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Beth Sadavoy
“Bearing the weight of a
mother’s mood”: Does a
history of depression
influence a woman’s attitudes
about having children?

ABSTRACT

This study attempted to answer the question of whether there is a relationship between a woman’s history of depression and her feelings and attitudes about having children. No research has been done on this precise topic; therefore this study was also intended to ascertain whether this issue was substantial enough to warrant further research and investigation.

A mixed method online 16-item questionnaire was completed by 66 participants, 60 of whom met inclusion criteria and were included in the findings. Two qualitative questions were included in order to illuminate the quantitative data. Participants were asked about their experience with depression, interest in having children, whether depression impacted their feelings about having children and if so, in what way.

Study participants were significantly depressed or had experienced significant depression, with 95% of participants affirming that their depression had interfered with their functioning and impacted their quality of life.

The resulting data was mixed. The responses of approximately half the women surveyed supported a clear link between a history of depression and concerns about having children. A substantial number of participants indicated that their depression made them reluctant to become pregnant, though 85% of respondents affirmed that they would like to have children at some point in their lives. The findings indicate that this is a

vital issue for some women and impacts attitudes and feelings about having children for a substantial percentage of the population surveyed.

“BEARING THE WEIGHT OF A MOTHER’S MOOD”: DOES A HISTORY OF
DEPRESSION INFLUENCE A WOMAN’S ATTITUDES ABOUT HAVING
CHILDREN?

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work

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2008

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CHAPTER I
INTRODUCTION

“Depression Is Not the Soul’s Annihilation” – William Styron

The purpose of this study is to investigate whether or not there is a relationship between a history of depression and a woman's decision to have children. I began by examining prior research on the effects of postpartum depression on women, the relationship between previous episodes of depression, and postpartum depression. Through this investigation, I discovered the vast amount of discourse and research on postpartum depression. Certain aspects of postpartum depression are well identified, including that women may be afraid of passing on genetic vulnerability to children, afraid of harming their children or themselves, and that a history of depression increases a woman’s chances of developing postpartum depression (Bernazzani, Saucier, David and Borgeat, 1997). Using this information, I formulated the following research question: Given the damaging effect of postpartum depression on both women, children and families, does a history of depression influence women’s feelings about having children?

Depression affects a significant portion of the population both in Canada and in the United States. The National Institute of Mental Health (NIMH) states that major depressive disorder affects approximately 14.8 million American adults, or about 6.7 percent of the U.S. population age 18 and older in a given year. Women in particular are

greatly affected by depression. According to Statistics Canada, women experience depression at almost twice the rate of men and the NIMH affirms that 12 percent of women in the United States are affected by depressive disorders. The NIMH also estimates that 10 to 15 percent of women experience postpartum depression after giving birth and many of these cases go undetected.

While there is a wealth of information regarding postpartum depression, there is almost no research examining the impact of a previous depression on a woman's feelings about having children. This lack of information extends to women's decision-making around pregnancy and childbirth regardless of mental health issues. In fact, I did not come across a single study that focused on this topic. The lack of research in this area clearly points to a need for further exploration and investigation.

The findings of this study may be useful to mental health professionals and physicians working with women who have a history of depression and are considering having children. Clinicians would have more insight into the possible feelings and concerns of this population regarding decision making and childbirth as it pertains to their history of depression. Ideally, information gleaned from this study will help to inform and enhance the service provided to this group of women.

For this study I used a quantitative research design. I created a 16-item online questionnaire focused on the experiences of women with a history of depression who may be considering having children as first time mothers. I included two qualitative questions in the survey in order to inform the quantitative data and gain a more complete understanding of women's attitudes, feelings and reactions. I utilized snowball sampling methods and applied to potential respondents using online networking sites such as

Facebook and through email contacts. Using this questionnaire, I surveyed women who had not yet had children and who had experienced a significant depression at some point in their lives. This was done in order to try to determine whether a history of depression impacts women's feelings about having children and if so, in what way.

