mechanisms are associated with the psychodynamic theory of the introjective (self-critical) personality type which is preoccupied with accomplishment and has rigid and often unrealistic standards. Blatt's introjective personality type is hypothesized to be concerned with defending and protecting a viable sense of self and employs counteractive strategies, such as projection, rationalization, intellectualization, doing and undoing, reaction formation and overcompensation (Blatt et al., 1995). Several studies have found self-criticism to be associated with PPD (Besser, Vliegen, Luyten, & Blatt, 2008; Priel & Besser, 1999).

The interpersonal sensitivity that we found in NPPD women fits in well with elements of Blatt's (1974; 1990) psychodynamic ideas of the anaclitic (dependent) as well as introjective (self-critical) personality types. All the depressed women in our NPPD study were in some way or another sensitive to and preoccupied with others' emotions or judgments. They often avoided confrontations, strove to seek others' approval, and felt ambivalent and anxious the few times they tried to assert their own autonomy. However, in this process they were also highly self-critical and self-punitive. They tended to repress their own feelings and reactions and engage in an excessive effort to live up to both their own expectations (self-perfection) and others' expectations (social perfection). These findings indicate that both dependent and self-critical dimensions were interacting in NPPD, which is congruent with Kagan's (2003) study where she found that self-critical and dependent dimensions often occur together and may be best understood as different expressions of the same fear of abandonment and rejection. Thus, vulnerability to PPD and NPPD may depend on whether the woman has a self-critical or dependent self-organization: Self-critical women are more vulnerable to PPD, whereas both self-critical and dependent women may be vulnerable to NPPD.

Feminist perspectives

Feminist perspectives on PPD and NPPD characteristically stress that unrealistic gender role expectations may lead women into depression (e.g. Jack, 1991; Jack & Ali, 2010; Mauthner, 1998; 1999; Nicolson, 1990; 1999). After giving birth, many Norwegian mothers find themselves suddenly confined to their home alone with their baby. After two

weeks most fathers go back to work, leaving the new mothers alone with the baby for many hours a day for 8-11 months. Thus, most mothers experience a radical shift from being out in the social world with other adults, involved in projects, etc, to being more or less isolated with a totally dependent baby. Many previous qualitative studies have interpreted the mother's depression as a form of loss; loss of former social life, working life and sexuality (Beck, 1992; 1996; Mason, Rice, & Records, 2005; Wood, Thomas, Droppleman, & Meighan, 1997). Although the mothers in our study did not directly describe the transition to motherhood as a loss, we may hypothesize that a sense of loss may have exacerbated the feeling of disconnection.

We find that the qualitative differences between PPD and NPPD cannot be fully understood solely in terms of the general cultural role transition and stress involved when giving birth to, and rearing, a child. One of the mothers in our study only became depressed after giving birth to her second child. For her, it was not the role transition, nor the stress connected to birth or childrearing, that induced her depression. Rather, it was what the birth of the baby girl meant to her; what engulfed her was how she perceived the girl's future based on her own incest experiences in the past. Thus, neither cultural gender expectations nor objective measures of risk factors for PPD can ever truly predict or capture what such circumstances/events mean for the mother, which in turn will determine how these so-called risk factors affect them.

Phenomenological perspectives

From within phenomenological perspectives, the differences between the three general meaning structures may be best understood as different ways of being in the world, that is, as different existential feelings. Ratcliffe (2008) describes existential feelings as central to the structure of all experience; they may or may not be constituents of, or accompanied by, standard emotions. He explains that "feelings more generally are not simply of the body or the world, but involve a relationship between the two in which one, the other, or neither might occupy the existential foreground" (p. 36). In PPD, the existential feeling of the threatening world (the world dimension) is in the foreground, whereas in NPPD it is rather the negative or critical other (the social dimension) that is in focus. Thus, there is a difference in the figure-ground Gestalt, where PPD is more existentially oriented whereas NPPD is more relationally oriented.

The depressed women in our study experienced either a sudden (PPD) or a gradual (NPPD) change in their relations between self and world. The PPD women experienced themselves as suddenly more disconnected to the world (and baby), whereas the NPPD women increasingly experienced themselves as infiltrated with others' negative emotions. But this experienced infiltration with others' emotions in NPPD women does not necessarily imply an increased attunement to the other. In our analysis we found that NPPD, but also PPD (Structure 1), women tended to relive their own past through the perceived emotions of others. The other triggered emotions connected to their own past, but which were perceived as belonging to the other and not to one's self. Thus, the different existential feelings of disconnection and infiltration do not necessarily correspond to a difference in attunement to the world and others. Ratcliffe (2008) proposes that pathological existential feelings typically involve a partial or complete loss of openness to interpersonal possibilities. This lack of openness may involve experiencing the world as threatening ("the looming threatening world"), other people as critical and condemning ("engulfed by others' negative emotions"), or one might experience an almost total loss of openness ("loss of my-ness").

8.4.3.2 The special quality of mood in "Loss of my-ness"

Here we discuss the special quality of PPD Structure 2, "loss of my-ness". In our view, the different evolutionary, psychoanalytic and feminist perspectives do not sufficiently account for the extreme feeling of depersonalization described in this essential meaning structure, thus these perspectives will not be discussed here.

