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POSTPARTUM DEPRESSION SYMPTOMS IN NEW MOTHERS AND THE DISCLOSURE
PROCESS

by

KELSEY LUNSFORD
B.A. University of Central Florida, 2020

A thesis submitted in partial fulfillment of the requirements
for the degree of Master of Arts
in the Nicholson School of Communication and Media
in the College of Sciences
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ABSTRACT

Using a qualitative approach, this study examined disclosure patterns of women who have experienced symptoms of postpartum depression (PPD). Postpartum depression is a mental illness that new parents are at risk of developing. If left unresolved, PPD can have severe, negative impacts on the development of the baby and the well-being of the parent. Unfortunately, due to the stigmatized nature of the illness, parents are sometimes reluctant to bring up their struggles with this illness and seek help. Eighteen women who had experienced PPD within the past five years were recruited and participated in an interview where they were asked questions regarding their disclosure behaviors. Using Communication Privacy Management Theory (CPM), the data were examined to explain disclosure patterns. Findings were discovered using a thematic analysis. Themes of disclosure processes, disclosure considerations, boundary maintenance, and effects of disclosure were prompted by the theory and several subthemes were discovered in the data.

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TABLE OF CONTENTS

LIST OF TABLES	vii
CHAPTER ONE: INTRODUCTION OF RESEARCH.....	1
Postpartum Depression	1
Stigmatized Mental Illnesses	2
Overview.....	3
CHAPTER TWO: LITERATURE REVIEW.....	5
New Parenting Issues.....	5
Postpartum Depression and Parenting	7
Self-Disclosure of Mental Illnesses	9
Non-Disclosure of Mental Illnesses.....	10
Communication Privacy Management Theory	12
CHAPTER THREE: METHODOLOGY	15
Participants.....	15
Procedures.....	16
Pilot Testing of Interview Guide.....	17
Analysis.....	17
CHAPTER FOUR: RESULTS	18
Disclosure Processes.....	18
<i>Disclosure Timing</i>	18
Disclosure Considerations	21
<i>Generational/Cultural Disclosure Considerations</i>	21
<i>Risk/Benefit Considerations for Workplace Disclosure</i>	23
Boundary Maintenance	26
<i>Boundary Assumptions</i>	26
<i>Boundary Turbulence</i>	27
Effects of Disclosure.....	29
<i>Close Interpersonal Relationships</i>	29
<i>Patient-Provider Interactions</i>	31
CHAPTER FIVE: DISCUSSION.....	35
Research Implications	35
Limitations and Future Research	39
Conclusion	39
APPENDIX A – RECRUITMENT POSTING.....	41
APPENDIX B – EXPLANATION OF RESEARCH.....	43
APPENDIX C – INTERVIEW QUESTIONS.....	46
APPENDIX D – DEMOGRAPHIC QUESTIONS	49
APPENDIX E – IRB APPROVAL LETTER.....	51

APPENDIX F – IRB MODIFICATION APPROVAL 53
REFERENCES 55

LIST OF TABLES

TABLE 1: PARTICIPANT DEMOGRAPHICS..... 16

CHAPTER ONE: INTRODUCTION OF RESEARCH

Postpartum Depression

Postpartum depression (PPD) is a complication that affects approximately one in nine new mothers after they give birth (Ko et al., 2017). Symptoms of PPD vary depending on the individual, and may include, but are not limited to: overwhelming fatigue and/or loss of energy, severe anxiety and panic attacks, recurrent thoughts of death and/or suicide, diminished ability to think, concentrate, or make decisions, intense irritability and anger, fear that one is not a good mother, insomnia, loss of appetite or binge-eating, difficulty bonding with the baby, thoughts of harming oneself or the baby, and withdrawing from family and friends. There is no direct cause of PPD, but it is thought that physical changes, like a drop in hormones, and emotional issues, like anxiousness and stress, can lead to the development of PPD. PPD is different (and much more severe) than the “baby blues” most new mothers face that includes mood swings, sadness, and irritability. Prevention of PPD is possible, especially if the mother is monitored properly by a doctor before the birth of the baby. Treatment for PPD includes psychotherapy or mental health counseling, alone or accompanied by antidepressants prescribed by a doctor (Mayo Clinic, 2018). This illness does not discriminate who it affects – mothers who recently gave birth (regardless of if the individual already has children), miscarried, or adopted a new child are all at risk of developing postpartum depression. Though the current research will focus on women with PPD, it is important to note that new fathers with a new child in the home can also develop postpartum depression. An estimated 10% of new fathers are diagnosed with PPD between three and six months postpartum (Paulson & Bazemore, 2010). PPD symptoms typically appear between two and six weeks after giving birth, but some new parents may not experience any symptoms until up to one year after giving birth (Bradley, 2020). Postpartum depression can

negatively affect one's quality of life and can potentially alter family dynamics, though the symptoms associated with the illness can vary in intensity and duration. The difficulties of this illness have only been heightened by COVID-19, where rates and severity of the illness have been increased in women since the start of the pandemic (Layton et al., 2021). Complications associated with PPD can greatly impact a parent's quality of life, and stigma associated with the illness can hinder how one deals with the illness.

Stigmatized Mental Illnesses

One key to managing postpartum depression is disclosing one's condition to healthcare providers and/or members of one's support system. However, many mothers are hesitant to disclose. This is likely, in part, due to the heavy stigmatization of mental health related illnesses relative to other illnesses. Individuals who suffer from stigmatized illnesses typically have little social support and are subjected to discrimination in the healthcare system. When an individual suffers from a stigmatized mental illness, they are often valued as less in the eyes of society which can lead to increased medication, treatment, and/or therapy costs and social disadvantages (Sartorius, 2007). Frequently, individuals with stigmatized illnesses, specifically mental illnesses, are reluctant to seek out professional medical treatment, thus resorting to the internet for medical guidance (Berger et al., 2005). When an individual does seek treatment for PPD, successful treatment may be hindered due to the communication barrier between the patient and healthcare provider that can be present. In other words, the patient cannot effectively articulate their feelings, causing the healthcare provider to struggle to provide adequate treatment (Pinto-Foltz & Logsdon, 2008).

This research seeks to examine the disclosure process in women with postpartum depression symptoms. Being open and disclosing mental health issues can allow an individual to

make sense of their illness and receive social support. Currently, little research exists that examining disclosure of PPD symptoms. Understanding disclosure of PPD symptoms (including self-disclosure of the symptoms, non-disclosure of the symptoms, and motives behind the disclosure) can help healthcare workers and loved ones of a patient have a better idea of what they can do to help the individual cope and make sense of their illness.

Overview

This thesis used Communication Privacy Management theory (CPM) to examine self-disclosure and non-disclosure of postpartum depression symptoms in new mothers. CPM explains that we are the sole owners of our private information, until we choose to share that information with others. Once disclosure happens, the disclosee now has co-ownership of the private information (Petronio, 2002). CPM also states that disclosers may set up protective boundaries to prevent the spread of their private information, though the boundaries are sometimes broken, causing boundary turbulence. CPM can help to make sense of the disclosure process of PPD symptoms, can help us understand the justification of the women's decisions to disclose, and provide insight to the results of the disclosure. Semi-structured interviews were conducted to determine to whom women with PPD symptoms felt comfortable disclosing their struggles, and conversely, from whom women with PPD symptoms hid their illness. This research also used CPM to examine the motives behind the disclosure of the illness, timing of disclosure, and effects from disclosure of the illness.

Chapter two of this thesis will review the existing literature concerning new parenting complications and the relation to postpartum depression, self-disclosure and non-disclosure of mental illness, and communication privacy management theory. Chapter three of this thesis will

cover the methodology utilized for this research. Chapter four outlines and details the findings and the fifth and final chapter of this thesis covers the discussion.

