Maternal Depression in Barbados: Exploring how Black Women Experience, Understand, Manage and Cope with Self-Reported ‘Baby Blues’ and Postpartum Depression

by

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A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy
Dalla Lana School of Public Health
University of Toronto

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Doctor of Philosophy
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Abstract

Postpartum depression is a major depressive disorder whose onset can appear up to one year after delivery and last for weeks, months or years (O’Hara, 1987). The ‘baby blues’ is a mild affective syndrome common during the first three days after birth and can last up to 10 days (O’Hara, 1987; Cole, 2009). Existing research on maternal depression in the English-speaking Caribbean uses epidemiological methods to investigate the incidence and prevalence of depression occurring during pregnancy and the postpartum period, but largely excludes research on the ‘baby blues’. Also absent from the Caribbean research are studies that use qualitative methods which can help build understanding about how women’s social worlds impact their mental health (Amankwaa, 2003; Almond, 2009).

To investigate these gaps, a qualitative research project was conducted with 11 (n=11) Black women in Barbados to explore how they have understood, managed, coped, and sought treatment for self-reported postpartum depression and the ‘baby blues’. Black Feminist and Caribbean Feminist Theoretical frameworks anchored the project and helped
consider how women’s social, historical, racial, and cultural backgrounds were linked to their maternal mental health.

The project’s findings show that early maternal depression literature from North America and Europe largely excluded women from diverse racial and cultural backgrounds. Studies conducted to fill this gap have recorded higher rates for the ‘baby blues’ and postpartum depression in Caribbean contexts. Research with Black Caribbean women in the Diaspora highlights their Intersectional experiences and explanatory models which have helped them understand maternal depression. Barriers that prevented research participants from receiving the maternal mental health care they needed included a lack of formal information and education on maternal depression at the postnatal stage; proliferation of international and non-local information sources on maternal depression; women’s intersecting race, class and gendered experiences with self-reported maternal depression; and social/cultural stigmas around mental health. The formal and informal supportive resources women discussed and critiqued during their maternal depression experiences included local healthcare institutions, family members, intimate partners, and religious and spiritual sources.

The research findings confirm that maternal depression exists in Barbados, and affirms that these conditions are a global public health concern. They also show that an Intersectional framework can facilitate analyses that acknowledge women’s multi-layered identities which can help transform how maternal depression is treated and prevented.
Acknowledgments

All Thanks and praise is due to Allah, without whom I would not be here and I would not have been able to do this work.

To my mother Jackie Taylor, you are an inspirational, bold, beautiful, and loyal woman and I love you. Thank you for allowing me to tell your story so many times to impact others. To my father Michael Abdur Rashid Taylor, you are the best father in the world and I love you. You both will never know how much I appreciate all the sacrifices you made for me and my education, and ‘thank you’ will never feel sufficient. Thank You both. I would like to acknowledge my supervisor Dr. Carles Muntaner for supporting me in doing the project I truly wanted to do. To my committee member Dr. Alissa Trotz whose work in the Caribbean is impactful and inspiring to me and so many others on so many levels. To my committee member Dr. Anne-Emanuelle Birn for being an amazing resource and for dedicating time and energy to this process. Thank You to you all. Joan Cuffie, Dr. Charmaine Crawford and all the women of the Institute for Gender and Development Studies. Thank You for welcoming me, housing me, supporting me, raising my consciousness and advising me since 2010. This is what feminism looks like! A special acknowledgment to Dr. Dawn Edge whose work on postpartum depression in the UK inspired my dissertation project. A totally trailblazing woman, Thank You. Myrna Taylor, Mustapha Taylor, Isa Taylor, Colleen Brewster, Sabrah Sandiforde, Hidaayyah Taylor-Sandiforde, and Kareem Taylor-Desir. Thoughts of your love and support kept me going during more lonely days than you would know. Thank You. To my husband Javan Best. You have never known me outside of being a PhD student and I cannot wait to be something else to you! I love you honey and Thank You for being supportive and listening to my conference papers and ideas all these years. To all my friends, extended family and loved ones. There are too many of you to list, but you know who you are, and I deeply appreciate the support and love you provided always and in all-ways. Thank You. Last, but certainly not least, Thank You to the 11 women who provided the rich, important and critical information for this thesis. You are brave and you are fearless. Thank you so much for helping me make this a reality.
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Introduction

The World Health Organization (2008) states that research on maternal depression has been conducted in 90% of high-income countries. Such studies have investigated conditions like postpartum depression which is described as a major depressive disorder whose onset can appear up to one year after delivery and last for weeks, months or years (O’Hara, 1987). Other research has explored the ‘baby blues’, identified as a mild affective syndrome common during the first three days after birth and which can last up to 10 days (O’Hara, 1987; Cole, 2009). Maternal depression research estimates that postpartum depression affects 10-15% of women (O’Hara, 1987; O’Hara, 1990; Pitt, 1968; Seyfried and Marcus 2003), while 30-80% of women will experience the 'baby blues' (Pitt, 1968; O’Hara, 1987; Seyfried and Marcus 2003; Pearlstein, Howard, Salisbury, and Zlotnick, 2009). However, a significant characteristic stands out amongst these facts and figures: they do not reflect rates for maternal depression in the Global South which omits a great number of women from around the world and excludes their diverse experiences with these conditions (WHO, 2008). These rates also do not always reflect the diversity of experiences of maternal depression amongst women living in the Global North. These gaps in the knowledge base prevent us from understanding how maternal depression is experienced, understood, and managed by diverse groups of women inside of North America and Europe, and by women living outside of these regions.

The Caribbean is a region where we see further evidence of this research disparity. Data on maternal depression from the English-speaking Caribbean is limited, and existing

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1 The term ‘Global South’ is used here to denote regions outside of North America and Europe which are sometimes low-income and politically or culturally marginalized (Dados and Connell, 2012).
research of the last 40 years primarily uses epidemiological methods to investigate the incidence and prevalence of depression occurring during pregnancy and postpartum, but largely excludes research on the ‘baby blues’ (see Davidson, 1972; Palmer, 1996; Galler, Harrison, Biggs, Ramsey, and Forde, 1999; Pottinger, Trotman-Edwards, and Younger, 2009; Wissart, Parshad, and Kulkarni, 2005). Noticeably absent from this literature are studies that use qualitative methods which can provide knowledge about women’s experiences with maternal depression and help build understanding about how their social worlds impact their mental health (Amankwaa, 2003; Almond, 2009).

To investigate these gaps in methodology and knowledge, a qualitative research project was conducted which explored Black women’s experiences of self-reported postpartum depression and the ‘baby blues’ in Barbados. Three manuscripts were developed from this endeavour which presents the research project findings.

The first manuscript is a narrative review of maternal depression research studies conducted with Caribbean-descent women living in the Diaspora and Caribbean women living in the region. The review of these studies was performed over a period of two years between 2011 and 2013. Also included are earlier maternal depression studies from North America and Europe whose findings provide context for later research that focused on women from diverse backgrounds and in different geographical areas. Most of these studies were conducted in Britain or the United States and highlight an Anglo-American bias. The review is organized according to three thematic areas that emerged from the research studies: the prevalence and incidence rates of postpartum depression and the ‘baby blues’, understandings and explanations of maternal depression and, grappling with
difference. By engaging with the existing body of research we situate the thesis and outline its contribution to the body of knowledge on maternal depression.

The second manuscript is organized around the narratives of the research project participants and presents four themes that were evoked from women’s self-reported maternal depression experiences. These are: the lack of formal maternal depression education and information at the postnatal stage, proliferation of international and non-local sources on maternal depression, women’s intersecting race, class, and gendered experiences with self-reported maternal depression and, social/cultural stigma around mental health. These themes were also identified as barriers to women seeking help and receiving care for maternal depression in Barbados.

The third manuscript focuses on women’s interactions with formal and informal supportive resources and their expectations of these during their self-reported experiences with the ‘baby blues’ and/or postpartum depression. The Barbados Maternal and Child Health Service (MCHS) is discussed and women’s interactions with it facilitate an analysis of their calls for certain formal maternal healthcare support services. The manuscript also explores how women accessed informal supportive structures such as intimate partners, family members, and religious and spiritual resources to help care for themselves and their children. These formal and informal resources are presented alongside some contradictory messages and perceived shortcomings also discussed by women.

These manuscripts are intended to complement and extend the analysis of Caribbean epidemiological studies on maternal depression. By exploring the distinct ways Black women in Barbados experienced self-reported postpartum depression and the ‘baby
blues’, the papers seek to advance and vary the knowledge base on maternal depression by including these women’s voices and focusing on their lived experiences with the conditions.

Research Objective and Research Questions

The objective of this research project was to investigate Black women’s experiences with self-reported maternal depression in Barbados in order to learn how they have understood, managed, coped, and sought treatment for them after giving birth. The research questions that guided this project were:

1. How have Barbadian women experienced maternal depression such as postpartum depression and the ‘baby blues’?
2. Do Barbadian women interpolate maternal depression through social and cultural frameworks?
3. How do Barbadian women identify and manage the ‘baby blues' and postpartum depression?
4. What have been Barbadian women's experiences seeking treatment for maternal depression within the Barbadian healthcare system?
5. What kinds of non-institutional forms of care have Barbadian women sought out and/or received to treat maternal depression?

Definition and Discussion of Terms

Maternal depression: The definition provided by the National Institute for Health Care Management (NIHCM) states that maternal depression is an “all-encompassing term for a spectrum of depressive conditions that can affect mothers (up to 12 months
postpartum) and mothers-to-be” (Santoro and Peabody, 2010). These depressive conditions include the ‘baby blues’ (also called Maternity Blues and Postpartum Blues), postpartum depression, antenatal depression, postpartum bipolar II disorder, postpartum panic disorder, and postpartum psychosis (Rondon, 2003; Logsdon, Tomasulo, Eckert, Beck, & Dennis, 2012; Santoro and Peabody).

‘Baby blues’: A mild affective syndrome common during the first three days after birth and can last up to 10 days (Cole, 2009). Symptoms of the ‘baby blues’ include irritability, restlessness, despondency, mild confusion and hypochondria (Halbreich and Karkun, 2006, p. 98). Other symptoms attributed to the condition include mood swings, crying, loss of or poor appetite, decreased concentration, difficulty bonding with the baby, sadness, feelings of isolation, and tension (Rondon, 2003, p. 168).

Postpartum depression: A major form of depression whose onset usually occurs within four or six weeks after birth (Almond, 2009). Cole (2009) elaborates on this and states that the condition’s “onset can appear up to a year later and last several weeks to months” (p. 460). Symptoms of postpartum depression include low mood, inability to find pleasure in activities that were once enjoyable, forgetfulness, low self-esteem, weight loss or gain, irritability, anxiety, sleep disturbance, and poor functioning (Almond, 2009; Halbreich and Karkun, 2006, p. 98). In some research, thoughts of self-harm or harming one’s child have been attributed to postpartum depression symptomatology (Almond, 2009; Fritz and McGregor, 2013).

Maternal mental health: This term denotes the relationship between women’s mental health and maternal health. The World Health organization indicates there is cause
for concern about this relationship, as they “directly and indirectly increase maternal morbidity and mortality” (WHO, 2008).

The research addresses the two most commonly experienced forms of self-reported maternal depression amongst the participants which were the ‘baby blues’ and postpartum depression. Focusing on these conditions reflects the experiences of the women in the study. Their experiences inform and guide the research endeavour which is significant to advancing the theoretical and methodological underpinnings of the project.

A secondary motivation behind focusing on the ‘baby blues’ and postpartum depression is that other studies have reported greater prevalence and higher rates of these forms of maternal depression in comparison to others (see Rondon, 2003; Pitt, 1968; Seyfried and Marcus, 2003). Focusing on these conditions enabled an analysis of how the ‘baby blues’ and postpartum depression have been specifically experienced by a sample of women in Barbados. This focus helped widen the scope of analysis of maternal depression research to include a qualitative sample from an English-speaking Caribbean country.

Self-Reporting as a Measure of Assessment

All of the women who consented to participate in the research project described self-reported symptoms and experiences of the ‘baby blues’ and/or postpartum depression which aligned with symptomatology recorded in previous research conducted on these conditions (see Almond, 2009; Fritz and McGregor, 2013; Halbreich and Karkun, 2006; Rondon, 2003). With the exception of two individuals, none of the women who participated in the project were diagnosed or screened by their health care service
providers for any form of depression, including the ‘baby blues’ and postpartum depression.

Women’s experiences, definitions, and self-reported symptoms of the ‘baby blues’ and postpartum depression were used to arrive at the sample. The project’s feminist theoretical orientation facilitated this approach to the research and data collection. Women were regarded as experts on their own conditions, as well their knowledge of and experiences with the conditions were privileged and used to guide and inform the research.

Participant’s self-reported symptoms and experiences of the ‘baby blues’ included feeling anxious, feeling disconnected from their babies, feeling overwhelmed since the birth of their baby, experiencing sudden changes in their mood, bouts of crying, sadness, experiencing a sense of loss, and feeling alone. Women’s self-reported symptoms and experiences of postpartum depression included weight loss, general loss of interest in activities, disconnection from their children, disconnection from family members and intimate partners/spouses, lack of interest in sexual intercourse, anxiety, prolonged and intense periods of sadness, prolonged and sudden bouts of crying, feeling helpless, and feeling hopeless. Two women in the research project discussed thoughts of suicide, and one of these women discussed having thoughts about harming her children. However, neither expressed plans or intentions to carry out these actions.

The intensity of women’s symptoms and the length of time experienced distinguished the ‘baby blues’ from postpartum depression amongst the sample. Women who self-reported the ‘baby blues’ described their symptoms as lessening some days, weeks or months after birth. Women who experienced self-reported postpartum depression
typically discussed the symptoms and experience as being intense and taking place over a course of months or years. Two women in the sample stated that they experienced the ‘baby blues’ and postpartum depression consecutively, and described the symptoms of the conditions as becoming more intense and prolonged as time went on.

Table 1: Women’s Self-Reported Symptoms of the ‘Baby Blues’ and Postpartum Depression

<table>
<thead>
<tr>
<th>‘BABY BLUES’</th>
<th>POSTPARTUM DEPRESSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disconnected from baby</td>
<td>Weight loss</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Loss of interest in activities</td>
</tr>
<tr>
<td>Feeling overwhelmed</td>
<td>Disconnected from baby</td>
</tr>
<tr>
<td>Mood swings</td>
<td>Disconnected from spouse/intimate partner</td>
</tr>
<tr>
<td>Crying</td>
<td>Anxiety</td>
</tr>
<tr>
<td>Loneliness</td>
<td>Prolonged and intense periods of sadness</td>
</tr>
<tr>
<td></td>
<td>Feeling helpless</td>
</tr>
<tr>
<td></td>
<td>Feeling hopeless</td>
</tr>
</tbody>
</table>
Research Design

The research project was designed as a descriptive, qualitative study. This design was selected based on its perceived ability to address the study’s objectives and research questions and facilitate the inclusion of a diverse set of sampling techniques, data collection methods and analytic styles (Sandelowski, 2000). A descriptive model also enabled a nuanced examination of the research topic wherein the researcher conducted semi-structured, one-on-one, in-depth interviews with study participants to investigate various angles and areas of inquiry of the research topic as they developed. For these reasons, the descriptive model was determined to be the most appropriate study design for facilitating an exploration of women's experiences with maternal depression in Barbados.

Ethical Considerations

The study received ethical approval from the University of Toronto Research and Innovation Board and the Barbados Ministry of Health Research Ethics Committee in September and October 2012, respectively. In addition to approval from these ethics boards, a letter was sent to the Senior Medical Officer of Health South in Barbados to gain permission to conduct recruitment in two polyclinics on maternal health clinic days (Appendices G, H, I).

Participants were verbally informed of their right to withdraw from the research project and the option was also addressed in the informed consent form (Appendix C). Participants were told that if they chose to withdraw from the research project all of the information they provided would be destroyed immediately. Participants were also informed that they would be unable to withdraw from the research project after data
analysis took place because that could compromise the research dataset and necessitate re-analysis of all the data.

Given the nature of the research project, participants were told that if they expressed intent to harm themselves or their children, and/or if there was a verbalization of suicidal intentions there is a duty to report according to Barbados law. In such cases, emergency psychiatric care may be required, and the principal investigator would contact the local authorities who would contact the emergency department of the local mental health institution.

Research participants described high mental health stigma in their communities, and this led to increased measures to ensure women’s confidentiality, anonymity, and the maintenance of a high level of data protection. All research interviews were anonymized, transcribed verbatim, and analyzed by the principal investigator. Research participants had their names masked during data collation, analysis, and storage stages. Pseudonyms were assigned to each woman throughout these stages to ensure confidentiality. Hard copy data including digital recordings and interview notes were entered into a secure password-locked computer at the Institute for Gender and Development Studies: Nita Barrow Unit at the University of the West Indies Cave Hill where it underwent analysis. These documents were accessible only by the principal investigator. After the data was entered into a secure password-locked computer, all hard-copy notes from interviews were destroyed. Participants’ information including personal identifiers, names, and contact numbers were kept confidential throughout the research endeavour. All informed consent forms were locked away in a filing cabinet at the Institute for Gender and Development Studies: Nita Barrow Unit. No personal identifiers, names, or information was used in the thesis and will
not be used in any knowledge dissemination activities, including publications in scholarly journals.

All soft copy data, such as transcribed interviews, interview notes, and other data remained stored in a secure password-locked computer at the Institute for Gender and Development Studies: Nita Barrow Unit at the University of the West Indies Cave Hill until the research project concluded. After this time, the soft-copy data was encrypted, transferred to a USB key, and transported back to Toronto, Canada with the principal investigator. The USB key travelled on person at all times with the principal investigator. Upon arrival in Canada, the encrypted data was transferred from the USB key to the principal investigator’s secure password-locked computer. This data will be kept for seven years after which time it will be transferred back onto a USB key and physically destroyed via pulverizing.

There were also specific measures taken to reinforce the principal investigator’s duty of care. Also, deliberate steps were taken to counter any emotional distress women may have experienced due to participating in the research interview. All of the women who participated in a research interview were given a brochure on maternal depression after the interview that outlined symptoms, methods of care, and local and online resources they could access (Appendix D). These resources included the cell phone number of the local coordinator of Postpartum Support International. In addition to this, prior to initiating the research project the principal investigator met with a trained mental health counselor in Barbados who agreed to conduct a hour-long session with women who felt that the interview made them feel emotionally or psychologically distressed, or if recalling their experiences with maternal depression brought up any negative feelings. Every woman who
participated in a research interview was given the contact number and name of the mental health counselor. Without disclosing the names of research participants, the counselor was contacted after several interviews where women stated they would call to arrange a session. However, no women contacted the counselor and none ever arranged a follow-up session. Upon further reflection, it occurred to the principal investigator that women may have perceived the research interview itself as being a therapeutic interaction, as several participants stated that they felt a burden had been lifted at its conclusion. While the principal investigator is not a mental health practitioner, and made this clear during the research interaction, it was also realized that women might not feel they needed such professional help at that time. What they may have needed was to unload a heavy burden they had been carrying, and it is possible that the research interviews provided this space and opportunity.

**Sampling Strategy, Participant Recruitment and Inclusion/Exclusion Criteria**

A purposive sampling strategy was selected to engage with participants who could provide rich information in a strategic and purposeful way (Patton, 2002). To accomplish this strategy a snowball sampling technique was used to recruit eligible research participants to the project. Noy (2008) states that snowball sampling facilitates researchers to partake in the “dynamics of natural and organic social networks” (p. 329). In the project, snowball sampling occurred when the principal investigator asked participants to refer other women from their social networks to the research project. Participants were asked to discuss the research project with women who had experienced or were experiencing the ‘baby blues’ or postpartum depression. They were asked to give these women the telephone number of the principal investigator to schedule an interview. This referral
method was selected to counteract women feeling pressured to participate or uncomfortable with a stranger contacting them. Women made the decision about whether they would get in contact with the principal investigator. Referrals through snowballing also enabled the principal investigator to interview women who may not have been aware of the research project.

Data was also collected by recruiting women at polyclinics on maternal health clinic days. These situations facilitated direct interactions with women who were already at the polyclinic to receive maternal healthcare services and had given birth recently (typically within three months of the recruitment). On maternal health clinic days, the principal investigator addressed attendees to explain the research project, discuss maternal depression in general, and hand out the project flyers to women individually. Women who expressed interest in participating were asked for their telephone number to arrange an interview time and place at a later date. In addition to this recruitment method, research project posters were also displayed in public areas such as the polyclinics and the University of the West Indies Cave Hill Campus (Appendix A).

Research interviews were semi-structured and were conducted using a protocol of open-ended questions with individual women (Appendix B). The topic guide and interview questions were generated from the project’s research questions. Using the research questions as guide for developing the interview questions allowed the principal investigator to remain cognizant of the project’s central objectives. Thus, the research questions were essential to developing interview questions that reflected the core interests of the project and advancing knowledge on the topic. Demographic information such as age, race, level of education, number of children, and relationship status was also collected.
during the research interviews. The interview protocol was piloted once to ascertain if the flow of questions and prompts were effective. Following the pilot interview, minor modifications were made to improve the protocol and were implemented for subsequent interviews.

A study sample of 11 (n=11) was collected. Women were eligible to participate in the study only if they were Black and of Barbadian or Caribbean origin, aged 18 years or older, were literate in English, had given birth within 10 years of the research interview, had an experience with the ‘baby blues’ or postpartum depression within 10 years of the research interview, and had given written, informed consent. Women who consented to participate in the research project had self-reported an experience with the 'baby blues' or postpartum depression. Women were targeted for participation in the study regardless of any previous mental health conditions or illnesses.

Women who agreed to participate in the project were interviewed by the principal investigator. Participants were given the option to choose the location of the research interview. The majority of the interviews took place in women’s homes and some were conducted in public places around the island such as at the University of the West Indies Cave Hill Campus, a farmer’s market, and a downtown public square in the capital city of Bridgetown. Each interview lasted between 30 and 120 minutes and was recorded using a digital audio recording device. Field notes were also taken throughout the data collection process.
Data Analysis

Analysis of the research data was conducted by the principal investigator. A combination of the NVIVO 10 software program, open and focused coding of the raw data, and thematic analysis were used. Open coding consisted of reading each interview transcript line-by-line to generate as many codes as possible (Hsiung, 2000). To facilitate this approach, transcribed interviews were transferred to a Microsoft Word document and were individually examined and codes attached. A code list and attendant definitions were also composed on a separate Microsoft Word document. Data were then combed through a second time to conduct focused coding. During this process, transcripts were re-coded and definitions updated according to a specific thematic issue (Hsiung, 2010). This two-pronged coding activity enabled the principal investigator to ensure that codes, their definitions, and the data were organized correctly and remained true to the research participants’ narratives.

Thematic analysis was used to help identify, describe, analyze, and report themes and patterns in the data (Braun & Clark, 2006, p. 6). This technique also helped to capture important information in the data in relation to the research questions, and search for patterned responses and meanings in the data set (Braun & Clarke, 2006, p. 10). Thematic analysis was used during the focused coding activity. Once identified, themes underwent processes of expansion and reduction until minor and dominant themes were identified according to the frequency they appeared. This was facilitated by uploading the transcripts and attendant themes and codes to NVIVO 10. This also helped the principal investigator compare and contrast various sections of the interview transcripts and determine more emergent themes from others.
Memos were also recorded in the transcripts to report thoughts about codes and themes. Charmaz (2006) writes that “memos catch your thoughts, capture the comparisons and connections you make, and crystallize questions and directions for you to pursue” (p. 72). Memos were useful to help recall field notes and observational information from the research interviews and link them to the emerging data.

Profile of Research Participants

The research participants were all Black women and most were born and raised in Barbados. Women who were not born in Barbados obtained legal rights to reside in the island via citizenship or work and study visas. Women who were born outside of Barbados hailed from Antigua, St. Vincent, and Guyana. These women had been living in Barbados for anywhere between 10 and 25 years.

Overall, research participants showed a diverse range of experiences and backgrounds. Women’s ages ranged from 18-49 years old and over half of the research sample was in their 30’s. Women’s educational backgrounds varied, and the majority had completed secondary school (high school) while others were pursuing or had completed University degrees and post-graduate degrees at the time of the interview. The employment status of research participants were also varied: some women were employed full-time or part-time, but over half of the women were engaged in jobs that were low-paying, on a casual basis, or were unemployed.

The relationship status of the participants was significant to the project based on research findings from earlier Caribbean-based maternal depression studies. Findings from Jamaican studies have asserted that unmarried women are at greater risk for having
maternal depression because the lack of support provided in marriages could influence depression (Davidson, 1972; Wissart et al., 2005). However, these studies overlook other intimate partnerships and living arrangements that have been investigated in Caribbean studies such as “visiting relationships”. These are described as “heterosexual unions without legal sanction and in which the partners do not live together but share a close relationship, usually including parenting” (Robinson, 2013, p. 426). Research participants were able to explain their relationship statuses on their own terms which allowed the principal investigator to more fully understand how they defined and accessed support from these structures. Based on this information, five women indicated they were in an intimate relationship, two women were single, three were married, and one woman was separated from her spouse and also in an intimate relationship with a different partner (Table 2).
Table 2: Profile of Research Participants

<table>
<thead>
<tr>
<th>NAME</th>
<th>AGE</th>
<th>CONDITION</th>
<th>EMPLOYMENT STATUS</th>
<th>NUMBER OF CHILDREN</th>
<th>RELATIONSHIP STATUS</th>
<th>EDUCATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dena</td>
<td>24</td>
<td>Baby Blues</td>
<td>Unemployed/Student.</td>
<td>1</td>
<td>In a relationship</td>
<td>In University</td>
</tr>
<tr>
<td>Lucy</td>
<td>40’s</td>
<td>Postpartum Depression</td>
<td>Manager/Entertainer</td>
<td>1 (deceased)</td>
<td>Married</td>
<td>Completed high School</td>
</tr>
<tr>
<td>Catherine</td>
<td>30</td>
<td>Baby Blues &amp; Postpartum Depression</td>
<td>Cashier/Student</td>
<td>2</td>
<td>In a relationship</td>
<td>In University</td>
</tr>
<tr>
<td>Mary</td>
<td>32</td>
<td>Postpartum Depression</td>
<td>Business Owner/Government Worker</td>
<td>2 (1 child deceased)</td>
<td>Married</td>
<td>Completed post-graduate degree</td>
</tr>
<tr>
<td>Nita</td>
<td>33</td>
<td>Postpartum Depression</td>
<td>Office Attendant</td>
<td>3</td>
<td>In a Relationship</td>
<td>Completed high school</td>
</tr>
<tr>
<td>Cynthia</td>
<td>35</td>
<td>Postpartum Depression</td>
<td>Cashier/Bookie &amp; Student</td>
<td>3</td>
<td>Single</td>
<td>In University</td>
</tr>
<tr>
<td>Patrice</td>
<td>49</td>
<td>Baby Blues &amp; Postpartum</td>
<td>Administrative Assistant</td>
<td>1</td>
<td>Single</td>
<td>Completed University degree</td>
</tr>
<tr>
<td>Mackenzie</td>
<td>38</td>
<td>Baby Blues</td>
<td>Unemployed</td>
<td>1</td>
<td>In a relationship</td>
<td>Unknown</td>
</tr>
<tr>
<td>Monica</td>
<td>18</td>
<td>Baby Blues</td>
<td>Casual Shop Assistant</td>
<td>1</td>
<td>In a relationship</td>
<td>Completed high School</td>
</tr>
<tr>
<td>Lina</td>
<td>Unknown</td>
<td>Baby Blues</td>
<td>Market Vendor</td>
<td>5</td>
<td>Separated and in a relationship</td>
<td>Unknown</td>
</tr>
<tr>
<td>Rene</td>
<td>32</td>
<td>Baby Blues</td>
<td>Teacher/Graduate Student</td>
<td>2</td>
<td>Married</td>
<td>Pursuing post-graduate degree</td>
</tr>
</tbody>
</table>
Country Profile

Barbados is a small English-speaking island located in the Eastern Caribbean (Appendix F). It measures 430 square kilometers and has nearly 290,000 inhabitants with women making up approximately 52% of the overall population (Index Mundi, 2014; Denis, 2003). It is estimated that 92.5% of the population is Black, 3.2% is white, 2.4% is mixed, and less than 1% are of East Indian, Syrian Lebanese, and ‘other’ ethnic backgrounds (Denis, 2003).