From the phenomenological perspective the extreme feeling of alienation and depersonalization involved in "loss of my-ness" has been described as a core dimension in melancholia, a severe form of depression which is qualitatively different from other types of depression. Kraus (2004; 2008) describes how melancholia involves a holistic alteration of the person's relationship to himself, others, and the world. It transforms all his psychic acts. Kraus further points out that the melancholic patient is not only cheerless, not only anhedonic, but that he experiences an immobility of emotion. Moreover, he describes this fixation of emotion as inexplicable, unmotivated and rendering the patient incapable of working through his mourning. Fuchs (2008) argues that the experience of depersonalization and derealization involved in melancholia is a

result of loss of bodily resonance. He uses Merleau-Ponty's (1945/1962) distinction between the lived and corporeal body, where the former comprises all our pre-reflective experiences mediated through our body, and the latter refers to the anatomical object of physiology and medicine. Merleau-Ponty describes how we can experience the corporeal body, especially in illness and shame, where our body ceases to be an invisible medium and becomes an object for our perception, a difficult tool to be handled. Fuchs (2008) describes melancholia as the corporealization of the lived body, as bodily restriction, which in its extreme forms inhibits feelings of sadness, guilt or remorse. This corporealization implies a loss of attunement or emotional resonance to an extent where the person no longer "is capable to be moved, addressed and affected by things or persons" (p. 75). In the most severe forms of depression the ability to sense feelings and atmospheres is almost totally lost, leaving only pain and anxiety.

8.4.4 A comparison of qualitative and quantitative findings

We cannot infer from our findings whether PPD women experience more symptoms of anxiety or depression than NPPD women. Those are quantitative research questions that require quantitative research. Our findings imply that the women's experience of PPD and NPPD in our study encompassed both anxiety and depression, but that these were lived in essentially different ways. However, such essential differences were not found in our quantitative review.

The lack of consistent differences between PPD and NPPD found in studies applying a quantitative design may be due to methodological differences between the studies included in the review, but it is also timely to question the ability of the various quantitative studies to identify symptoms of anxiety. For example, the distinctions between the anxiety in "the looming threatening world" in PPD, the anxiety related to interpersonal sensitivity and the experience of being "engulfed by an alienated and threatening emotional body" in NPPD represent a difference in meaning not easily accounted for by anxiety rating scales or by just adding on 2 to 4 general anxiety symptoms listed in DSM-IV-TR (APA, 2000) or ICD-10 (WHO, 2004).

In our opinion, the symptoms of depression listed in DSM-IV-TR (APA, 2000) and ICD-10 (WHO, 2004) may be too unspecific to enable identification of the

differences that we described between the essential meaning structures, especially between PPD Structure 2 compared to PPD Structure 1 and NPPD.

Some psychiatrists and clinical psychologist may consider the second structure identified in the PPD sample to reflect melancholia. Kraus (1994) claims that even though there is prevailing agreement among practicing psychiatrists concerning the special *quality* of mood involved in melancholia, this difference is now ignored by many clinicians and poorly identified by current diagnostic criteria . Today, in the DSM-IV-TR and ICD-10 classification systems, the diagnosis MDD with melancholic features specifier (DSM-IV-TR) or somatic syndrome (ICD-10) is arrived at by adding so-called melancholic/somatic features (e.g. loss of interest, anhedonia, diurnal variation) to the mood symptoms. Thus, the alteration of mood in MDD is not necessarily considered as different when the melancholic features specifier (DSM-IV-TR) or somatic syndrome (ICD-10) is added. Although DSM-IV-TR does include one symptom which describes the distinct quality of depressed mood in melancholia as different from mourning, it is not well defined and does not need to be present in order to satisfy the criteria for the melancholic features specifier. Kraus points out that the diagnostic systems separate disturbances of functions that should not be separated because the type of depersonalization involved in melancholic depression alters the whole meaning of the interrelated symptoms. Such separation of symptoms or disturbances of functions may lead to an ignorance of the essential aspect of melancholia which we have described as “the loss of my-ness”. This essential mood quality is not captured by the added somatic symptoms which subsequently do not successfully distinguish between melancholia and “simple” depression.

8.5.0 Additional comments

The ability to understand others’ affective states, to empathize, is essential for our relationships (Minkowski, 1933/1970; Scheler, 1912/1970). In PPD the problem resides in the feeling of alienation and disconnection in relation to the world and the baby, whereas in NPPD the problem is rather an experienced heightened sensitivity to others’ distress or negative judgments. Thus, there is a difference in the development of PPD and NPPD which seems to be centered around two opposites, namely experienced disconnection versus heightened sensitivity in relation to the world and the other. This

difference is, however, not necessarily accompanied by a difference in attunement to the world and the other (baby). The experienced disconnection and alienation in PPD can be conceptualized as existential depression and anxiety as they revolve around the basic feeling of being in the world, whereas the increased sensitivity can be conceptualized as a more relational depression and anxiety which revolves around interpersonal relations (I-Thou). Hence, the differences between the essential meaning structures pivot around different ways of finding oneself in the world. These are thus different existential facets of being-in-the-world, which involve different existential feelings that constrain the structure of all one's experience (Ratcliffe, 2008).

Within a phenomenological perspective, meaning is the most critical aspect of psychiatric disorders. DSM-IV-TR (APA, 2000) rests on the biomedical model and includes assumptions about what is normal as opposed to abnormal, and that this distinction can be estimated, assessed and observed through a set of observable symptoms (Giorgi, 2005). Thus, symptoms are often understood and treated as objective facts and any information about what it actually means for the person to develop and have these symptoms is ignored. What is measured is the set of symptoms, their intensity, and their frequency of occurrence or duration. Barbro Giorgi (2005) claims that when we reach our breaking point, we can assume that we will no longer function optimally and that we will exhibit a number of symptoms. However, she also argues that the nature of these symptoms is not as important as what in the person's life contributed to reaching the breaking point. Giorgi proposes that we should not treat the symptoms as the problem that needs to be resolved, but rather see them as carrying information about what is troubling the person, as pointing to the client's lived meaning.