CHAPTER TWO: LITERATURE REVIEW

Postpartum depression, a mental health complication that affects several million people every year around the world, can bring serious, and often long-lasting symptoms that can be difficult to manage. Individuals suffering from PPD experience a range of emotional, mental, physical, and behavioral symptoms, similar to any other type of depression. However, some individuals with PPD develop specific, negative feelings about their baby, which is a distinctive symptom of PPD (Carberg & Langdon, 2021). These thoughts may involve violence towards their child, but the thoughts rarely get acted upon, so clinicians typically downplay these feelings (Mason, 2022). Though symptoms of PPD vary in intensity, duration, and type, those who experience PPD (and who received a formal diagnosis) will usually need treatment which can include medication and therapy. There is no singular event or characteristic that leads to the development of PPD. Rather, a range of reasons, from physical changes like lack of sleep, to relationship issues such as marital conflict or struggles at work, can contribute to the development of the illness.

New Parenting Issues

First-time parents, or those growing a family, marks a period in life that is often filled with joy, but it is seldom without obstacles along the way. Individuals may face several complications from being a new parent. First, issues may arise from interpersonal relationships -- specifically, conflict with a partner or spouse. Pregnancy, delivery, and lactation all significantly impact sexual function in new mothers. The decrease in sexual function, if left unresolved, can affect marital stability, which can cause additional conflict and even increase the chances of divorce, in extreme situations (Torkzahrani et al., 2016). Furthermore, spousal conflict can arise

in situations where there is unequal partner support. Dennis and Ross (2006) found that women with low partner support experience higher levels of conflict with their partner, and because of the conflict, women experience more depressive symptoms in the postpartum stage. With little to no support, the increase of maternal investment (i.e., tending to the baby) can lead to the corresponding increase of maternal fatigue, which is strongly correlated to depressive symptoms in postpartum women (Gunst et al., 2021). Additionally, disruption in adequate sleep in the postpartum stage can lead to interpersonal relationship issues, and thus, an additional strain on mental health. Existing literature shows that both sleep satisfaction and duration is substantially reduced in the postpartum stage. Ritcher et al. (2019) found that even six years after the birth of a child, new mothers and fathers were not receiving the same quality and duration of sleep as they were receiving prior to having a child. Persistent disruption in sleep is associated with a steep decline in marital satisfaction, too, due to the stresses associated with insufficient energy (Medina et al., 2009). Lack of adequate sleep can lead to dysphoric mood and irritability, which can lead to more interpersonal and intrapersonal issues (Swain et al., 1997).

In addition to interpersonal struggles, new parents often need to overcome barriers associated with their place of employment. Cooklin et al. (2015) found that work-family conflict is worsened in the postpartum stage which increases stress and mental health difficulties. Associated with work-family conflict is managing childcare demands. Deciding when to return to work after the birth of a child and finding a schedule to fit the childcare demands can cause increased stress which can lead to the development, or the worsening, of depression symptoms and related mental health difficulties (Leung et al., 2005). Work-family conflict is not only associated with high levels of depression, but it is also linked to poor physical health and the occurrence of hypertension (Frone et al., 1997). Additionally, because of the “role juggling” that

parents who also hold full-time jobs have (i.e., being both an employee and parent/partner), there can be mood spillover – meaning, issues that arose at work causing an unpleasant mood would cause the unpleasant mood to carry over after getting home from work, affecting family dynamics. Conversely, issues that arose at home can cause mood spillover into the workplace environment, which can cause work performance issues (Williams & Alliger, 2017).

Physical adjustments may also play a role in postpartum depression. New mothers often experience lactation struggles; an estimated 92% of mothers experience some lactation issue within the first three days postpartum (Wagner et al., 2013). Lactation struggles can lead to the feeling that one is not a good enough mother, which is a major indicator of postpartum depression. A study by Graef et al. (1988) found that 81% of new mothers reported concerns about their health after suffering complications with breastfeeding. Additionally, regardless of delivery method, many new mothers experience persistent pain after giving birth. If this pain is chronic, or left unresolved, these mothers are at an additional risk of developing mental health difficulties (Eisenach et al., 2008). Women also experience increased body image issues after the birth of a child. Hartley et al. (2019) found that women with postpartum depression symptoms experienced poorer self-image when compared to postpartum mothers who did not have depression. Complications from childbirth and parenting leave many women at a heightened risk of developing depressive symptoms. These depressive symptoms can bring negative implications to not only the mother's health, but the baby's well-being, too.

Postpartum Depression and Parenting

Not only does PPD impact the parent with the illness, but PPD can also have effects on children. Paulson et al. (2006) found that depressed mothers were approximately 1.5 times more likely to engage in inadequate or less healthy sleep and feeding practices with their infant. The

same study found that depressed mothers were also less likely to engage the child in positive enrichment activities like reading, singing, and storytelling. Similarly, Field (2010) found that feeding practices (i.e., breastfeeding), safety practices (like infant vaccinations), healthy sleep routines, and well-child visits are all compromised because of postpartum depression. The same study found that the effects of PPD appeared universal, meaning, cultural and/or socioeconomic factors did not influence the disturbances. Forman et al. (2007) found that even at six months postpartum, depressed mothers viewed their infant more negatively than nondepressed mothers and after eighteen months, the depressed mothers (even with treatment) reported higher behavioral issues in their children, lower attachment security with their children, and higher negative temperament within themselves. This study called for treating PPD by focusing on treating mother-child relationships in addition to the mothers' personal depression symptoms. Overall, depression in mothers is strongly associated with poorer quality parenting, and as a result, a lower quality of a parent-child relationship. Unfortunately, many treatments currently used for mothers with PPD focus solely on treating the depressive symptoms itself but fail to reduce the impact of the depression on the child's outcomes (Galbally & Lewis, 2017).

The illness can also have negative effects on a partner or spousal relationship, which can also affect parenting. Letourneau et al. (2012) state that because of the lack of energy and negative feelings of worthlessness, self-doubt, and incompetence, mothers with PPD often need to rely on their spouse or partner for support, which increases the stress, physical strain, and mental strain on the partner, resulting in additional strain on the relationship. Furthermore, Johansson et al. (2020) note that PPD can cause loneliness in both mothers and fathers simultaneously in a relationship which can lead to an increase in spousal relationship issues. It is abundantly clear in the existing literature that PPD not only has severe negative effects on the

afflicted parent, but also impacts the child's development and can challenge partner stability, too, even with current treatment prescribed by professionals.

Self-Disclosure of Mental Illnesses

This range of negative impacts both in the long and short term make it important for mothers with postpartum depression to be able to seek and receive support. However, little research currently exists about self-disclosure of PPD. Literature about self-disclosure of mental illnesses more broadly reveals that several factors influence disclosure status of individuals with a mental illness. First, Pahwa et al. (2017) concluded that women are more likely than men to disclose their mental illness status and Taniguchi and Thompson (2021) found that women are more likely to be recipients of disclosure, too, which may be because women are usually seen as more supportive and accepting when compared to men. Furthermore, Pahwa et al. (2017) also found that those with stronger support systems have a greater chance of self-disclosing their illness, compared to those with not as much social and emotional support. Similarly, existing research shows that people feel more comfortable disclosing their mental illness to certain people, and are hesitant to disclose to others, and the decision to disclose often depends on the amount of support received from the disclosee (Taniguchi & Thompson, 2021). Taniguchi and Thompson (2021) found that young adults with a mental illness are most likely to disclose their struggles to their mothers, close friends, and romantic partners first. The study found that the same individuals were less likely to disclose their mental illness status to their fathers, siblings, and other relatives. Chaikin and Derlega (1974) did early research on disclosure of mental illnesses and found that individuals who suffer from a mental illness are more likely to disclose their illness to other individuals who are the same age.

Self-disclosure of mental illnesses can oftentimes bring great benefits to the individual suffering from the illness. Existing literature overwhelmingly agrees that individuals who disclose their mental illness to a friend or family members receive more social support and feel less self-conscious around that individual (Chaudoir & Fisher, 2009; Mulfinger et al., 2019). Additionally, Corrigan and Rao (2012) note that those who disclose their mental health struggles face less self-stigmatization, which leads to individual empowerment and a better quality of life. According to the U.S. Department of Health and Human Services (HHS, 2008), disclosure of a mental illness can be beneficial to both the discloser and the person to whom the information was disclosed. HHS further notes that after disclosure, the individual suffering from a mental illness no longer has to worry about hiding their illness or struggles with the illness, can find others who struggle with the same illness, and can find someone who can provide additional help to cope with the illness, all of which can lead to a sense of empowerment as the stigma is being challenged.