Welch (2003) argues that public health in Barbados cannot be understood without considering the broader social, political, and historical factors that have shaped the island-nation since slavery. Barbados was home to one of the most lucrative sugar industries in the region before the abolition of slavery in 1834. The island also had an unbroken British colonial rule from the period of enslavement until independence in 1966 (Rodney and Copeland, 2010). Today Barbados ranks high in human development, boasts the highest literacy rate in the Caribbean (98%), provides free healthcare, provides free primary and secondary education to its citizens, and is considered one of the most socially and economically “developed” countries in the Caribbean region (Rodney and Copeland, 2010). However, since the recent global economic crisis the country has seen a rise in unemployment, increased food costs, and a decrease in tourism which is the island’s main source of revenue (Bailey, 2013). Furthermore, almost 59% of poor households in Barbados are headed by women who are still more vulnerable to low wages and unemployment (Bailey, 2013). This disparity exists in spite of women having more representation in government and educational institutions (Rodney and Copeland, 2010).
Positionality

I am inspired by Gooden and Hackett’s (2012) reflexivity about their positionality which was also influenced by their Intersectional and feminist frameworks. In doing this reflective work I seek to locate myself in relation to my research, the academic research process, and the Caribbean space I have inhabited for five years.

I identify as a Black, Muslim woman of Barbadian, Canadian, and African-American heritage. I was born in Canada and I am a dual citizen of the country and of Barbados.

I am able-bodied and identify as heterosexual. I have gained various privileges through these identities as well as through the education I have been afforded and have pursued. I do not have any mental illnesses, but I do engage with mental health practitioners for self-care.

I became acutely aware of my “outsider-within” position during the research project data collection and interviewing stages. Being an outsider-within denotes the shifting movement between one’s subjectivity and researcher role (Gooden and Hacket, 2012). In my case it also encompasses being a literal outsider due to not being born or raised in Barbados.

My race and gender provided bridges between myself and the women who participated in the research project. Through these identities I was able to identify some power relations women discussed which were mediated by their experiences with sexism, racism, and discrimination. I was also able to emotionally connect with women through my
mother’s experience with postpartum depression. My narrative about this featured in nearly every interview I conducted. My family experience with my mother’s mental health challenges seven years ago catalyzed me to do this research and it also gave me an experience, albeit technically not firsthand, with maternal depression.

However, I was also an outsider on various fronts. I recognize that my status as a foreign researcher with institutional membership to two Universities (the University of Toronto and the University of the West Indies Cave Hill) created a power dynamic between myself and the women in the research project. This established unavoidable professional and legalistic parameters within the research spaces. Women also viewed me at various points as an “expert” on maternal depression in spite of the theoretical frameworks that informed my project and which sought to establish them as experts on their own health conditions. This made the power dynamics more palpable and reinforced my awareness of the power of professionalization and medicalization even though I was still a graduate student of public health science.

Not being born or educated in Barbados also cast me as an outsider. However, I also recognized that women may have felt a sense of anonymity or comfort because I was not perceived to be a “real Bajan”. Therefore, women may have believed that the information they disclosed would be held in stricter confidence because I lacked local social networks connecting me to communities and neighbourhoods where I could spread details about their personal lives. Finally, I was also an outsider because I did not have children at the time of the research data collection. Due to this fact, I could not understand experiences of birth, motherhood, and mothering that women described. However, I learned a great deal

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2 A Bajan is the shortened form of Barbadian and is commonly used on the island and in its Diasporas.
about these topics from women and there were many interactions where research participants were teachers to me and fielded questions about labour, delivery, and prenatal and post-natal healthcare.

By mapping my positionality and engaging in this reflexive exercise I affirm that I am situated within my research and not a passive, objective witness to it. It is important for researchers to reflect on the ways that we construct knowledge during the research process and how our personal experiences and identities influence the analysis and production of the texts we create (Gooden and Hackett, 2012; Guillemin & Gillam, 2004). Through self-reflection about how I co-created these research spaces I aim to be as transparent with my readers and research participants as possible.
Theoretical Framework

Three pertinent concepts/debates from Caribbean Feminist Theory and Black Feminist Theory anchored the research project: Intersectionality, sexual and reproductive representations of Black women, and Caribbean feminist debates on mothering and motherhood. Caribbean Feminist Theory and Black Feminist Theory were chosen because they are reflective of the racial identities and geographical locations of women in the research project, and they offer unique social, historical, political and cultural analyses that are useful for such women-centered research. Rather than venturing outwards it seemed appropriate to look within to highlight the rich analysis about Black and Caribbean women’s lives these theories, and the selected debates and concepts, have engaged in.

Intersectionality

Intersectionality is a key concept from Black Feminist Theory which has gained momentum from Black and non-Black academics in various academic research spaces (see Seaton, Caldwell, Sellers, and Jackson, 2010; Hankivsky, Reid, Cormier, Varcoe, Clarke, Benoit, and Brotman, 2010; Lykke, 2011; Rogers and Kelly, 2011; Gooden and Hacket, 2012; Robinson, 2013). However, the historical foundation of Intersectionality is important to discuss in order to understand how the concept was mobilized by Black women even before the term was coined by legal scholar Kimberle Crenshaw and operationalized by contemporary researchers and academics.

Among the first Black female voices to articulate a relationship between race, class, and gender was Sojourner Truth (1995) who in an 1851 speech asked the question: “Ain’t I a woman?” (p. 36). In her speech, Truth highlighted how Blacks were denied humanity
because of slavery as she listed the back-breaking tasks she was made to perform while simultaneously weaving into her narrative the double burden she also bore being a woman with no rights (p. 36). Contemporary Black feminist theorists have posited that this speech allowed Truth to insert Black women’s distinct experiences of being doubly status-less into discussions being had by 19th century White women’s rights activists who were advocating for their liberation without acknowledging Black women’s specific realities (Hill-Collins, 2000; hooks, 1984).

In 1892, Black, female activist Anna Julia Cooper (1995) described the complex ways that racism and sexism manifested in Black women’s lives, and she asserted that Black women had to contend with inequalities related to their race and gender, yet they remained unknown and unacknowledged in either situation (p. 45). In 1904 the president of the National Association of Colored Women, Mary Church Terrell (1995), also discussed the link between Black women’s racial oppression and inequalities that stemmed from their gender and alluded to their equal importance (p. 64).

In the latter part of the 20th century, the Combahee River Collective (1995) statement of 1977 was issued. This was widely heralded as the earliest dialogue on Intersectionality and made interjections from Black, lesbian feminists. In addition to highlighting sexuality, the Collective also asserted that patriarchy was equally pervasive as race and class in Black women’s lives (p. 232). On its heels, the concepts ‘double jeopardy’ and ‘multiple jeopardy’ were introduced to highlight the multi-layered oppressions Black women faced as a result of exploitation and marginalization due to their race, class and gender (Beal, 1969; King, 1995).
As a concept, Intersectionality highlights the nuanced relationship between factors such as race, class, and gender and emphasizes that none can be fully understood without acknowledging that each is reproduced and given new meaning when they interact with the other (Hill-Collins, 2000). Crenshaw (1991) emphasized this point by stating that, “the intersection of racism and sexism factors into Black women's lives in ways that cannot be captured wholly by looking at the women race or gender dimensions of those experiences separately” (p. 2). In short, in order to fully understand Black women’s lives and experiences you must view these identities in an unfragmented way. In doing so the layers of experience and oppression become evident and can potentially build greater understanding of women’s subjective experiences as gendered, raced, sexualized, and classed beings.

The examples that led to the formation of the concept Intersectionality are built upon African-American women’s lives and their experiences with enslavement, oppression, racism, classism, and gender-based violence. These experiences do not stand as a blanket representation for all Black women whether they live in the Caribbean or other Diasporic settings, and it is not a uniformity of Black women’s experiences being sought out or promoted in this research project. In fact, the element of difference lies at the root of Intersectionality and this approach is useful for research that seeks to understand how maternal depression is experienced by non-White women inside and outside of North America and Europe.

Hill-Collins (2009) writes that Intersectional paradigms allow relationships between knowledge and empowerment to be untangled which can shed light on how domination is maintained. Black women’s gender-based experiences, geographic locations,
and many other factors vary our life experiences from each other’s and also from other non-Black women. In spite of this, much of the research and data on maternal depression has been centered on White women in certain North American and European contexts. These studies erase difference and in doing so paint a homogenous picture of maternal depression which privileges one group’s experiences and knowledge over the diversity of others. Intersectionality can be used to de-centre the knowledge and bring Black women’s experiences with maternal depression from the margins to stand among other women’s as valid and equally important. This is a crucial task if we wish to know more about how women differently experience, understand, manage, and cope with mental health challenges. Health and illness are not experienced in the same ways, and so different expressions and experiences of them must be facilitated.

Within research spaces, Intersectionality has been operationalized as tool of critical analysis to investigate various topics. Black feminists continue to highlight the usefulness of Intersectionality to de-center knowledge production so that research participants can be regarded as experts on their own experiences which are then privileged and allowed to guide these endeavours (Seaton et al., 2010; Gooden and Hacket, 2012). Non-Black academics have identified the usefulness of the concept in health research settings to focus on diversity and difference, shed light on social factors that impact women’s health, and highlight inequities in health that are caused by racism, immigration, and sexism (Guruge and Khalou, 2004; Hankivsky et al., 2010). Some Caribbean feminists have operationalized Intersectionality to analyze how public and private domains have intersected throughout history to legitimize (or reject) citizenship and intimate partnerships.

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3 An in-depth, narrative review of this research and literature is conducted in the first manuscript in this thesis.
Through operationalizing Intersectionality, scholars have been able to focus on marginalized study groups by using a critical lens to examine their lived experiences which can uncover various institutional and systemic barriers in areas like health care, immigration, and conjugal partnerships.

While the operationalization of Intersectionality continues to be discussed and endeavoured upon (see James, 2007; Lykke, 2011; Denis, 2008; Hankivsky et al., 2010; Hankivsky and Cormier, 2011), the roots of the concept planted by its earliest theorists have established it to be a dynamic one. There may not be clear guidelines about how to “do” Intersectionality, yet it has been critical to enhancing dialogues about women’s lived experiences. This has resulted in richer data and information being produced that is more reflective of women’s lives. It also enables women to be sources of information and agents of change.

**Sexual and Reproductive Representations of Black Women in Caribbean Feminist Theory and Black Feminist Theory**

A central debate in Black Feminist Theory focuses on sexual and reproductive representations of Black women in historical and contemporary contexts. Proponents of Black Feminist Theory assert that representations of Black women have been mainly relegated to two pervasive images; the Mammy and the Jezebel (Hill-Collins, 2000; hooks, 1999; Sharpley-Whiting, 2007). The attributes of these images shift slightly over time, but

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4 Denis (2008) posits that Intersectionality has been also been implicitly operationalized in some Caribbean research endeavours. Among the examples provided she points to the Women in the Caribbean Project (Massiah, 1982; 1986; 1988). In this project, women’s socioeconomic status and class were considered significant factors that impacted their gendered experiences. While Intersectionality is not mentioned as a tool of analysis in the study, Denis (2008) asserts there is implicit use of the concept by these factors being central to the project.
continue to be rooted in base understandings of Black women’s sexuality and their reproductive functions (see Hill-Collins, 2000; hooks, 1999; West, 1995; Wallace, 1999). Hill-Collins (2000) asserts that both the Mammy and the Jezebel are powerful and controlling constructions, and interpretations that challenge them have become a core debate within Black Feminist Theory (p.44, p. 89).

The ‘Jezebel’ is typically portrayed as the ‘bad Black girl’ and was characterized as loose and always sexually available (West, 1995, p. 462). Black feminists have identified a related but slightly different image in the realm of the sexualized Black female called the ‘Sapphire’ who is characterized as “evil, treacherous, bitchy, stubborn, and hateful” (hooks, 1984, p. 85). The Sapphire’s out-of-control sexuality was believed to emasculate Black men which necessitated the control and taming of her body and mind (West, 1995, p. 461). Contemporarily, an amalgamation of these images has emerged in popular culture, as the image of the ‘video vixen/girl’ proliferates through music videos, men’s magazines, and other forms of media (Sharpley-Whiting, 2007). hooks’ (2003) posits that Black women who appear in such media are characterized by voluptuous bodies and sexually suggestive poses and dancing, and that they are contemporary representations of historical images of the sexually immoral and expendable Black woman.

Black feminists have argued that these sexualized representations demonstrate that attention is only given to Black women’s bodies when they are constructed as obtainable and consumable (hooks, 1999). Black feminists have also interrogated these images through highlighting their historical and social roots, asserting that hyper-sexualized representations of Black women such as the Jezebel, the Sapphire, and the video vixen also work to re-inscribe ideals of who and what a proper (White) lady is (Hill-Collins, 2000, p.
90-93). In this way, Black feminists also contribute to mainstream feminist theorizing by breaking down these binaries and stereotypes. By highlighting how they negatively impact Black and non-Black women through ascribing rigid understandings of womanhood and sexuality, Black feminists show that all of these images are unreflective of the diversity of women’s experiences as sexual beings.

In juxtaposition to this sexualized Black female imagery is the construction of the Mammy figure which originated in the southern United States during slavery and represented the desexualized, nurturing, passive Black female. The Mammy is significant in Black Feminist Theory because she facilitates a greater understanding of the controlling and historical images that have worked to reproduce expectations of Black women’s caregiving roles (hooks, 1984; Hill-Collins, 2000). The Mammy’s primary function was domestic service as a house-slave, which was characterized by long hours of labour and work responsibilities that extended from the field to the main house. Her function required that she be a subordinated subject, nurturin care-giver, and self-sacrificing at all times (West, 1995, p. 459). Her care-giving role is a key attribute because the Mammy is also constructed to be capable of mothering her White master’s children while simultaneously managing her own home and dealing with injustice and poverty. hooks (1984) asserts that not only was the Mammy image constructed by racist Whites, it also “epitomized the ultimate sexist-racist vision of ideal black womanhood” (p. 84). The Mammy was tolerable, loyal, and unwilling to seek change for her circumstance- in fact, she was supposedly happy with it (hooks, 1984). Hill-Collins (2000) states that the Mammy was constructed to influence Black maternal behavior, uphold White supremacy and transmit oppressed behavior to her off-spring (p. 80). While the Mammy held some maternal
imagery, her care-giving was never directed towards her progeny, and only towards White children who would later grow up and acquire ownership over her. A later representation that Black feminist theorists have linked to Mammy is the Black Matriarch who is commonly characterized as a single mother that has failed at completing her duties as a woman and care-giver to her children (Hill-Collins, 2000, p. 82). However, the link is never made between her perceived failures and the socio-historical context of Black women’s care-giving roles.

Caribbean Feminist Theory also engages in debates about sexual and reproductive representations of Black women, many of which were also established during enslavement. While terms like the Mammy, Jezebel, and Matriarch are not always used in Caribbean feminist literature and Caribbean historical accounts, there are some commonly shared attributes of these controlling images. However, the point here is not to offer a comparative view of the theories or highlight sameness; instead we seek to pull out pertinent articulations on Caribbean women’s reproductive and sexual representations that have characterized how Black women were idealized during and after their theft from regions in West Africa and importation to the Caribbean. We are also interested in the connections made by Caribbean feminists and historians between these characterizations and current debates in the region so that we can also build off this trajectory and situate our own research within these endeavours. Insight about the sexual and reproductive constructions of Black Caribbean women have been gleaned from Caribbean feminists, feminist

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5 A controlling image related to the Black Matriarch is the Welfare Queen which was popularized in the 1980’s during the Reagan administration. These women were highlighted as being economically dependent on the state to care for their homes and children, and were portrayed as “highly materialistic, domineering, and manless working-class Black woman” (Hill-Collins, 2000, p. 88).
Caribbeanists, and Caribbean historians and scholars in order to depict a fuller understanding of how Black women’s sexualities and reproductive functions have been characterized.

In the Caribbean, Rodney (1998) asserts that during slavery Black women were viewed the same as men in terms of their productive capacities and were put through excessive physical labour. In addition to this they also experienced psychological and physical trauma due to their gender and race. Women were made to work in the fields during their pregnancies and as a result abuse, malnutrition, and rates of miscarriages were high (Rodney, 1998, p. 93-94). Such accounts are an indication of the racism and sexism that was ingrained into the social fabric of Barbadian society. They also give insight into how Black women’s bodies and (re)productive and maternal functions were regarded at the time. Black women were not viewed as human beings, much less women, and enslavement simultaneously prevented their personhood, denied their womanhood and legitimized their mistreatment.

Reddock (1985) confirms the racialized and gender-based expectations that enslaved Black Caribbean women encountered with regard to work and production. She writes that women were relegated to the role of plantation or domestic workers which could begin as early as four years old (Reddock, 1985). In the fields women were viewed as equal producers to their male counterparts, and they were expected to generate the same yields and were oftentimes worked just as hard (Reddock, 1985; Rodney, 1998; Turner, 2011). From this perspective Black women were both gendered and de-gendered: their work capabilities and strength were not differentiated from men’s, yet their bodies were also regularly subjected to gender-based exploitation and sexual violence. Contradictions
of this kind were a part of Black women’s lives and this is illustrated in Gadsby’s (2006) analysis of Mary Prince. Prince was a Black woman whose account of enslavement in Bermuda and Antigua was one of the first to be published and used for anti-slavery movements. Yet even after her escape to England and subsequent freedom, she faced constant risk of sexual abuse and violence because of once being a slave and also because she was a Black woman (Gadsby, 2006, p. 78). Women like Mary Prince were made to “suck salt” or endure hardship over long periods due to their gender and in spite of it (Gadsby, 2006).

Processes of sexualization and their impact on representations of Black women’s sexuality in the Caribbean were central to how they were regarded and characterized during the colonial period. Mair (2006) traces portrayals of Black Caribbean women (and men’s) sexual immorality to White colonizer’s depictions of African societies, and asserts that their traveler accounts of polygamous African societies had negative implications on how women’s sexuality and morality were constructed in the colonies (p. 44). Kempadoo (2000) links the sexualization of Black women and girl’s bodies to their experiences on slave ships, and points to sexual servitude on these vessels as being the initialization of their sexual subordination which was further perpetuated in the islands. Through such processes of sexualization, once arrived in the Caribbean women were perceived to be sexually available and were simultaneously devoid of rights due to their enslavement.

The construction of Black women’s sexuality as untamed and lascivious was also central to the project of building obsolete and dichotomous characterizations of Black women vis-à-vis upper class White women (Alexander, 1994). Kempadoo (2000) points to the centrality of sexual labour in Caribbean history and highlights that Black women in
these colonial contexts were relegated to roles of wet-nurses, prostitutes, and breeders of slaves. They were also characterized as promiscuous and sensuous in a manner similar to animals which were qualities that stood in opposition to decent (White, upper-class) women (Alexander, 1994; Kempadoo, 2000; Francis, 2004). The centrality of sex points to power which was exercised through sexual dominance from White men and experienced by Black Caribbean women. To this end Francis (2004) writes that “sex is one vehicle through which power is exercised over the minutest details of women’s lives” (p.62). As a result, very specific boundaries that policed all women’s sexualities and created narrow ways to view them were established and these worked to reinforce patriarchy and White male dominance (Beckles, 1993).6

When discussing sexuality the topic of sexual reproduction cannot be avoided. Similar to the demands placed on their production capabilities and constructions of their sexualities, Black Caribbean women also experienced imposed expectations on their reproductive functions. Caribbean feminists write that the reproductive capacities of slave women solidified “gendered racial” differences thereby creating dichotomous arrangements where Black women were seen as deviant, yet intrinsic to the literal production of future labour forces (qtd. in Turner, 2011). Beckles (1993) reinforces this

6 With knowledge of these histories, some contemporary Caribbean feminists and Caribbean writers have consciously used sexuality as an analytical tool to further understandings of women’s gendered experiences and create narratives about the region and Caribbean families (Danticat, 1994; Alexander, 1994; Francis, 2004; Kempadoo, 2000; Smith, 2011;). However Haynes (2013) asserts that there is still much progress to be seen. This is evidenced by the “ongoing silence on sexuality that coexists with Caribbean feminist scholarship and queer theorizing which reveal the connections between geopolitics, political economy, coloniality and sexuality, in ways that are not always/often recognized in canonical gender and sexuality studies” (p. 91). This insight is both telling and challenging for persons implicated in investigating Caribbean women’s sexualities. These histories cannot be erased, nor should they be, yet there is also movement towards learning how to cultivate new ways to interrogate sexuality that allow agency and empowerment to be as prevalent as these historical accounts of Black women’s sexuality (Smith, 2011; Francis, 2004).
through stating that “white males valued black women's fertility solely in terms of the reproduction of labour for the plantation enterprise” (p.69). Turner (2011) states that their reproductive capabilities made Black women important to the Caribbean slave system since all children legally belonged to the plantation owners. In spite of this importance, the living and work conditions for women were poor and gynecological complications during pregnancy and childbirth were commonplace (Reddock, 1985; Rodney, 1998).

Debates on representations of Black women’s sexuality and reproductive functions from Black Feminist Theory, Caribbean Feminist Theory, and other cited Caribbean scholars and historians depict the harrowing circumstances through which Black women in the Caribbean and the US were made to live in. Both theories emphasize the devaluation of Black women’s sexualities which reinforced gendered and racialized views of women’s bodies. These facilitated sexual dominance and violence which were a part of most women’s everyday lives. With regard to reproductive representations, Black Feminist Theory outlines the ways in which women became narrowly viewed as either passive caretakers or failed mothers. In Caribbean texts women’s reproductive capacities were narrowly viewed in economic terms as producers of slave populations which would increase slave owners wealth. However, the failed mother/Black Matriarch discourse is also prominent in Caribbean Feminist Theory and will be taken up more extensively in the section to follow.

**Caribbean Feminist Debates on Mothering and Motherhood**

Mothering and motherhood have long been a significant area of inquiry for Caribbean feminist thinkers, scholars, and researchers. This is because women are attached
to families and the Caribbean family has undergone considerable analysis for decades. While she may not be considered a Caribbean feminist, it is fitting to begin with anthropologist Edith’s Clarke’s work *My Mother who Fathered Me*. This text’s comparative study of families in three rural Jamaican communities in the 1950’s preceded the country’s failed Mass Marriage Movement of 1944-1945 which was orchestrated in an attempt to rectify the perceived promiscuity, concubinage, and high rates of cohabitation amongst Black Jamaicans (Clarke, 1999, p. xxiii). Clarke’s study explored the domestic activities, economic contexts, and familial relationships of the households with careful analysis. In these Black working class families Clarke also highlighted that female-headed homes are intrinsic to Jamaica’s social fabric (p. xx).

Female-headed homes have also been referred to as female-led and matrifocal arrangements (Massiah, 1982; Robinson, 2013). These familial structures are defined as “a wide range of domestic arrangements typified mainly by the absence of an adult male in

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7 Robinson (2013) offers a useful critique of some of these categories and the socially and politically-driven movements enacted at different historical points to rename them. She asserts that the renaming (i.e. from concubinage to common-law) is always set atop social and political movements to legitimize and delegitimize various Caribbean family forms and intimate partnerships (Robinson, 2013). In this case, concubinage typically referred to a relationship between a White man and a Black enslaved woman. Renaming this arrangement ‘common-law’ changed the parameters of who could be involved in the union which essentially made these old formations more taboo/illegal/socially unacceptable in post-slavery societies.

8 Bolles (1988) and Barrow (2001) attribute work like Clarke’s to the advent of British structural-functionalists who came to Caribbean islands to study its family forms. The shift in focus from the origins in history to the ways structures like the family functioned in contemporary contexts gave rise to problematic and narrow analyses of Caribbean families that were not wholly representative of the complex economic, historical and cultural factors at play (Barrow, 2001). Black (1995) provided the following critique of the work which outlines why women cannot father. She states, “An Antiguan mother does not ‘father’ her child because kinship and gender ideology and practice describes and values differently what ‘fathering’ entails, how it is accomplished, and to whom it is assigned” (Black, 1995, p. 65). To her the social norms that govern women and relegate them to specific mothering tasks are inherently gendered and therefore expected to be performed by women.
the relation of spouse or partner of the dominant female‖ (Massiah, 1982, p. 7). Reasons for the formations of these family structures include historically non-nuclear family patterns, economic factors leading to immigration, and women’s increased independence due to improved socioeconomic factors (Massiah, 1982). MacDonald’s (2007) analysis of these family forms highlights the years after Emancipation when economic difficulties experienced by Caribbean men forced them to leave their families to search for work in other places leaving women to parent alone (p.184). Significantly, in all of these examples and many others, female-headed homes are racialized and became synonymous with Black Caribbean women (Massiah, 1982; Senior, 1991; MacDonald, 2007).

In spite of the social, historical and economic explanations for the formation of female-headed homes, they have been blamed for various social ills in the Caribbean and women framed as the problem. Bolles (1988) writes that negative opinions on female-headed homes have been present since the mid-19th century when the Caribbean’s perceived weak family structure became a source of contention for colonial bureaucrats, clergy, social workers, and members of the upper class. The lack of an authoritative father figure was seen to be at the root of poverty and disenfranchisement (Bolles, 1988). Barrow’s (2001) research on the “Black family breakdown” in Barbados asserts that there are two dimensions of perceived familial fragmentation; firstly a movement away from the traditional family structure to nuclear arrangements, and secondly a further fragmentation to single-parent or female-headed homes. The latter arrangement is perceived to be problematic as evidenced by public perception and discourse (Barrow, 2001).

\[9\] M.G Smith contributed the concept of matrifocality which was “produced by the marginalization of husband-fathers, whose status and functions as household heads is depressed because of their lowly status in the society as a whole” (qtd. in Robinson, 2013, p. 437).
Some feminists and scholars have highlighted the perceived marginalization of men in female-headed homes which made women and their familial arrangements so negatively portrayed. Robinson’s (2013) analysis on the changing terminology for Caribbean conjugal relationships such as “visiting relationships” asserts that these partnerships typified immorality due to their casual and promiscuous nature and cast men in marginal roles to the loose family structure. Leo-Rhynie’s (1997) work on race, class, gender, and child-rearing points to the perceived inadequacies of women to teach masculinity and other male behaviours to young boys. Thus, female-headed homes were perceived to place men in marginal positions rendering them unable to be strong male role models (Leo-Rhynie, 1997, p. 38). The focus on women as failed mothers who helped to degenerate society and emasculate men and young boys features prominently in these examples, and women are also became blamed for the poverty they experienced. These images of the failed mother harken back to the Black Matriarch stereotype which Senior (1991) asserts is mythological, yet pervasive in the Caribbean. She highlights the fact that women who are the primary breadwinners for their homes face poverty and are usually under-educated, underpaid and employed in the most unwanted jobs (Senior, 1991, p. 102). By pointing out the unfairness of this blame being cast on Caribbean mothers we are urged to revisit the social, historical, and economic contexts that have given rise to these familial structures rather than developing knee-jerk reactions that reinforce patriarchy and self-blame.