In our opinion, the essential meaning structures of a phenomenon include information about both the relevant past and the present, because the past is always implicitly present. Knowledge of how the past constrains the possibilities for thinking, feeling and acting in the present is vital in order to identify, understand and treat the disorder. However, we agree with Giorgi that we need to go beyond the overgeneralized and insufficiently specific symptoms listed in DSM-IV-TR (APA, 2000) and ICD-10 (WHO, 2004) and to describe the essential meaning structures of the phenomenon.

9 Implications

9.1 Psychotherapeutic implications

The phenomenological perspective helps us to reorient our focus from considering symptoms as the main problem to be resolved towards exploring, describing and understanding how depressed women exist in their world. Thus a fundamental goal of clinical intervention is to recognize and validate the depressed women's way of existence, or being-in-the-world.

PPD

From a phenomenological perspective it is of vital importance to understand and validate how our patients exist in their world. We found that PPD can be described first and foremost as an existential crisis which is lived as the looming alienated and threatening world. The women suffered an existential depression which can be understood as a form of sudden desynchronization. On the basis of our findings, psychotherapy should assist the patient in the process of resynchronization. Different therapies which focus directly on the mother-baby relation and on attachment, such as the Circle of Security intervention (Powell, Cooper, Hoffman, & Marvin, 2009) and the Marte Meo method (Vik & Bråten, 2009), may be effective in promoting increased attachment. Other activities to enhance the mother's attunement to the baby such as increased emotional and physical contact through e.g. imitation games or baby massage could form part of the therapeutic process. Previous studies have shown the importance of paternal support in the treatment of PPD, which indicates the potential benefits of triad oriented therapy including the mother, baby, and partner (Misri, Kostaras, Fox, & Kostaras, 2000; Montgomery, Baily, Purdon, Snelling, & Kauppi, 2009). Also, planned activities involving social contact with others, especially other mothers, can help restore synchronicity to the social world. The experienced guilt and shame underscore the need for a therapeutic atmosphere of openness, trust and assurance of confidentiality.

Our findings harmonize with Stern's (1995) description of the essential themes in the motherhood constellation. According to Stern, psychotherapy for new mothers needs to take into account the special type of self-organization involved in the motherhood constellation. He stresses that depressed mothers primarily need a holding environment

provided by experienced maternal figures in order to successfully solve the different essential issues involved.

Our case study, however, revealed how important the traumatic past can be for the development of PPD and it might be possible to prevent this type of depression by identifying and alleviating the traumatic experiences of some women before the birth. One might gradually and tactfully help her to perceive and acknowledge her self-restricting patterns of being in the world and subsequently introduce the unfolding possibilities of existence (Mook, 1985). We hypothesized that mothers suffering from a loss of primordial my-ness (PPD, Structure 2) might also benefit from pharmacological treatment directed towards restoring synchronization of fundamental biorhythms. Considering their unbearable anxiety and internal pain they are at high risk for committing suicide, underscoring the need to assess possible suicidal ideation and plans.

NPPD

Our findings indicate that the NPPD women's depression is caused by a combination of feeling entrapped, sensitivity to others' negative emotions, feelings of guilt and shame, excessive feelings of responsibility and overworking and ignoring their own emotional body.

The depressed women's feelings of guilt and shame were described as the motivating factor for their engagement in self-destructive activities, such as overworking to the extent that they became overwhelmed and exhausted. Thus treatment should aim at reducing these excessive feelings of responsibility, shame and guilt. Emotion focused therapy (Greenberg & Watson, 2006) might help to elaborate on, differentiate and change the underlying feeling of weak or bad self and thus reduce the excessive feelings of guilt and shame. Treatment which increases the depressed women's attention to their emotional body, such as mindfulness oriented therapy (Fjordback, Arendt, Ørnbøl, Fink, & Walach, 2011; Michalak, Burg, & Heidenreich, 2012), and encourages them to act on the corresponding signals could help the women to control their urge to overwork or over-involve themselves.

9.2 Research implications

On the basis of our findings on PPD, future phenomenological research could investigate whether other major transformations or existential crises would give a similar essential meaning structure to “the looming threatening and alienated world” or whether it would be essentially different. Also, it would be interesting to investigate the essential meaning structure in men’s experience of PPD and compare it with our findings on PPD in women.

Another interesting line of research would be to further explore the essential meaning structures of how anxiety and depression interact in both in PPD and NPPD from within the descriptive phenomenological perspective.

The phenomenological aspects discussed in the separate articles might inform and generate hypotheses for future larger-scale research. For example, one could investigate how frequently women with a history of child sexual abuse develop PPD after birth and whether the sex of the baby is an associated risk factor. Knowing the scale of the problem would provide important information when considering implementation of screening for CSA and other childhood trauma in pregnant women. Another line of research suggested by our findings would be to study differences in the quality of anxiety experienced by patients suffering from different types of depression compared to those suffering from primary anxiety disorders.

10 Conclusion

The aim of this thesis was to describe and compare the phenomena of PPD and NPPD from within a phenomenological perspective. We have identified two different essential meaning structures of PPD. PPD may be experienced by the mother as suddenly finding herself in a threatening and alienated world, concomitant with a strong feeling of anxiety and insecurity. We termed this way of experiencing PPD ‘the looming threatening world’. Alternatively PPD may be experienced as a fundamental depersonalization and derealization where the mother no longer feels ownership of her perceptions, thoughts and actions. We named this way of experiencing PPD ‘loss of my-ness’. NPPD, on the other hand, may be experienced as feeling entrapped in a personal mission in which the woman overworks or over-involves herself. Crumbling under the perceived disapproval of others, she doubts her own judgments and she experiences the negative emotions of others almost as if these were her own. Excessive feelings of responsibility are coupled with strong feelings of shame and guilt. In the process she ignores her increasingly alienated and frightening embodied emotions in which she is ultimately submerged. We referred to this experience of NPPD as ‘Engulfed by an alienated and threatening emotional body’.