Non-Disclosure of Mental Illnesses

While there are many benefits associated with the disclosure of a mental illness, there is substantial literature surrounding reasons for non-disclosure of mental illnesses. Not everyone suffering from a mental illness makes decisions about disclosure the same way. In fact, decisions about disclosure are frequently made on a case-by-case basis, especially when there are power differentials in complex social contexts or if safety is compromised (Marino et. al, 2016). Peterson et al. (2011) found that because disclosure is irreversible, individuals carefully weigh the decision to disclose prior to engaging in the disclosure. The study further noted that there are certain relationships, like workplace relationships, where individuals are unlikely to practice disclosure, as the individual may fear discrimination, retaliation, and judgement from the

employer and coworkers. Lang et al. (2012) observed that often the decision to disclose involves “the fear of being treated differently or unfairly, losing credibility in the eyes of supervisors and colleagues, rejection, and becoming a target for gossip” (p. 855). Toth and Dewa (2014) conducted in-depth interviews to analyze employees’ decision about disclosing a mental health disorder at a workplace. They found that individuals begin in a neutral position when deciding to disclose. To move from the neutral spot, those individuals need a specific reason to prompt them to either disclose, or not disclose their mental illness struggles to someone in the workplace. Before making a disclosure decision, employees conduct an internal risk-benefit analysis about the situation, which is typically the case in other relationships outside the workplace, too. The authors concluded by mentioning that one of the main problems associated with nondisclosure is stigmatization from coworkers and management.

Non-disclosure of mental health symptoms has been studied within close relationships, too. Love et al. (2021) studied individuals who had suicidal ideations and found that non-disclosers felt as though disclosing their struggles to their romantic partners would not change the circumstances, meaning there were no perceived benefits of disclosure. Similarly, Mérelle et al. (2018) found that nearly half of adults with suicidal ideations did not disclose their condition largely in part to perceived loneliness and lack of support. Furthermore, Wilson et al. (2019) concluded that some individuals with mental health issues avoid disclosure to their friends and family because as the discloser, they got emotional when discussing their illness and they did not want to project those feelings onto others. Macdonald and Morley (2011) found that psychotherapy patients more commonly practiced non-disclosure to avoid labelling and judgement from others and to also avoid self-criticism and shame. Walsh Carson et al. (2019) studied women who experienced sexual trauma and developed PTSD and/or depression as a

result. They discovered that nearly 25% of women had not disclosed their condition to anyone and reasons of non-disclosure involved shame, fear of consequences, and minimization of the experience. Even when individuals sense support in interpersonal relationships, many still choose non-disclosure so they do not place the burden on others, they can avoid judgement, and they can avoid being emotional around those closest to them.

Communication Privacy Management Theory

This study examines disclosure through the lens of Communication Privacy Management theory (CPM). Developed by Petronio (1991, 2002), communication privacy management theory assumes that self-disclosure decisions are made within a rule-based structure. It demonstrates that as individuals, we have private information that we often keep to ourselves, as this allows us to feel secluded from others as we maintain confidentiality. There are several tenets of CPM: (1) we are the sole owners of our own information, until we choose to share that information with others; (2) when we do choose to share our private information, those we disclose to are now co-owners of the information; (3) co-owners of the information need defined rules regarding telling the information to others; (4) these rules are mutually agreed upon by the primary owner of the information and the co-owner; (5) if the rules are not adequately negotiated, or followed poorly by the co-owner, boundary turbulence will occur. Furthermore, CPM states that people will disclose issues that are of great importance to them, and when they do so, they must find ways to manage any potential risks to themselves as a result of the disclosure. In order to manage the risks, individuals will outline protective boundaries that will serve to control the flow of information between themselves and other individuals. Ultimately, CPM demonstrates that individuals choose to whom they disclose to, when they disclose, and how much they disclose. The theory explains that “private disclosures are dialectical, that people make decisions about

revealing and concealing based on criteria and conditions they perceive as salient, and individuals fundamentally believe they have a right to own and regulate access to their private information” (Petronio, 2002, p. 2). The determining influences of disclosure that CPM outlines are gender, culture, context, motivation, and risk/benefit ratio.

There is a wide array of literature and empirical research that utilizes CPM. The theory has been particularly applied in research regarding illnesses and other health complications. Herrman and Tenzek (2017) used CPM to study revealing and concealing of eating disorders on an online platform. Their findings demonstrate that disclosure patterns on online platforms have the affordances for users to remain anonymous or use pseudonyms, giving the user complete control of their private information and allowing users to prevent privacy dilemmas. Steimel (2021) studied disclosure of pregnancy loss in women to coworkers and found that disaffirming messages received from coworkers and supervisors heightened the desire to not disclose the loss to others. The study concluded acknowledgment and affirmation of the loss allowed for sensemaking. Miller and Rubin (2007) used CPM to examine self-disclosure of positive HIV diagnoses in men and women in Kenya. The results supported the theory of CPM by confirming that motivations for disclosure are largely dependent on the relationship between the discloser and the disclosee. Recently, CPM has been utilized to study disclosure and contact tracing of COVID-19 (Jung Hong & Cho, 2021).

Although there has been research done using CPM concerning disclosing existing depression to children (Starcher, 2019) and disclosing parenting struggles to others (Vik & DeGroot, 2021), there is a gap in literature analyzing CPM in the context of disclosure of postpartum depression symptoms. This project expands the literature about CPM and on the

topic of disclosure of mental illnesses, while also contributing to better understanding the complications associated with postpartum depression.

CHAPTER THREE: METHODOLOGY

This thesis employed a qualitative approach, using in-depth interviews with mothers with postpartum depression symptoms. Ethical approval was obtained from the university's Institutional Review Board (IRB) prior to contact with potential participants.

Participants

Participants were recruited primarily through social media, specifically on Reddit and Facebook. Recruitment posts were made on postpartum support pages on the two sites (see Appendix A). The Facebook group used to recruit participants is titled "Postpartum Support Group". The group is relatively new on Facebook, created approximately a year ago, and has around 4,500 members. This specific group has over 500 new posts each month. On Reddit, participants were recruited through the subreddit called r/Postpartum_Depression. This group has 4,900 members and was created in 2014. These groups were chosen for recruitment because they have international representation and are specific to women in the postpartum stage. In addition to social media posts, participants were recruited through a snowball sampling method or via referral. This second method was selected since many mothers who have PPD, or have had it in the past, likely know another mother who has history with the illness. Participants were recruited until data reached saturation. A total of 19 participants agreed to participate, but one participant was excluded from the analysis since she had primarily dealt with perinatal depression, not postpartum depression.

The following demographics are from the 18 participants included in the analysis. All participants were women who were between the ages of 18-39 (with most participants aged 30-39). Though it was not a requirement to participate, all interviewees were currently being seen or

had recently been seen (within the past 5 years) by a medical professional for the treatment of postpartum depression. All participants in this study resided in either the United States or Canada. Table 1 shows the dispersion of the participants' ethnicity and highest level of education completed.

Table 1: Participant Demographics

Participant Ethnicity		Participant Highest Level of Completed Education	
Asian	2	High school diploma or GED	1
Black or African American	1	Associate's degree	1
Hispanic/Latino	3	Bachelor's degree	5
White	10	Master's degree	8
Multiple Races	2	Doctorate	1
		Other	2

Procedures

Participants were given an explanation of research (see appendix B) at the start of the interview. After oral consent was obtained, semi-structured individual interviews were conducted with each participant via the video conferencing platform Zoom. Each interview was video and audio recorded and lasted between 10-30 minutes. During the interviews, participants were asked a series of questions regarding their experiences with disclosure and postpartum depression (see Appendix C). The questions were created by the researcher and were purposefully guided by the

theory. No questions were asked outside of the appendices unless needed to further understand an emerging theme (e.g., “Can you tell me a little more about that?” or “What happened next?”).

At the end of the interview, participants filled out a three-question demographic questionnaire (see Appendix D). Each audio was transcribed through the Zoom transcription setting and was checked and corrected by the researcher for accuracy. To protect the identity of participants, they were assigned pseudonyms from a random name generator at the start of the interview. Additionally, all identifiable information was removed from data analysis.