As a response to such limiting and problematic views of Caribbean motherhood, some women-centered studies that addressed Caribbean families were conducted to explore the complexities of their social, intimate, and economic lives. The Women in the Caribbean Project (WICP) remains one of the region’s most prominent studies that sought
to explore the economic characteristics of women who headed households and asserted that poverty was their main issue (Massiah, 1982). Perhaps its biggest contribution was that the WICP challenged the notion that Caribbean women enjoyed parity with Caribbean men and that Caribbean society was matriarchal by highlighting the barriers women experienced in public and private domains (Trotz, 2009). Broadber’s (1986) contribution to the WICP concluded that although men did not live in the households of the women in her study they maintained some social and economic ties to the homes thereby reinforcing the different contexts in which each home was submerged.

Mohammed and Perkins (1999) also examined motherhood in a study that included African descent women of childbearing ages (15-44) in Barbados, St. Lucia and Dominica. The authors noted a shift in attitudes towards childbearing which was linked to development, while economic constraints were cited as reasons for some women deferring or limiting the amount of children they had. (Mohammed and Perkins, 1999, p. 11). Also significant amongst the study’s findings was that women were becoming less likely to link their femininity to their fertility. This highlights the individual choices some Caribbean women make with regard to their family lives and their self-perceptions as potential mothers. These studies show that Caribbean women’s lives cannot be broadly homogenized into a single experience that typifies the female-headed home or even motherhood, and that women were still subjected to economic disenfranchisement which prevented them from effectively supporting members of their families.

No doubt spurred by these debates and issues; other Caribbean feminists have ventured to uncover the day-to-day workings of women’s lives and their mothering experiences. Michelle Rowley’s (2002; 2003a; 2003b) interjections are particularly
pertinent as they address how mothering amongst Afro-Trinidadian women is impacted by state welfare policies. Rowley (2003a) asserts that Trinidadian mothers who interact with social welfare programs are forced to perform narrow and denigrating roles of maternal identity which creates a patriarchal relationship between them and the state (p. 31).

Significant to our thesis is Rowley’s attention to mothers’ mental health and wellness. She writes,

“Economic analyses with indicators such as cost of living, minimum-wage and living wage are very relevant aspects on the continuum to acknowledge the complexity of maternal subjectivities. These indicators however, are unable to address the textual, the ideological, or the psychological aspects of this location. They are unable to address the psycho-social impulses of aloneness that feed into the pressures and demands of child care; neither can they address the role of the state in disciplining women's maternal bodies” (p. 56).

Rowley’s work acknowledges that many of the economic and social analyses of motherhood and female-led homes lack attention to women’s mental health. She asserts that women who are constantly at the receiving end of assumptions about their mothering capabilities and various development-focused initiatives, studies, and programmes suffer in profound yet unnoticed ways (Rowley, 2003a, p. 56).

In an earlier work, Rowley (2002) discusses the process of becoming a mother as related to her by women in a Tobagonian study. Their narratives illustrate the importance placed on pregnancy and childbirth which signifies womanhood, maturity and

10 A more recent study that explored the emotional well-being of women was the 2012 Gender and Livelihoods Study initiated by the Institute for Gender and Development Studies: Nita Barrow Unit. This project sought to explore the socio-economic challenges experienced by women who are the primary caregivers of children living with chronic illnesses (Hutchinson Miller and Jackson, 2012). Women’s emotional well-being also featured prominently in the qualitative findings. Women cited stress and anxiety to be the most dominant mental health challenges they encountered while caring for children with chronic illnesses like Sickle Cell Anemia (Jackson, forthcoming publication). The project stands out in its attention to Caribbean women’s mental health and wellness, and its recognition of the difficulties they encountered in their day to day care-giving activities.
responsibility to themselves and their communities (p. 36). Later in this work Rowley discusses women’s lack of access to economic security and relaxation in relation to their self-perceptions of strength and perseverance through adversity (p. 39). Women characterized not only themselves but Caribbean women in general as “strong” and able to “take real pressure” (Rowley, 2002, p. 39). Once again, Rowley makes a critical interjection that addresses Caribbean mothers’ emotional well-being, and the work further nuances existing research on Caribbean motherhood. Rowley’s investigation into how notions of womanhood and idealized femininity restrict women’s capacities to fully articulate the difficulties of mothering is profound because it is missing from many other reports, papers, and projects that have been produced in the region. Women in her study surely buy into these notions, but they also take the opportunity to bring attention to the emotional costs of their gendered roles and identities. By making these inclusions Rowley also sets the stage for future work that can expand this analysis and more explicitly consider Caribbean women’s mental and emotional health and well-being.\(^\text{11}\)

A recently edited volume entitled ‘Feminist and Critical Perspectives on Caribbean Mothering’ includes social, cultural, political, and personal accounts of motherhood in the region and Diaspora (Silva and Alexander, 2013). The collection includes author’s personal accounts of abuse and the emotional ramifications of this (Adisa, 2013), while

\(^{11}\) Insight on this can be gleaned from proponents of Black Feminist Theory and researchers of Black women’s mental health who have conducted analyses that explore Black women’s notions of idealized strength. Some have viewed it from a mental health perspective (see Jackson and Naidoo, 2012; Schreiber, Stern, and Wilson, 2000; Hall, Everett, and Hamilton-Mason, 2012). Others highlight self-perception of Black women’s unwavering strength which is viewed as a valiant alternative to weakness (see Etowa, Keddy, Egbedeyi, & Felicia, 2007; hooks, 2005; Wallace, 1999; Hill-Collins, 2000; hooks, 1984). These representations have also been challenged by Black feminist scholars who assert that the ‘strong’ Black woman is mythological despite her imagery continuing to inform the way Black women conceptualize themselves (hooks, 2005).
others critique textual representations of motherhood and mothering (MacDonald, 2013). Although none of the chapters explicitly addresses maternal depression or women’s mental health, some explore the emotional aspects of mothering for Caribbean women living and working abroad and whose children are left in the islands they migrated from. Crawford (2013) writes about Caribbean women’s transnational and migratory experiences and brings attention to the emotional consequences of physical distance through discussing a poem by Olive Senior which alludes to the mother eventually “going mad” (p. 147). The discussion of the effects of migration also includes the impact on children and their surrogate caretakers, such as grandmothers, both of whom may feel resentment towards the situation but are not considered (p. 149). Crawford’s work highlights the ways in which motherhood and migration have far-reaching and long lasting emotional affects which sheds more light on Caribbean women’s mental health.  

These debates on motherhood and mothering illustrate that the topic is attached to historic, socioeconomic, racial, political, and cultural forces and has been addressed in a multitude of ways by Caribbean feminists and scholars. Feminists have built strong critiques to “talk back” to problematic ideas of gender, family and femininity as they relate to Caribbean motherhood. However, there is still work to be done to extend these analyses and address Caribbean women’s emotional and mental health. We see movement towards this endeavour in the work of Caribbean feminists who have addressed the complexities of women’s roles in relation to the state and transnational motherhood. The attention to social

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12 Caribbean literature actively addresses transnational motherhood and explores the mother-daughter dynamic. Kincaid’s ‘Annie John’ (1985); Silvera’s ‘The Heart Does Not Bend’ (2003); Danticat’s ‘Breath, Eyes, Memory’ (1994); and Brodber’s ‘Jane and Louisa Will Soon Come Home’ (1980) are some of the literary contributions from Caribbean women writers in the region and Diaspora which explore the complexities of these familial arrangements and resultant relationships.
and cultural beliefs about women’s idealized strength helps to depict women’s lives in fuller and more encompassing ways. It also helps to recognize that women’s emotional and mental health is affected by their material and social circumstances. Work that intentionally addresses Caribbean women’s mental and emotional health will help to further build up these debates about Caribbean mothering and motherhood so that they are even more reflective of women’s lives.

Because Black women are central to our research project, the feminist scholarship presented here pays explicit attention to key debates, concepts and discussions about Black Caribbean women in Caribbean Feminist Theory. However, we do not assert that these topics are representative of all Caribbean women. Indo-Caribbean women, Chinese-Caribbean women, Arab-Caribbean women and Indigenous-Caribbean women have distinct histories and experiences with motherhood and specific ways that their reproductive roles and sexualities have been framed in Caribbean contexts. We do not seek to silence other women’s narratives, and instead we welcome the engagement of other researchers and scholars so that the experiences of all Caribbean women can be discussed in progressive and useful ways.

There is a significant and growing body of scholarship on Indo-Caribbean women’s experiences. Topics relating to indentureship, motherhood, family, activism, sexuality, and femininity have been explored which give further insight into Indo-Caribbean women’s lives (see Mohammed, 2002; Peake and Trotz, 2002; Kanhai, 2011; Mohammed, 2012; Kanhai, 2012; Reddock, 1985; Hosein and Outar, 2012; Kasim, 2012; Pragg, 2012; Robinson, 2013; Kempadoo, 2013). Literature on the Chinese-Caribbean women’s experience is limited but Lee’s (2008) research on Hakka women in Jamaica during the first wave of immigration offers poignant insight into how Chinese women’s work and spousal roles were conceptualized in the mid-1800’s and early 1900’s. The documentary ‘Chinee Girl’ by Wei (2011) gives insight into Trinidadian-Chinese women’s racial, cultural and social lives.
A Narrative Review of Maternal Depression Research Focusing on Women of Caribbean Descent in the Diaspora and Caribbean Women in the Region

Abstract

Maternal depression is a global public health issue (Almond, 2009); however, much of the existing research for conditions such as the ‘baby blues’ and postpartum depression has been conducted with White women in North America and Europe. This narrative review includes maternal depression research studies conducted with Caribbean descent women living in the Diaspora, women in the English-speaking Caribbean, and work from North America and Europe to explore three emerging themes. These are: the prevalence and incidence rates amongst these sample groups, understandings and explanations of the ‘baby blues’ and postpartum depression, and how women’s social realities and identities have been grappled with by researchers.

The major findings of the review indicate that women from diverse racial and cultural backgrounds have largely been left out of the earlier maternal depression research conducted in North America and Europe. Studies that have sought to fill this gap in the research show that prevalence and incidence rates for postpartum depression and the ‘baby blues’ in the English-speaking Caribbean are higher than rates found in earlier North American and European studies, but these studies generally lack qualitative inquiry. Research conducted with Caribbean descent women in the Diaspora highlight women’s explanatory models which help them understand postpartum depression and emerge from their social, cultural, and historical contexts. As well, researchers have grappled with women’s difference through shifting attention to Black, Caribbean women’s Intersectional
lives. However, these experiences of maternal depression also omit some groups of Caribbean women. The paper concludes with a discussion about what kinds of interventions and conceptual/theoretical tools can be useful to advancing the study of maternal depression amongst Caribbean and Caribbean descent women.

**Introduction**

The postpartum period can bring significant emotional and mental health challenges to women who experience maternal depression. North American and European research on postpartum depression estimates a 10-15% rate for the condition (O’Hara, 1987; O’Hara, 1990; Pitt, 1968; Seyfried and Marcus 2003), while studies on the ‘baby blues’ indicate a rate of 30-85% (Pitt, 1968; O’Hara, 1987; Seyfried and Marcus 2003; Pearlstein et al., 2009).

Postpartum depression is described as a major form of depression that can share the same characteristics of other depressions (O’Hara, 1987). Its onset usually occurs within four to six weeks after birth and can last for several weeks, months, or years (Cole, 2009). Symptoms of the condition include forgetfulness, low mood, low self-esteem, anxiety, inability to find pleasure in activities that were once enjoyable, weight loss or weight gain, irritability, sleep disturbance, poor functioning, and in some cases thoughts of self-harm or harming one’s child (Almond, 2009; Halbreich and Karkun, 2006; Fritz and McGregor, 2013).

The ‘baby blues’ is described as a mild affective syndrome common during the week after birth and can last up to 10 days (O’Hara, 1987; Cole, 2009). Symptoms of the
condition include irritability, restlessness, despondency, mild confusion, hypochondrias, mood swings, crying, poor appetite, inability to concentrate, difficulty bonding with one’s baby, sadness, feelings of isolation, and tension (Halbreich and Karkun, 2006; Rondon, 2003).

Early studies that have explored postpartum depression and the ‘baby blues’ are largely based on research conducted in high-income nations like the United States and the United Kingdom.\textsuperscript{14} Within these contexts women from diverse backgrounds may report experiences with maternal depression that are different due to the interplay of factors like race, income, culture, and identity. For example, postpartum depression research conducted amongst Black Caribbean descent women in the United Kingdom discovered that financial difficulties were believed to be a common pathway that triggered psychological distress (Edge and Rogers, 2005, p. 18). Experiences of maternal depression may also differ amongst women living in the Global South. Research from Barbados highlights socioeconomic issues and their relation to women’s maternal moods, and found that this was a significant risk factor which negatively impacted their maternal mental health (Galler et al., 1999). In spite of such reported differences in their experiences, maternal depression research that focuses on women from diverse backgrounds, such as Black Caribbean women, is lacking in comparison to available research on White women (Edge and Rogers, 2005).

\textsuperscript{14} The term ‘high-income nations’ is used here and at various points in the study in accordance with terminology utilized by Almond (2009) to advance his analysis on global rates of postpartum depression from a public health perspective.
To further investigate the available research on maternal depression, a narrative review of studies from Europe, North America and the English-speaking Caribbean is presented and which is organized according to emerging themes from these bodies of work. The review explores prevalence and incidence rates of postpartum depression, some explanatory models used by women that helped them understand the ‘baby blues’ and postpartum depression, the ways these bodies of research have explored and grappled with women’s different maternal depression experiences, and also whose voices have been left out of these analyses.

The central questions that guide the narrative review are:

1. From the previous literature, what do different focuses on postpartum depression and the ‘baby blues’ tell us about women’s experiences with these conditions?

2. What are the central explanations given for postpartum depression and the ‘baby blues’ in research from Europe, North America and the Caribbean?

The review includes a section on the methods, inclusion and exclusion criteria that were used to assess the research studies. Following this is the presentation of three thematic areas which are: prevalence and incidence of the ‘baby blues’ and postpartum depression; explaining and understanding maternal depression; and grappling with difference. The paper concludes with a discussion that further problematizes some of the gaps in the research and discusses what kinds of interventions and conceptual/theoretical tools may be useful to advancing the study of maternal depression amongst Caribbean descent women in the Diaspora and Caribbean women living in the region.
Methods, Inclusion and Exclusion Criteria

A review of the literature was undertaken using the ERIC, PubMed, ProQuest, and University of Toronto online library databases at several points over the course of approximately two years between 2011 and 2013. The key terms searched were postpartum depression, Caribbean, West Indian, postnatal depression, maternal depression, baby blues, postpartum blues, and perinatal depression. Studies were selected which addressed maternal depression, and specifically the ‘baby blues’ and postpartum depression. Studies that examined antenatal depression were also included in order to expand the literature contained within in the review and include other pertinent information on maternal depression.

Studies were included if they were written in English, were peer-reviewed or a dissertation, and focused on Caribbean descent women living in the Diaspora and Caribbean women living in the region. Studies were excluded from the review if they were not written in English and lacked an English abstract.\textsuperscript{15} In total, fourteen relevant articles and dissertations were located.

Research that explores the ‘baby blues’ and postpartum depression in North America and Europe are also included in the review to provide context and explore how these led to some of the divergences which the Caribbean-focused studies make. Due to the expansive dataset and body of literature on these conditions from North America and Europe and the limitations of this narrative review, an exhaustive list of studies on the

\textsuperscript{15} Recognizing that the majority of the Caribbean is comprised of non-English speaking countries, we acknowledge the limitation of restricting the review of literature to research presented only in English, and the drawbacks that this this criteria places on the literature review.
topic is not included, nor did these studies undergo the same methods, inclusion and exclusion criteria used to locate studies on maternal depression amongst Caribbean descent women in the Diaspora and the Caribbean region. We also recognize that the bulk of the North American and European research comes from the United States and Britain, and acknowledge the Anglo-American bias of these studies and the limitations this presents.

Prevalence and Incidence Studies of Maternal Depression

Many early studies of the ‘baby blues’ and postpartum depression from the United States and Britain use epidemiological measures to explore the prevalence and/or incidence of these conditions (Pitt, 1968; Davidson, 1972; Yalom, Lunde, Moos, and Hamburg, 1968; Stein, Marsh, and Morton, 1981; Harris, 1980). Prevalence refers to the number of existing cases of a disease or condition at a specific point in time and within a specific population, while incidence refers to the number of new cases of a disease or condition within a specific population and period of time (Enticott and Kandane-Rathnayake, 2012). By engaging in this kind of work, researchers were able to examine how many women in a given population were affected by postpartum depression and the ‘baby blues’, and how many new mothers experienced the conditions at a given time.

Among the earliest studies on the incidence of postpartum depression and the ‘baby blues’ is Pitt’s (1968) mixed methods research project involving new mothers in a London hospital. His study found a 10.8% incidence rate for postpartum depression and a significantly higher incidence rate for the ‘baby blues’ at 50% (Pitt, 1968). These findings led the author to conclude that maternal depression is both a common and significant
experience at the postpartum stage, and that more information needs to be generated on both conditions (Pitt, 1968).

Subsequent studies interested in learning the nature, cause, and prevalence of the ‘baby blues’ and postpartum depression cite Pitt’s findings for context and precedence. Researchers also utilized different tools of measurement such as the Beck Depression Scale, the Present State Examination, and the Montgomery and Asberg Depression rating Scale. The prevalence rates reported in these studies are comparable to the incidence rates found in Pitt’s work, and range from 8.7% to 12% (Cooper et al., 1984; O’Hara et al., 1984). Studies to ascertain the prevalence of the ‘baby blues’ vary and some studies show rates of 26%–41% (O’Hara, Zekoski, Philipps, and Wright, 1990), while another found a 67% prevalence rate (Yalom et al., 1968).

A significant feature of the these studies examining the prevalence and incidence rates of the ‘baby blues’ and postpartum depression is that they are conducted in Britain or the United States, and the study samples are predominantly comprised of White women. For example, Pitt (1968) discloses that his sample is relatively homogenous, while O’Hara et al. (1984) indicates that 98% of the sample was comprised of White women. Research from Cooper et al. (1988), Yalom el al. (1968), and a later study from O’Hara et al. (1990) do not discuss race as a variable at all, and it is unclear if any non-White women were included in the samples. The lack of racial diversity of the study samples and these “colour-blind” approaches to the research omits a great number of women and also disallows an analysis of how factors like race may influence and impact women’s experiences with the ‘baby blues’ and postpartum depression. However, as more research on the conditions is generated we begin to also see an emerging interest in examining the
prevalence and incidence rates amongst racially and geographically different sample populations.

Caribbean maternal depression research studies conducted in English-speaking islands show a marked difference in the incidence and prevalence rates of the ‘baby blues’ and postpartum depression. The earliest incidence study conducted in Jamaica reports a combined rate of 60% for mild and severe ‘baby blues’ amongst a sample comprised almost entirely of Black women (Davidson, 1972). A later study on the incidence of postpartum depression records a 26% rate, again with a sample of mainly Black women (Palmer, 1996). After the mid-nineties, there was an emergence of Caribbean research studies from English-speaking islands that examined the prevalence of postpartum depression. In a Barbadian study, a 16-19% rate for mild depression amongst women was found, while 34% of women included in a Jamaican research project demonstrated mild to marked depression (Galler et al., 1999; Wissart et al., 2005). In addition to providing racial and geographic variation to the existing maternal depression prevalence and incidence studies, the findings show that rates for the ‘baby blues’ are comparable to rates from the United States and Britain (Pitt, 1968; Yalom et al., 1968; Davidson, 1972). However, postpartum depression incidence and prevalence rates are higher amongst the Caribbean samples in comparison to these studies. One explanation for this can be gleaned from examining some of women’s specific risk factors which highlight the connection between their health experiences and social conditions.

The higher rates of postpartum depression is said to be a common finding in research conducted amongst women living in the Global South (Almond, 2009). Halbreich and Karkun’s (2006) appraisal of 143 studies from 40 countries concludes that the
incidence rate of 10-15% commonly stated in postpartum depression research studies cannot apply to women living in the Global South, and they suggest the prevalence can be as high as 60%. Rahman, Iqbal, and Harrington’s (2003) postpartum depression study with a Pakistani sample shows that 28% of the women had a depressive disorder. Fisher, Morrow, Nhu Ngoc, and Hoang Anh’s (2004) study on postpartum depressive symptomatology in Vietnam showed the incidence rate to be 32%. And an Indonesian sample collected by Edwards, Shinfuku, Gittelman, Ghozali, Haniman, Wibisono et al. (2006) found an incidence rate of 22%. Some factors behind these higher rates may be attributed to women in the Global South experiencing greater social and economic burdens, and that many have less access to opportunities like education and gainful employment (Almond, 2009; Pottinger et al., 2009). This highlights the significance and centrality of women’s socioeconomic conditions, and recognizes the role of the state, rising inequities, and gender-based inequality in women’s maternal depression experiences.

The consideration of income and socioeconomic conditions as risk factors has also led to important findings in projects coming out of the so-called “developed world”. A meta-analysis of research studies conducted mainly amongst women in the United States and Britain found that having less financial resources were associated with an increased risk for postpartum depression (O’Hara and Swain, 1990, p. 41). While a study looking at the link between supportive resources and postpartum depressive symptoms amongst a sample of low income African-American women showed that they viewed money as being an important form of assistance from their families and intimate partners (Logsdon, Birkimer, and Usui, 2000). These findings corroborate the study findings from a Barbados-
based project on maternal mood, breastfeeding, and infant cognitive development which indicates that women’s socioeconomic conditions, limited support from the state, and family income were risk factors linked to depressive symptomatology (Galler et al., 1999; Galler et al., 2000). Jamaican maternal depression studies from Pottinger et al. (2009) and Davidson (1972) also highlight women’s low incomes and deprived socioeconomic conditions which were linked to depressive symptoms.

Analyses of risk factors like income and socioeconomic conditions allows for a consideration of women’s Intersectional experiences with maternal depression. This signifies a shift from entirely medicalized analyses of postpartum depression and the ‘baby blues’, which are facilitated by prevalence and incidence studies, and moves towards more nuanced investigations that sees these factors as being central to women’s experiences with the conditions. By considering income and socioeconomic conditions it is acknowledged that research which only examines prevalence and incidence will be insufficient on its own to build an understanding of the complexities and multi-layered experiences of maternal depression amongst women. This also opens up the door to other analytical lenses and explanatory models which facilitate a more encompassing view of the ‘baby blues’ and postpartum depression.

**Explaining and Understanding Maternal Depression**

In the early research there has been some debate around the explanatory models used to understand maternal depression, and particularly for postpartum depression. Pitt (1968) initially characterized the condition as atypical because of the prominence of neurotic symptoms such as irritability, anxiety, and phobias. In later studies this
description is challenged, and researchers found that the characteristics of postpartum depression resemble depression that occurs at any other time (O’Hara, 1987). It is deemed a nonpsychotic presentation of depression that can be identified by standardized diagnostic criteria and not just the severity of women’s depressive symptomatology (O’Hara et al., 1990; O’Hara, Neunaber, and Zekoski, 1984). These explanatory models for postpartum depression are important because they advance medicalized understandings of the condition which also impacts diagnostic procedures and activities. But there are also challenges made to these explanations about postpartum depression from feminists that pertain to the exclusion of women’s voices, explanatory frameworks, and understandings of the condition (Mauthner, 1993). These concerns are significant and legitimate because much of the earlier research on both postpartum depression and the ‘baby blues’ is epidemiological and did not include qualitative methods to evoke such an analysis.

Emerging research conducted with Black Caribbean descent women living in Diasporic settings helps to expand the knowledge base on postpartum depression. That much of it is qualitative or uses mixed methodological techniques helps to push the existing frameworks of analysis and shed light on how women explain and understand these conditions. Women’s social, cultural and historical contexts emerge as being significant, and their experiences with the condition allow us to see how it is interpolated by them through these frameworks.

Edge, Baker, and Rogers’ (2004) comparative, mixed methods research study investigates postpartum depression amongst Black Caribbean women and White British study participants. Their qualitative findings highlight Black Caribbean women’s social and historical world-views which are central to shaping their understandings about and
explanations of the condition. Study participants reflect on the mediating factors they believe impact their maternal mental health, and they discuss other Black women who overcame legacies of slavery, racism, discrimination, and disadvantage and the perceived common bond they share with them which help shape their self-concept of being a Strong Black Woman (Edge et al., 2004; Edge and Rogers, 2005). This re-inscribes a particular type of strength that is rooted in social and historical ideals about Black women’s survival which allows them to persevere in spite of material hardship and systematic injustice (Edge and Rogers, 2005, p. 24). Edge et al. (2004) state that for some women depression may be perceived as a disproportionate response to adverse circumstances, and raising the threshold for coping with the condition is their only recourse (p.434).

Similar self-concepts that idealize a particular type of strength of Black women also emerge in research that explores the incidence of postpartum depression amongst African-Canadian women. Ayela’s (2008) work describes how Black women in Canada understand, negotiate, and experience postpartum depression and the process of Being Strong emerged through the project’s theoretical engagement. Like the Strong Black Woman, Being Strong is also based on the idealized strength of Black women, and requires that they live up to the cultural imperative to manage depression with grace (Schreiber et al., 2000). Research with Black minority ethnic women from the UK conducted by Templeton, Velleman, Persaud, and Milner (2003) also highlights how certain socio-cultural frameworks help cultivate women’s understandings of postpartum depression, and they discuss how these led study participants to differently conceptualize mental illness altogether. Women in the study attribute mental illness to negativity, and dealing with postpartum depression is believed to be done within the family rather than
going outside for help in order to avoid ‘hanging out their dirty laundry’ (Templeton et al., 2003, p. 215). Davy’s (2013) research with immigrant Caribbean women in the United States found that women’s conceptualizations about the causes of postpartum depression were based on a mixture of social explanations and cultural ideologies which included poverty, witchcraft, malicious spirits, and homelessness (p. 73-75). In addition, research from Edge (2008) locates some of women’s explanations and understandings about postpartum depression in religious and spiritual discourse. Edge (2008) found that Black Caribbean women’s reliance on these sources for help during a postpartum depression experience could also lead them to believe that being depressed was a sign of moral weakness and personal failure.