PPD mothers felt in essence disconnected and alienated from the world and others (including the baby), whereas in NPPD the problem was rather that the women experienced heightened sensitivity to others’ distress or negative judgments. This difference in the development of PPD and NPPD seems to represent two opposites in relation to the world and others, namely experienced disconnection versus heightened sensitivity. We conceptualized the former as existential depression, and the latter as a relational type of depression. These findings have potential psychotherapeutic implications. In order to strengthen and validate our findings, these results should be supported by future similar studies.

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Paper I-III

EMPIRICAL STUDIES

A case study of a mother's intertwining experiences with incest and postpartum depression

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Abstract

The association between childhood sexual abuse (CSA) and major depression disorder (MDD) gives reason to suspect that many mothers with postpartum depression (PPD) have a history of CSA. However, few studies have investigated how CSA and PPD are related. In this case study we explore how the experience of incest intertwines with the experience of postpartum depression. We focus on participant subject "Nina," who has experienced both. We interviewed her three times and we analysed the interviews with Giorgi's phenomenological descriptive method to arrive at a contextualised meaning structure. Nina's intruding fantasies of men who abuse her children merge with her recollections of her own incest experiences. She may succeed in forcing these fantasies out of her consciousness, but they still alter her perceptions, thoughts, and emotions. She feels overwhelmed and succumbs to sadness, while she also is drawn towards information about CSA, which in turn feeds her fantasies. The psychodynamic concepts of repetition compulsion, transference, and projection may provide some explanation of Nina's actions, thoughts, and emotions through her past experiences. With our phenomenological stance, we aim to acknowledge Nina's descriptions of her everyday life here and now. With reference to Husserl, Heidegger, Merleau-Ponty, and Minkowski, we show that Nina's past is not a dated memory; rather it determines the structure of her consciousness that constitutes her past as her true present and future. Incest dominates Nina's world, and her possibilities for action are restricted by this perceived world. Any suspension of action implies anguish, and she resolves this by incest-structured action that in turn feeds and colours her expectations. Thus anxiety and depression are intertwined in the structure of this experience.

Key words: *Child sexual abuse, incest, postpartum depression, descriptive phenomenology, case study*

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Psychological trauma from childhood may haunt a person in her everyday experience of both herself and others and restrict her possible thoughts, actions, and feelings. Pregnancy and birth may elicit memories of abuse and contribute to the development of postpartum depression (Buist & Janson, 2001; Mason, Rice, & Records, 2005). The prevalence of childhood sexual abuse (CSA) in women has been estimated at between 8.2 and 30.4%, largely dependent on the definition of CSA, the measurement, and population studied (Anderson, Martin, Mullen, & Romans, 1993; Finkelhor & Dzuiba-Leatherman, 1994; Heimstad, Dahloe, Laache, Skogvoll, & Schei, 2006; Sariola & Utela,

1994). Narrowly defined sexual abuse (contact abuse) has a prevalence of about 5.6% and a yearly incidence of 3.2% (Finkelhor & Dzuiba-Leatherman, 1994). Childhood abuse and neglect have been associated with increased risk for major depression disorder (MDD) (Widom, DuMont, & Czaja, 2007). An estimated 5% of all new mothers experience MDD and many of these remain undetected and untreated (Gavin et al., 2005; Glavin, Smith, & Sorum, 2009). Also, studies have shown an increased incidence of depression during the first 5 months postpartum (Eberhard-Gran, Tambs, Opjordsmoen, Skrondal, & Eskild 2003; Gavin et al., 2005; Munk-Olsen et al., 2009). Subsequently, it is not

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unreasonable to assume that there are many postpartum depressed mothers with a history of CSA.

A few studies have investigated how CSA might affect the experience of birth and motherhood (Cohen, 1995; Eberhard-Gran, Slinning, & Eskild, 2008; Heimstad et al., 2006; Mason et al., 2005; Parratt, 1994). Childhood sexual abuse is associated with fear of childbirth and increased risk of complications during delivery (Eberhard-Gran et al., 2008; Heimstad et al., 2006; Leeners, Richter-Appelt, Imthurn, & Rath, 2006). Parratt (1994) found that experiences concerning privacy, touch, and control during childbirth were potent links to memories of sexual abuse, but found few commonalities between different cases in how these memories affect childbirth experiences. Mason et al. (2005) found that childbirth contributed to the recall of abuse where the women engaged in a cognitive frame of reference similar to abuse; they felt easily victimised and out of control. However, they concluded that the mothers' experience of PPD was similar to that of women not exposed to CSA.

Childhood sexual abuse victims are likely to experience parenting difficulties. Cohen (1995) compared 26 incestually abused mothers with a control group. The results indicated that the sexually abused mothers were less skilful in maternal functioning than the control group. Survivors of incest had an increased tendency to have rigid role expectations, to be non-cooperative, and to be less able to share responsibilities with their partner. There was a clear tendency for these mothers to have a negative view of their own competence and to feel they were a failure, overwhelmed, exhausted, inadequate, and guilty. In addition, they found that survivors of incest had a reduced ability to communicate freely and openly with others. Douglass (2000) found that women with a CSA history more often report distress in intimate child care because they associate it with their abuse. Other researchers found that abused parents have reported being more overprotective, have a more intrusive and impulsive parenting style, to have low self-esteem and ambivalence about parenting, difficulty setting limits, and feeling resentments towards their children (DiLillo & Damashek, 2003; Möhler, Biringen, & Poustka, 2007; Möhler et al., 2009). In addition psychological disturbances, especially MDD, posttraumatic stress disorder, and generalised anxiety disorder are found to mediate the relationship between CSA and parenting difficulties (Schuetze & Eiden, 2004).