Pilot Testing of Interview Guide

Two mothers outside of the sample were recruited for a pilot test of the interview guide. The goal was to ensure the questions were structured in a way that are not only easy to understand for participant but detailed enough to align with the theory. Pilot testing also ensured that the interview could be completed in under 30 minutes as outlined by the procedure.

Analysis

After transcripts were checked for accuracy, a thematic analysis was conducted to identify similarities and differences between each interview (Norwood, 2012). Through the open coding process (Charmaz, 2008), the data were interrogated to fully understand and conceptualize the findings. The researcher used a digital codebook to find themes amongst each participant’s responses. More specifically, the researcher looked for themes based off the theory regarding disclosure processes, disclosure considerations, effects of disclosure, and the use of protective boundaries. Through the thematic analysis process, the raw interview data were interpreted to develop a more complex understanding and created uninflected conceptions (Owen, 1984). The findings with the identified themes are outlined in chapter four.

CHAPTER FOUR: RESULTS

CPM prompted themes of disclosure processes, disclosure considerations, boundary maintenance, and effects of disclosure in the data analysis. Several subthemes were found within each theme. The results are organized by theme and will be addressed individually below.

Disclosure Processes

When disclosing an illness, such as postpartum depression, several factors are considered during the disclosure process itself. Subthemes of disclosure timing and unintentional disclosure emerged in the data.

Disclosure Timing

Mothers with PPD disclosed to different individuals at different times. Often, the mother's partner or spouse would be the first disclosee. In many circumstances, the participants would disclose their PPD to their spouse or partner soon after experiencing symptoms, before the official diagnosis. This timing was, in part, due to the partner living with the mother experiencing PPD symptoms. In other words, it was easiest for the discloser to open up to their partner first since they were interacting with each other daily. If the spouse or partner was the first disclosee of the mother with PPD, the second disclosee was almost always someone within the discloser's family, whether a parent or a sibling, if the participant had a stable pre-existing relationship with the family member.

When disclosing to individuals outside immediate family or romantic relationships, many mothers expressed that they did not disclose until they were receiving formal treatment from a medical professional and/or their symptoms of the illness had subsided a great amount. Phoebe explained when she disclosed to her in-laws: "Whenever I mentioned it to my mother-in-law and my sister-in-law, it wasn't in the acute phase. [...] It was like, after I was starting to feel better."

Some mothers explained that when disclosing to those outside of immediate family or very close relationships, they would do so only after receiving treatment, but they would also down-play the severity of the illness. More specifically, some mothers with PPD would describe their experience with the illness in past-tense, as if they were no longer dealing with the illness, when in actuality they were still struggling. Robin shared her story about opening up in the workplace and to some medical professionals:

[In the workplace] I would share [my PPD] in like a, “It happened to me” not, like, “This is something that I’m still, kind of, struggling with” even though I was. [...] I was disclosing it like “Oh, this happened to me,” not, like, “I’m still dealing with some of the side effects [of PPD] now and it still impacts me on a daily basis.” [...] I would mention [my PPD] to, like, my son’s pediatrician like, “Oh, I had depression before with him,” but I always talked about it, like “had,” not something that was, again, impacting my life on a regular basis.

In the discloser’s mind, disclosing PPD in past-tense made the conversation easier. By describing the illness as if it was no longer being experienced, the mothers felt more comfortable opening-up about the illness and felt like less of a burden.

Disclosure timing is usually dependent on how the mother is feeling when dealing with the symptoms of PPD. Sometimes, mothers would disclose quickly to those closest to them to receive some support. Others would wait to disclose until treatment had been received or would create a false narrative that the experience with PPD happened in the past and was not being lived currently.

Unintentional Disclosure

Women with postpartum depression often expressed that the decision to disclose to certain people in their life was chosen by default, not because of their own motivation to disclose. This default decision was arrived at as the participants with PPD were experiencing symptoms that were difficult to conceal, and other individuals who were around the participant regularly witnessed the symptoms. Melissa shared her story finding out she had PPD and disclosing by default to her husband:

I hadn't talked to anyone really. Like I knew I was like, "I'm feeling particularly crappy," but I still filled out the [PPD] questionnaire [at the doctor's office] honestly and that's when like I got flagged [for PPD] [...] So my husband was [at the doctor's appointment] and so he was, like, the first person we had to talk to about it and he was, I think, he was very surprised because he was not awake during those times [I was struggling] and then he also was like, I think, concerned that he felt like I should have been able to have this conversation with him.

Christina shared that her sister was at her home in the first few weeks postpartum to help around the home. She initially disclosed her struggles with PPD to her husband, but not her sister. She did not plan on telling her sister at that moment, but her sister overheard her on the phone trying to contact a therapist. It was in this moment that Christina unintentionally disclosed her PPD symptoms to her sister.

Similarly, many participants noted that prior to formal diagnosis of PPD, other individuals, like the participants' partners, recognized the symptoms that the participant was experiencing, so the decision to disclose PPD by the participant was not premeditated. Lauren shared her experience with her spouse noticing her symptoms:

My husband noticed as well. He started, like, checking in a little bit more, and I noticed that he was checking in. [...] So I trust his input when he was like, “You're having more bad days than good.” I'm like, “Oh,” and then I start checking myself like, “Yeah, you're right.”

Madeline shared a similar story and noted, “Sometimes I feel like the people around you notice before you do.” Many participants stated that often, it was difficult to conceal PPD-related symptoms, despite the desire to not want to outwardly exhibit them.

In summary, women with PPD typically did not plan who to disclose to and when to disclose. Rather, disclosure of PPD was arrived to at default, or done unintentionally by the discloser, especially in close interpersonal relationships. It is important to note, however, that this unintentional disclosure was almost always when the discloser was newly experiencing PPD symptoms, or was newly diagnosed with PPD. Once the discloser had experienced PPD for quite some time, or after the discloser received formal treatment, they were more likely to be open about their illness and disclose, making unintentional disclosure less likely.

Disclosure Considerations

Before disclosure formally happened, disclosers often weighed pros and cons of the act of disclosure. In this sample, the place of the disclosure and the relationship with the disclosee had to be considered before formal disclosure. Specifically, participants in this study mentioned that there were generational/cultural disclosure considerations as well as risk/benefit workplace considerations that they needed to evaluate.

Generational/Cultural Disclosure Considerations

Some women spoke of difficulty disclosing to friends and/or family members. More specifically, the discloser felt as though there was a level of difficulty to disclosing to friends

and/or family members who were from a different cultural background or from a different generation. Many women interviewed explained that mental health was viewed differently, or not understood fully, by people of different age groups or cultural backgrounds than their own. As a result of this conflict, some women chose non-disclosure of their PPD. Christina explains why she did not disclose to her mother: “She’s, you know, an old-school traditional Asian lady. She doesn’t really understand mental health issues, to be honest with you, since [she’s] more like ‘Tough it out and pray.’” Annie shared a similar story when attempting to disclose to her mother:

I tried to talk to my mom, but I feel like there’s generational gaps, you know? She just does it, she just did it [dealt with parenting]. You’ve got to move forward, put your boots on, and get out the door, so I really only talked to my psychiatrist about it.

Some women explained that they had a desire to disclose to friends and family members, but there was hesitancy. Because of this hesitancy, some women wouldn’t define their illness as PPD. Rather, they would talk about their illness to others, but not specifically disclose or explicitly state the word “depression.” The avoidance of the term PPD, or depression in general, often stemmed from cultural or generational conflicts. Millie explained her limited disclosure to her mother:

My mother is from a different cultural background, so it was harder for her to really understand. I don’t exactly phrase [PPD] as depression because she’ll just be like, “Oh it’s from your dad’s side. You know, you guys are all crazy on that side.” So, like, I don’t phrase it the same way that I would, like, to my friend or my husband.

Robin shared a similar story, where she wouldn’t use the term PPD when talking about her struggles due to cultural reasons. She explained:

The community I'm from, nobody talks about postpartum depression, like, nobody knows what it really is, or why it happens, or the implications. So, I would mention it to a friend here or there and it would be more like, I would say, "Oh, you know, I'm going to the gym to work out to, like, try to feel better!" And they'd be like, "Oh, that's great!" [...] I just don't think people, really at least the people in my circle, really understood what it is.