These studies and their findings deepen the existing knowledge base on maternal depression by bringing attention to Black Caribbean women’s distinct experiences, and exploring how these influence their explanations and understandings of postpartum depression. They show that women’s interpolations of the condition are not solely based on medicalized frameworks; rather, they emerge out of the Intersections of their material circumstances, social contexts, culture, and spiritual and religious frameworks. These nuances are largely missing from those earlier, epidemiological studies based in North America and Europe which exclude the very women we have discussed. These findings show that their inclusion is critical to the project of developing a more inclusive view of postpartum depression that values women’s knowledge and sees it as being valid and part of the knowledge production endeavour.

The aforementioned studies also facilitate a consideration of Black women’s racial and socio-cultural frameworks of analysis and how these influence their understandings of
postpartum depression and an idealized womanhood. The Strong Black Woman concept and Being Strong highlight the ways Black women have learned to transmit techniques of survival to future generations. In Edge and Rogers’ (2005) research, this self-concept also influences women’s understandings of the causation of postpartum depression, and they construct the genesis of the condition as being an outcome of Black women’s continuing adversities. This shows that women do not divorce their mental health challenges from other life challenges, be them historical or contemporary, and they all become a part of the ongoing experience of injustice and hardship. Such insight supports the notion that women’s experiences, explanations, and understandings of postpartum depression, and even womanhood, are not uniform, nor are their methods for managing and coping with the expectations of them.

Grappling with Difference

The maternal depression research charts a progression from the earlier studies conducted in Britain and the United States with majority White samples to more recent research that focuses on Caribbean women in the region and Diaspora. These latter studies are examples of research that is actively engaging with the question of difference, and which is interrogated in several ways. For example, the research study conducted by Edge et al. (2004) sought to formulate a response to anecdotal evidence from primary care providers who suggest Black Caribbean women in the UK do not present postpartum depression as much as women from other ethnic groups or White women. Research from Barbados on postpartum depression was interested in learning whether depressive symptoms would be more common amongst mothers from low income backgrounds (Galler et al., 1999). Such focuses on difference facilitates an analysis and consideration of
women’s social contexts and allows them to be grappled with in the health research space. The focus on difference also addresses a central concern underlying these studies which is whether all women with maternal depression have the same social experiences. Factors like culture, race, religious background, and class/income/socioeconomic conditions indicate that women’s social experiences during a maternal depression experience and outside of it are undoubtedly different and that these must be considered to nuance and enrich the research.

By considering women’s differences the studies acknowledge how central Intersectionality is to women’s lives and experiences. Intersectionality has been a concept discussed by Black women since the first wave of the feminist movement when they were critiquing the exclusion of their specific experiences with overlapping race, class, and gender inequalities (see Truth, 1995; Cooper, 1995; Terrell, 1995). Crenshaw (1991) later coined the term and explained that it alluded to the fact that “the intersection of racism and sexism factors into Black women's lives in ways that cannot be captured wholly by looking at the women race or gender dimensions of those experiences separately” (p. 2). This highlights the notion that Black women’s social experiences and multi-layered identities are mediated by one another, and they must be looked at in relation to each other rather than in isolation from each other. While the research projects that have been included in this review do not explicitly use an Intersectional analysis to highlight difference, they do make significant contributions towards advancing this framework by grappling with difference and/or using it to bring women’s voices and experiences from the margins to the centre.
While the research evidence shows that Caribbean women’s social experiences and identities are different from women included in the earlier maternal depression research, the question of ‘whose social experiences are being included’ must also be asked. This query is particularly important to pose to the maternal depression research coming out of the English-speaking Caribbean, and here the question of race re-emerges. In the research by Davidson (1972), Galler et al. (1999) Wissart et al. (2005), and Palmer (1996), the samples are comprised almost entirely of Black women. The studies facilitate important information about these women such as the prevalence and incidence of maternal depression, and how marital status, education, and socioeconomic conditions impact their maternal mental health. However, the Caribbean is made up of many racial and ethnic groups which include Indian, Chinese, Arab, and Indigenous women whose difference is also demonstrated by their race, culture, and history.

To consider another component of identity, the majority of the maternal depression research from the English-speaking Caribbean discusses marital status and single motherhood at length, and these are debated as being risk factors for depression (Wissart et al., 2005; Pottinger et al., 2009). Hankivsky et al. (2010) critiques that such focuses on women in health research have led to lesbian and bisexual individuals being understudied and unacknowledged. By overlooking these persons it becomes assumed that Caribbean women are all Black and are only involved in heterosexual family forms and intimate partnerships, which is untrue. The point here is that difference cannot only be limited to race or geographic location because within these contexts there will be diversity and divergences due to women’s Intersectional identities.

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16 Indo-Caribbean feminist scholarship has been effective in detailing and describing the differing experiences of Indian descent women with regard to motherhood, family, sexuality, and femininity (see Hosein and Outar, 2012; Mohammed, 2012; Pragg, 2012). Research on Chinese-Caribbean women’s identity and topics like work and motherhood role are limited, but are also growing and important to also consider (see Lee, 2008; Wei, 2011).
Discussion

The prevalence and incidence studies of the ‘baby blues’ and postpartum depression show that these conditions are significant and should be addressed amongst Caribbean women in the Diaspora and women in the Caribbean region. In particular, the high rates of postpartum depression that have been recorded in the Caribbean indicate that it is a serious maternal health condition that must be acknowledged through further research. The review also shows that there is a lack of qualitative research on maternal depression from the English-speaking Caribbean, while research from the Diaspora shows that this kind of data can help us learn how it is experienced, managed and understood by women. Conversely, the lack of maternal depression incidence and prevalence studies amongst Caribbean descent women in the Diaspora shows that there is a gap in this knowledge base. This disallows comparative analyses between these women and other women from diverse racial and cultural backgrounds from being done. Both of these concerns can be addressed by generating more data from these sample populations to reduce the research gaps. Intersectoral and interdisciplinary efforts can be effective in this regard, and bringing together practitioners and scholars of public health, women’s health, and mental health can help to address these issues.

The studies included in the review provide insightful information on women’s experiences with maternal depression. However, there is a clear disparity in the research on the ‘baby blues’ in comparison to research on postpartum depression. This is apparent in the maternal depression studies conducted amongst Caribbean descent women in the Diaspora and also with women in the English-speaking Caribbean. As a result, there is a lack of information about how these women experience, understand, and explain the ‘baby
blues’. There is a need for increased qualitative and quantitative research on the ‘baby blues’ so that this condition can also be more fully explored and investigated.

The use of theories that enable deeper analyses of women’s lives, experiences and insights and which reflect their social, economic, political, and cultural realities would be useful to future research on the ‘baby blues’ and postpartum depression. Edge et al. (2004), Edge and Rogers (2005), and Templeton et al.’s (2003) discussion of the Strong Black Woman and Being Strong are influenced by Black Feminist Theory’s on-going discussion about Black women’s perceived ability to manage and survive life’s difficulties. This has been linked by Black feminists to historical representations of Black womanhood such as the Mammy whose strength was rooted in her reproductive and care-giving capacities, and required that she be a subordinated subject, nurturing care-giver and self-sacrificing at all times despite injustice and poverty (West, 1995; Hill-Collins, 2000). Through exploring such concepts that have emerged from Black Feminist Theory, researchers can critically engage with ideas that have been gleaned from scholars who have sought to de-marginalize women, privilege their experiences, and put them at the centre of analysis. There is power in doing this, and the act of de-centring knowledge production opens the doors to solutions, dialogue, and further engagement.

The Black feminist concept Intersectionality is a useful tool to further engage with women’s articulations about how race, class, and gender affect their experiences with maternal depression. In the research studies from the Diaspora and the Caribbean, women discussed mediating factors in their lives which also impacted their mental health after birth (Templeton et al., 2003; Edge et al., 2004; Pottinger et al., 2009; Palmer, 1996; Galler et al., 1999; Davy, 2013). An Intersectional approach helps researchers further grapple
with these factors and devise strategies to acknowledge the complexities of women’s lives and experiences rather than compartmentalizing illness and health from other parts of their realities (see Crenshaw, 1989; Hill-Collins, 2000). Intersectionality also helps to deepen the analysis by uncovering structural and systemic issues in healthcare interactions and the health inequities and inequalities that these create. And importantly, an Intersectional approach makes space for women’s diverse identities and social experiences which include race, culture, sexuality, ability, and class.

**Conclusion**

Postpartum depression and the ‘baby blues’ are significant phenomena that affect women across race, class, culture, and socioeconomic lines. Research that investigates these conditions must be sensitive to women’s differences and approach these endeavours with an awareness of how this diversity can impact and shape the ways women perceive, experience, understand, and explain their maternal mental health. Diverse research methodologies are also an important component of advancing maternal depression research amongst all women. It is important that women’s voices and experiences are regarded as important sources of data in the same ways that epidemiological research is viewed and valued. As a result, using theoretical frameworks that help nuance examinations and explanations of women’s experiences with maternal depression is an exercise that health researchers must be unafraid to participate in. These informed frameworks can help to continue transforming the knowledge base of postpartum depression and the ‘baby blues’.
“Don't End up in The Mental”: Exploring Black Women’s Social and Personal Experiences of Self-Reported Maternal Depression in Barbados

Abstract

This paper explores Black women’s experiences with self-reported ‘baby blues’ and postpartum depression in Barbados. Epidemiological research from the English-speaking Caribbean shows that women experience maternal depression, and recorded incidence and prevalence rates of postpartum depression are higher than those found in North America and Europe (Palmer, 1996; Galler et al., 1999; Pottinger et al., 2009; Wissart et al., 2005). However, there is a lack of qualitative analyses to provide insight about Caribbean women’s first-hand experiences with maternal depression, and none that use feminist theory to make this enquiry.

The findings and results discussed in this paper are organized around the narratives of 11 (n=11) Black women in Barbados who describe their experiences with self-reported maternal depression, and draw attention to the barriers that prevented them from seeking and receiving the maternal mental health care they needed. Such barriers include: lack of formal information and education on maternal depression at the postnatal stage; proliferation of international and non-local information sources on maternal depression; women’s intersecting race, class and gendered experiences with self-reported maternal depression; and social/cultural stigmas around mental health. The paper concludes with a discussion of the research findings, related research on maternal depression, and some key Black and Caribbean feminist concepts and debates such as Intersectionality which extend the analysis of the findings.
Introduction

The ‘baby blues’ and postpartum depression are forms of maternal depression women may experience after giving birth (Puckering, 1989). The ‘baby blues’ is a mild form of depression that is common during the first three days after birth and can last for up to 10 days (Cole, 2009). Reported symptoms of the ‘baby blues’ include restlessness, despondency, hypochondria, mood swings, irritability, crying, loss of appetite or poor appetite, difficulty concentrating, difficulty bonding with the baby, sadness and mild confusion (Halbreich and Karkun, 2006; Rondon, 2003). Postpartum depression is a major form of depression as defined by the DSM-IV, and its onset usually occurs within four or six weeks after birth and can last several weeks, months, or years (Seyfried and Marcus 2003; Cole, 2009; Almond, 2009). Some symptoms associated with the condition include weight loss or weight gain, forgetfulness, low self-esteem, irritability, anxiety, irregular sleep patterns, low mood, and inability to find pleasure in activities that were once enjoyable (Almond, 2009; Halbreich and Karkun, 2006).

Although maternal depression affects women around the world, the existing research is largely based on North American and European studies that use samples which do not always reflect the diversity of women living in these contexts. These studies estimate that postpartum depression affects 10-15% of women, and 30-80% will experience the 'baby blues' (Seyfried and Marcus, 2003; Brill, 2006; Friedman, 2009; Pearlstein et al., 2009). Data from studies conducted in the Global South are not included in these rates, but Almond (2009) estimates that rates for postpartum depression are higher due to greater social and economic burden experienced by women (Almond, 2009).
Data on maternal depression from the Caribbean are limited, but two epidemiological research studies from Jamaica found that prevalence rates for antenatal and postpartum depression were at 25% and 26%, respectively (Palmer, 1996; Pottinger, Trotman-Edwards, and Younger, 2009). A Barbadian epidemiological study that explored the relationships between maternal mood, maternal depression, breastfeeding practices, and infant cognitive development discovered that depression was experienced by 16% of the study respondents at seven weeks postpartum and increased to 19% at six months (Galler, et al., 1999; Galler et al., 2000; Galler, Harrison, Ramsey, Chawla, and Taylor, 2006). These studies show that maternal depression is a public health concern and maternal mental health is an issue in these Caribbean islands. However, missing from these quantitative analyses is qualitative research which has proven to be useful in providing knowledge about maternal depression and its relation to women’s social worlds (Amankwaa, 2003; Almond, 2009).

The findings from a qualitative research project are presented here to complement and extend the analysis of Caribbean epidemiological studies on maternal depression by exploring the ways Black women in Barbados experienced self-reported postpartum depression and the ‘baby blues’. The findings also seek to advance and vary the knowledge base on maternal depression by including the voices of women located in the Global South.

**Theoretical Framework**

This research project was initiated from a combined Black and Caribbean Feminist Theoretical framework, and operationalized an Intersectional approach throughout the planning, data collection, and data analysis stages. Intersectionality has traditionally
encompassed an analysis of co-mediating factors that are race, class, and gender (see Truth, 1995; Terell, 1995; Cooper, 1995; Crenshaw, 1989; Hill-Collins, 2000). Key debates from these theoretical paradigms also recognize that women’s sexual and reproductive functions are affected by socio-cultural constructions of Black and Caribbean womanhood which can frame their experiences with motherhood and mothering (see Hill-Collins, 2000; hooks, 1999; Rowley, 2003). The feminist orientation of the project allowed the principal investigator to place women at the centre of the project in order to treat them as experts on their own experiences (Gooden & Hackett, 2012). This was particularly important due to the fact that women’s experiences with maternal depression were self-reported.

**Methods**

The research findings come out of a descriptive, qualitative study on maternal depression among Black women in Barbados. The purpose of the study was to learn how women understand, experience, manage, and cope with self-reported ‘baby blues’ and postpartum depression. Qualitative research methods were determined to be the most appropriate to facilitate in-depth interviews and explore women's experiences. A descriptive model enabled the inclusion of a diverse set of sampling techniques, data collection methods and analytic styles (Sandelowski, 2000).

The study received ethical approval from the University of Toronto Research and Innovation Board and the Barbados Ministry of Health Research Ethics Committee. Additionally, the Senior Medical Officer of Health South in Barbados was contacted via letter to request permission to conduct recruitment in two polyclinics on maternal health clinic days.
Data was collected in Barbados by the principal investigator using a purposive sampling strategy. A snowball sampling technique enabled the principal investigator to ask research participants to refer other women to the study who experienced the ‘baby blues’ and postpartum depression. This technique tapped into research participants’ social networks to gain access to women who may not have been aware of the research project. Data was also collected through recruitment at local polyclinics during maternal health clinic days. During these interactions the principal investigator addressed attendees to explain the research project, discuss maternal depression, and hand out flyers to women individually.

The research interviews were semi-structured and used an interview protocol comprised of open-ended questions. The topic guide and interview questions were generated from the project’s research questions. These include:

1. How have Barbadian women experienced maternal depression such as postpartum depression and the ‘baby blues’?
2. Do Barbadian women interpolate maternal depression through social and cultural frameworks?
3. How do Barbadian women identify and manage the ‘baby blues' and postpartum depression?

Using the research questions as a guide for developing the interview questions enabled the principal investigator to remain mindful of the project’s central objectives. Thus, the research questions were essential to developing interview questions that reflected the core interests of the project and advanced knowledge on the topic. Key topics explored in the interviews were women’s knowledge about maternal depression, their experiences
with self-reported ‘baby blues’ and postpartum depression after giving birth, the kinds of support structures they had access to, and their antenatal and postnatal care experiences in Barbadian hospitals and health centres. Women’s demographic data such as age, race, education, relationship status and number of children were also collected to capture information that may not have been captured through the interview questions (Appendix E).

A study sample of 11 was collected. Women were eligible to participate in the project if they were Black and of Barbadian or Caribbean origin, aged 18 years or older, were literate in English, had given birth and experienced self-reported ‘baby blues’ and/or postpartum depression within 10 years of the research interview, and had given written informed consent. Women were targeted for participation in the study regardless of any previous mental health conditions or illnesses.

Each interview lasted between 30 and 120 minutes and was recorded using a digital audio device and field notes were taken. All of the transcription, collation, analysis, and storage of the research data was conducted by the principal investigator. Pseudonyms were given to study participants throughout these stages to ensure confidentiality. A combination of the NVIVO 10 software program, open and focused coding of the raw data, and thematic analysis were used for data analysis. Open and focused coding enabled a two-pronged approach to this process. An initial line-by-line reading to generate codes was followed by focused coding which was conducted according to updated code definitions and emergent thematic issues (Hsiung, 2010). During thematic analysis, themes and patterns were identified, analyzed, described and reported (Braun & Clark, 2006). Themes underwent processes of expansion and reduction until minor and dominant themes were
identified according to the frequency with which they appeared. This was facilitated by NVIVO 10 software, and helped the principal investigator compare and contrast various sections of the interview transcripts and determine more emergent themes from others.

**Self-Reporting as a Measure of Assessment**

Women who participated in the research project described self-reported symptoms and experiences of the ‘baby blues’ and postpartum depression. With the exception of two participants, none of the women that consented to take part in the project were diagnosed or screened by health care service providers for any form of depression.

The project’s feminist theoretical orientation facilitated women’s experiences, definitions, and self-reported symptoms of the ‘baby blues’ and postpartum depression were used to arrive at the sample. A similar self-reporting technique was used by Amankwaa (2003) which facilitated an exploration of African-American women’s experiences with postpartum depression, and this allowed women to discuss their own explanatory models and how they managed and coped with the condition. In our study, women were regarded as experts on their conditions and their health. Their knowledge and experiences were privileged and used to inform and guide the research endeavour.

Women discussed a range of symptoms which they linked to their experiences of the ‘baby blues’ and postpartum depression. These also aligned with much of the symptomatology recorded in other research conducted on the conditions (see Almond, 2009; Fritz and McGregor, 2013; Halbreich and Karkun, 2006; Rondon, 2003). Women who experienced self-reported ‘baby blues’ discussed feeling disconnected from their baby, feeling overwhelmed since the birth of their baby, having mood swings, crying,
sadness, experiencing a sense of loss, and loneliness. Women’s self-reported symptoms and experiences of postpartum depression included weight loss, loss of interest in activities they once found pleasure in, feeling disconnected from their baby, feeling disconnected from family members and intimate partners/spouses, decreased interest in sexual intercourse, anxiety, crying, feeling helpless, feeling hopeless, and sadness (Appendix J). Two women from the sample also discussed having thoughts of suicide and one described thoughts about harming her children. However, neither woman discussed plans or an intention to carry out these actions.

The key attributes that distinguished women’s symptoms and experiences of the ‘baby blues’ from postpartum depression was the intensity and length of time they occurred. Women typically described a decrease in the intensity of symptoms of the ‘baby blues’ after several days, weeks, or months after birth. Women who experienced postpartum depression described more intense symptoms which lasted for months and sometimes even years. Two women stated that they experienced the ‘baby blues’ and postpartum depression consecutively, and described their symptoms as becoming more intense and lasting for a longer period as time elapsed.

**Findings**

In the research interviews, women discussed their experiences with self-reported maternal depression and out of their narratives four dominant themes emerged. These were also identified as being barriers to women’s maternal mental health. These were: lack of formal maternal depression education and information at the postnatal stage; proliferation of international and non-local information sources on maternal depression; women’s
intersecting race, class and gendered experiences with self-reported maternal depression, and social/cultural stigma around mental health.

1. Lack of Formal Maternal Depression Education and Information at the Postnatal Stage

Research participants discussed formal sources of maternal depression education and information which were identified as healthcare service providers like nurses and nurse-midwives. Women’s regular interactions with these healthcare service providers throughout their pregnancy and after giving birth was cited as being a significant reason for them being recognized as ideal persons to provide information and education on maternal depression. Dena, a 24 year old woman, described her experience at the island’s major hospital after giving birth to her son. She characterized the interaction as being limited to nurses teaching her how to care for her new-born. She explained,

“In the hospital [the nurses] just mainly showed how to bathe the baby. It would have been [helpful] in case that you did go through postpartum you would know maybe how to handle yourself.”

Nita experienced self-reported postpartum depression for the first time after the birth of her third child and echoed a similar sentiment based on her experience at the same hospital. She said,

“No one cares how you feel. They just want you to know how to bathe the baby. [If the] baby breastfeeding and what’s not so they could go to bed or so they can go-long.”

In discussing the perceived shortcomings, Nita and Dena’s narratives also highlight the important function of hospital nurses at the postnatal stage. Logsdon et al. (2012) state that hospital nurses who interact with women at the postpartum stage are the most
significant healthcare service providers they come into contact with because they are in a position to assist women to overcome barriers or difficulties they may encounter after birth. In Barbados, nurses are charged with administering maternal healthcare information at the antenatal and postnatal stages. Although they have this important role, women in the study stated that they were not receiving information or education about maternal depression, and typically left the hospital without any mention of their emotional or maternal mental health.

Postnatal clinic visits presented similar situations, and women receiving care in these environments were not offered maternal depression education or information. In Barbados, postnatal clinic visits begin after birth to start the child’s immunization schedule. In Catherine’s case she was not provided any literature, nor was she engaged in discussions by healthcare service providers after any of her births, even though she stated to nurses that she had been feeling depressed. She explained,

“I remember saying to the nurse, ‘I does feel real depressed. I feel real depressed, you know.’ And I keep saying that. ‘I don’t know why, I just feel real depressed then!’ And she was like [kisses teeth] ‘you got man problems, that is what wrong with you. You know wunna young girls.’ It was always this negative, you know, you come somewhere you expecting to go home feeling a little better. You go home with that same downtrodden, negative feeling. It doesn’t help. It didn’t help.”

Catherine’s depressive symptoms were dismissed by her healthcare service provider as being symptomatic of problems in her intimate partnership with the father of her two children. Catherine was also in her late teens at the time of both births, and her age and the perceived inability of young women to have healthy, intimate relationships was seen by the nurse to be a more significant factor that outweighed her expressions of depression. Catherine’s age is important in light of research findings from a Jamaican
study on antenatal depression which found that younger women in the sample were significantly more likely to be depressed in comparison to older women (Pottinger et al., 2009). However, the negative reaction she describes also highlights some of the specific barriers that young women may face within healthcare environments, and the ways ageism can impede their emotional and mental health from being addressed.

As these women’s narratives indicate, in the hospitals after birth and at postnatal clinic visits they received information from healthcare providers about how to breastfeed, bathe their new-borns, and other care-based strategies that primarily focus on their and their children’s physical well-being. However, information about maternal mental health was continuously missing from these visits, and in some cases their feelings and experiences of depression were rejected by healthcare service providers entirely.

An exception to the reported lack of formal maternal depression information and education was found in Mary’s experience. She was the only woman to enlist a paid, private midwife throughout her pregnancy. Although her midwife did not specifically discuss maternal depression, Mary mentioned the effort she made to regularly ask about her mental and emotional state during the pregnancy. She stated,

“The nurse-midwife that we started to see […] asked like if I was happy about the pregnancy, asked my husband what he felt about it, like what was our relationship and stuff like that. But she never mentioned [postpartum depression or the ‘baby blues’]. I guess she was trying to find out our mental state kind of thing.”

That Mary was the only woman in the research project to access paid, private prenatal care through a midwife in addition to public healthcare is significant. Other participants only had access to the National Health Service’s prenatal and postnatal care which highlights the connection between healthcare access and class in Barbados. A two-tiered medical
system exists on the island, and individuals who are middle class or upper class can choose to pay for private care for most health-related matters including pregnancy and birth. Aside from more emotional care, Mary also developed a relationship with her midwife that helped increase her overall awareness about maternal depression. This finding is supported by research which infers that midwives have become increasingly involved in the provision of care to women with depression during pregnancy and after birth (Sanders, 2006). Also, research from the UK shows that British midwives view pregnancy as being an ideal time to intervene and address the needs of Black and minority ethnic women (Aquino, Edge, and Smith, 2015). These study findings highlight the importance for all healthcare service providers to be involved in providing education and information about maternal depression to pregnant women and new mothers.

2. **Proliferation of International and Non-Local Information Sources on Maternal Depression**

According to women, the main media that transmitted maternal depression information was television, magazines, and movies. In every case, these sources were from international and non-local multimedia sources that focused on postpartum depression almost exclusively. Catherine experienced self-reported ‘baby blues’ and postpartum depression, and she highlighted the lack of discourse in the local Barbadian media while representations of postpartum depression in international movies abounded. She explained, “Watching a movie and seeing the state of a person to the extent [...] where the person is on the verge of committing suicide, you know. Drop the child in the garbage can. Do those type of things. But to actually say in my environment, people surrounding me or from the media, local media here in Barbados or anything, I have never. I know the word, I know the name if I hear it, it would stand out. But to actually [see it, hear it] I have never heard of it.”
Mackenzie was experiencing self-reported ‘baby blues’ at the time of the interview, but she credited a storyline in an American soap opera and the American actress Brooke Shields with providing the bulk of her knowledge about postpartum depression. She stated, “So right now even on Bold and the Beautiful they’re basically playing out that scene [about] postpartum depression […]. But what made me knew about it was […] that actress Brooke Shields. When she had it and she felt that she couldn’t bond with her children and you know that kind of thing.”

The risk women may incur from receiving information about maternal depression only from sources like soap operas or made-for-television movies is that these outputs typically sensationalize and conflate conditions like postpartum depression, the ‘baby blues’, and the more severe postpartum psychosis in favour of intriguing storylines and ratings (Miller, 2002). The way this manifested in the research project was that some women assumed that to be depressed after birth automatically meant being at risk of harming themselves or their children which overlooks the variation in women’s maternal depression experiences and the differing ways they may experience symptoms of maternal depression. Furthermore, while some women could point out various examples of postpartum depression in television and movies they could not do the same for the ‘baby blues’. This condition was essentially left out of most multimedia outputs.

At various points during the data collection stage, it became apparent that some women were conflating the symptoms of the ‘baby blues’, postpartum depression, and postpartum psychosis with one another. Most often women conflated the ‘baby blues’ with postpartum depression, and postpartum depression with postpartum psychosis. The latter conflation was exemplified by several women in the research project who said that they understood postpartum depression to be characterized by infanticide; specifically when
“women end up killing their babies” (Mackenzie). To this end, a recent story about a young Barbadian woman who attempted to kill her new-born child was used by several women to illustrate a localized understanding and example of postpartum depression. Lucy lived nearby the area where the baby was found and she explained how she believed the woman’s actions were symptomatic of a possible mental illness. She said,

“A girl from this area […] put her baby in a bag and hid it on the beach. And the child started crying and a man found it and saved it really. But she obviously was dealing with some kind of a depression.”

Research participants who associated postpartum depression with this local story, and other similar international stories involving infanticide or attempted infanticide, shows how perilous the simultaneous lack of local media and abundance of international media on maternal depression is. This also impacted the research space in that time had to be dedicated to discussing and fleshing out women’s ideas about the causes, symptoms, and behaviours associated with postpartum depression, the ‘baby blues’, and postpartum psychosis.