These studies give important clues about how motherhood may affect survivors of incest. However, there is little research describing how a history of incest intertwines with the experience of PPD. This

article is a preliminary attempt to fill that void by using a descriptive phenomenological approach (Giorgi, 2009).

Method

We report on a single case to make possible an in-depth analysis of the complex meaning patterns of incest and PPD intertwined. The participant was involved in a larger phenomenological study on the general meaning structure of PPD (Røseth, Binder & Malt, accepted for publication). Only she related PPD to incest, and her rich descriptions called for, and made possible, a separate case study analysis enabling a comprehensive understanding of the phenomenon.

The study is anchored in a phenomenological philosophy that originated with Husserl (1962). This philosophy was developed further by, amongst others, Merleau-Ponty (1962) and made accessible to psychology as a scientific research method by Giorgi (2009). Husserl articulated the insight that consciousness is intentional; it is always directed towards an immanent object (e.g., memories, fantasies, or hallucinations) or a transcendent object (an object in the physical world). He pointed out that all phenomena are a product of both the intentional act and the intended object, thus phenomena are in essence relational and context dependent.

The phenomenological method requires that the researcher suspends, or "brackets," theoretical, and practical preconceptions and assumptions about the phenomenon that is the object of study (Husserl, 1962; Merleau-Ponty, 1962). Another important methodological process is to withhold an existential claim, meaning that the researcher suspends belief in the existence or "reality" of the phenomenon under investigation (Giorgi, 2009; Husserl, 1962). To bracket and withhold the existential claim helps the researcher to keep an open mind and to see the phenomenon in a fresh light and thus let it "speak for itself." However, this does not mean that it is possible to become totally free from preconceptions and prejudices due to prior knowledge. A basic pre-understanding of the phenomena under investigation is also a premise for understanding it (Heidegger, 1962). In this context, bracketing simply means an attitude towards the experience of the participant in which the researcher disciplines herself not to actively add her own preconceptions and theories.

A phenomenological research interview does not correspond to any usual type of conversation, it is a special inter-subjective situation aimed at exploring the participant's lifeworld. Both the researcher and the participant are motivated to fulfil this aim. A

good interview depends on the interviewer's ability to make the participant feel safe and comfortable, thus enabling her to reveal sensitive and sometimes painful information about herself (Kvale & Brinkmann, 2009).

For this case study we have used Giorgi's descriptive phenomenological method. This method usually involves at least three subjects; several persons share their view on and experiences with one and the same phenomenon. However, in this study we describe and discuss the phenomenon through one women's experience of living and reliving her incest as part of her PPD. We refer to her as Nina. Nina was interviewed three times, with each interview lasting from 45 min to 1.5 h. She initially felt insecure in the interview setting and needed assurance of our independence from the public health care system. It was important that the interview was conducted in a relaxed atmosphere in her home and that we spent some time to "attune" to each other before the digital recorder was turned on. The resulting descriptions were rich in meaning and well suited for a case study.

We analysed the interviews with Nina in four logical steps (Giorgi, 2009). The first step was to read the entire transcript of each interview several times to get a sense of the whole. Secondly, for each interview we divided the transcript into meaning units by being sensitive to and marking shifts in the psychological meaning of what was said. In the third step, we transformed the meaning units into a psychological language, where we identified the more general character by imaginative variation. During imaginative variation, the researcher probes her descriptions by trying out different formulations and thereby teasing out invariant meanings. Here the researcher also reads between the lines, teasing out the coherence between explicit meanings and meanings lying implicit in the descriptions. For the fourth and final step, we synthesised the transformed meaning units of all three interviews into a contextualised meaning structure. We did not, however, proceed through these steps in a strictly linear fashion; the analysis was a dynamic process where we moved back and forth between steps, especially steps three and four, until the final contextual meaning structure was described.

The participant received information about the study both verbally and in writing. She was assured confidentiality and any information in her description that might reveal her identity has been changed or removed. The participant gave her informed consent both verbally and in writing to take part in the research project. She was informed of her right to withdraw from the study at any

chosen time without stating a reason. The Norwegian Regional Committee for Medical Research Ethics had approved the study beforehand (nr: S-08247a).

Findings

Nina is a second time mother, married and in her mid-20s. She was subjected to childhood sexual and physical abuse by her father. When she disclosed the abuse to her mother, her mother chose to support her father and stay with him. As a consequence Nina felt it impossible to live with her family and moved to a foster home. Since she left her family she has had no contact with her father, and for many years she did not talk to her mother. She has difficulties trusting and opening up to others with details about her past—this includes close friends and lovers. Over the years she has managed to keep her memories and the accompanying feelings at a distance by having many superficial relationships and by working a great deal, leaving little time to think about and reflect on her childhood trauma. But when she entered the study she was diagnosed with MDD and posttraumatic stress disorder. Nina found that her incest experiences suddenly resurfaced after the birth of her second child, a daughter. Her trauma invaded dramatically how she existed in her lifeworld and how she anticipated her future.