Some women with disclosure hesitancy would finally end up using the term "postpartum depression" explicitly with friends and family but would wait some time before doing so. Helen explained her difficulties talking about PPD with her husband:

He's also mentioned in the past that he does not particularly believe in like things like ADHD or, like, mental health issues in general and like we live in [state], so it's very, like, conservative over here. A lot of his family is very much the same way, like, "Oh, that kid doesn't need medication. He needs a spanking," so the attitude around, like, mental health isn't very good here. So, while he's like always been, like, really supportive and everything, I was still nervous about talking to him, since I know his family and the way he was brought up. Their attitudes around mental illness we're not the best.

In this sample, women would frequently choose non-disclosure if there were generational and/or cultural conflicts present between the discloser and the disclosee. Some mothers, however, still had the desire to disclose, so they would avoid explicitly mentioning depression, and would discuss general parenting difficulties more broadly.

Risk/Benefit Considerations for Workplace Disclosure

Mothers with PPD did not typically disclose their illness to coworkers or colleagues in the workplace. Prior to making a disclosure decision, women would weigh the risks and benefits to disclosing in the workplace environment. The decision not to disclose to co-workers was often

dependent on the industry the discloser worked in and the workplace atmosphere. Jasmine explained her decision not to disclose in the workplace: “I already work in, like, a very male-dominated industry, and if you show any sort of, like, emotion or weakness, it just doesn’t go well for you.” Phoebe shared a similar sentiment, “I work in the healthcare field, [...] you don’t say that you’re gonna kill yourself, because then you might have to get like, mentally evaluated.”

When the women with PPD did disclose their symptoms to others at their place of employment, it was almost always to other women who have children or women who were pregnant. Most frequently in this sample, those who were disclosees of the private information were trusted by the discloser and defined the relationship as going beyond just coworkers. Aysha explained her decision to disclose to a female coworker:

I was lucky that another girl at my work had a baby three months before me, so we were on maternity leave at the same time, so her and I did talk about [postpartum depression] a lot, however, she did not, you know, communicate anything back to our workplace. It was more of like, a personal friendship we had outside of work.

Often, when women did decide to disclose in the workplace, particularly to a female, they did so to provide support to other women, specifically mothers. Phoebe explained that she chose to disclose to educate other pregnant women and provide support:

I just told like my coworkers kind of like, “Well I’m struggling with, you know, postpartum depression. It really sucks. People don’t talk about it enough.” [...] I wanted to raise awareness, because there was also a few other girls that were pregnant around that time too.

Others would choose to disclose in an attempt to receive some support from other coworkers, especially those who were mothers who had recently given birth. Though disclosure

in the workplace could be difficult, and could pose negative consequences, those who did decide to disclose in the workplace thought that the benefit to the disclosure was more beneficial to their coping of the illness than any potential harms that the disclosure may have brought. Helen explains how disclosing helped her feel better about her postpartum experience:

I talked to one of my coworkers before my appointment. She was pregnant around the same time I was, and she had twins. I was like, “Why are you always glowing and perfect all the time? I don't understand how you can do all this,” and she's like, “I was literally in the closet crying my eyes out the other day” and I was like, “Oh, me too.”

Some women chose to disclose in the workplace to feel validation from other coworkers.

Jamie explained her decision to disclose:

[At work,] when we have, like, a moment of passing, we'll sometimes, you know, throw in little conversations and that's one of the opportunities I took to just kind of say [that I had PPD] because I wanted to just say it to somebody. I felt like the feelings would be validated if I spoke to somebody like [my female coworker] because we've talked a lot, we got to know each other since we've been working together, so I know that I could vent [to her].

Some who participated in this study chose not to disclose in the workplace due to fear of judgement or other repercussions. Those who chose non-disclosure mentioned wanting to maintain a separation of work life and personal life. It is important to note that most participants who disclosed to coworkers did not set up any protective boundaries to limit further spread of the disclosure in the workplace. Those who disclosed felt comfortable enough being open to others in the workplace or trusted the disclosee with their private information without the need to set up boundaries. Those who chose to disclose also maintained that the coworkers who now “co-

owned” their information did not further spread the private information to others. Whether to educate, provide support, or simply just to make the illness known, women who disclosed PPD in the workplace felt as though their private information was safe with their coworkers and felt that the disclosure would provide benefit to their illness coping.

Boundary Maintenance

When deciding to disclose private information, CPM states that disclosers sometimes set up protective boundaries to ensure that the spread of their information was limited or non-existent. Boundary maintenance was an important aspect of this study which is guided by the theory. Sub-themes of boundary assumptions and boundary turbulence were discovered in the data.

Boundary Assumptions

Communication Privacy Management (CPM) theory states that prior to and/or during the disclosure process, the discloser will often outline set rules to the disclosee to follow regarding the private information. Women who experience PPD are usually selective in their choice of people to whom they disclose, likely because of the fear of judgement they may receive. Many women interviewed, however, did not set up explicit boundaries for their spouses or families following the disclosure. Rather, many of the mothers interviewed assumed that the boundaries were already present and felt as though they did not explicitly need to establish boundaries verbally. Aysha explained why she didn't set up boundaries with her husband: “I didn't have to because my husband knows that I'm a very private person, so he wouldn't discuss my personal things. So, you could say it was kind of understood that he wouldn't.”

There was a certain level of trust when disclosing PPD in close relationships. Many women interviewed did not fear that their private information would be shared with others

following disclosure to specific people. Lauren explained why she also did not set up boundaries, specifically with her spouse: “I never told him not to disclose because I didn’t feel that I needed to. I knew that he would be sensitive with [my information].” Those interviewed were selective when disclosing, so they felt as though there was no need to set up boundaries. Many women explained that they did not even think to set up boundaries with certain people, because they thought the disclosee was unlikely to spread their personal information. In other words, boundaries were only set up if the discloser thought the disclosee might spread the private information. If there were no fears of the information being spread, boundaries were assumed, and not explicitly stated.

Boundary Turbulence

Most women with PPD did not frequently set up boundaries regarding their disclosure of their illness, though some still did with close family members or their spouses. There were several reasons why some mothers chose to set up boundaries. Often, it was because they did not want their information shared with certain people, like those who weren’t directly within the family or those who did not have an intimate relationship with the discloser. In this sample of mothers with PPD, when protective boundaries were set up with the mother’s immediate family members, the request to not further spread the private information was always adhered to. When boundary turbulence did occur, it was always by the spouse of the mother with PPD, or the father of the child. Jasmine originally did not want to share her struggles with PPD with her partner at the time but was encouraged to do so by a postpartum support organization. Despite the organization’s encouragement to her to disclose, she experienced boundary turbulence. She explained setting up boundaries with her partner at the time, and then the boundary turbulence that occurred:

I told him I didn't really want to share, you know, [PPD], with everyone. I am much, like, private in that way, I guess. I didn't want people to see me struggling. [...] I don't want people to know that I'm crying uncontrollably and, you know, wanting to kill myself. [...] He's told everybody. [...] If I could have, I would've never told him.

Marie shared a similar story when she set up boundaries with her family members and her spouse. Though her family members agreed to keep her struggles with PPD private to them, her spouse did not adhere to the designated boundaries, resulting in boundary turbulence:

For the most part, I just, like, wanted everyone to think that I kept it together. Especially, like, it made me very self-conscious, especially seeing, like, acquaintances and other friends that, you know, had babies and, like, they felt like they were just so connected and have it so together, like they didn't feel like a headless chicken, and so I didn't want to make it seem like I said, it's obvious that I'm a rookie, so overall, I tried to, like, downplay it a good amount. [...] Where we live at, we're observant Jews and we live in a community where everyone kind of knows each other. So, I heard indirectly from a friend [...] that my husband was complaining to the community's Rabbi's wife, saying that, like, "You know, I think Marie's oversensitive. I'm worried how she's going to get a grip on being a mom." So, I did feel betrayed there.

Boundary turbulence can occur whether the boundaries were implied or verbally stated. In this sample, turbulence was not something that many mothers faced, though it did still occur. Mothers who experienced boundary turbulence expressed that it felt like betrayal and expressed regret in disclosing to the individual who broke the boundary.