3. Women’s Intersecting Race, Class and Gendered Experiences with Self-Reported Maternal Depression

Women involved in the research project discussed the distinct ways they experienced self-reported maternal depression, which usually involved other co-occurring factors in their lives. Addressing women’s interlocking experiences and oppressions aligned with the project’s theoretical framework, and an Intersectional analysis facilitated deeper analyses with women while also making space in the research interview to discuss these compounded issues at length.
Throughout the data collection endeavour it became apparent that most women’s experiences with self-reported ‘baby blues’ and postpartum depression were also tied to socioeconomic issues (class) and social ideas of motherhood (gender). Discussions about race were tied into women’s articulations about gender and class, and they highlighted certain cultural imperatives which were understood to be distinctive of Black womanhood. Such experiences differ from other women’s due to the distinct social and historical contexts of Black Caribbean women who have been articulating their complex and multi-layered lived realities brought on by overlapping racism, sexism, economic disenfranchisement and other forms of discrimination (see Massiah 1986; Mohammed and Perkins, 1999; Crawford, 2012).

Five of the 11 participants were unemployed or underemployed at the time of the research interview, and they spoke of the impact this had on their lives and ability to care for themselves and their children. Monica, an 18-year old and the project’s youngest participant, spoke about being underpaid, underemployed, and unable to find meaningful work to support her new baby. She explained,

“Right now I ain’t really doing anything cuz I can’t say working for two days [a week], getting a hundred dollars is a job.”

She went on to list the expenses she incurred while caring for her child which depleted the meagre amount she received through working on a casual basis for a family member. After paying for diapers and formula, there was little left over to meet any of her personal needs. She also expressed a desire to buy a home and help her intimate partner start a business, but these dreams could not be realized due to the financial constraints she was experiencing.
Mackenzie was also encountering financial hardship at the time of her interview. Shortly after she became pregnant she was made redundant from her job as a maid and care-taker to an elderly person. She discussed the difficulties she faced going from an independent woman to one who now relied on her partner and family for financial assistance. She said,

“I have my own place [...] so I accustomed to getting up on a morning and going to work. And you know, when a Friday come you got your own money and when you get paid you pay your own bills and you do the necessary things. You don’t gotta wait on nobody, that kind of mentality. So in a sense that too does got me off-set.”

Being “off-set” alludes to being put in a situation that causes stress and strain. For Mackenzie and other women from working class families their jobs are also tied to imagery of what a strong, Black independent woman is. Her experience highlights the centrality of race in the discussion of class. For Black Caribbean women who have historically linked their identity as Black women with their ability to work and earn, these connections simply cannot be unbound from one another (Crawford, 2012). Lack of employment or being underemployed was not only a blow to women’s pockets, but also to their gendered and racialized identities.

Discussions about gender were also highlighted through talk about the social expectations of motherhood. To some women, having maternal depression meant that they were existing outside of the boundaries of what a “good mother” was, which included being emotionally nurturing to her family, intimate partner, and children. While these expectations were placed on women by their own selves, they also encountered gender-based expectations of womanhood from people within their immediate family circles. Cynthia, a mother of three, had recently broken up with her partner of 17 years. She
explained how the expectations he placed on her womanhood created a contentious environment that was intensified by her self-reported experience of postpartum depression. She stated,

“He just come home and wanted food, and he said ‘well, what part my food?’ and I said ‘I didn’t cook.’ [He said] ‘You’re home all day and you didn’t cook?’ I said ‘well you could cook for yourself too; your hand ain’t leaving your mudda!’ 17 And them is the things he telling me up to today. I talk to him and he said ‘Cynthia thens the things you was telling me, how you could tell me them things you’s a woman. You’s my woman. You got be there and take care of me. Never mind that you got kids, you home the whole day I gone and work and come home and you ain’t got no food for me and you ask me if my hand ain’t left my mudda.’”

Although her partner was aware that she was experiencing some challenges to her mental health since giving birth, she still had to contend with expectations to cook and carry out other duties that were expected of her which also included sexual intercourse. The situation was complicated further because of their household structure which placed Cynthia’s partner as the main breadwinner while she adopted more traditional gender roles of homemaker and caretaker.

Women’s multiple layers of hardship were also intensified by their geographical location and the constraints of living in the Global South. Patrice’s discussion of the triple burden she experienced through her nationality, gender, and culture is a poignant example of their interlocking nature. These identities also heightened her struggle with self-reported ‘baby blues’ and postpartum depression. She explained,

“[It’s] a combination of all three. Caribbean, because we’re small so we have to show that we can and we’re just as good as the big boys. You know, […] Black women come under so much scrutiny; we have to show that we are capable of handling [everything]. And because of that we tend to take on more than we should on our own because we have to prove over and above that we can, and we can do it

17 Meaning: “well you can cook for yourself, you are not living with your mother!”
just as good or even better than our White counterparts. Or other religions, or ethnic groups because the Indians probably have their support systems so they don’t have to worry, but a lot of Blacks don’t so they have to prove themselves. […] And just being a woman, ya. A Black Caribbean Woman; a triple whammy!”

Being located in the Caribbean and the lack of access to specific resources are presented as an outcome of her Black, Caribbean womanhood. In the 1980’s, Joycelin Massiah wrote that while Caribbean women enjoy advantages like greater life expectancy and primary and secondary-level education, “socioeconomic conditions in the region continue to restrict women’s participation in the local economy, limit their mobility, and ignore the deleterious effect on women of the macroeconomic development strategies” (1989, p.965). These concerns and issues have not subsided, and in light of the recent global economic crisis women like Patrice feel even more vulnerable to larger economic policies and constraints.

In Patrice’s experience, social ideals about Black motherhood and womanhood are also associated with strength in spite of women’s personal or familial contexts. Black Caribbean women like her are expected to transcend their Intersectional experiences and flourish in spite of any challenges that affect their lives and compound with other factors. This expectation ignores the structural and systemic nature of issues such as unemployment/income inequality, racism, and access to health care in favour of stories that highlight personal exceptionalism.

4. Social/Cultural Stigmas Around Mental Health

Social and cultural stigma about maternal depression was framed atop characterizations of mental illness in general and was also impacted by women’s socio-cultural contexts. Women in the research project discussed fears of disclosing their mental health challenges even if they had personally come to terms with it. When it came to
telling others about their difficulties or when they demonstrated symptoms of mental illness, women like Cynthia were warned not to disrupt dominant images of idealized mental wellness. In Cynthia’s case it was her mother who first noticed her uncharacteristic behaviour shortly after giving birth. She also gave her strong advice that related to maintaining an image of idealized mental health. Cynthia recounted,

“[My mother told me] ‘Cynthia you’re going to end up in the Mental, don’t end up in the Mental.’”

The “Mental” is a popular colloquial term for the local psychiatric institution which is formally called the Black Rock Psychiatric Hospital. For Cynthia (and her mother) the Black Rock Psychiatric Hospital was also a site of personal contention because her brother experienced an episode of psychosis and was admitted there several years before the interview took place. She also had to visit the building regularly for psychiatric appointments and to be given medication by her doctor. She discussed the stigmatized response she received from persons who knew she frequently visited the hospital. She said,

“People would be laughing and saying ‘you going into the Mental!’ I said ‘I never went in the Mental; I went there to see the psychiatrist’. [They said] ‘Oh, you mean you went in, what part you went?’”

The Black Rock Psychiatric Hospital exists for many Barbadians as a site of negativity and symbol of social ostracization. To be associated with it indicates existing outside of localized parameters of social normalcy and respectability.18 A Jamaican study on psychiatric worker’s attitudes towards the deinstitutionalization of mentally ill persons also found that stigma and discrimination was a major theme, and that these can add to the burden of living with mental illness (Pusey-Murray, Hewitt, and Jones, 2014). Altogether

18 In Barbados, respectability is a complex and significant value that is usually linked to notions of citizenship, nationalism, and personal character (Murray, 2012, p. 110).
mental health stigma, lack of public education and discourse on mental illness, and ideas of respectability creates an environment where discussions about mental health are taboo. Such personal and social characterizations about mental health silenced women like Cynthia, and for her, the fear of social stigma was so high that she had not revealed her mental health status to her sister who relocated to Barbados from Guyana to help care for her children.

Nita, another participant who was receiving mental healthcare from a psychiatrist, explained why she believed people in Barbados were not forthcoming with their mental health. She said,

“You does got to ease your way into a conversation. Some people may speak, some people may not because everybody […] not as open as they should be with their emotions. Cuz I am not as open as I should be with my emotions.”

That women would hide their mental health status from family members or felt unsafe or unable to reveal how they were coping and living with mental health challenges is indicative of dominant ideas about mental illness in the region which depict it as being taboo and dangerous (Arthur, Hickling, Robertson-Hickling, Haynes-Robinson, Abel, and Whitley, 2010). Such ideas also marginalize people and perpetuate perceptions of mental illness that liken it to something that needs to be kept away or institutionalized.

For some women, maternal depression was seen as being a particularly deviant mental health condition because it indicated they were failed mothers and this brought on a significant amount of shame (Kantrowitz-Gordon, 2013). Catherine reflected on the reaction she had to her second child after birth which was also her second experience with self-reported postpartum depression. She explained,
“When I came out of surgery and they woke me up I can remember somebody saying ‘oh a little girl’. And I literally [kissed my teeth] and that is not me as a person. I am bubbly, and you know. So I knew something was wrong. I was like [makes sucking teeth sound] ‘I ain’t gine like this child.’ You understand. I start to feel that feeling coming on.”

Catherine’s narrative discusses that she knows feeling disconnected from her child is not standard social or cultural behaviour expected of a new mother; but she also indicates that it was beyond her control. This resulted in women blaming themselves and silencing their experiences with self-reported maternal depression thereby limiting access to necessary support structures and resources.

Such gender-based assumptions that idealized mothers’ roles as emotional caretakers of others and possessing inherent strength were present in many women’s narratives, but women also openly discussed not being able to fulfil such standards. Patrice had her first and only child at 40-years old, but she often felt helpless with regard to caring for him and herself. She stated,

“They don’t expect this of you, you know. They expect, well you’re a strong woman, you should be able to deal with that, but there’s no training for becoming a mother.”

The “they” who Patrice speaks of is never identified, yet it is apparent that she is referring to a general societal and cultural perception which shapes how motherhood and womanhood are constructed. Her narrative discusses feeling that she had failed at being a mother and also caring for her own emotional and mental health. However, it must also be said that the very act of women participating in the research project was a bold and courageous move. Their willingness to disclose personal information which they knew would be stigmatized and goes against social and cultural ideas of idealized motherhood
cannot be understated. This act of agency is a testament to these women’s investment in uncovering and discussing their self-reported maternal depression experiences in Barbados. By doing this, each woman fought against social stigma and taboo in favour of knowledge creation and self-empowerment.

**Discussion**

Women articulated various factors which prevented them from accessing the kind of care they needed to address self-reported maternal depression. Among these was the lack of formal information and education from health care professionals. Women’s narratives mainly focused on nurses they encountered at the Barbados state-run public hospital and polyclinics before and after birth. Edge (2007) found that Black Caribbean women in the UK who overcame fear of statutory services or personal barriers to seek help for postpartum depression also felt that service providers were unable or unwilling to assist them effectively. Although Edge’s study highlights cultural barriers as a reason for this, participants in our study indicated that some nurse’s responses to their self-reported maternal depression symptoms also worked to minimize, overlook, or ignore their experiences. By simplifying these complex emotions to being an outcome of relationship issues with their intimate partners, for example, the opportunity to properly counsel women was lost. An exception to these experiences with healthcare providers was found with one woman who accessed a paid midwife throughout her pregnancy. Midwifery research recognizes the significant role they play as primary care providers, and asserts that early detection and appropriate treatment strategies will improve many women’s health (Sanders, 2006). The one-on-one interaction with women and personalized care helped this
research participant to be more aware of her emotional health, although maternal depression was never discussed explicitly.

Women discussed the proliferation of international and non-local examples of maternal depression which they encountered through media outlets such as television, movies and documentaries. These sources did not reflect Black women’s class, race, relationship status, and geographical location. Edge’s (2008) research findings also show that Black Caribbean women in the UK turned to popular media to gain more understanding about postpartum depression, but they did not see a reflection of their realities and lives on the screens nor did these depictions reflect their racial or cultural identities. Dubriwny (2010) argues that, in the last decade several stories have dominated the discussion about maternal depression and these have all focused on White, middle class, heterosexual, married, North American women. These depictions are narrow and did not fit the realities of women in the study, nor do they fit the realities of most women in Barbados. Such representations of maternal depression also led to the conflation between conditions like the ‘baby blues’, postpartum depression and the more severe postpartum psychosis. However, women in the research study were not alone in their confusion between the conditions. Martinez, Johnston-Robledo, Ulsh, and Chrisler (2000) found that maternal depression research also conflated the ‘baby blues’ and postpartum depression with one another, and contradictions between the two were found in most scholarly articles reviewed in their study. This is also exemplified by the near absence of discussions about ‘baby blues’ in women’s social environments and from the multimedia they accessed and discussed in the research interviews.
Women discussed other factors that impacted their experiences with maternal depression, and an Intersectional analysis facilitated an understanding of how class, race and gender compounded and impacted their mental health. The historical context of the Caribbean and its legacies of enslavement, colonialism, and economic and sexual exploitation inflicted over generations offer some insight into how class and race inequalities are experienced and perpetuated (see Williams, 1944; James, 1989; Newton, 2000; Shepherd, 2009; Beckles, 2013). These injustices set the foundation for contemporary macro-level processes of neoliberal globalization and imperialism which have been felt since “Third World” nations were encouraged to take loans from international lending institutions, private banks and foreign governments in the 1970’s (Scott, 2006). The outcomes of these exploitative relationships continue to affect Caribbean women (and their families) on micro-levels through rising unemployment and the deterioration of economic conditions (Khalideen & Khalideen, 2002). Women in these contexts often have to “make do” as a response to job loss and on-going economic difficulties (Senior, 1991; Khalideen & Khalideen, 2002).

Class, underemployment, and unemployment were particularly prevalent in women’s discourses, and financial instability was a recurrent theme in their narratives. Women who were unemployed or underemployed at the time of the research interview tied the stress brought on by their material circumstances to their self-reported maternal depression experiences. In many cases this stress was described as occurring on a continuum, particularly amongst women who lost their jobs while they were pregnant or who could not find gainful employment in the months after giving birth. Maternal depression research conducted with Jamaican, Barbadian, and Black Caribbean women in
the UK also discovered that mothers experienced repercussions with being unable to financially provide for their families (Edge & Rogers, 2005; Pottinger et al., 2009; Galler et al., 1999). These studies and ours show that some Black Caribbean women link their racial and gender identities to their ability to earn a living. To this end, Crawford (2013) reflects that “working class African-Caribbean women saw their economic role as providers as an essential part of their role as mothers- they did not separate the two” (p. 162). When their economic roles are limited or threatened, it can have a direct impact on how women conceptualize themselves and also on their experience with maternal depression.

When gendered expectations about Black womanhood and motherhood were discussed, research participants pointed to the difficulty of being able to maintain the image of strength throughout their experiences with self-reported maternal depression. This highlights the fact that women in the study linked their race and gender together, and an idealized kind of Black womanhood and motherhood which valorised unwavering strength was described. This also added a layer of complexity to their experiences with self-reported postpartum depression and the ‘baby blues’ because these were perceived as deviating from race and gender-based roles. The notion of strength has been taken up by various Black feminists and Black women researchers whose work focuses on Black and Caribbean descent women experiencing depression and postpartum depression (see Amankwaa, 2003; Edge and Rogers, 2006; Hill-Collins, 2000; hooks, 2005; Jackson and Naidoo, 2012; Etowa et al., 2007). Insight can also be gleaned from Schreiber et al.’s (2000) discussion of ‘Being Strong’ which explores how Black Caribbean women in Canada manage depression while also contending with assumptions of their resilient
womanhood. These authors and researchers have asserted that women link their strength to a legacy of resilience that is inherited from women who had to be strong to overcome slavery and racial oppression (Edge et al., 2004; Edge and Rogers, 2005). Such discourses help women to cope with and manage mental illness. However, our findings also show that these discourses do not always provide room for women to express vulnerability or carve out opportunities to seek help for their mental health. Women may learn how to be Strong Black Women during difficult times and pass these survival techniques on to future generations. But tools and techniques to help them deal with these issues may not also be transmitted, leaving women to internalize their issues or ignore them.

Stigma was conceptualized as a multi-level issue caused by social and cultural attitudes towards mental illness in Barbados, and social and personal expectations of motherhood. Gender-based expectations of Caribbean motherhood valorised strength and made little space for women to express experiences of vulnerability or weakness. Women’s narratives discussed failing to meet certain social expectations of motherhood like being instantly connected to their children and this was understood to be at the root of the perceived deviance. Ellis’ (1986) work on Caribbean motherhood highlights the high value women place on their mothering identity which impacts their self-image. Crawford’s (2012) discussion of maternal guilt which leads women to shame or blame themselves for failing to live up to personal and social ideals of being a good mother is a reality for Caribbean women in the region and in transnational spaces. Expectations about motherhood were typically co-constructed by women in the research project and by social and cultural ideas about mothering in Barbados. The experience of stigma also uncovered negative connotations associated with the island’s psychiatric hospital and colloquial
language that was used to refer to it which simultaneously marginalized it and those who utilized out-patient services. Research conducted in the Caribbean has found that mental health is largely neglected and mental illness is seen as deviant and stigmatizing (Baird et al., 2012). Furthermore, people fear ostracization, social shaming, and rejection from the communities that they may be a part of which can prevent them for being forthcoming about their challenges (Baird et al., 2012).

**Research Limitations**

The research had several limitations. Women were included in the project based on self-reported experiences with postpartum depression and the ‘baby blues’, and no one included in the sample underwent screening for the condition from health care service providers, nor were any diagnosed with the condition by health care service providers. This could potentially introduce bias into the project such as recall bias, telescoping bias, and selective memory. Allowing women to participate in the research based on their self-reported experiences with maternal depression aligned with the feminist theoretical orientation of the project wherein women were considered experts on their health experiences and their information was privileged and informed and guided the research. Future research on postpartum depression in the Caribbean and Barbados could utilize this theoretical orientation and also recruit women who have been diagnosed with maternal depression to learn how they interacted with screening tools and experienced the diagnostic process. This could accomplish privileging women’s experiences in a meaningful way and help build understanding about diagnostic, screening, and treatment methods for the condition in local health care institutions.
Given that the research project is a qualitative endeavour, the findings are not generalizable to the larger population. The findings may be transferable to readers and researchers who can use them to develop explanatory models for similar situations and research contexts.

**Conclusion**

The Intersectional findings of this study show that this framework can work to advance maternal depression research in Barbados and in other locations where Black, Caribbean women live. An Intersectional framework moves toward what Black feminists and Black women activists have been calling for since the first wave women’s movement which is increased attention to examining the multi-layered experiences and identities of Black women in order to transform how they are understood. Through the Intersectional framework we are able to see how factors such as race, class, and gender are impacted by one another, and how they affect women’s experiences with self-reported maternal depression. Further analyses that employ Intersectionality can help us to more fully understand Black Caribbean women’s experiences and also continue to transform the landscape of maternal depression research. The findings of this study also show that in order to truly understand the barriers that prevent women from getting the maternal mental health care they need, we must be open to considering how they discuss, experience and describe self-reported postpartum depression and the ‘baby blues’ on their own terms.
“We Cannot Let Her Walk Away; We Got to Deal with it”: Addressing Women’s Access to Formal and Informal Supportive Resources for Maternal Depression in Barbados

Abstract

Maternal depression affects women around the world which includes those living in the Caribbean. Studies from the English-speaking Caribbean have shown that women demonstrate higher rates of conditions such as antenatal depression and postpartum depression in comparison to women living in high-income nations (Pottinger et al., 2009; Wissart et al., 2005; Galler et al., 1999; Galler et al., 2000). Some of this may be attributed to the lack of access to resources and higher social burden experienced by women living in the Global South (Almond, 2009). Although the research shows that maternal depression is a concern in the Caribbean and strides have been made to address women’s maternal health through national healthcare plans, these do not always acknowledge maternal mental healthcare and the specific needs that are associated with conditions like the ‘baby blues’ and postpartum depression.

This paper presents key findings from a descriptive, qualitative research study wherein Black women were interviewed in Barbados who experienced self-reported postpartum depression and/or the ‘baby blues’. It discusses how they have experienced this lack of attention to their maternal mental health first-hand through the formal supports they accessed. Women’s informal supportive resources are also outlined which were sometimes accessed in lieu of, or in addition to, these services. Focusing on formal and informal
supportive resources enables an analysis of the ways women request, seek out, and at times even reject supportive resources during their maternal depression experiences in Barbados.

**Introduction**

Since the early 1980’s, maternal health services in Barbados have been administered from the island’s three district hospitals, the Queen Elizabeth Hospital and eight community health centres commonly called polyclinics (Rodney, 1998; Inniss, 2007; St John, 2010). Polyclinics are sub-divided into districts and serve catchments of 17,000-50,000 clients per year (Ministry of Health, 2003). Between 2004 and 2006, these community health centres facilitated 8555 to 8762 visits to the Maternal and Child Health Service (MCHS) alone (St John, 2010). Although they manage to provide primary care to a large catchment of individuals, polyclinics and the health centres are generally overcrowded, lack necessary resources, and experience a chronic shortage of nurses (Ministry of Health, 2003).

The MCHS is mandated to provide free primary care at the point of service which includes antenatal care, mental healthcare referrals, family planning services, medical screening, reproductive health counselling, routine care, and child health services such as immunizations and foetal growth assessments (St John, 2010; Inniss, 2007). Women who access the MCHS learn about the benefits of breastfeeding, and mothers with HIV/AIDS can access the pMTCT programme which prevents transmission of the virus to new-born children (Inniss, 2007). In addition to this, women also have access to maternity grants and benefits made available through the National Insurance Scheme (Inniss, 2007). The MCHS offers important services to pregnant women, new mothers and children, but noticeably
absent from its services are any specific provision for maternal mental health in spite of research that shows it is a global public health concern (Almond, 2009).

Similar omissions of maternal mental health are characteristic of maternal health services and policies in other Caribbean nations. In 2011, the Trinidad and Tobago Ministry of Health revised its Maternal and Child Health Policy and emphasized its commitment to strengthening obstetric and midwifery procedures and improving antenatal care services (Khan, 2011). However, maternal mental health was not included or addressed in its revamped framework. In Jamaica, the 2006-2010 Ministry of Health Strategic Plan highlighted maternal healthcare services, but focused almost exclusively on reducing maternal morbidity and mortality and the promotion of breastfeeding (Lewis, 2005). Between 2000 and 2007, Antigua and Barbuda’s Ministry of Health improved antenatal care offered through the Maternal and Child Health Services, and decreased maternal mortality to zero (Henry and Thomas, 2000; Health Systems 20/20 and SHOPS, 2012; PAHO, 2013). But maternal mental health was not included in the guidelines of the twin-island nation’s MCHS. These examples show that health plans implemented across the English-speaking Caribbean are making important strides to provide necessary

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19 The Barbados government and Ministry of Health have indicated they are working on a comprehensive framework for prenatal and postnatal healthcare (Inniss, 2007); however, there is no known date for when this will be released or implemented.

20 These gains in improving antenatal care and decreasing maternal mortality are also reflective of widespread commitment from Caribbean governments to the UN Millennium Development Goals (MDGs). MDG 5 was to improve maternal health by 2015, and its indicators included the maternal mortality ratio, proportion of births attended by skilled health personnel, and antenatal care coverage (WHO, 2014). The MDGs and its indicators garnered criticism for their limited scope which overlooked systemic gender inequality and the lack of access to comprehensive reproductive and maternal health services in the region (Antrobus, 2005). Furthermore, noticeably absent from MDG 5 was maternal mental health (WHO, 2008). Countries like Barbados, Trinidad and Tobago, Jamaica, and Antigua and Barbuda who “bought into” the MDGs may have seen some success according to the specific indicators, but in the process continued to overlook maternal mental health.
healthcare to women. But their lack of attention to maternal mental healthcare indicates that these plans are not prioritizing this significant aspect of women’s health.

The lack of attention to maternal mental health at the institutional level does not mean that women in the Caribbean do not experience maternal depression. In fact, studies from Jamaica and Barbados show that women have higher rates of antenatal and postpartum depression in comparison to studies conducted with women in high-income countries (Pottinger et al., 2009; Wissart et al., 2005; Galler et al., 1999; Galler et al., 2000). This information led us to question whether women in these contexts experience a lack of attention to their maternal mental health from healthcare institutions and providers; do they receive care from formal supportive sources; how does this happen and are they satisfied with it; and what informal supportive resources are they also accessing in lieu of, or in addition to, formal support sources? To address these questions, the paper uses the narratives of women with self-reported postpartum depression and the ‘baby blues’ in Barbados to explore some of their experiences accessing formal and informal supportive sources on the island, and any drawbacks they may have also experienced in connection to them.

Research Design and Methods

The research findings emanate from a descriptive, qualitative study which sought to learn how the ‘baby blues’ and self-reported postpartum depression are understood, experienced, coped with, and managed by Black women in Barbados. Qualitative methods helped facilitate in-depth interviews to explore women’s first-hand experiences with the
conditions, and also facilitated the use of a diverse set of sampling techniques, methods of data collection, and analytic styles in the research space (Sandelowski, 2000).

The study received ethical approval from the University of Toronto Research and Innovation Board and the Barbados Ministry of Health Research Ethics Committee. Upon receipt of these approvals, a letter was also sent to the Senior Medical Officer of Health South in Barbados to gain permission to conduct recruitment in two polyclinics on maternal health clinic days.

All research data was collected in Barbados by the principal investigator. A non-probability sampling technique was used to achieve the research sample which included snowball sampling and direct recruitment in two local polyclinics. In the first sampling technique, research participants were asked to refer women from their social and familial networks to the study who experienced the ‘baby blues’ and postpartum depression. This allowed the principal investigator to gain access to women who were not initially included in recruitment activities and/or who were unaware of the project. Data was also collected by recruiting women who were attending maternal health clinic days at two polyclinics. During these recruitment days, the principal investigator addressed attendees to explain the research project and discuss maternal depression, hand out project flyers to women, and discuss the project with them individually.

The research interviews were semi-structured and an interview protocol comprised of open-ended questions was used by the principal investigator. The project’s central research questions were used to help develop the topic guide and interview questions. This
allowed the principal investigator to remain mindful of the project’s core objectives. Some of the research questions were:

1. What have been Barbadian women's experiences seeking treatment for maternal depression within the Barbadian healthcare system?

2. What kinds of non-institutional/informal care have Barbadian women sought out and/or received to treat maternal depression?

   Key topics explored in the interviews were women’s antenatal and postnatal care experiences in Barbadian health centres, and the kinds of support structures and resources they accessed during their experiences with self-reported postpartum depression and the ‘baby blues’. Questions about women’s demographic information were also included at the beginning of the interview to capture information that may not have been brought up in the interview questions.

A study sample of 11 was collected. Women were eligible to participate in the study only if they were Black and of Barbadian or Caribbean origin, aged 18 years or older, were literate in English, had given birth and experienced the ‘baby blues’ or postpartum depression within 10 years of the research interview, and had given written informed consent. Women were targeted for participation in the study regardless of any previous mental health conditions or illnesses.