Despite the lack of research done in this area, there is evidence that the connection between depression and childbearing is of concern to many women. This is exemplified by a recent article in *The New York Times Magazine*. The author, Lauren Slater (2007), wrote about her experience with depression and what it may mean for her children. She wrote: "I was concerned about the depression that ran in my gene pool, but I also worried about things that were more nurture than nature, like having a child who bears the weight of her mother's mood" (Slater, 2007, p.32). My hope for this research is that it will assist clinicians to better serve women who may be struggling with one of the most important decisions of their lives. It may shed light on a problem that has remained unexamined, unexplored and untreated and inspire further research on this vital topic.

CHAPTER II

LITERATURE REVIEW

“Without the mother, there is no such thing as a baby” – D.W. Winnicott

Introduction

Winnicott, among others, explored the nature of the relationship between mother and infant. He developed the concept of the “good enough mother” – highlighting the notion that while no mother is perfect, she may provide “good enough” care, support, and love to her infant, thereby creating a safe environment and secure bond for the infant to grow. However, what happens when the mother is unable to provide the necessary environment for her child? “It is when there is a breakdown of the natural protective forces that one notices how vulnerable the mother is” (Winnicott, 1965, p. 23).

The link between depression and motherhood has been explored in the literature from the perspective of women who are already pregnant or have already given birth. Specific issues surrounding motherhood and depression have been studied extensively, including the nature of the relationship that develops between a depressed mother and her infant, the relationship between prior depressive episodes and postpartum depression, treatment and intervention strategies for depression during pregnancy and postpartum depression. However, little seems to be known about attitudes towards childbearing for women who have experienced depression and do not yet have children. This review

examines the literature with the focus on answering the question of how a personal history of depression might influence a woman's decision to have children.

This chapter examines the link between depression and attachment, early-parenting and decision-making through the work of theorists such as Bowlby, Ainsworth, Main, Fonagy and Winnicott. The review also outlines the importance of women's attitudes towards childbearing and highlights key themes by exploring the topics of epidemiology, mental and emotional disturbances during pregnancy, decision making, effects of postpartum depression and interventions. I also begin to examine a connection between attachment theory, depression, and motherhood.

I attempted to uncover literature dealing more specifically with women's feelings about having children in relation to a history of depression: however I did not find any literature on this exact topic. PsychInfo was the primary search engine for the literature search together with databases geared more specifically to women's issues including Medline Plus, MayoClinic and Health Reference Center. Search terms employed were: women, pregnancy, postpartum, depression, anxiety, decision-making, childbirth, childrearing, motherhood, children, kids, choice, choices, concerns, affects, affect regulation, attachment, attachment style, object relations, and any combination thereof. I found that for the most part, aside from statistical data, none of the databases apart from PsychInfo yielded relevant articles. Nevertheless, I was able to examine a substantial amount of literature on more general related subjects such as effects of post partum depression, interventions and treatment for depression and postpartum depression, treatment of depression during pregnancy, statistics about depression, women, and number of women who decide to have children.

Epidemiology

Depression

In order to fully understand the extent of the problem of depression and the decision to have children, it is important to examine the effects of depression in general and the epidemiological factors associated with mental illness and childbearing.

Depression is an illness that affects a large percentage of the population worldwide. The World Health Organization predicts that depression will be the number one disease in the world by 2012 (Bonari, et al., 2005). Since women are more often diagnosed with depression compared to men, the majority of these cases will be diagnosed in women.

In an attempt to uncover whether depression plays a role in a woman's decision to have children, I examined general statistics regarding women and childbearing to see if there may be a clue as to why women may or may not choose to have children. According to the U.S Census Bureau, 44.6% of women between the ages of 15 and 44 were childless in 2004. (U.S Census Bureau). Hence a large number of women in North America are making the conscious choice to remain childless and many women are also choosing to have children later in life (Gillespie, 2000). This can lead to problems with infertility, since it has been proven that fertility declines with age (Gillespie, 2000). Despite the rise in infertility, I decided not to examine infertility as a decision-making factor. Women who are trying to decide about pregnancy when they are infertile are also faced with the possibility of having to make alternate choices surrounding children such as fertility treatments and adoption. In examining issues surrounding infertility it seemed clear to me that while these issues are important in themselves, they add an extra layer of

complication in women's decisions to have children which would obscure rather than extend the knowledge about motivation associated with depression.