Effects of Disclosure

Effects of disclosure mentioned by this sample were of two types: effects of disclosure to family or a romantic partner and effects of disclosure to healthcare providers.

Close Interpersonal Relationships

After disclosure occurred in close interpersonal relationships, such as within the family, in romantic relationships, or in friendships, responses were mostly positive. Participants explained that they received support and encouragement from those whom they were closest with. Marie shared her positive story about disclosing to her mother:

I told my mom because I always felt that she just loves me unconditionally and I have come across some friends and family that could only handle me at my best, but not at my worst, but I knew that, at the end of the day, [my mother] would be able to handle me at my worst, so I felt the most comfortable opening up to her.

Many of the mothers interviewed mentioned that they received positive support from friends, family, and spouses. The mothers were able to receive support in forms of emotional support, like checking in routinely on the mother, and physical support, like watching after the baby, bringing cooked meals to the mothers' home, and going on social outings.

Those who expressed they experienced mental health complications in the past had an easier time disclosing, as they knew they would receive support from others, just like they had previously. Lacey explained her history with mental health and experience disclosing PPD:

I have been seeing a psychiatrist since I was 17. [...] [My family has] all seen me in a depressed mode before, so [after disclosing PPD] they were all, you know, "We believe you. We know this is happening and we're sorry for you. We know that this is very, very hard, but also we know that you can get better, and you know that there are things you

can do to get better. There's medication to get better and time will help as well." So they were all very supportive immediately, almost to the point where I was like, "Stop it. I just want to complain for a second." But, there was no one that was like, you know, questioning why I felt this way or disbelieving me when I said I felt that way.

Madeline shared a similar story about disclosing her PPD to her spouse:

My husband, he's very, like, in tune with my mental health needs, given the historical anxiety and depression that I have felt. So, he was just very supportive and just like, you know, "Let me know what I can do, or if there's anything I can do to help you more," but he wasn't necessarily surprised.

Despite overwhelming positivity in close interpersonal relationships, some disclosees were worried for the mother's well-being. Tamara explained her family's response to her disclosure:

All of [my family members] were super positive. You know, they were super supportive of me, and of me getting help, but they were worried. They were definitely worried about me just because of the severity of the symptoms, and kind of realizing [what I was going through], kind of coming to a conclusion what was going on. I think that it was scary for them.

Dealing with any sudden illness can bring fear to those involved and those who interact with the individual dealing with the illness. Despite the worry, these mothers with PPD maintained that there was still positivity stemming from partners and close family and friends. The positivity helped them cope with the illness, by making them feel heard, understood, and loved.

Negative responses after disclosing PPD were not as common, because the mothers with PPD were selective about who they disclosed their illness to. If the mothers did not have a strong

relationship with the other individual, disclosure would not occur. Similarly, if the mother with PPD knew the disclosure could bring any negative effects, non-disclosure was practiced. Aysha explains that she had a positive experience when disclosing to her spouse and friends but avoided disclosure to her mother as she anticipated a negative response. She explained, “I don’t have a great relationship with my mom, so she would have been definitely someone that I wouldn’t go to for something like emotional support or anything like that.” Lauren shared a similar story of why she chose non-disclosure with her mother-in-law:

[My mother-in-law] loves the baby and I remind myself that she loves the baby, but I find her to be a little bit judgmental. I felt like if I told her, she would see it as me being weak as opposed to, I don’t know, being able to take care of me and the baby. She’s generally a very nice lady, but I’m not super comfortable with her talking about mental health.

Overall, mothers with PPD had mostly positive responses when disclosing their illness in close interpersonal relationships. The positivity can be explained, in part, due to the mothers being selective in who they disclose their illness to. The participants made it clear that if a negative response could happen, non-disclosure was chosen. By being selective in who to disclose to, many of the mothers were able to receive mostly positive responses, which helped them cope with their illness.

Patient-Provider Interactions

All the women interviewed had spoken to at least one medical professional about their struggles with PPD. After disclosing to medical professionals, those interviewed were able to receive help in numerous ways – whether receiving emotional support in the form of therapy or receiving medication to help minimize the symptoms. It is important to note, however, that receiving treatment for PPD was difficult for many women interviewed. Those who struggled to

receive help noted that they had the desire to speak to a medical professional but finding one in their area was a challenge. Robin explained her struggles to find a therapist: “I couldn’t find a therapist that was within my insurance network, that was close to home or close to work that would have been convenient, so I was like I don’t know what to do.” Millie shared a similar story about struggling to find a mental health professional:

I tried reaching out to get mental health help just because I have a history of depression, but I wasn’t able to find anything that would be able to take me within, like, a couple of months. I ended up having to reach out to, like, someone from the [Native American] health reservation and they said that they would see me even though I didn’t have any Native American blood, just so that I would be able to get some sort of assistance.

Freya also shared a similar story. Her OB doctor referred her to a therapist who specifically handled PPD. The therapist had a long waitlist. She received a call for treatment one year after putting in an inquiry for help. Many women interviewed expressed difficulty in finding someone who could diagnose and treat their PPD symptoms. Though eventually all participants were able to get help, many participants expressed the need for more mental health professionals to be readily available to help those struggling with potentially life-threatening illnesses, such as PPD.

After disclosing to a mental health provider, the mothers interviewed had mixed reactions. Most women interviewed had neutral experiences with their healthcare provider – the interaction wasn’t negative, but wasn’t necessarily positive, either. Lacey explained disclosing her PPD to her OBGYN:

[At] my six-week appointment, my OB, she asked, you know, “How are you doing?” And I was not doing well. I told her, “I think my baby [...] gets bathed more often than I do,” and her advice to me was, you know, “Go take a shower,” which is fine. They

referred me to [a local counseling center]. [...] I applied twice to talk to someone at [the counseling center] but they had such a volume of patients they're trying to get in that I've never heard from them again. So, my OBGYN's first line of defense for postpartum [depression] I never heard anything from.

Some women expressed that their medical professional brushed off their symptoms of PPD, leaving the participant to seek help on their own. Madeline explained that she works in a mental health facility, where participants are screened regularly for PPD. She scores the PPD scales frequently. When it came to be time for her to take the PPD questionnaire herself at her OBGYN office, she knew for a fact that she scored within the "danger zone" for PPD. The doctor at the office did not bring up the results of the questionnaire. "She just did my checkup and said 'Alright, well, see you in a year,'" Madeline explained. Fortunately, Madeline already had a therapist that she had seen in the past who she was able to discuss her PPD with. Millie shared a similar story of being "brushed off" by her OBGYN after disclosing her PPD symptoms:

The first medical person I really talked to was my OB and it was around my six-week checkup. At that time, I had already started to feel the symptoms, because I started feeling them about a month [postpartum]. I kind of just mentioned [the PPD symptoms] because, you know, they're kind of required to ask you those questions, and I'm like, "Yeah, you know, I don't think I'm feeling too well, but I'm not sure if it's, like [PPD] because I have no thoughts of, like, harming my child whatsoever," and she kind of just brushed it off. [...] I just don't feel like she was very personable.

Unfortunately, it was not uncommon for the mothers with PPD to not feel fully supported by their OBGYN. Many times, the women were referred to counselors or therapists after being

diagnosed with the illness. Though the women were able to receive the emotional support they needed through a therapist or counselor, many women expressed disappointment in not receiving more support after disclosing to their OBGYN. Phoebe shared her experience disclosing to her OBGYN:

I don't feel very supported, like I never felt supported by my OB besides, "Oh, here take some meds," but that's kind of [it]. I feel like that's all they know, is to prescribe meds. They don't really talk to you. They did say, "Go to counseling," but that's about it. I don't know, I was expecting a little bit more.

Though many women interviewed expressed overall, general positive experiences with some medical professionals, there weren't many positive experiences that stood out to the participants. Rather, more participants expressed frustration and disappointment in receiving medical assistance regarding PPD. Some women interviewed were, fortunately, able to receive help easily and had receptive and supportive medical professionals who were behind them, but overall, despite receiving help, many experiences with medical professionals were just average.