Interviews lasted between 30 and 120 minutes and were recorded using a digital audio device. Field notes were also taken by the principal investigator during the interview to record any environmental or observational information. All transcription, collation,
analysis and storage of research data were conducted by the principal investigator. To
ensure confidentiality, pseudonyms were given to study participants.

A combination of open and focused coding of the raw data, thematic analysis, and
the NVIVO 10 software program were used to facilitate data analysis. Open and focused
coding enabled a two-pronged approach to the data analysis endeavour. Initially,
transcripts were read line-by-line to generate codes. This was followed by focused coding
which was conducted according to updated code definitions and emergent thematic issues
(Hsiung, 2010). During thematic analysis various themes and patterns were identified,
analyzed, described and reported (Braun & Clark, 2006). Themes then underwent
processes of expansion and reduction until minor and dominant themes were identified.
Dominant and minor themes were identified according to the frequency they appeared and
NVIVO 10 software was used to facilitate this. This technique also helped the principal
investigator to compare and contrast various sections of the interview transcripts and
determine more emergent themes from others.

**Theoretical Orientation**

Black Feminist Theory and Caribbean Feminist Theory anchored the research
project. These paradigms offer unique racial, social, historical, political, and cultural
analyses of Black and Caribbean women which were deemed useful for this research
endeavour. Black Feminist Theory has effectively highlighted the complexities of
women’s oppression and compounded experiences of inequality through the concept
Intersectionality (Crenshaw, 1989; Hill-Collins, 2000). Intersectionality highlights the
relationship between race, class, gender, and other factors in women’s lives and
emphasizes that none can be fully understood without acknowledging that each is reproduced and given new meaning when they interact with the other (Hill-Collins, 2000). Intersectionality has been used as a tool of critical analysis to investigate issues in health care such as social factors that impact women’s health and health inequities that are caused by racism, immigration, and sexism (Guruge and Khalou, 2004; Hankivsky et al., 2010). An Intersectional framework can also help to de-centre knowledge production by allowing participants to guide research endeavours and be regarded as experts on their own experiences (Seaton et al., 2010; Gooden and Hacket, 2012).

Caribbean Feminist Theory offers historical analyses of sexual and reproductive representations of women which have impacted how mothering and motherhood are presently regarded in the region (Massiah, 1982; Senior, 1991; Rowley, 2002). Caribbean Feminist Theory also highlights the ways Black women’s bodies became commoditized, sexualized, and exploited for production and reproduction throughout colonialism (Reddock, 1985; Kempadoo, 2000; Turner, 2011). These legacies are significant to building an understanding of how women interact with social welfare systems and create understandings of themselves and their emotional strength (Rowley, 2003a). Together, Black Feminist Theory, Caribbean Feminist Theory, and Intersectionality facilitate an understanding of how co-existing identities, overlapping inequalities, and historical and political factors impact women’s lives, identities and health.

Profile of the Research Participants

All of the women involved in the research project accessed the MCHS during their pregnancies and/or after birth. Among the research participants self-reported postpartum
depression and the ‘baby blues’ were the most commonly experienced forms of maternal depression. Rondon (2003) describes the ‘baby blues’ as “a mild affective syndrome experienced by women, sometimes around one week to 10 days after childbirth” (p. 168). Symptoms of the condition may include inability to or difficulty concentrating, sadness, difficulty bonding with the baby, crying, loss of appetite, mood swings, and mild confusion (Halbreich and Karkun, 2006; Rondon, 2003). Postpartum depression is described as a major depressive disorder whose onset can appear up to one year after delivery and last for weeks, months or years (Cole, 2009). Symptoms include low self-esteem, irritability, anxiety, low mood, weight loss or gain, anxiety, irregular sleep patterns, forgetfulness, and an inability to find enjoyment in activities that were once enjoyable (Almond, 2009; Halbreich and Karkun, 2006).

Women who consented to participate in the project described self-reported symptoms and experiences of the ‘baby blues’ and postpartum depression, and these descriptions were used to arrive at the sample. Of the 11 participants only two were screened and diagnosed by health service providers for depression. All of the women were regarded as experts on their health, and the symptoms and experiences they self-reported informed and guided the research endeavour. The project’s feminist theoretical orientation facilitated this approach to the data collection and research, and their knowledge of and experiences with self-reported postpartum depression and the ‘baby blues’ were privileged and used to guide and inform the research.

Women described a range of symptoms that were linked to their experience with ‘baby blues’ and postpartum depression. In most cases these symptoms mirrored symptomatology from other research on the conditions (see Fritz and McGregor, 2013;
Rondon, 2003; Halbreich and Karkun, 2006). Women who discussed experiencing the ‘baby blues’ explained that they felt overwhelmed since birth, had mood swings, experienced sudden bouts of crying, experienced sadness, felt disconnected from their baby, felt lonely, and experienced a sense of loss. Women who self-reported symptoms and experiences of postpartum depression described feeling disconnected from their family members and intimate partners/spouses, decreased interest in sexual intercourse, felt anxious, hopeless, experienced dramatic weight loss since birth, experienced prolonged and intense feelings of sadness, had a loss of interest in activities that were once pleasurable, and experienced sudden bouts of crying (Appendix J). Of the 11 participants, two women discussed having thoughts of suicide and one discussed having thoughts of harming her children. However, neither woman discussed a plan or intention to carry out these thoughts.

The key features that distinguished women’s symptoms and experiences of the ‘baby blues’ from postpartum depression was the length of time they occurred and their intensity. Women with ‘baby blues’ usually described a decrease in the intensity of symptoms after several days, weeks, or months after the birth of their child. Women who experienced postpartum depression typically described symptoms that were more intense and long-lasting. Some women said these feelings and experiences persisted for several months, and others stated they lasted for several years after birth.

The research participants were all Black women and the majority were born and raised in Barbados with the exception of three women who immigrated to the island from St. Vincent, Guyana, and Antigua, respectively. Women displayed a range of ages, educational levels, employment statuses, number of children, and relationship statuses.
Women’s ages ranged from 18-49 years old and over half of the research sample was in their 30’s. Most participants had completed high school while others were pursuing university degrees, post-graduate degrees, or had completed post-graduate degrees at the time of the interview. Just under half were employed full-time, while the rest of the sample were unemployed or involved in part-time and casual employment at the time of the interview. Women’s relationship statuses also showed some variation: over half of the sample reported that they were married or in relationships, while two women were single at the time of the research interview (Appendix E).

Most women lived in homes with members of their nuclear and/or extended families. Women who were married typically lived with their spouses and children. However, most women in relationships lived in intergenerational homes which typically consisted of their mothers, siblings, and sometimes a female grandparent.

**Findings**

*Expectations of Formal Supportive Structures and Emerging Contradictions*

Women in the study discussed their experiences with polyclinics and psychiatric services they accessed during pregnancy and after birth, and expressed what kinds of support they wanted from these to help them address their depressive symptoms and experiences.

Women suggested that it would be beneficial for healthcare service providers in polyclinics to address emotional issues early in their pregnancy when they had just begun to access the MCHS. The Barbados Ministry of Health encourages women to become
registered and begin visiting their local polyclinic from the 12th week of gestation so that their pregnancies can be monitored (St John, 2010). In these community health centres, women regularly interact with nurses, doctors, midwives, and senior sisters, and it is not uncommon for them to see the same individuals throughout their pregnancy and after giving birth. These routine interactions with healthcare service providers led some of the study participants to suggest that antenatal clinic visits were an opportune time for women to be counselled about their emotional health. This was framed as a possible preventative measure that could help them to develop their understanding about emotional changes related to pregnancy and how they could prevent this from also affecting them after birth.

Catherine, a mother of two, attended the antenatal clinic at her local polyclinic during both pregnancies. She explained that she was not counselled about maternal depression by the nurses she saw throughout her pregnancy, but believed this could have been advantageous. She said,

“...I feel they should got some kind of counselling session because there is antenatal care at the polyclinic, you understand? You supposed to have classes while you are pregnant. They don’t. [...] It is not structured properly. They just come, they put up some diagrams, and they show you how to sit down from how not to sit down, and how to hold the baby, and how to nurse the baby, and that is it. No one speaks about the emotional aspect, or the emotional side of it, or make these things readily available.”

In Catherine’s case she felt depressed during both pregnancies, and she self-reported experiencing the ‘baby blues’ and then postpartum depression. Her experience and suggestion for antenatal services corroborates with antenatal depression research from Jamaica which found that women need to be encouraged to talk with their healthcare service providers about their feelings during pregnancy, and those who felt their healthcare service providers were supportive were less likely to be depressed (Pottinger et al., 2009,
Catherine’s focus on the antenatal stage is particularly relevant when it is considered alongside research that suggests that there is continuity between depression experienced at the antenatal stage and postpartum depression (Pitt, 1968; Cooper et al., 1988). Her narrative also highlights the important role that nurses and other healthcare service providers can play to intervene at an early stage in women’s pregnancies which can work to address their emotional well-being and make them feel supported (Bowen and Muhajarine, 2006).

Psychiatric services are another example of formal healthcare structures where women who utilized them expressed the need for counselling but felt these went unaddressed. Cynthia became depressed immediately after the birth of her third child and was referred to a psychiatrist who operated out of the psychiatric hospital. Although the physician acknowledged that her recent birth and depression were related and Cynthia stated that she needed counselling, arrangements were not made for her to receive the services. She recounted,

“From the time that she hear that I have a young baby she was like, over her head like ‘Oh my God! You got a young baby?’ And she call her nurse quickly and said, ‘look, we got one here. We got to deal with this right away. We cannot let her walk away; we got to deal with it.’ […]”

She is the one that could medicate me cuz she told me that [the] doctor that she called […] she’s just to counsel me, not the one to give me medication, but she is the one who has to say what medication to give me.”

Cynthia is referring to the limitations placed on the psychiatric profession which allowed her physician to prescribe medicine to her but prevented them from also offering her counselling (Logsdon, 2012). In her interview Cynthia clearly expresses that receiving talk-therapy to supplement the medications she was taking would be helpful since she
believed these only addressed one aspect of her mental health. Her request is substantiated by research which shows that therapeutic interventions for maternal depression that use a combination of techniques like interpersonal therapy, supportive and cognitive behavioural therapy, antidepressant medications and talk-therapy can be beneficial to women (Bowen and Muhajarine, 2006; Sanders, 2006). The narrative also indicates that there was fragmentation in the healthcare services when she was not referred to secondary care even after being told she would be. Addressing these kinds of systemic issues are major components of mental health reform in Barbados (Ministry of Health, 2003), but while the government works to address them women like Cynthia slip through the cracks.

Importantly, women’s calls for counselling made to their various healthcare providers also reveal some contradictions when they are considered alongside their under-utilization of a counselling intervention that was specifically designed for the research project. Each participant was given one free session with a local mental health counsellor if they wished to further discuss any feelings that came up in the interview or any issues related to their maternal mental health. Women were assured that any information they shared with the counsellor would be kept confidential and private, similar to the assurance of confidentiality made in the research interview. Nearly half of the women stated that they would call to arrange a session, but none of them followed through to make an appointment with the counsellor. The reasons for this could be attributed to a number of factors including that women possibly saw the research interview as being a counselling experience or cathartic in and of itself. To this end, some participants stated that a “weight was lifted off my shoulders” (Cynthia) at its conclusion even though they were told that the principal investigator was a student conducting research and not a trained mental health
professional. It is also possible that they may have been discouraged by the idea of divulging their personal information once again to a new and unknown individual, or worse yet, to someone they might know and who could then discuss details of their personal lives with mutual friends or family. Black Caribbean women in Edge’s (2008) postpartum depression research raised similar concerns about confidentiality. They suggested that talking about their issues in a counselling environment could be beneficial, but also expressed concern that counsellors may not adhere to strict rules of confidentiality and were worried that personal information disclosed during a session would be divulged to the broader community (Edge, 2008, p. 385). Research from a Barbadian study on the knowledge, practices, and attitudes about healthcare ethics and laws among doctors and nurses found there was an overall lack of knowledge of ethics and law amongst the healthcare professionals, and nurses in particular had a weak opinion on practical ethics around issues like confidentiality (Hariharan, Jonnalagadda, Waldrond, and Moseley, 2006). When one also considers the size and population of Barbados which is approximately 430 square kilometers and roughly 290,000 people (Index Mundi, 2014; Dennis, 2003), and the closeness of some communities women’s concerns are understandable and certainly valid. The emerging contradiction about counselling shows that there is a tension between what women said they wanted, and what formal supports they were actually willing to access. This does not mean that counselling services for maternal depression would be unsuccessful in Barbados. But it does indicate that there are interlocking personal, cultural and social apprehensions that could prevent women from seeking help for mental health-related issues.
While research participants’ calls for formal counselling revealed some contradictions, they were clear about wanting support groups that could bring women together under a shared common experience of maternal depression for mutual support. This was particularly true amongst women whose first experience with self-reported postpartum depression or the ‘baby blues’ occurred after their most recent birth but not with other children, and for women with only one child. They believed a support group could be a useful intervention for women who were unable (or unwilling) to access other sources for support. Patrice, a mother of one who experienced self-reported postpartum depression and the ‘baby blues’, envisioned that the support groups could be offered in an undisclosed, judgment-free environment so that women did not have to worry about facing stigma. She suggested,

“How about […] setting up a, like a women’s support group? Where […] all these women can actually come together in confidential, private environment where they can just sit down and just air all these things without feeling [judged]? Nobody’s going to look at them and say ‘what is wrong with you?’ Cuz we’re all experiencing similar things.”

And Cynthia echoed similar sentiments,

“I say why the heck it ain’t got a support group I could have gone to pon a Sunday evening or something and sit down and all a we just share, and share, and share. And hug each other when we done, and just tell each other that everything going to be alright. And you get little sandwiches, whoever bring little sandwiches, bring a bun and everything. A support group! We need a support group!”

Both narratives highlight the potential emotional support, guidance and resource-sharing these groups could provide. Women’s capacities to help one another heal or simply share their difficulties are deemed to be valuable, and the support group structure is perceived as being a non-threatening space because everyone who attends is in a similar
situation and is vulnerable enough to be forthcoming about it. Anderson (2013) posits that women who access support groups for postpartum depression are not just seeking information that can help them manage or overcome the condition; they are also looking for a sense of normalcy that can be provided by connecting with people that can relate to their realities. The support group format has also been found to foster peer support, information-sharing, and may be beneficial to women experiencing mild to moderate symptoms of postpartum depression (Mahoney, 2005; Behnke, 2004). Importantly, these groups cannot be thought of as being completely problem-free, and issues of confidentiality and privacy that were raised by women in the study may be of similar concern in the support group structure.

*Informal Supportive Resources and their Potential Drawbacks*

It was a central research objective to learn how women coped with conditions like self-reported postpartum depression and the ‘baby blues’. Understanding how they were able to persevere through their difficulties was an important discussion taken up in the interviews, and it became apparent that women accessed informal supportive resources to help them deal with their circumstances.

Religiosity and spirituality were identified by many women as being key supportive sources that helped them manage and cope with maternal depression. This was usually a result of them being unable or unwilling to receive formal assistance from healthcare institutions and healthcare service providers. Some women referred to either religion or spirituality in their discussions, while others used both terms interchangeably. Musgrave, Allen, & Allen (2002) outline some useful ways to think through these subjective concepts.
and state that spirituality refers to inner connection with oneself, nature, other people, and/or a Supreme Being. Religiosity indicates practice, attendance, or activity in an organized religion (Musgrave et al., 2002).

The majority of the research participants identified as being a member of the Christian faith with the exception of one woman who was born Christian and converted to Islam later in life. Even if women were not religious in the sense of attending the church or mosque regularly, many participants credited religion and/or spirituality with helping them manage and cope with maternal depression. Catherine identified as a Christian and described how her relationship with God and prayer helped her through the difficulties she experienced after having her children and while experiencing maternal depression. She said,

“I prayed a lot for strength although I wanted to run away and that type of thing. I prayed a lot for like, strength cuz I can’t do this on my own.”

Prayer provided women with an opportunity to be vulnerable yet also seek strength and support from a higher power. This act enabled Catherine to continue to function in her roles as a mother, student, and worker throughout her experiences with maternal depression. Black Caribbean women in Edge’s (2008) study were also found to draw support from spiritual and religious sources like prayer and attending church during times of distress, and Edge et al. (2004) assert that attending services and maintaining spiritual beliefs can influence women’s ability to cope with difficulties including postpartum depression. The church and spiritual beliefs are significant because they allow women to express the difficulties they are experiencing, and convey what kind of help they are willing to seek and receive (Edge et al., 2004, p. 435). However, Edge (2008) also cautions...
that the support women receive from these resources may be nullified if they feel morally compromised and/or perceive help-seeking as a sign of failure or weakness. This highlights the power and potential drawbacks of messaging from church sermons, religious texts, spiritual guidance, and other outputs of religious resources. If these contradict or dismiss women’s mental health experiences, it can lead to inner turmoil and even rejection of their issues.

Nita also identified as a Christian; she regularly attended church services and had a close relationship with her pastor. In spite of her strong belief system, she admitted to having suicidal thoughts during her experience with self-reported postpartum depression. When asked what prevented her from acting on these thoughts she stated that a religious text kept her from self-harm. She explained,

“The Bible. That’s the [only] thing that stopped me, you know. Nobody telling me not to do it, nobody trying to explain to me that I got more trouble to live for and my children ain’t going to be as happy, and they might go through a lot of stress and people might treat them bad. That didn’t stopping me. It’s only when I take up my Bible and I start to read my Bible that I remember certain things.”

Research on depression and postpartum depression amongst Black women discovered that coping strategies for these mental health conditions included meditating on the Bible, talking to God, prayer, and spiritual and emotional support from Black churches (Edge et al., 2004; Etowa et al., 2007; Bobb-Smith, 2007). These studies reinforce what women in our research project also indicated; that religiosity and spirituality are important to some women’s mental health and helped them to cope with mental health challenges. Further, their narratives also indicate that sometimes women rely on these structures for
solace and support in lieu of formal mental health counselling which was not available through the polyclinic or psychiatric care they accessed.

In spite of the support that religion and spirituality provided, Nita also discussed the competing messages she received from health service providers and faith leaders with regard to her mental health. Nita had been prescribed medication by a psychiatrist and divulged this information to her pastor. He told her that she did not need the depression medication and insisted that prayer was a more valiant alternative. Nita explained,

“Cuz even my pastor was telling me I do not need medication. But the doctors say when you go off the medication then you would have another breakdown.”

The competing information Nita had to contend with is reflective of how mental illness is sometimes framed as a reflection of a person’s spiritual self without recognition of the social, chemical, and biological determinants that impact a person’s mental health. Researchers have found that some adherents to Christianity believe mental illness is a punishment for wrong-doing or a sign of moral weakness, and in more extreme views it may be seen as the result of demon possession (Atkinson, 1993; Loewenthal, 1995). This kind of information does not benefit anyone dealing with mental illness or challenges to their mental health, and in this case it could have derailed the progress Nita made.

In addition to spiritual and religious resources, women’s family networks and intimate partners were also highlighted as important supportive sources. The kinds of support they received were most typically free child care and financial help. Dena lived in her mother’s home after the birth of her son, and she discussed how her mother helped with various care-taking activities. This assistance was important because her child’s father
did not live with her and could not be there to assist with the day-to-day responsibilities of caring for a new-born. She explained,

“My mom would like help take care of him on mornings and stuff, so it wasn’t that hard on me taking care of him. Then after a while family members became supportive, so. I would say not long after he was born they would like, come visit and like show support.”

Like Dena, Catherine also lived in her mother’s home who periodically provided free childcare. The father of her two children lived close by but not within the household, and she also received support from him which was typically financial assistance. This kind of support was valuable because she did not work immediately after the birth of her first child, and the money he provided helped to buy necessities like diapers and formula. In spite of this support she also critiqued that there was a lack of emotional support from him after birth. She explained,

“Dad was there, but […] you know how some fathers are. They’re not all into the emotional thing. Some of them seem to think this is a woman’s job, you know. The baby cry, you deal with the baby. They’re going to support financially and that is it. But emotionally-wise, I had a problem.”

Patrice spoke of a similar experience,

“It’s not that I had a partner there that was helping to support me […] all the time because his dad as I said was overseas working. And you know as much as at the time there was some financial support, there was no emotional support from him. And yes, wherever a few extra dollars a month that he would send […] may help to pay for this, but what happened when I need some down time? It was really nobody there to say well you take him.”

Dena, Catherine, and Patrice’s narratives reflect a shared experience amongst many of the research participants which highlighted the benefits and limitations of support from their family members and intimate partners. Some research participants who lived in their mother’s homes stated that they could turn to these women for babysitting, and this eased
some of the burden and stress that can be brought on by the lack of access to childcare at the postnatal stage (O’Hara and Swain, 1996). This was also a benefit of women living in intergenerational homes which are common Caribbean family forms where women’s mothers and grandmothers may provide childcare services at no cost (Crawford, 2012). However, even within these environments the emotional stress placed on these “other-mothers” sometimes goes unaddressed and can result in feelings of resentment and difficulties for older women (Crawford, 2012). While Patrice and Catherine were receiving financial help from their partners they also critiqued the absence of emotional support which prevented them from openly discussing their mental health experiences. This highlights an important but oftentimes overlooked intersection of Caribbean women’s lives which is their emotional and mental health and well-being. Rowley (2003) posits that the disregarding of Caribbean women’s psychological and emotional needs occurs at the macro-level and is evidenced by Caribbean states being hyper-focused on economic and financial indicators of low income Caribbean mothers, but this kind of surveillance does not also consider how women experience loneliness and what impact this has on their mental health. These macro-level processes may mirror women’s interpersonal relationships within their homes and with their partners where unequal attention is placed on meeting their financial/material needs, but their emotional and mental health needs go unaddressed. What women are calling for appears to be a more holistic nurturing of the full spectrum of their health and material well-being. Financial security is important, and undue stress and pressure brought on by socioeconomic issues are significant risk factors that have been linked to depressive symptoms and maternal depression amongst women in the Caribbean (Pottinger et al., 2009; Galler et al., 1999). But their emotional health must
also be nurtured and acknowledged by the people closest to them. According to Logsdon (2012), a barrier to this is that family members are often unable to provide assistance or promote help-seeking due to a lack of understanding about maternal depression. This highlights the need for comprehensive and accessible education about the ‘baby blues’ and postpartum depression to be disseminated to all of the people that are surrounding women who are experiencing these conditions.

**Discussion**

There is a tension that emerges in this study which is nestled between our calls for increased government attention to maternal mental health services beyond what women in the study are saying, and a critique of the dominant medical model of maternal health services that renders women’s experiences with self-reported maternal depression invisible or brings them into medical discourses in limiting and one-dimensional ways. We acknowledge this tension, and seek to address it by discussing how medical bureaucratic structures might be reframed and transformed. Beyond being responsive to women’s needs according to a medical model, they must truly engage the multi-dimensional and complex ways in which women experience maternal depression, as well as familial, community, religious, and spiritual networks which are critical to their well-being.

One entry point to engage with the nuances and complexities of women’s experiences is through their Intersections. Throughout the research study, race, class, and gender were themes discussed by women, and these were oftentimes linked to the specific ways they experienced self-reported postpartum depression and the ‘baby blues’. In this analysis, class emerged very clearly as being central to women’s interactions with informal supportive resources, and even as they critiqued the limitations of only receiving financial
support from their intimate partners they also acknowledge its importance to theirs and their children’s survival. Women also described the importance of being able to work and financially provide for their families which is intrinsically linked to their gendered, racial, and cultural identities of being Black Caribbean women. These examples illustrate that study participants did not isolate their financial situations/class, gender-based expectations, and racial/cultural identities from their maternal depression experiences. Instead they discussed all of these as being connected to and mediating of one another. Patricia Hill-Collins (2000) reminds us that Intersectional paradigms help us to remain cognizant of the fact that oppressions experienced by women cannot be reduced to one fundamental type, and that they work together to reproduce injustice and inequality (p. 21). For medical structures to begin reframing how they understand Black women’s experiences of maternal depression in Barbados and elsewhere they must work across women’s differences and meet them at these Intersections. At the most basic level this entails greater efforts toward cultural competence within medical environments so that women’s social, historical, political, and economic backgrounds are considered in health care interactions. Medical systems must be willing to push against isolating and treating women’s health issues without also acknowledging the contexts they emerge from and how these influence their health and expressions of ill-health. At a more challenging level, health care systems must also be willing to engage in a transformation of understanding and practice. This fundamental shift can work against viewing maternal depression as symptomatic of a mind-body crisis triggered by childbirth and residing only there. Instead, it can be perceived as something whose production and treatment can only be understood against the broader kinds of questions that have guided this research.
The importance placed on women’s families show that it is imperative for medical structures to be responsive to the roles these networks play in women’s lives, and to grapple with how they can be integrated into reframing responses and approaches to women’s needs. It is imperative for women’s families to be included in medical models of care, and for these to be given adequate education and information about maternal depression so that the conditions can be properly understood and addressed within the home. Our findings also show that there is a gendered component of care at work that must be acknowledged and which is exemplified by the study participants mainly highlighting their mothers as being providers of particular kinds of support. Amankwaa’s (2003) research with African-American women who self-diagnosed/self-reported postpartum depression also found that they identified their mothers as being the person they relied on most for support. While it is important for medical structures to recognize the significant role these women can play and make strides towards including them in meaningful ways, there must be a cognizance of over-burdening them with these responsibilities based on conceptualizations of care that are influenced by gender norms. We must also take great care not to substitute the family for public provision of and investment in health infrastructure, and these cannot become an excuse for neoliberal disinvestment in state provision of health and social services. Rather, in addition to adequate maternal health services, women’s entire families and communities should be viewed as a part of the web of support formed around them which they can tap into to increase their health and wellness after birth.

Our findings do not mark the first time Black Caribbean women have emphasized the support that religion and spirituality provide when they are experiencing challenges to
their mental health (see Edge et al., 2004; Edge and Rogers, 2005; Schreiber et al., 2000). This highlights the need for holistic care that acknowledges the various parts of an individual’s identity, and emphasizes the importance of acknowledging the multiple ways healing may be sought out. Like women’s families, their places of worship and religious leaders must also be given adequate information about maternal depression so as not to perpetuate stigma about mental health that can marginalize women or perpetuate negative beliefs of mental illness amongst congregations. It is also useful to reflect on what it might mean to infuse secular spaces of medicine with more holistic approaches to care that include women’s spiritual and religious identities. In one-on-one mental health care interactions, Koenig (2008) suggests that health care professionals can consider some interventions when treating patients which includes taking their spiritual history, respecting and supporting their beliefs, challenging beliefs that may be problematic or blocking their well-being, and consulting or doing joint therapy with trained clergy. At the institutional level, health care structures must be responsive to the diverse multi-faith needs of patients, their religious pluralisms, diverse spiritual paths and beliefs, and these structures must also be willing to challenge religious stereotypes and biases that can negatively affect patients.