Contextualised meaning structure

For Nina, PPD means to be thrown into a world full of men who abuse children. Before giving birth she could keep traumatic memories of incest at the fringe of her daily life consciousness. After giving birth she is overwhelmed by an anxious vigilance and intruding fantasies of men who abuse children. Her fantasies merge with recollections of her incest experiences. This intertwined Gestalt of memories, fantasies, and experiences is so painful that she hardly ever succeeds keeping it out of her consciousness, and as a consequence it has an enormous impact on her daily life. It alters her perceptions, thoughts, and emotions, i.e., her mode of existence. Overwhelmed, Nina succumbs into fatigue and sadness. Nevertheless the CSA experiences of unknown people interests and attracts her. She actively seeks out information about CSA, which in turn feeds her anxious vigilance and fantasies.

This contextualised meaning structure reveals three highly interrelated constituents that can be separated for the sake of analysis: from maintaining distance to overwhelming closeness, the attraction of

the world of abuse, and difficulty separating self from baby.

From maintaining distance to overwhelming closeness

Already during her second pregnancy, Nina worries about what would happen to the unborn girl and preferred to have a boy. She explained this worry as based on the belief that girls are more exposed to sexual abuse than boys. She does not experience birth itself as traumatic, but her troubling perception of the baby girl as vulnerable and easy prey to abuse increase steadily after birth. The anxiety thus dominates her perceptions of the world, her thoughts, and emotions.

So it's also a big ... after the birth, that I've had a girl ... I'm so afraid that ... although it can happen to boys too ... of course. But I'm really afraid that one day someone will abuse her or do something to her ... These are things I just can't get out of my head ... Sometimes it's fantasies too, but I try to push them far away, I don't want to go into detail, it's kind of all in my head. I just don't want to think about them at all.

The vulnerability and dependence of the baby girl activated general anxious vigilance and fantasies concerning the girl's possible future abuse. Most of her fantasies are vague and general, more correctly described as an anxious situation, any situation where her children are alone with any man. Her fantasies are so painful that she tries to force them out of her conscious focus. She described her increased vigilance and fantasies as closely related to her own memories of incest, which came to the forefront again after giving birth.

It's come more often ... I haven't always managed to force it to go away, so to speak. In the past, it would sometimes come like a flash into my life again, and then I've just thought that it was something that happened then ... it'll never happen again. It's not a part of my life any more. And then I've managed to get rid of it again. But now I've seen how vulnerable children are ... and they don't have a chance against grown-ups ... When you see how vulnerable they are, you feel helpless on their behalf. Because ultimately there's nothing I can do ... I'm afraid that something will happen to them. [Researcher asks: the same that happened to you?] Yes, or worse things. So I notice that I'm really hung up on it [sexual abuse] ... it really gets to me ... I get so upset about what happened [to me] before, so I feel afraid that it's going to happen to my children.

I'm very ... I'm absolutely terrified that something will happen to them, that they'll meet the wrong kind of people who'll mess them about or ...

Our analysis shows that memories from the past experience with incest merge with anxiety provoking fantasies about possible future abuse. This merger is more difficult to push out of conscious focus than it was before the childbirth. This future moves in on Nina mercilessly and she grieves as if the anticipated abuse has already happened. She is overwhelmed by the insight that she cannot protect her children forever. Her daily functioning such as preparing meals, playing with the children, or socialising with friends diminishes. She becomes depressed, feeling powerless, and immobilised; her body is fatigued and filled with emotions that she cannot control. In short, when actual and possible abuse merge, anxiety and depression intertwine.

The attraction of the world of abuse

Nina watches the news or reads about abuse of children on the Internet and experiences their pain as if it was her own.

I identify with the feelings they [abused others] have, I know how many of them can feel, and then I experience the grief that I had ... Yes, I know the fear, and feel sorry on their behalf.

The information about the abuse experience of other people's children, feeds fantasies about her own children being abused. To this, she reacts emotionally with strong and sustained feelings of anxiety, grief, and anger. Moreover, the information on the Internet fuels her perception of men in general as sexual abusers, which increases her anxiety. Yet these strong negative emotional reactions do not prevent her from seeking this kind of information. On the contrary, she actively searches for information on CSA; she conveys that she feels drawn towards it.

[A]nd then I'm really upset about—I don't know, after I've got really very upset—I let things get at me so much, what goes on in the world, and so on. And then I'm stupid enough to sit and read a lot of stuff on the Internet, about children and so on. Abuse and violence and things like that. It really gets into me.

Anxiety provoking and destructive as it may be, information about CSA attracts her. Moreover, much of her daily life, especially her relations to

men next to kin, is coloured by fantasies about abuse of her children. Nina says:

They are very sick thoughts to think, but they are about the sexual abuse that I have experienced. That I don't trust him [my husband] ... When he takes the children in the shower, or reads for them in bed, then I get very ... I prefer that my husband is not in the room when my children are in bed ... And this is not just about him, it counts for all men.

Difficulty separating self from baby

Nina's vigilance and anxiety concerning the possible future abuse of her children is closely connected to her own past experience with CSA. Nina says that she knows that the incest experience influences her present depression.

Well, it just makes me go around being afraid of it, all the time. And it was actually a thought that stuck in my mind before the birth, when I was pregnant, that I didn't want a girl, I feel afraid that more things can happen to a girl than a boy. And that's obviously because it happened to me before; I had a father who was, you know, not quite all right.

However, in her descriptions during the interview, she was not fully able to separate her own suffering from the potential suffering of her child. The insight that she professed, did not seem to change her obsessive worry about her child's safety. Most of the time Nina did not concern herself with her own traumatic past, rather she seemed fully immersed in the anticipated traumatic future of her children.

Our analysis shows that she did not generally experience her strong sustained feelings of anxiety, grief, and anger as related to her own abuse, despite her rational understanding of this relation. She experienced her feelings as connected to her children's future abuse. Accompanied by her fantasies she thus grieved this anticipated abuse. She had clear aggressive and vengeful fantasies of how she would hurt the abusive men if she could catch them. The drama of incest presents itself to her as an ongoing threat, not as a traumatic part of her past. Thus, her past trauma approaches her from the future, haunting her through her own children.