CHAPTER FIVE: DISCUSSION

Research Implications

This study explored several types of disclosure patterns and behaviors of women who have suffered from postpartum depression. The onset of symptoms and initial diagnosis can prompt a lot of uncertainty and stress. The uncertainty and stress are only heightened for those who are living with a stigmatized illness. Those who experience an illness that is stigmatized may experience negative effects on their mental and physical health and can be subjected to social disadvantages which can also lead to increased stress (Link & Phelan, 2006). Often, to overcome some health-related anxiety and to receive support, one must disclose one's illness to others. Disclosure is typically challenging due to the complex nature of some illnesses and fear of negative disclosure effects, which mostly occurs when an illness is stigmatized. When an individual has a stigmatized mental illness, social support is difficult to achieve, but research suggests that those who do disclose their illness receive more social support and, thus, are able to cope better with their illness (Chaudoir & Fisher, 2009; Mulfinger et al., 2019). The mothers interviewed in this study were aware of the stigma that surrounds PPD but chose to disclose to at least one other individual in hopes of receiving some sort of support, which they all mentioned that they did receive.

In this sample of mothers with PPD, the interviewees were selective in who they disclosed to and when they disclosed. This finding aligns with existing literature that states that individuals with a mental illness feel comfortable disclosing to some people but pick and choose to whom they are most comfortable disclosing (Taniguchi & Thompson, 2021). This study suggests that there are several reasons that women with PPD would disclose their illness to some and refrain from disclosure to others. Often, this decision is weighed for risks and benefits prior

to the disclosure itself, which CPM states is one of the influences of the act of disclosure (Petronio, 2002). Specific to workplace disclosure, current literature suggests that some are hesitant to disclose an illness due to fear of judgement (Peterson et al., 2011), but the results from the current study suggested a different, overriding motivation. Many women interviewed in this sample chose to disclose their PPD in the workplace as they thought it would bring benefits to them, like receiving social support and supporting others.

In an interpersonal, family communication context, the current findings suggest that disclosure would sometimes be avoided within the family if there were generational and/or cultural differences between the discloser and the disclosee. Non-disclosure in these situations was chosen due to the fear of judgement that the disclosure would bring. Additionally, participants expressed the fear of the disclosee not understanding the illness (due to the generational/cultural differences), which could also lead to judgement from the disclosee. Participants made it clear that if there were generational and/or cultural differences between the two parties, disclosure of the PPD would not be worth the troubles it could bring. CPM notes that when nondisclosure is chosen, it is usually dependent on context, culture, gender, and other factors (Petronio, 2002). These findings suggest that despite the desire to disclose, some mothers with PPD would choose nondisclosure because they felt as though challenges brought with the disclosure would be too difficult to maneuver, so not saying anything at all would be more beneficial to their well-being.

Disclosure of private information, like an illness, is often pre-planned, but many women in this sample stated that disclosure of their PPD was done by accident or unintentionally. CPM states that when disclosure happens by accident, or is done unintentionally, the receiver automatically establishes a boundary with the discloser. Furthermore, CPM states that a disclosee

who receives private information, but was not the intended disclosee, may feel responsible for preserving the information but will feel like there is less of an obligation to establish or negotiate privacy rules with the discloser (Petronio, 2002). In this sample, few recipients of unintentional disclosure received boundaries explicitly stated by the discloser, and none of the unintended disclosees further spread the information. In other words, in this study, those who were unintended disclosees of the private information did not try to establish a boundary regarding the information, nor did the discloser feel as though they needed to establish a boundary with the unintended disclosee. Still, though, the disclosee preserved the discloser's private information by not further spreading it.

Examining the data through CPM, one finding is particularly noteworthy. In this sample, often boundaries were not specifically articulated by women with PPD to limit the spread of their information. Rather, the boundaries were assumed. In other words, some women with PPD felt as though they did not need to tell their disclosees not to tell other people about the illness. Instead, the disclosers felt like the disclosees automatically knew that they should not speak to others about it, so protective boundaries were never verbally established. Since CPM is a rule-guided theory, this finding suggests that perhaps some of the "rule work" has been tested and established over the course of the relationship. The expectation in CPM that privacy boundaries are sometimes assumed rather than articulated was repeatedly confirmed in this study. CPM states when a disclosure initially happens, there is an "expected guardianship of the information" that is assumed by the discloser and the disclosee and then boundaries can be established, if both parties so choose (Petronio, 2002, p. 11). CPM also states that borderlines of boundaries are sometimes defined solely on the nature of the relationship. For example, a spouse or members within immediate family will know the boundaries of private information based on the

relationship alone and, for the most part, respect each other's private information. This tenet of CPM may explain why some mothers chose not to explicitly set up boundaries with those who were closest to them, like a spouse or a family member. Those who had boundaries that were assumed did not experience any boundary turbulence – the assumed boundaries were enough for disclosees to respect the discloser's private information. A few mothers who did explicitly set up boundaries experienced boundary turbulence. This finding may suggest that there may have been a history of failed negotiation in the relationship. The boundary turbulence was described by the mothers as an act of betrayal, which is an intentional rule violation as outlined by CPM (Petronio, 2002).

Finally, and importantly, the results in this study highlighted some challenges that women with symptoms of PPD experience when trying to receive a diagnosis of the illness. Specifically, there were concerns expressed with treatment received from obstetricians. Some women felt as though the disclosure of their symptoms were either dismissed or outright ignored. The lack of attentiveness or miscommunication could result in a delay of diagnosis, and as a result, a delay in treatment. Existing literature highlights the communication difficulties in patient-provider interactions, which can have negative implications on one's health (Pinto-Foltz & Logsdon, 2008; Sparks & Villagran, 2010). Specific to obstetrician-patient relationships, this study adds to existing literature which demonstrates that current postpartum care needs more physician-guided support (Sega et al., 2021). When patient-provider interactions are strong, medical treatment is more effective (Neumann et al., 2010). It is important that patient-provider interactions, specifically with women with PPD symptoms and their OB, are improved to help these women receive adequate treatment to ensure good health of the mother and the baby.

Limitations and Future Research

The current study is not without its limitations. First, this study had a relatively small sample size, which may affect the transferability of the results. Moreover, the sample recruited was highly educated, with most of the participant's holding a bachelor's degree or higher, and mostly white. In other words, this was a relatively privileged sample. Future research should expand the sample size to account for a greater range of educational and socio-economic status. Furthermore, recruitment for this study was primarily done through social media. The social media groups that were chosen were specifically for mothers in the postpartum phase and for those who have experienced PPD. Thus, the mothers who participated in this study are already comfortable with disclosure to some extent, simply by being active on the social media groups. Future research could employ alternate recruitment methods to reach mothers who may not be as open with disclosure.

Finally, future research should examine mothers' disclosure to a doctor or other medical professional more closely. The current study demonstrated the need to examine and understand mothers' and obstetricians' relationships better. Specifically, future studies should examine obstetricians' responses to PPD symptom disclosure.

Conclusion

Postpartum depression is a mental health illness that can severely impact parenting for new mothers. The complications of the illness, coupled with the stigmatization of the illness from society, makes coping with the illness extremely difficult. One method to cope with the illness and receive social support is through disclosure of the condition. The decision to disclose is often made on a case-by-case basis and is dependent on several factors like culture, context,

and a risk/benefit ratio. These considerations helped to determine the decision to disclose, the disclosure timing, and the disclosees themselves. Despite the difficulties associated with disclosing a stigmatized mental illness, most mothers in this sample had positive experiences when disclosing. Overall, the mothers interviewed agreed that disclosure of the illness has been beneficial to their lives and recommended that other mothers with PPD disclose to someone they trust. These women's narratives of their experiences with PPD help provide insight into disclosure behaviors and patterns, as well as effects of disclosure of women with the illness.

APPENDIX A – RECRUITMENT POSTING

Women with history of postpartum depression symptoms needed for research!

Principal investigator, Kelsey Lunsford, and faculty supervisor, Dr. Ann Miller, with the University of Central Florida are currently recruiting participants for a study regarding postpartum depression. We are interested in learning about how mothers with postpartum depression symptoms make decisions about who to tell and who not to tell about their condition.

We want to hear your story regarding your disclosure process of the symptoms you have endured!