To actualize any of these approaches requires a complete revolutionizing of the ways mental health is conceived beyond stigmatizing, isolating, and “Othering”. bell hooks (1999) describes Black women’s healing as an expression of liberatory political practice, and to heal also requires the co-construction of nurturing environments that will facilitate rather than prevent this.
Conclusion

This study explores some of the formal and informal support structures and resources that were discussed, proposed and critiqued by women in Barbados who experienced self-reported postpartum depression and the ‘baby blues’. The fact that women discuss both formal and informal supportive structures shows that there is a need for all of these resources to be integrated into frameworks of care. Care frameworks should acknowledge how each structure can address women’s maternal mental health needs while also realizing the importance of one another. By breaking down the separation between informal and formal support structures we can learn how to unite both areas under a common goal of improving and transforming women’s maternal mental healthcare.
Looking Back, Moving Forward

In the fall of 2010, I began an academic exchange and internship at the University of the West Indies Cave Hill. I also started discussing a research project that I began conceptualizing to explore maternal depression in Barbados. I talked about the idea with lecturers at the University, other graduate students, friends, acquaintances, family members, and my mother whose experience with postpartum depression in 2007 inspired me to do this doctoral research. It elicited many different responses, but the ones that stood out most were from people who questioned if I would get anyone in Barbados to come forward and speak to a stranger about their mental health. This was also a concern of mine, as I was acutely aware that mental health and illness can be taboo subjects for many, including people from the Caribbean. Instead of being deterred by potential barriers, I thought about the research participants and how they might view the interviews as an opportunity to discuss important issues they were holding on to but were unable to share. Adopting this attitude helped me to connect with 11 women who disclosed their experiences of self-reported maternal depression and whose narratives have guided and informed this research project.

Recap of the Findings

The first manuscript presented a narrative review of the findings from several groups of studies on maternal depression. Focusing on research studies that address postpartum depression and the ‘baby blues’ conducted in the English-speaking Caribbean, with Caribbean descent women living in the Diaspora, and work from North America and Europe allowed their findings to be discussed and juxtaposed with one another. The
manuscript’s findings are organized around three themes which emerged from the studies. These are: prevalence and incidence studies of postpartum depression and the ‘baby blues’, understandings and explanations of the ‘baby blues’ and postpartum depression, and grappling with difference. The first theme discussed the higher incidence and prevalence rates that were found in research amongst women in the English-speaking Caribbean in comparison to research with White women in North America and Europe (Pitt, 1968; O’Hara, 1987; Palmer, 1996; Davidson, 1972; Galler et al., 1999; Wissart et al., 2005). Women’s socioeconomic conditions are discussed as being a possible mediating factor for these higher rates which highlight the role of the state, rising inequities, and gender-based inequalities. The second theme discussed the differing ways postpartum depression has been explained and understood, first among health researchers and then with explanatory models used by Black Caribbean descent women. The shift from the condition being regarded as ‘atypical’ (Pitt, 1968) to it being understood as a nonpsychotic presentation of depression with similar characteristics to any other depression (O’Hara, 1987; O’Hara et al., 1990; O’Hara et al., 1984) helps track how attitudes and beliefs about this condition have changed within the medical community. Black Caribbean descent women’s explanations and understandings of postpartum depression are introduced as a way to learn how they interpolate the condition from their distinct point-of-view. Women’s understandings and explanations of postpartum depression are not based on medicalized frameworks alone; they emerge from the intersections of their gendered and racialized identities, social contexts, material situations, cultural backgrounds/beliefs, and spiritual and religious frameworks (Edge et al., 2004; Edge and Rogers, 2005; Templeton et al., 2003; Ayela, 2008; Davy, 2013; Edge, 2008). The final theme in this manuscript discussed
how existing maternal depression research from the Caribbean and studies conducted with Caribbean descent women in the Diaspora has grappled with women’s differences and Intersectional lives. However, it points out that this research has also overlooked other groups of Caribbean women and Intersections such as sexuality and ethnic/racial differences within the sample populations. This finding takes up the question of ‘whose social experience is represented in the research’, and pushes us to consider how other women’s experiences may be left out of these endeavours. The manuscript concludes by discussing the need for increased maternal depression research that uses qualitative and quantitative methods to focus on diverse women and their experiences. It also discusses how Black Feminist Theory and Intersectional approaches to research can be useful to facilitate this analysis due to their attention to women’s distinct social, political, historical, cultural, and racial backgrounds.

The research findings presented in the second manuscript discussed some key findings that were also barriers to women with self-reported maternal depression. These were the lack of formal information and education on maternal depression at the postnatal stage; proliferation of international and non-local information sources on maternal depression; women’s intersecting race, class and gendered experiences with self-reported maternal depression; and social/cultural stigmas around mental health. In some cases, these barriers directly impacted one another. For example, the lack of formal maternal depression education and information from healthcare service providers in Barbados left doors wide open for international and non-local sources of maternal depression information to be the places women accessed facts on conditions like the ‘baby blues’ and postpartum depression. This happened in spite of the non-local sources typically being
soap operas, television shows and movies which conflated the conditions and focused on White, fictional women in high-income countries (Dubriwny, 2010; Martinez et al, 2000). Barriers like mental health stigma also prevented some women in the project from being forthcoming about their mental health challenges to their family members and friends. In addition to this, the stigma women described was also related to them feeling that they might be perceived as a failed mother or lacked the expected inherent strength of Black women because of their self-reported maternal depression experiences. Women’s experiences with maternal depression illuminated intersecting factors in their lives such as gender, race, and class and under/unemployment. Women’s narratives reinforced that race, class, and gender cannot be divorced from the experience of maternal depression because they are bound together. The manuscript concludes by reiterating the significance of an Intersectional framework in maternal depression research to help better understand how women experience these conditions, and so that greater awareness can be fostered and better care can be provided.

The third manuscript focused on the kinds of informal and formal supportive resources women accessed during their experiences with self-reported postpartum depression and the ‘baby blues’. Barbados’ state-run MCHS is highlighted in the article, and its lack of attention to maternal mental healthcare and similar practices in other English-speaking Caribbean islands are used as a springboard to discuss women’s first-hand experiences with the service. Women’s narratives about their unheeded calls for counselling in antenatal clinics are outlined, but this is also presented alongside their under-utilization of a counselling intervention that was incorporated into the research project. This brings attention to the seemingly contradictory messages about what kinds of
maternal mental healthcare support women request and the care they are actually willing to access. Women’s calls for counselling to supplement psychiatric healthcare and their suggestions for a maternal depression support group round out the kinds of formal supportive resources they emphasized in the research interviews.

Women’s informal supportive resources are also presented which were typically received from their male intimate partners in the form of financial assistance, and other women family members in the form of childcare. There are drawbacks associated with these, and women discussed the lack of emotional support from their intimate partners and how this impacted them during their experience with self-reported maternal depression. Spiritual and religious resources like the Bible, religious text, church, and prayer were also relied on during their self-reported maternal depression experiences. However, women discussed some of the competing messages they received from these sources which characterized mental illness in a negative light, and mental health interventions like prescription medication as being less valiant forms of help in comparison to prayer. These findings highlight the importance of education and information amongst women’s family networks and places of spiritual and religious solace, and the integration of all these resources to better support women.

**Contributions of the Dissertation**

The intellectual contribution this dissertation makes is firstly to the women who participated in the project, and to all other women in the Caribbean who have had similar mental health experiences. Grounding my work in feminist theory, Intersectional frameworks, and using qualitative methods were done to place at the women the centre of
this research endeaour. It also enabled me to use privileges afforded through education and other opportunities to create a project that may in some way effect change and/or create information on this issue. At the very core of who I am is an activist, and as a growing scholar I have been able to do work that can generate social change. This also speaks to the necessity of Scholar-Activists who “are willing to employ a Black consciousness and who continually strive to include the experiences of Black women and other women of colour in their teaching and research, [and] are invaluable to academic disciplines” (Reece, 2007, p. 266).

The dissertation also makes an intellectual contribution to the Caribbean health research knowledge base. Given the existing lack of maternal depression research and absence of qualitative methods within it, a project on this topic conducted amongst Black women in Barbados contributes to knowledge-creation on women’s maternal mental health. It must also be said that finding research on mental health from the Caribbean was a challenging task. Information that was found provided rich texts that addressed issues like mental illness stigma and used qualitative methods to do so (Arthur et al., 2010, Pusey-Murray, 2014). However, there was a dearth of research on the topic which is symptomatic of the stigma that continues to keep these issues from coming to the fore in academic spaces and in Caribbean communities.

The dissertation also contributes to regional feminist work on women’s mental health. Its methods and theoretical framework make an intellectual contribution to Black Feminist Theory and Caribbean Feminist Theory. My thesis interjects into these theories through focusing on Black women’s health, which I assert is as significant as our race, class, sexuality and gender. Black women’s health and particularly our mental health are
areas which Black and Caribbean feminists have urged us to explore more deeply. In “Sisters of the Yam” bell hooks (1999) writes, “Though many of us recognize the depth of our pain and hurt, we do not usually collectively organize in an ongoing manner to find and share ways to heal ourselves” (p. 11). In her contribution to Canadian Black feminist theorizing, Llana James (2007) asserts, “Feminist activism and theorizing within the African Diaspora […] must include discussions about our physical and psychic well-being in order to truly generate strategies for surviving and thriving” (p. 229). And Caribbean feminist Michele Rowley (2002) states,

“Economic analyses with indicators such as cost of living, minimum-wage and living wage are very relevant aspects on the continuum to acknowledge the complexity of maternal subjectivities. These indicators however, are unable to address the textual, the ideological, or the psychological aspects of this location. They are unable to address the psycho-social impulses of aloneness that feed into the pressures and demands of child care […]” (p. 56).

In different ways and for different purposes, these scholars advocate for increased attention to Black women’s health, mental health, and our personal and collective wellness. Recognizing that we cannot be wholly understood or acknowledged without a focus on our health makes room for Black women to refute and/or nuance conceptualizations of ourselves like the Strong Black Woman or processes of “Being Strong” (see hooks, 1984; hooks, 2005; Hill-Collins, 2000; Schreiber et al., 2000; Jackson and Naidoo, 2012). Mental health and wellness is central to our survival, yet there is limited information and research within Black and Caribbean Feminist Theory that investigates this. The lack of information and concerted attention to our mental health and wellness motivated me to do research that focuses on Black women in the Caribbean, and in doing so I have been able make a contribution to the existing knowledge base and look towards future areas of research and inquiry.
On Theory

The dissertation’s theoretical framework highlights three concepts/debates that my work engages with and is influenced by. These are Intersectionality, sexual and reproductive representations of Black women, and Caribbean feminist debates on mothering and motherhood. The findings of my work do not always explicitly address each debate or concept, but each of these has enabled me to more fully understand and analyze women’s narratives. For example, a minor theme that came out of the study was women’s negative birth experiences at the Barbados public hospital. Some women discussed being ignored by hospital nurses and staff, and feeling improperly cared for during the birth process. Some women attributed their negative experiences to their age, while others believed that it was because of their working class status or being unmarried. Black and Caribbean Feminist Theory’s rich theoretical engagement with sexual and reproductive representations of Black women facilitated the formation of deeper insight about how our bodies have been historically viewed as sites of (re)production, and how giving birth was inherently linked to the accumulation of wealth for the racist, capitalist slave economy and its benefactors (Rodney, 1998; hooks, 1999; Reddock, 1985; Turner, 2011; Kempadoo, 2000). Women’s present day experiences with birth are not the same as enslaved Black women’s, but the influence of these ideas that were projected onto Black women’s maternal bodies still exist and can frame how women are perceived in contemporary times. In our current contexts women’s maternal bodies are no longer tied to relationships with the slave economy, but they are mediated by the state which enforces patriarchal relationships through social welfare policies and its services (Rowley, 2003a).
Another example of the analytical usefulness of these theories is when women discussed feeling like failed or “bad” mothers because of their maternal depression experience. This was further understood by considering the Caribbean feminist debates on mothering and motherhood. Not every woman in the project was the sole parent in their households. But debates on female-led homes, matrifocality, and the ways in which women were depicted as being a central problem of Caribbean family breakdown were immeasurably helpful in increasing my understanding of the stigma and social pressure in which women have been embedded (Barrow, 2001; Massiah, 1982; Robinson, 2013; Trotz, 2009). The debates on mothering and motherhood provided a framework of analysis to make links between women’s feelings about their mothering capabilities, their experiences with self-reported maternal depression, and the ongoing and problematic framing of Black Caribbean mothers.

By far, Intersectionality was the most prominent debate with which my dissertation engaged. It was important for me to engage with the works of earlier Black feminists because I have realized that attaching Intersectionality to feminist texts, academic courses, and research, regardless of whether the work is actually Intersectional is popular. I was also challenged by Caribbean feminists at the Institute for Gender and Development Studies: Nita Barrow Unit to acknowledge the early articulations of women like Sojourner Truth, Mary Church Terrell and the Combahee River Collective during a 2012 seminar that I presented which discussed the Swedish gender professor Nina Lykke’s (2011) use of the concept. By situating my Intersectional framework with the work of Black women who discussed their overlapping experiences of discrimination beginning in the late 1800’s and continuing through the late-1900’s, I was able to bring the concept back to its earliest
discussants who had been engaging with these ideas before the concept was popularized and coined by Kimberle Crenshaw. Making this connection kept me cognizant of the purpose and foundation of the research, and it served as a reminder of why highlighting Black women’s multiple identities, oppressions, and experiences is critical to the project of doing feminist work.

Intersectionality also provided an opportunity to be theoretically and conceptually experimental with the research project’s conceptualization, methodology, research question formulation, and data analysis. While it was challenging to understand how to “do” an Intersectional project because there are no clear guidelines, this was an opportunity to chart my own course while remaining tethered to the concept and the larger theoretical frameworks that anchored my research. Hankivsky et al. (2010) also discuss five issues that can make it difficult to translate Intersectionality within health research spaces. While these are presented as barriers to operationalizing Intersectionality into methodology, I believe they can also be used as a blueprint to begin to understand how to “do” Intersectional health research. These are: 1) a disconnect between Intersectionality scholarship and the conceptualization of research questions and designs; 2) lack of clarity about how, when and where Intersectionality frameworks should be and can be applied; 3) the difficulty in applying Intersectionality to empirical designs, particularly in areas that are dominated by quantitative research methods; 4) determining when intersections may be relevant or more salient; and 5) accessing health information that oftentimes does not exist (Hankivsky et al., 2010, p. 3). I have addressed several of these drawbacks above, specifically the lack of information on maternal depression in the Caribbean and mental health research in general, and the reasons for situating my research in earlier discussions.
of Intersectionality initiated by Black women activists. Additionally, “doing” Intersectionality was for me a constant reflexive exercise that began at the very beginning stages of the project. Focusing on Black women in Barbados, for example, immediately signaled to me that I would need to create research environments that facilitated the consideration and discussion of various mediating factors in women’s lives. I knew that I could not leave out or avoid discussions of class, race, income, and gender in my research interviews. In fact, I had been advised by other researchers and colleagues in Barbados that class may come up in the research space more than race due to the social and cultural climate of Barbados and its history of being a plantation-slave economy under British colonialism. These factors came out through women’s narratives, and as is indicated in manuscript two, discussions about gender, class, and race were oftentimes bound up with one another. Having an Intersectional approach meant that when those discussions emerged I made space for them and engaged with them, regardless of whether they seemed to fit in with my questions at that moment.

Intersectionality was also useful to the project’s data analysis activities, and it was particularly useful for interpreting women’s discussions of maternal depression. Through the concept I was able to recognize that when women discussed self-reported ‘baby blues’ or postpartum depression it was never about the condition on its own. Rather, it was always tied up with other factors in their lives like internally and externally projected gender-based expectations, unemployment/class, and ideas about race and nationality. I believe that this is what Crenshaw (1991) means when she explains that the Intersections in Black women’s lives cannot be fully grasped by looking at them separately (p. 2). These experiences do not take place in isolation from other experiences, although women may try
to compartmentalize more pressing matters from others at varying points. Rather, they exist in a matrix that crisscrosses with one another, and as a researcher that can be an overwhelming or enlightening experience. Intersectionality allowed me to step back and remember the larger picture, and as a result I was able to learn about these multiple and overlapping factors in women’s lives that were all a part of the maternal depression experience.
Conclusion

Research Gaps Addressed

Upon reviewing postpartum depression studies from Barbados and the English-speaking Caribbean, I noticed several gaps in the existing research. These included an absence of qualitative research, a lack of research on the ‘baby blues’, and a lack of diverse, theoretical frameworks to explore the research topic. I do not purport that these gaps have been completely filled by my research and its findings; however, the project does enhance existing knowledge about maternal depression in Barbados which, in turn, contributes to the development of Caribbean research on these conditions.

Initially, this was intended to be a research project about self-reported postpartum depression in Barbados. However, literature reviews for the condition brought up a limited group of studies from the English-speaking Caribbean and very few on the ‘baby blues’. Seeing this gap in both research areas prompted me to widen my scope from focusing only on self-reported postpartum depression to viewing the condition within the category of maternal depression which includes various forms of depression experienced before and after birth (Puckering, 1989). By including self-reported ‘baby blues’, I address an unforeseen research gap, and the inclusion of this condition enhanced the overall project because it enabled me to reach more women.

I also observed a pronounced gap with regard to the kinds of maternal depression research that had been conducted in the English-speaking Caribbean. These used quantitative methods to explore antenatal and postpartum depression, and some utilized self-administered tools like the Edinburgh Postpartum Depression Scale (EPDS) to learn if
women were at risk for the condition. However, the voices of Caribbean women were a glaring omission from these analyses. While these studies told us that postpartum depression and antenatal depression affected 26% of women in Jamaica and up to 19% of women in Barbados, it was unclear how, why and in what ways they were affected (Galler et al., 1999; Wissart et al., 2005; Pottinger et al., 2009). On the other hand, several research studies conducted amongst Caribbean descent women in the Diaspora used qualitative methods to explore maternal depression, and through this methodological approach researchers conducted in-depth analyses that explored how women described and experienced the conditions (Edge and Rogers, 2005; Davy, 2013; Edge et al., 2004). These studies also facilitated discussions about the effects of Black Caribbean women’s histories and cultures on their experiences with maternal depression (Edge and Rogers, 2005; Edge 2007; Ayela, 2008; Davy, 2013). These qualitative studies inspired me to look beyond the prevalence and incidence of maternal depression so that women’s socio-cultural frameworks could be considered alongside their maternal mental health experiences. Knowing how women understand maternal depression, interpolate their experiences alongside other co-mediating factors, seek support from family and friends, and the kinds of health care interactions they have had provides valuable information that can help identify personal and institutional barriers. By highlighting the effectiveness of qualitative research methods I do not seek to undermine the importance of epidemiological research. However, the richness of the data collected in this project reaffirms the importance of qualitative research and its usefulness to future researchers who may use these methods to further complement and extend the existing analyses. No singular research method can tell
the whole story of health or illness, but we can approach data collection using diverse methods that can help us better understand them.

Finally, my project also addresses a theoretical gap in the maternal depression research which is evidenced by the use of key debates and concepts from Black and Caribbean feminist theories. During the literature reviews I encountered maternal depression studies that made little indication of their theoretical framework, and this was particularly true for some Caribbean epidemiological research on maternal depression (Davidson, 1979; Wissart et al., 2005; Pottinger et al., 2011). Conversely, I saw Caribbean-descended researchers in Diasporic contexts engaging with concepts from Black Feminist Theory to explore topics and ideas introduced by research participants (Edge and Rogers, 2005). This realization coincided with my personal development, as I also started to use Black and Caribbean Feminist Theory in other writings and recognized their potential use in health research (Jackson and Naidoo, 2012). I could have utilized social scientific theories such as embodiment or a Foucauldian framework to facilitate an exploration of power relations, the body, illness, and various structures that are used to maintain dominance and exercise control (Foucault, 1973; Foucault, 1980; Terry and Urla, 1995; Mascia-Lees, 2011). However, using theories that have been conceptualized from Black women’s intellectual engagement with the complexities of our lives and experiences was a more experimental endeavour and it also made more sense considering my topic and the women involved in the project. Recognizing this theoretical gap and my growing interest in this rich body of literature, I chose to explore Black women’s lives using Black and Caribbean feminist theories to politically and intellectually situate my research as a woman-centred and feminist endeavour.
These methods, approaches, and theories utilized for the project help to address the aforementioned gaps and move maternal depression research forward by providing empirical data that shows how women in Barbados experience self-reported maternal depression and how they understand, manage, and seek help for these conditions. The project also exclusively focuses on the English-speaking Caribbean which moves women who have been on the fringes of maternal depression research to the centre. This disruption is both important and necessary because it reinforces the notion that no singular experience can stand for all women, and that colour-blind or white-washed representations of women’s health conditions are inadequate. Showing the variation and difference helps us better understand maternal depression and brings us a step closer to better addressing the condition when it arises.

Bias and Limitations

Methodological limitations, around the sample size, lack of prior research on the topic, and a recall bias were pressing issues that I had to explore and resolve during the course of the research.

The sample size of 11 may be perceived as small, and at times I struggled with feeling that I had to conduct more interviews to increase the size to a number that would be deemed “scientifically acceptable”. However, I was guided by existing qualitative research conventions which dictate that five to eight data sources are sufficient for creating a homogenous sample (Kuzel, 1999; Denzin & Lincoln, 2000). Additionally, a qualitative project in the UK with Black Caribbean women also had a sample size of 12 and evoked significant findings (Edge and Rogers, 2005), as did a qualitative project on African-
American women’s self-reported and self-diagnosed experiences with postpartum depression (Amankwaa, 2003). Given that sampling techniques were purposive and that the research project used a descriptive model, it was realized that a smaller sample would adequately address the core research objective and questions.

I also resolved these insecurities by reaffirming the objectives behind the project’s selected research methods. The point of the using qualitative research methodologies was to learn women’s experiences of self-reported maternal depression so that a clearer picture about how they understood, managed, and coped with them could be formed. Qualitative research allowed me to hone in on these factors by co-creating research spaces that facilitated the transmission of information, knowledge-sharing, and grappling with complex ideas. Moving past the preoccupation with numbers and towards achieving data saturation and maintaining the quality of the research interactions were the major factors that would legitimize the sample size. By the sixth interview, I noticed several dominant themes (e.g. lack of local information and education, the role of women’s families and faith structures, etc) and patterns (e.g. all of the research participants accessed the MCHS, gave birth in the island’s public hospital, and had not been informed of maternal depression by health service providers at these times, etc). By the tenth interview, I was confident that I had reached data saturation because these themes were repeated and no new information was presented in the interviews. I stopped collecting data after the 11th interview with confidence knowing that the information presented would be both new and useful to expanding the existing research base.

Another limitation I had to confront was the lack of prior qualitative research on maternal depression in the Caribbean. There was very little English-language Caribbean
data to base my work off of or look to for precedence. As a result of this, I had to review data conducted amongst Caribbean descent women with maternal depression living in the Diaspora. Although women in the Diaspora may racially, culturally, politically and socially identify with specific Caribbean islands or the region in general, their experiences of immigration, racism, discrimination, and sexism would be different to women living in the Caribbean (see Edge et al., 2004; Edge and Rogers, 2005; Whitley, 2009; Ayela, 2008; Whitley, 2009; Davy, 2013). I managed this limitation by accepting the lack of prior research and the inherent differences that Diasporic and Caribbean maternal depression research would evoke. I did not seek out sameness; instead I welcomed difference knowing that this would help to more fully tell women’s stories about maternal depression from their own distinct contexts.

Recall bias most affected my data collection since participants were asked to remember past events related to their maternal depression. While many participants were experiencing a form of self-reported maternal depression at the time of the interview, particularly new mothers recruited from the polyclinics, some had to reach back into their memories to recall events that happened up to 10 years before participating in the project. I took measures to reduce this bias by framing the research questions in ways that facilitated an accurate recalling of information. For example, I asked for clarification during the interviews when needed, and I posed follow-up and probing questions to fully understand women’s perspectives. Research interviews were also permitted to go past 90 minutes so that women could transmit as much information and detail as was needed. Discussing the issue of recall bias with a potential participant who experienced postpartum depression five years before the project was initiated revealed that for her the hindsight provided once the
event passed allowed a clearer picture of how her life was impacted by maternal depression. In short, being past the situation allowed her to remember the details better because she did not have to contend with the emotional and mental health difficulties. While this insight does not erase or minimize the potential for this kind of bias, it does offer another side to recall bias and the question of remembering impactful events in mental health research spaces.

**Research and Public Health Implications**

The inclusion of a research sample comprised entirely of Black women living in Barbados has implications on early maternal depression research which largely excluded women from diverse racial and cultural backgrounds (Pitt, 1968; O’Hara, 1987; O’Hara et al., 1990; O’Hara and Swain, 1996). The focus on White women in North America and Europe has created what Hill-Collins (2000) calls a “controlling image” of maternal depression that erases different experiences of conditions like postpartum depression and the ‘baby blues’ (Dubriwny, 2010). To provide balance, researchers have conducted studies that focus on Black women, Caribbean women, and women from diverse racial and cultural backgrounds to learn their experiences with maternal depression (Davidson, 1979; Logsdon et al., 2000; Amankwaa, 2003; Edge et al., 2004; Edge and Rogers, 2005; Wissart et al., 2005; Pottinger et al., 2009; Ayela, 2008; Davy, 2013). This project joins these maternal depression studies and helps moves the body of research towards being more representative of women’s diversities and complex lives/identities/experiences. Future Caribbean maternal depression research would benefit from more qualitative and mixed methods research being done, and the inclusion of other forms of maternal depression. Using different methods and focusing on other forms of maternal depression can help to
uncover more information which is critically needed. Future research would also benefit from the inclusion of Caribbean healthcare service providers and professionals so that a better understanding of the healthcare environments (and challenges within them) can be garnered.

The findings from the research project confirm that maternal depression exists amongst Black women in Barbados which was first explored in Galler et al.’s (1999) research. This finding also affirms Almond’s (2009) research which sought to demonstrate that conditions like postpartum depression are a global public health concern. Women’s narratives also discuss some of the barriers to healthcare they experienced, and research that addresses this at an institutional level should be endeavoured upon. Using qualitative methods in these research projects can also work to relay healthcare service provider’s distinct experiences caring for women with maternal depression, and some of the difficulties they may have encountered.

**Future Maternal Depression Studies**

Future maternal depression research would benefit from studies that assess the cultural validity of postpartum depression screening tools such as the EPDS and the newer PDSS. Some Caribbean researchers have begun to assert that routine postpartum depression screening which utilizes tools like the EPDS can help to recognize the condition in new mothers (De La Haye and Lowe, 2006). This finding supports international studies that point to similar results (see Almond, 2009; Georgiopoulos, Bryan, Wollan, & Yawn, 2001; Evins, Theofrastous, & Galvin, 2006; Cole, 2009; Buist, Condon, Brooks, Speelman, Milgrom, Hayes, et al., 2006). However, research about how the EPDS and the PDSS
perform in Barbados and the English-speaking Caribbean is not available, and there are no reports that assess its cultural validity in these contexts. This must be seriously considered in light of analyses which indicate that factors such as women’s socio-economic status and stigma attached to mental illness may influence the expression of depressive symptoms (Halbreich and Karkun, 2006). Rather than advocating for a wholesale implementation of routine screening and diagnostic procedures for postpartum depression administered by healthcare service providers, we call for research studies that test the cultural validity of tools like the EPDS and the PDSS in Caribbean contexts.