A phenomenological description of Nina's "here and now"

The birth of her baby girl alters Nina's everyday life. Increasingly she finds herself in a world full of

dangerous men who will abuse her children if given the chance. While struggling to hold her traumatic memories and images at a distance, she is tormented by a general anxious anticipation and fantasies concerning possible sexually abusive situations that her children may encounter. Nina's past casts long shadows forward, especially onto her children's future, shadows that have an enormous impact on her life here and now. How can we understand this?

In phenomenology, the experience of a coherent self and a continuous world is described as inherently temporal and historical. Husserl's description of time perception provides us with an understanding of how Nina's experience is structured with regard to time (Van Gelder, 1999). According to Husserl, a person's consciousness has a triple structure: retention, primal impression, and protension. Retentions are intendings of past events. A primal impression is what happens now. Protensions are intendings of future states. Retentions are not memories; they are direct experiences and not representations. Likewise protensions are not images, they do not reveal something absent as something present but rather anticipations, "directedness" towards future events. This threefold structure of time perception is the basis for our sense of continuity, both the continuity of our self and the world around us.

Heidegger's (1962) work *Being in time* provides a further understanding of the complexity of lived time. When we anticipate a future event, the future in some way happens now. It is part of the current phase of consciousness, even though it is directed towards an event that may happen in the future. Moreover, we approach the future on the basis of our past. Also, the past and the future form the present; what is now is the way it is because of the past and the future. Thus, we are in some way already committed to the future by the present we perceive. This phenomenological description clarifies how Nina's past informs her anxiety about the future and how, depressed, she lives and grieves this future in the present. "The experience is held together and derives its coherence and meaning from the future event to which it refers and for which it is preparatory" (von Eckartsberg, 1972, p. 167).

Merleau-Ponty (1962), with his description of the object-horizon structure of our consciousness, clarifies further how events from the past can lie in the horizon of our consciousness and colour our whole existence. Merleau-Ponty was inspired by Gestalt psychology when he wrote about the dynamic figure-ground structure where perceptions, thoughts, and feelings may change from being in focus to lying at the fringe of the experiential horizon and vice versa.

An important aspect of the Gestalt principle is that for the creation of meaning, the fringe of the horizon is as important as the focal object. Moreover, any change in the horizon may alter the whole meaning of what is in focus for consciousness. There is no doubt that the birth of a baby girl implied a major alteration of Nina's life. However, it was not the baby girl herself, but the meaning she had for Nina that changed her mode of existence. Nina's world is once again dominated by abusers and victims, only now it is her child and not herself that is perceived as a victim and all men are abusers, not only her father. Merleau-Ponty (1962) explains that new perceptions and new emotions may replace the old ones, but that it is only the content that changes and not the structure of experience. The traumatic "memory" that dominates Nina's life is not representational. It survives as "as a manner of being and with a certain degree of generality" (Merleau-Ponty, 1962, p. 83). This past is not like a dated memory, a representation of the past that can be made present in Nina's consciousness; rather it determines the structure of her consciousness that constitutes her past as her true present and future.

Traumatic memories seem to be lingering in the horizon of her consciousness and may at any time become the focus of her attention. Even though Nina directs her attention elsewhere, the traumatic memories form the background of her experience, giving the focal intentional object its form and colour. She is not unconscious of her trauma, but chooses not to address it directly. Merleau-Ponty (1962) supports this description: "Forgetfulness is . . . an act; I keep the memory at an arm's length, as I look past a person whom I do not wish to see" (p. 162). Contextual changes, such as the birth of a baby girl, may change and reorganise the whole experiential Gestalt, where the memories of CSA prevail in Nina's effort to create meaning in her lived world.

Experience has an ever-present atmosphere of elusiveness, of something incomplete and out of reach (Shapiro, 1976). Experience is therefore filled with tension; it is both a threat and an attraction. We may never fulfil the elusive event; it might continue to hover over us. The elusiveness of experience is evident in Merleau-Ponty's object-horizon structure as it implies that we can only focus on one facet of an object at the same time, while all the other facets are present as possibilities for approach. Thus, the horizon presents possibilities that might be experienced in the future. These possibilities afford approaching, they afford straining at or leaning towards. Incest dominates Nina's world and her possibilities for action are restricted by this perceived world. Minkowski (1970) states that the opposite of

action is expectation. In action we move towards the future. But in expectation the future closes in on us, moving towards us. And expectation always implies intense anguish as it is a suspension of activity—activity which is "life itself," as Minkowski (1970, p. 88) writes. To stay in anguish over time is unbearable; action must overcome expectation. Nina acts in an attempt to reduce overwhelming anguish when she seeks information about CSA on the Internet. But unfortunately for Nina, the action of seeking information does not overcome the uncertainty; instead it feeds and colours the expectation, creating intense anguish. Her anguish-creating action stalls time, which is an important aspect of depression (Minkowski, 1970). Anxiety and depression are thus intertwined in the structure of Nina's experience. They are two sides of the same coin.