If you are chosen to participate in this study, you will be required to attend a 30–60-minute recorded Zoom interview. Participants will be asked questions regarding disclosure of postpartum depression. You will be given a pseudonym and your information will remain confidential.

You may be eligible if:

- You currently have postpartum depression symptoms
- You have had postpartum depression symptoms within the past five years
- You are over 18 years of age
- You are a woman

Please complete this brief questionnaire on the following link if interested. The principal investigator will reach out to you to schedule your interview. We thank you for your time!

APPENDIX B – EXPLANATION OF RESEARCH



EXPLANATION OF RESEARCH

Title of Project: Postpartum Depression Symptoms in New Mothers and the Disclosure Process

Principal Investigator: Kelsey Lunsford

Faculty Supervisor: Dr. Ann Miller

You are being invited to take part in a research study. Whether you take part is up to you.

The purpose of this study is to determine the disclosure process of women suffering from postpartum depression (PPD) symptoms.

You will be asked questions regarding disclosure of postpartum depression symptoms and a few demographic questions. Interviews will be scheduled and will take place over Zoom and will last 30-60 minutes. The Zoom interview video and audio will be recorded. For your confidentiality, you will be assigned a pseudonym. After the interview, the recordings will be kept in a secure location until data interpretation is complete. Only the principal investigator and faculty supervisor will have access to the recordings. All data will be stored for a minimum of 5 years after study closure.

Your participation in this study is completely voluntary and confidential. Your answers will be recorded by the research team and used for educational research purposes. There are no foreseeable risks or participant discomfort associated with participating in this study.

Your participation in this study is voluntary. You are free to withdraw your consent and discontinue participation in this study at any time without prejudice or penalty. Your decision to participate or not participate in this study will in no way affect your relationship with UCF, including continued enrollment, grades, employment or your relationship with the individuals who may have an interest in this study.

You must be 18 years of age or older to take part in this research study and must currently have postpartum depression symptoms or have had postpartum depression symptoms within the past five years. A formal diagnosis is not required for this study.

Study contact for questions about the study or to report a problem: If you have questions, concerns, or complaints please contact Kelsey Lunsford, Principal Investigator, at kelsey.lunsford@ucf.edu or Dr. Ann Miller, faculty supervisor at ann.miller@ucf.edu

IRB contact about your rights in this study or to report a complaint: If you have questions about your rights as a research participant, or have concerns about the conduct of this study, please contact Institutional Review Board (IRB), University of Central Florida, Office of Research, 12201 Research Parkway, Suite 501, Orlando, FL 32826-3246 or by telephone at (407) 823-2901, or email irb@ucf.edu.

ATTENTION: This survey contains questions that may cause you to reflect on past emotional events. If answering these questions has caused you to experience any kind of distress or made you feel uncomfortable in any way, please contact the:

- National Postpartum Depression Warmline: 1-800-773-6667
- National Suicide Prevention Lifeline: 1-800-273-8255

Please keep a copy of this consent form for your records.

APPENDIX C – INTERVIEW QUESTIONS

1. Please tell me about when you experienced symptoms of postpartum depression for the first time. What were the symptoms? How long did the symptoms persist before you made the connection to postpartum depression?
2. When you realized you were struggling with PPD symptoms, who did you first tell about your symptoms, and why?
3. How did you tell these individuals about your symptoms? (e.g., Did you tell them face-to-face? Over text/phone call? Did someone else tell them for you?) How long after the symptoms began did you begin to disclose your symptoms? Did you make any requests for them not to share about your PPD with others? Why/why not?
4. Did the people you told adhere to your request about who to tell or not to tell? How?
5. Were there any individuals in your life where you knew you did NOT want your struggles to be known to? If so, who and why?
6. If you were employed at the time you were struggling with postpartum depression, did you make your illness known to anyone in the workplace? If yes – how did the person/people you told respond? In what ways was the disclosure a good thing? Were there any “down sides” to your disclosure? If no, what were your reasons for or against disclosure in the workplace? If you disclosed to someone at your workplace, what did you ask them to do about keeping your information secret, or not?
7. What kinds of responses did you get after disclosing your struggles? (e.g., How did your spouse/partner respond? How did your family respond? How did friends respond?) Did they keep your information as private as you wanted them to?

8. Did you have any bad experiences (beyond any already mentioned) as a result of disclosing about PPD? If so, can you tell me a story of what their response to you has been like?
9. How do you believe disclosure of your symptoms, in general, has been beneficial and/or detrimental to your life?
10. If you chose not to disclose to someone, did you regret the decision? Why or why not?
11. Did you ever speak to a medical professional about your symptoms? How did the medical professional respond?
12. Based on your experience, what advice would you give to another mom about disclosing about PPD?

APPENDIX D – DEMOGRAPHIC QUESTIONS

1. What is your ethnicity?
 - A. American Indian or Alaskan Native
 - B. Asian
 - C. Black or African American
 - D. Hispanic/Latino
 - E. Native Hawaiian or Other Pacific Islander
 - F. White
 - G. Multiple

2. What is your age?
 - A. 18-29
 - B. 30-39
 - C. 40-49
 - D. Over 50

3. What is the highest level of education you have completed?
 - A. High school degree or GED
 - B. Associate's degree
 - C. Bachelor's degree
 - D. Master's degree
 - E. Doctorate
 - F. Other

APPENDIX E – IRB APPROVAL LETTER



UNIVERSITY OF CENTRAL FLORIDA

Institutional Review Board
FWA00000351
IRB00001138, IRB00012110
Office of Research
12201 Research Parkway
Orlando, FL 32826-3246

EXEMPTION DETERMINATION

January 12, 2022

Dear Kelsey Lunsford:

On 1/12/2022, the IRB determined the following submission to be human subjects research that is exempt from regulation:

Type of Review:	Initial Study
Title:	Postpartum Depression Symptoms in New Mothers and the Disclosure Process
Investigator:	Kelsey Lunsford
IRB ID:	STUDY00003610
Funding:	None
Grant ID:	None
Documents Reviewed:	<ul style="list-style-type: none"> • HRP-251, Category: Faculty Research Approval; • Demographic Questions , Category: Survey / Questionnaire; • Eligibility Questions Recruitment, Category: Other; • HRP-254, Category: Consent Form; • HRP-255, Category: IRB Protocol; • Interview Questions , Category: Interview / Focus Questions; • Recruitment Posting, Category: Recruitment Materials;

This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made, and there are questions about whether these changes affect the exempt status of the human research, please submit a modification request to the IRB. Guidance on submitting Modifications and Administrative Check-in are detailed in the Investigator Manual (HRP-103), which can be found by navigating to the IRB Library within the IRB system. When you have completed your research, please submit a Study Closure request so that IRB records will be accurate.

If you have any questions, please contact the UCF IRB at 407-823-2901 or irb@ucf.edu Please include your project title and IRB number in all correspondence with this office.

Sincerely,

APPENDIX F – IRB MODIFICATION APPROVAL



UNIVERSITY OF CENTRAL FLORIDA

Institutional Review Board

FWA00000351
IRB00001138, IRB00012110
Office of Research
12201 Research Parkway
Orlando, FL 32826-3246

EXEMPTION DETERMINATION

January 24, 2022

Dear Kelsey Lunsford:

On 1/24/2022, the IRB determined the following submission to be human subjects research that is exempt from regulation:

Type of Review:	Modification / Update
Title:	Postpartum Depression Symptoms in New Mothers and the Disclosure Process
Investigator:	Kelsey Lunsford
IRB ID:	MOD00002550
Funding:	None
Grant ID:	None
Documents Reviewed:	• HRP-255, Category: IRB Protocol;

This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made, and there are questions about whether these changes affect the exempt status of the human research, please submit a modification request to the IRB. Guidance on submitting Modifications and Administrative Check-in are detailed in the Investigator Manual (HRP-103), which can be found by navigating to the IRB Library within the IRB system. When you have completed your research, please submit a Study Closure request so that IRB records will be accurate.

If you have any questions, please contact the UCF IRB at 407-823-2901 or irb@ucf.edu Please include your project title and IRB number in all correspondence with this office.

Sincerely,

Kamille Birkbeck
Designated Reviewer

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