A mixed methods project approached from an Intersectional framework, that includes a prevalence or incidence study of postpartum depression and the ‘baby blues’ in Barbados would be a useful future research endeavour. The existing research from Galler et al. (1999) contains significant findings about the rates of maternal depression in the country. However, studies which specifically focus on postpartum depression and the ‘baby blues’ can expand the knowledge base and bring attention to these conditions without other variables like infant cognitive development being considered (Galler et al., 2000). A qualitative component is essential to including women’s voices and experiences, and, as evidenced by this research project, it adds rich data and depth. Initiating a project that views these methods as being of equal importance could lead to significant research on the topic from the Caribbean.

A comparative, qualitative study of maternal depression that includes women from across the Caribbean region (including the Hispanophone, Francophone, and Dutch Caribbean) and Caribbean descent women in the Diaspora would also be a useful future research endeavour. Given that much of the existing research focuses on Black Caribbean
women, it would be important to include diverse sub-samples of Indian, Chinese, Arab, and Indigenous Caribbean women. There is a lack of information and data about maternal depression that focus on women living in these geographical areas, and as Caribbean people continue to move between these spaces the need to know this kind of information increases. This research can also contribute to the development of mental health research in the Diaspora and the Caribbean region.


Hurston, Z. N. (1937). *Their eyes were watching God*. Chicago, IL: University of Illinois Press.


Appendices

Appendix A: Research Poster/Flier

Have You Recently Had a Baby? Would You Like to Participate in A Research Study?

We are looking for participants to take part in a project about women’s emotional health after giving birth.

To participate you must be:

- 18 years old or over,
- Given birth in the last 10 years,
- Experienced “Baby Blues”, Postpartum Depression, or Postpartum Psychosis,
- Willing to give 1-1.5 hours for an interview.

If you are interested please contact Fatimah Jackson at 417 4887 (office) or 831 9481 (cell).
Interview Protocol

1- Can you tell me your age, what you do for a living, and how many children you have?

2- Tell me how you felt after having your most recent child

3- What have you heard about baby blues, postpartum depression, and postpartum psychosis?

4- After having your child did you experience:
   - Baby blues where you felt sad/‘brown’, anxious, or emotional for a few weeks after having your child?
   - Was it postpartum depression where it was a longer period of more intense sadness, excessive crying, stress, anxiety, loss of appetite or overeating, not having any interest in your baby, being afraid of hurting the baby or yourself?
   - Was it psychosis where you had thoughts of hurting your child or yourself and had to be diagnosed by a doctor or psychiatrist?
   - Follow-up: Were you diagnosed by a doctor, psychologist, or psychiatrist?

5- When/How did you know something had changed (emotionally) after having a child?
   - Probe: what were the signs you or others noticed?

6- What kind of treatment did you receive for your condition?
   - Probe: Public or private medical care?
   - Follow-up: Was it helpful?
   - Follow-up: If you didn’t get professional help, what did you do?

7- Did you get any support from family or friends after having your child?

8- Do you think women in Barbados experience baby blues, postpartum depression, or postpartum psychosis?

9- How do Bajan women talk about these kinds of mood disorders?
   - Probe: how have you heard baby blues, postpartum depression, or postpartum psychosis spoken about on Bajan tv, radio, magazines, etc?
   - Probe: How did your mom, grandmother, and other people talk about it?

10- What do you want to tell me about baby blues, postpartum depression, or postpartum psychosis?
Appendix C: Informed Consent Form

Informed Consent Form

Date:

**Study Name:** Investigating Women's Experiences of Postpartum Mood Disorders in Barbados

**Researchers:** Ms. Fatimah Jackson, Principal Investigator. Institute for Gender and Development Studies. University of the West Indies Cave Hill Campus. P.O. Box 64. Bridgetown, Barbados.

Dr. Carles Muntaner, Supervisor. Bloomberg Faculty of Nursing. Health Science Building. 155 College St. Suite 381. Toronto, Ontario M5T 3M7

**Purpose of the Research:** The purpose of the research is to learn about Bajan women’s experiences with postpartum mood disorders.

Some of the questions we will ask you are:

1. How do you understand conditions like postpartum depression, 'baby blues', and postpartum psychosis?

2. Does culture play a part in helping you understand these conditions?

3. How do you manage conditions like 'baby blues', postpartum depression, and postpartum psychosis?

4. What kinds of treatment have you gotten from Bajan hospitals and polyclinics?

5. What kinds of treatment have you gotten outside of Bajan hospitals and polyclinics?

**What are Postpartum Mood Disorders:** Postpartum mood disorders are emotional conditions that some women develop after having a baby. Some of these are baby blues, postpartum depression, and postpartum psychosis.
What You Will Be Asked to do in the Research: We will ask you to participate in an audio recorded interview with Fatimah Jackson, the principal investigator, to discuss the questions listed above. This interview should last for 1-1.5 hours. The interview will be taped with a digital audio recorder so that Ms. Jackson can review it later.

Risks and Discomforts: Possible risks involved in this research study include emotional and/or psychological risks. These include feelings of discomfort, embarrassment, and upset in relation to emotions that may come out during the interview. To reduce these possible risks the researcher has designed an information sheet that she will give to you after the interview. These give more information about postpartum mood disorders, ways to prevent them, and resources to help you treat these if you need help. The researcher has also partnered with a local counselor who will offer you 1 free session if you feel you need to talk about anything that has been brought up in the interview.

Benefits of the Research and Benefits to You: You might not see or feel the benefits of this research study immediately, but the information we get from you can help us learn how Bajan women experience postpartum mood disorders. There is not a lot of information on this right now, and the information you share may increase knowledge about postpartum mood disorders in Barbados. The information you share may also improve the health care women get after having babies.

Voluntary Participation: Your participation in the study is completely voluntary and you can choose to stop participating at any time. If you decide not to participate it will not influence any treatment you may be receiving or any relationship you have with a healthcare provider.

Withdrawal from the Study: You can stop participating in the study at any time before data analysis is completed. If you choose to stop participating all the information from you will be withdrawn and destroyed right away.

Please note: If you choose to stop participating after the information you give has been analyzed and/or published, the information you give will not be withdrawn or destroyed.

Confidentiality: All the information you give during the research will be held in confidence and your name will not be in any report or publication of the research. All the information you give will be stored safely in a password locked computer, and only Ms. Jackson and a research assistant will be able to see, hear, or read this information.

Please note: If you express the intention to harm yourself or your children or if you verbalize the intention to commit suicide the principal investigator must report this to the local authorities because you may need emergency care.
Questions about the Research: If you have questions about the research in general or about your role in the project, please feel free to contact Ms. Fatimah Jackson either by telephone at 417 4887, or by e-mail fatimahjackson@gmail.com. If you have further questions or concerns about the research you can also contact Mr. Daniel Gyewu, Research Ethics Board manager, University of Toronto at 416 946 5606, or by email at dgyewu@utoronto.ca. You may also contact Dr. Mike Campbell, IRB University of the West Indies 429 5112, or by email at Dr.Mike.Campbell@gmail.com

Legal Rights and Signatures:

I______________________________________________, consent to participate in the research study entitled *Investigating Women's Experiences of Postpartum Mood Disorders in Barbados* by Ms. Fatimah Jackson. I have understood the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

___________________________________________  Date _________________

Participant’s Signature

___________________________________________  Date _________________

Witness’ Signature
Maternal Depression Brochure

Stories from other mothers

“This was my third baby, but it wasn’t the happy, joyful experience I had expected. I felt anxious and irritable. I didn’t want to get out of bed in the morning. I didn’t feel connected to my baby.”

– Sharon

“We were thrilled to bring home our first healthy baby. But in those first few weeks I felt tired and cried easily. I thought it was just the hormones and getting used to a newborn. After six months, when little things would still set me off, my husband convinced me to talk to my doctor.”

– Tina

“I love children and couldn’t wait to have my own. Then my husband went back to work, and I started having thoughts about hurting my baby. No matter what I did, I couldn’t stop the thoughts. I lived in fear but kept it a secret.”

– Isabel

“It has been two months since I saw my doctor, and I feel like a different person. The medicine has helped and my family has been very supportive. I have energy again, and I love being a mother.”

– Malia

You are not alone

Recent research reveals that postpartum mood disorders are more common than you may think. 10-20% of women experience depression after giving birth and up to 80% of women experience baby blues. A smaller number of women, about 1% may experience postpartum psychosis. Although postpartum mood disorders are common, they are serious—and treatable. If you think you might have one, tell your doctor or a health care provider. With help, you can feel like yourself again.

The Postpartum Period
In pregnancy, reproductive hormone levels in a woman's body are 20-30 times greater than normal. At delivery, hormone levels drop abruptly, along with changes in amino acids, neurotransmitters, and thyroid hormones.

The sudden drop in estrogen, progesterone, endorphins, and other hormones may trigger depression the same way moodiness may be triggered by premenstrual changes in these hormones.

Thyroid levels may also drop sharply after birth. A new mother may develop a thyroid deficiency that can produce symptoms that mimic depression. (It is always recommended that a woman have a thorough physical examination for this reason).

Many women feel exhausted after labor and delivery and may need a long time to fully recover. Cesarean births require an even longer recovery.

New mothers rarely get adequate rest. In the hospital, they are awakened by nurses and the baby's feedings. At home, feedings continue every 2-4 hours, around the clock, along with usual household tasks. This extreme lack of sleep continues for weeks and months and can be a major reason for depression.

Babies who are born prematurely or with a birth defect may present the new mother with even more stress and the overwhelming realization that her baby is not the "perfect" being she had envisioned.

Other tasks which may pose a stress on a new mother include:

- establishing successful breast/bottle-feeding
- coping with sleep deprivation
- forming an attachment to the child
- re-negotiating family relationships and responsibilities
- giving up the fantasy of what the baby would look like or be like
- facing whether or not one is an adequate parent

One must also effectively integrate all these new experiences.

Feelings of loss are very common after childbirth. These "losses" include:

- loss of freedom
- feeling tied down
- loss of an old identity
- loss of control
- loss of a slim figure
- loss of a sense of attractiveness

- Since motherhood is typically viewed as a "happy time" and childbirth is seen as an event from which a woman should "bounce back" within a few days, many women experience a lack of understanding and/or support from those around them.

- Mothers need significant coping skills to deal with so many new challenges. Four aspects of the postpartum period which demand significant coping abilities are:
  - 1) the physical adjustment
  - 2) initial insecurities about one's ability to parent
  - 3) relying on support systems for tasks that one feels she "should" do
  - 4) loss of a previous identity as one who is taken care of and the birth of a new identity as the caretaker.

**The “Baby Blues”**

Having a baby brings big changes in a woman’s life. These changes can be overwhelming. The “baby blues” are a mild form of depression that can be confusing because they are also mixed with happy feelings. Some mothers have called it “an emotional rollercoaster”.

First-time moms are at a higher risk of developing the “baby blues”. While most moms get past the “baby blues” within the first two weeks, some struggle for longer.

Some symptoms of the baby blues are:

- Fatigue/ Exhaustion
- Feelings of sadness
- Crying spells
- Anxiety
- Mood swings/ Irritability
- Confusion
- Feeling overwhelmed
- Inability to cope
- Oversensitivity
- Inability to sleep
- Feelings of loneliness

- **Causes of the "Baby Blues":** include biological factors (drop in hormone levels), social/environmental factors (marital stress, lack of support system, low SES), stress, and sleep deprivation, in addition to the physical aftermath of labor and delivery.

- First-time moms are at a higher risk of experiencing the "Baby Blues".

- The "Baby Blues" typically does not require professional treatment and should subside within two weeks after delivery.

- **Treatments include:** validation of the existence of the phenomenon, labeling it as real but a normal adjustment reaction, assistance with self/infant care, and family support.

### Postpartum depression

It is easy to confuse the symptoms of postpartum depression with normal hormone changes. How can you tell if it’s serious? Watch for these symptoms:

- Feeling sad, anxious or “empty”
- Lack of energy, feeling very tired
- Lack of interest in normal activities
- Changes in sleeping or eating patterns
- Feeling hopeless, helpless, guilty or worthless
- Feeling moody and irritable
- Problems concentrating or making simple decisions
- Thoughts about hurting your baby, even if you will not act on them
- Thoughts about death or suicide

- **Risk factors for postpartum depression include:** 1) First-time motherhood, 2) ambivalence about keeping the pregnancy, 3) history of postpartum depression, bipolar, or another mood disorder, 4) lack of social support, 5) lack of stable relationship with partner and/or with parents, 6) woman's dissatisfaction with
herself, 7) history of infertility, 8) unrealistic expectations of parenthood, 9) recent stressful event, 10) previous aversive reaction to oral contraceptives or severe PMS.

- **Causes of postpartum depression include:** 1) biological/physiological factors (genetic predisposition, hormone-related, severity of physical damage from labor and delivery), 2) environmental factors (stress, feeling alone, lack of support), 3) psychological factors (things that affect a woman's self-esteem and the way she copes with stress), or 4) infant-related factors (infants with difficult temperament or colic, infants born with problems). **Most likely it is a combination of all of these**.

- **Treatments include:** 1) individual and/or couple's therapy, 2) group therapy or support groups, 3) psychotropic medications, 4) practical assistance with child care/other demands of daily life.

- If a woman experiences postpartum depression, her chances of postpartum depression with subsequent children are 10-50%.

**Postpartum Psychosis**

Postpartum psychosis is a very serious mental condition that requires immediate medical attention. It is very rare for women to have this condition, but the onset of it is usually quite sudden, most often within the first 4 weeks after giving birth.

Signs of postpartum psychosis include:

- Hallucinations
- Delusions
- Illogical thoughts
- Insomnia
- Refusing to eat
- Extreme feelings of anxiety and agitation
- Periods of delirium or mania
- Suicidal or homicidal thoughts

- **Risk Factors include:** 1) previous postpartum psychosis, 2) manic-depressive (bipolar) history, 3) prenatal stressors (lack of supportive partner, social support, low socioeconomic status), 4) obsessive personality traits, 5) family history of mood disorder.
• **Treatments include:** 1) hospitalization with 2) antipsychotic medication (lithium, when indicated) and 3) temporary removal of infant from mother's care, also 4) sedatives, 5) electroconvulsive therapy, 6) psychotherapy, and 7) social support.

• There is a 10% rate of suicide/infanticide associated with this disorder. Thus, **immediate treatment is imperative.**

• Women are **20-30 times more likely** to be hospitalized for a psychotic episode in the first 30 days after delivery than at any other time in their life.

• Women with a history of bipolar illness have a **40% chance** of developing Postpartum Psychosis after their first child is born.

• Almost all women with previous episodes of Postpartum Psychosis will experience repeat episodes in subsequent pregnancies. *Preparing for this ahead of time is key.*

**Things you can do**

Being a good mom means taking care of yourself. If you take care of yourself, you can take better care of your baby and your family. Here is what you can do:

• Get help. Talk with your care provider, call an emergency support line or ask a loved one to help you get the care you need.

• Ask your care provider about medicines that can be safely used for postpartum depression.

• Talk to a therapist, alone or in group therapy.

• Ask your faith or community leaders about other support resources.

• Learn as much as you can about postpartum mood disorders like baby blues, postpartum depression, and postpartum psychosis.

• Get support from family and friends. Ask for help when you need it.

• Keep active by walking, stretching, swimming and so on. Exercise (after your doctor gives the 'ok') is an extremely important tool in helping you feel healthier and stronger both physically and emotionally. Even going for a short walk can help.

• Get enough rest. Rest is extremely important. Sleep when the baby sleeps, or get someone to help care for the baby while you nap.
• Eat a healthy diet. Be sure to monitor your nutrition habits and water intake in order to keep your body healthy and full of energy.

• Give yourself permission to do less. Allow others to help with household chores and other daily tasks. Don't try to overdo it.

• Shower and dress each day. This will help keep your spirits up.

• Get out of the house or take some "me" time each day. This is extremely important in helping you keep yourself mentally well.

• Talk about your feelings with your partner, a friend, or family member. Find others who have experienced motherhood and use them as a support system.

• Join a postpartum support group or mother's group where you can talk with others who are sympathetic to your situation.

• Be specific about how your husband/boyfriend/partner and others can help you. Assign specific tasks and don't allow yourself to feel guilty.

• Remember that your partner and other loved ones are going through this too. Try to appreciate the efforts they are making.

• Remember that becoming a mother is a life-changing event that takes time to completely understand and get used to.

• If your "baby blues" don't go away within two weeks, if your symptoms are intensifying, or if you are having suicidal thoughts, seek professional help in order to obtain therapy and medications when needed.

• Don’t give up! It may take more than one try to get the help you need.

Who to contact for help

❖ **Fatimah Jackson, Researcher for the Postpartum Mood Disorders Study:** 555 2222

❖ **Ms. Patrice Daniel, Mental Health Counselor:** 555 3333

❖ **Daphne Ewing Chow, local Coordinator of Post Partum Support International, 555 4444 or localcoordinator@matdep.com**

❖ **The Mental Health Team at your local Polyclinic**

❖ **Parents Education for Development in Barbados (PAREDOS): 555 5555**
Postpartum Support International: [http://www.postpartum.net](http://www.postpartum.net)


**Information for this handout was obtained from the Minnesota Department of Health and Christina G. Hibbert, Psy.D.**
### Appendix E: Profile of Research Participants

<table>
<thead>
<tr>
<th>NAME</th>
<th>AGE</th>
<th>CONDITION</th>
<th>EMPLOYMENT STATUS</th>
<th>NUMBER OF CHILDREN</th>
<th>RELATIONSHIP STATUS</th>
<th>EDUCATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dena</td>
<td>24</td>
<td>Baby Blues</td>
<td>Unemployed/Student.</td>
<td>1</td>
<td>In a relationship</td>
<td>In University</td>
</tr>
<tr>
<td>Lucy</td>
<td>40’s</td>
<td>Postpartum Depression</td>
<td>Manager/Entertainer</td>
<td>1 (deceased)</td>
<td>Married</td>
<td>Completed high School</td>
</tr>
<tr>
<td>Catherine</td>
<td>30</td>
<td>Baby Blues &amp; Postpartum Depression</td>
<td>Cashier/Student</td>
<td>2</td>
<td>In a relationship</td>
<td>In University</td>
</tr>
<tr>
<td>Mary</td>
<td>32</td>
<td>Postpartum Depression</td>
<td>Business Owner/Government Worker</td>
<td>2 (1 child deceased)</td>
<td>Married</td>
<td>Completed post-graduate degree</td>
</tr>
<tr>
<td>Nita</td>
<td>33</td>
<td>Postpartum Depression</td>
<td>Office Attendant</td>
<td>3</td>
<td>In a Relationship</td>
<td>Completed high school</td>
</tr>
<tr>
<td>Cynthia</td>
<td>35</td>
<td>Postpartum Depression</td>
<td>Cashier/Bookie &amp; Student</td>
<td>3</td>
<td>Single</td>
<td>In University</td>
</tr>
<tr>
<td>Patrice</td>
<td>49</td>
<td>Baby Blues &amp; Postpartum</td>
<td>Administrative Assistant</td>
<td>1</td>
<td>Single</td>
<td>Completed University degree</td>
</tr>
<tr>
<td>Mackenzie</td>
<td>38</td>
<td>Baby Blues</td>
<td>Unemployed</td>
<td>1</td>
<td>In a relationship</td>
<td>Unknown</td>
</tr>
<tr>
<td>Monica</td>
<td>18</td>
<td>Baby Blues</td>
<td>Casual Shop Assistant</td>
<td>1</td>
<td>In a relationship</td>
<td>Completed high School</td>
</tr>
<tr>
<td>Lina</td>
<td>Unknown</td>
<td>Baby Blues</td>
<td>Market Vendor</td>
<td>5</td>
<td>Separated and in a relationship</td>
<td>Unknown</td>
</tr>
<tr>
<td>Rene</td>
<td>32</td>
<td>Baby Blues</td>
<td>Teacher/Graduate Student</td>
<td>2</td>
<td>Married</td>
<td>Pursuing post-graduate degree</td>
</tr>
</tbody>
</table>
Appendix F: Barbados Map and location of health centres
Appendix G: University of Toronto Ethics Approval Letter

UNIVERSITY OF TORONTO
OFFICE OF THE VICE PRESIDENT, RESEARCH

PROTOCOL REFERENCE # 27668
September 17, 2012

Dr. Carles Muntaner
FACULTY OF NURSING

Miss Fatimah Jackson
FACULTY OF NURSING

Dear Dr. Muntaner and Miss Fatimah Jackson,

Re: Your research protocol entitled, "Investigating women's experiences of postpartum mood disorders in Barbados"

ETHICS APPROVAL

| Original Approval Date: September 17, 2012 |
| Expiry Date: September 16, 2013 |
| Continuing Review Level: 1 |

We are writing to advise you that the Health Sciences Research Ethics Board (REB) has granted approval to the above-named research protocol under the REB’s delegated review process. Your protocol has been approved for a period of one year and ongoing research under this protocol must be renewed prior to the expiry date.

Any changes to the approved protocol or consent materials must be reviewed and approved through the amendment process prior to its implementation. Any adverse or unanticipated events in the research should be reported to the Office of Research Ethics as soon as possible.

Please ensure that you submit an Annual Renewal Form or a Study Completion Report 15 to 30 days prior to the expiry date of your current ethics approval. Note that annual renewals for studies cannot be accepted more than 30 days prior to the date of expiry.

If your research is funded by a third party, please contact the assigned Research Funding Officer in Research Services to ensure that your funds are released.

Best wishes for the successful completion of your research.

Yours sincerely,

Judith Friedland, Ph.D.
REB Chair

Daniel Gyewu
REB Manager

OFFICE OF RESEARCH ETHICS
McMurtrie Building, 12 Queen's Park Crescent West, 2nd Floor, Toronto, ON M5S 1S8 Canada
Tel: +1 416 946-3275 • Fax: +1 416 946-5763 • ethics.review@utoronto.ca • http://www.research.utoronto.ca/for-researchers-administrators/ethics/
Dear Ms. Jackson,

Re: Investigating Women’s Experiences of Postpartum Mood Disorders in Barbados

I write on behalf of the University of the West Indies-Cave Hill/Barbados Ministry of Health Research Ethics Committee/Institutional Review Board to conditional approval of the above proposal.

Before proceeding, please place contact information for the Cave Hill IRB on the consent form for participants and submit the revised version for our records.

Please note that ethical approval does not imply endorsement of your research design.

This approval is effective from the date of this correspondence for one year.

Please remember that you must also secure approval from any individual site or organization, i.e., the relevant ministry, agency, or company, if this is required.

If you have not already done so, please forward your certificate of completion for ethics training at www.citiprogram.org to kristina.bryant@cavehill.uwi.edu.

All research data and forms must be kept for no less than five years after completion of the approved project. Conditions of storage are subject to data security procedures outlined in your proposal. When your research is complete (even if earlier than the approval period ends), please notify the Board in writing to officially close your protocol.
If you anticipate the duration of data collection to exceed one year, please send a letter to the Board at least one month prior to the expiration date. You should indicate why you want the research to remain open (e.g., additional accrual necessary for more robust results, funding from an outside source to continue). Continuation is contingent on Board approval.

Please remember that any changes to the protocol will require the submission of a revised protocol via a complete application to the IRB before implementation of the revision.

**You must report any unanticipated adverse event experienced by a research subject within five days** to the Chair of the IRB through this letterhead address or via e-mail kristina.bryant@cavehill.uwi.edu.

The Committee wishes you the best of luck in your research endeavors. Please feel free to contact us at any time should you have questions or concerns. I remain,

Yours sincerely,

Michael H. Campbell, Ph.D.
Chair

CC:
Ms. Gale Hall, Deputy Chair
Prof. Alan Cobley, Coordinator of Graduate Studies
Mrs. Anita Kinch, Graduate Studies
Dr. Charmain Crawford, Supervisor
Ms. Kristina Bryant, Office of Research
IRB File
Appendix I: Letter to Senior Medical Officer of Health South (Barbados)

October 16, 2012

Dr. Elizabeth Ferdinand, Senior Medical Officer of Health South
Ministry of Health
Frank Walcott Building
Culloden Road, St Michael
Barbados

Dear Dr. Ferdinand,

My name is Fatimah Jackson and I am currently a fourth year doctoral student at the Dalla Lana School of Public Health University of Toronto. This letter is intended to formally request access to the ________, ________, and ________ Polyclinics to carry out recruitment for my doctoral research project entitled “Investigating Women's Experiences of Postpartum Mood Disorders in Barbados”. The objective of this qualitative research project is to investigate Barbadian women’s experiences of postpartum mood disorders in order to learn how they have understood, managed, framed, and treated these after giving birth. Based on a literature review I conducted there is limited research and data about Barbadian women’s experiences with postpartum depression, baby blues, and/or postpartum psychosis. Including Barbadian women’s voices and experiences is a major aim of the research project, as it seeks to insert them into ongoing discussions being had about women’s maternal health. In doing so, I intend to diversify the existing knowledge base while also filling a gap in the research.

I have identified the ________, ________, and ________ Polyclinics as optimal places for recruitment of eligible women to the study. I aim to recruit 20-25 women to the project through print advertisement and in-person recruitment. I intend to post posters, hand out flyers that detail the project, and attend breastfeeding clinics and any post-natal events occurring at the clinics. I have been in consultation with Ms. ____________ at the ________ Polyclinic. I have identified Ms. ________ as a partner, and I intend to grow my network to also locate partners in the ________ and ________ facilities. I have also developed a partnership with the Institute for Gender and Development Studies: NBU at the University of the West Indies. My work with this department has been ongoing since June 2010 in the capacity of a research intern, and their support will facilitate a successful research endeavour.
I have included the letters of approval for the research project from the IRB’s of the University of Toronto and the University of the West Indies/Ministry of Health for your review.

I ask that you look favourably upon my request to conduct my research at the ________, ________, and ________ Polyclinics. The results of this project have the potential to benefit the Polyclinics’ maternal health care programming, and by extension other health care facilities on the island. Further, the results of this research study will also work to improve the health of an important segment of Barbadian society: our women.

Please do not hesitate to contact me for any further information about this research project by mail, telephone at 417 4887 (office), 831 9481 (cell) or email at fatimah.jackson@mail.utoronto.ca

I look forward to being in touch with you.

With best wishes,

Fatimah Jackson
Appendix J: Women’s Self-Reported Symptoms of the ‘Baby Blues’ and Postpartum Depression

<table>
<thead>
<tr>
<th>‘BABY BLUES’</th>
<th>POSTPARTUM DEPRESSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disconnected from baby</td>
<td>Weight loss</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Loss of interest in activities</td>
</tr>
<tr>
<td>Feeling overwhelmed</td>
<td>Disconnected from baby</td>
</tr>
<tr>
<td>Mood swings</td>
<td>Disconnected from spouse/intimate partner</td>
</tr>
<tr>
<td>Crying</td>
<td></td>
</tr>
<tr>
<td>Sense of loss</td>
<td>Lack of interest in sexual intercourse</td>
</tr>
<tr>
<td>Loneliness</td>
<td>Anxiety</td>
</tr>
<tr>
<td></td>
<td>Prolonged and intense periods of sadness</td>
</tr>
<tr>
<td></td>
<td>Feeling helpless</td>
</tr>
<tr>
<td></td>
<td>Feeling hopeless</td>
</tr>
</tbody>
</table>