Mental Illness

Mental illness is the leading cause of disability in the United States and Canada for people between the ages of 18-44, with major depressive disorder being the number one leading cause of disability (Stewart, 2006). Women develop depression at a far greater rate than men and are believed to have an increased risk due to distinctive biological, psychosocial and cultural factors (Nolen-Hoeksema, 1987). Previous incidents of depression in women can also increase their susceptibility to depression during pregnancy and in the postpartum period (Bernazzani et al., 1997).

Mental and Emotional Disturbances During Pregnancy

A significant number of new mothers are affected by postnatal depression. As many as 8%-15% of mothers experience postnatal depression and many others will suffer milder or less enduring depressive symptoms (Feeney, Hohaus, Alexander & Noller, 2003).

Attachment, Relationship and Depression

For the purposes of this paper, I will examine the effect of early attachment relationships on later attachment styles and the possible link between attachment style and depression.

John Bowlby (1982) described attachment as a dependable, consistent connection provided by a parent to a child that allows the child to experience a sense of safety and security. The sense of security felt by the child allows him or her to explore their environment and engage with the world around them. The attachment style of the child,

which is formed by early childhood experiences with trusted caregivers, can influence the development of emotional attachments both in the early years and throughout the child's life (Buist, 2002).

I will begin by discussing the main theorists who contributed to Attachment Theory, including John Bowlby, Mary Ainsworth, Mary Main and Peter Fonagy.

John Bowlby believed that attachment is a biological need of the infant. According to Bowlby (1969), a strong attachment relationship to a caregiver is vital to babies' emotional and physical development and even to their very survival. Ainsworth noted the importance of nonverbal communication in the attachment relationship. She held that non-verbal communication has a profound impact on the way in which an infant relates to and makes sense of his or her own feelings (Ainsworth, Blehar, Waters & Wall, 1978). Ainsworth also developed what she termed the "Strange Situation", in which she placed children in various situations in order to assess their attachment and separation behavior (Ainsworth & Wittig, 1969). Main examined the importance of these early non-verbal communications. She theorized that these communications lead to internal representations that influence behavior and emotional responses as the child grows into adolescence and adulthood (Main, Kaplan, & Cassidy, 1985). Fonagy, along with Main (1991), revealed that a secure early attachment had an impact on attachment quality in later life. They also demonstrated that secure attachment influenced an individual's ability to establish a secure bond with their own children (Fonagy, Steele, & Steele, 1991). Finally, Winnicott believed that infants need to feel a sense of security from a caregiver who is able to manage successfully in the world (Winnicott, 1965).

A large amount of work has been done regarding the relationship between insecure attachment and depression (Scharfe, 2007). The development of depression has been connected with both inadequate child-rearing experiences and insecure attachment (Scharfe, 2007). According to psychodynamic theory, depression is connected with early frustration and deprivation of needs by primary love objects (Acklin, Sauer, Alexander & Dugoni, 1989). Bowlby suggests that "emotionally significant bonds between individuals have basic survival functions and therefore a primary status" (Bowlby, 1988, p.2). Since there appears to be a link between depression and attachment style, depression and negative impacts on pregnant women, and postnatal depression and harm to the mother and infant, it stands to reason that women could be more likely to be fearful, anxious or worried about becoming pregnant if they have experienced depression in the past.

Depression is linked with insecure attachment and insecure attachment is linked to poor early parental experiences. Winnicott and Fonagy (1965, 2001) reason that initial attachment relationships are created based on a need for protection from someone who is able to manage in the world (Blatt & Maroudas, 1992). The child may develop an internal working model based on early interactions where he or she experienced a sense of safety and security, or lack thereof. These working models eventually become fixed and impact the individual's way of relating to the world (Brisch, 2002). Insecure attachment is a manifestation of impaired early parental experiences (Winnicott, 1965). Similarly, internalized identifications of parenting images may be distorted in individuals who have had poor or impaired parenting themselves (Brisch, 2002). A lack of protection and sense of safety can negatively impact one's sense of the world as an adult.