Discussion

Nina's re-entry into a world of abuse may be interpreted as the need to work through and master her experience of CSA. However, the way she acts in this world does not lead to any mastery or learning; on the contrary, it increases anxiety and depression. What is more, Nina describes how she seeks destructive information against her better judgement. Her search for information about CSA on the Internet seems partly involuntary. A possible explanation for the driven, persistent quality of such behaviour may lie in Freud's concept of repetition compulsion (Freud, 1958). The individual feels compelled to repeat the repressed material as contemporary experience. Fairbairn (1986) explains repetition compulsion as the effort to master traumatic experience through a fixation on a painful situation. In this view, repetition compulsion may be an unconscious repetition of a traumatic relationship with a traumatising bad object, where the subject has a concealed hope that the bad object eventually will turn into a good object. From this perspective, Nina hopes that she (or her mother) will be able to protect her children (or herself) from abuse. If not, she hopes that she (or her mother) at least will be able to detect it and punish the abusive man (or her father), i.e., that the mother in the end will prove to be good. We could also assume that she hopes that the men (or her father) in her surroundings do not end up abusing her children and, thus, also in the end turn out to be good. Thus, repetition compulsion can be seen as an attempt to master a situation by wanting unconsciously to go through the same situation, and hoping that it does not end badly as it did in the past. The person who repeats compulsively is then described as loyal to her primary objects, despite the traumatic and difficult relationship to them. The loss

of a “bad” primary object is, according to Fairbairn, equal to an objectless world, which is experienced as far more distressing because it also implies the loss of parts of the original ego.

Nina holds very painful memories and anxiety that thrust her away from her focal consciousness. In recent psychoanalytic literature, Bromberg (2003) theorises that traumatic events that we find difficult to incorporate are dissociated away from the self as a “not-me,” in order to protect the perceived vulnerable self. Thus, a part of oneself becomes detached and hidden in the unconscious. Somehow, however, the detached part continues to hover over the person, as the dissociation is not complete. The conscious self still has some access to the “not-me.” The previously dissociated “not-me” experiences are enacted by transference and projection into the surrounding world.

In this psychodynamic line of thinking, Nina’s emotional and pre-symbolic memories are lived as a real threat in the present and near future, the threat of sexual abuse of her children. Nina does indeed seem to exist in a world full of perpetrators and victims. Her feelings towards her abusive father can be said to be transferred or redirected towards all other men. She somehow transfers her past into the present and the future, and projects her own feelings onto her children, who thus take on the role of victims. Thus a possible psychodynamic interpretation is that Nina’s compulsion to seek destructive information on the Internet is motivated by complex and contradictory emotions connected to her trauma.

The concepts of transference, projection, dissociation, and repetition compulsion rest theoretically on the construct of the unconscious. Nina’s repetition compulsion is then explained by unresolved conflicts that are repressed into her unconscious and that motivate her recurring projection and transference. What really only exists in Nina’s mind is unconsciously transferred and projected onto the world and the people around her.

In his seminal book from 1972 *A different existence* van den Berg directs our attention to this way of reasoning. The concept of projection, van den Berg points out, implies that something within the person departs from her, moves towards and attaches itself to objects and other persons in the world. In the case of transference, a feeling that she has for one person can detach itself from that person and latch onto other people in the world. Thus transference and projection indicate that emotions can be objectless and attached to other objects at will. van den Berg infers from this that these psychodynamic concepts imply that the person in essence is detached from the world and others. This in turn means that transfer-

ence and projection imply a negation of the person’s reality. “Transference” denies what the person sees in others and “projection” denies what the person sees in the here and now; the person sees only herself (Giorgi, 1985; van den Berg, 1972). In a more recent critique of such Cartesian trends in psychodynamic thinking, Stolorow, Orange, and Atwood (2001) point out that this “doctrine bifurcates the subjective world into outer and inner regions [and] reifies the resulting separation between the two” (p. 469). The mind appears as an isolated container of internalised relationships that can be studied largely detached from the surrounding context.

Taking seriously Nina’s account of her situation, and in consistence with our research method, we prefer the phenomenological understanding of how incest and depression intertwine in Nina’s lifeworld. In doing so we open up for mental health work grounded in and directed at her illness experience. This experience gives her little room to act: Nina’s anxiety and depression are two sides of the same coin; that is, aspects of a world with a “frozen” structure in which all new experiences are given old meaning. For the mental health worker or psychotherapist this would imply that instead of seeking incidents in the past that serve as causal explanations for current problems, it may be more fruitful to concentrate on the patient’s current difficulties and elaborate on her situation in the here and now—helping to “melt down” the frozen structure. In her world the problems lie in her non-knowledge, in what she is not directly conscious of, but which severely restricts her potentialities (Mook, 1985). In therapy the aim is to tactfully and gradually reduce her restricting non-knowledge and to uncover what her limited mode of existence means to her. Thereby the therapist gradually introduces the unfolding possibilities of existence for her. Thus, instead of speaking of transference and projection, the therapist accepts the client’s descriptions of her world. Nina’s problems lay in her relationship to significant others in her world and it is in this world that she has to regain her health (Mook, 1985). The therapist could start working with the fact that Nina has difficulty trusting men in her surroundings and what this difficulty actually means for her. As both past and future meet in the present, their appearance is dependent on how we view them from the present. It follows that it is Nina’s present mode of existence in her world and the consequences it has for her that we must take seriously and not a superimposed theory.

Conclusion

Through a case study we analysed how a mother’s experiences with incest and PPD intertwine. Using

Giorgi's phenomenological method of analysis we derived a contextualised meaning structure of the experience. In this structure, traumatic past experiences merge with destructive present behaviour and anxiety-filled expectations about the future. Past, present, and future pivot around sexual abuse by untrustworthy men. The psychodynamic understanding of this meaning structure of experience emphasises projection and transference as concepts bridging past, present, and future. Together with the concept of repetition compulsion, projection and transference may explain the participant's mode of being in generic terms. But we preferred to stay close to Nina's specific descriptions of the world she lives in and moved on to a phenomenological understanding. This allowed us to describe Nina's perceived past and future as intricately related to her here and now intertwining experiences of anxiety and depression.

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