Fonagy (2001) also notes the relationship between parental nurturance and attachment. “Maternal caregiving makes a clear contribution to attachment security. In particular, maternal sensitivity, responsiveness to distress, moderate appropriate stimulation, interactional synchrony and warmth, involvement, and responsiveness have all been demonstrated to be predictors of attachment security” (Fonagy, 2001, p.25-26).

This can be manifested in various ways. One important marker is the nature of attachment in such individuals. Attachment may be anxious or insecure and can encompass a number of different traits including temperamental difficulty, negative reactivity, fear, preoccupation and dismissiveness (Fonagy, 2001). A woman who is considering motherhood may be affected in her thinking by her internalized self-concept. If a woman was poorly parented as a child, she may have internalized a negative parental object and negative relationship schema (Acklin, Sauer, Alexander, & Dugoni, 1989). She may have been deprived of a secure holding environment and hence may lack object constancy and may have been deprived of a secure holding environment. “Along with the recognition of the whole object comes the beginning of a sense of dependence, and therefore the beginning of the need for independence. Also, the perception of the dependability of the mother makes possible the existence of the quality of dependability in the infant” (Winnicott, 1965, p. 14).

A woman’s ability to view herself as a competent, capable mother may be impacted by not having had a model on which to base her own concept as a mother. If a woman grew up with a negative self-image/self-concept/self esteem, she could become depressed as a result. Her negative self-concept could affect her confidence in areas of

intimate intense relationships such as mothering a child as well as her sense of worth as a parent.

Winnicott stressed the importance of the mother-infant dyad. He discussed the importance of object relating between the mother and the infant. “These very primitive matters get started up when the mother, identifying with her infant, is able and willing to give support just when it is needed” (Winnicott, 1965, p.26). If a woman was neglected as an infant and developed an insecure attachment to her own mother, this may have caused her to become depressed. In thinking about becoming a mother herself, she may have unconsciously disconnected herself from the painful memories of having been poorly parented and instead see herself as someone who is unable to effectively parent a child.

Depression as Related to Maternity

A number of factors seem to be associated with emotional difficulties during pregnancy including a past history of psychiatric illness (Bernazzani et al., 1997). Bernazzani et al., in an empirical quantitative study, examined the implications of women’s fears around pregnancy. The authors hypothesized that fears would be related to factors such as psychiatric history. “More specifically, we theorized that depressive symptoms would influence the level of ambivalence and fears [related to maternity]” (Bernazzani et al., 1997, p. 392). While this is a useful theoretical approach regarding the possible impact of depression on women who are not yet pregnant, including the impact on their worries and ambivalence about pregnancy and motherhood, Bernazzani et al., for the most part, discuss the impact of psychiatric history and environmental stressors on

women who are already pregnant as opposed to women who are in the process of making a decision about motherhood.

According to Wisner et al., women of childbearing age frequently suffer from major depression with rates ranging from 10% to 25% in women between the ages of 25 and 44 (Wisner, Zarin, Homboe, Appelbaum, Gelenberg, Leonard & Frank, 2000).

Hart and McMahon examined the relationship between mood and maternal identity in the adjustment to pregnancy and motherhood (Hart & McMahon, 2006). “The formulation of a maternal identity is interwoven with the process of developing an emotional tie to the child and it is believed that both processes begin during pregnancy and continue after birth” (Hart and McMahon, 2006). They stated that “mothers who do not develop a maternal identity during pregnancy are less likely to develop positive feelings about the fetus or come to terms with the pregnancy and the demands of the mothering role” (Hart and McMahon, 2006).

Object relations theory, specifically as articulated by Winnicott, stresses the importance of being able to create a secure holding environment for infants. A holding environment is created when the infant receives enough care and attention from the parental figure. If the mother is unable to develop positive feelings for her infant, it will likely be difficult for her to create and maintain a secure environment for that infant. “It is interesting to consider that the way people adjust to stressful life events may leave residual effects when they cope and adjust to subsequent life events of a similar nature” (Lydon, Dunkel-Schetter, Cohan & Pierce, 1996, p.150). Women who experienced depression at some point in their history may have a more significant negative response to re-experiencing depression when they are pregnant or have a child.

In an empirical, quantitative study, Brockington et al. discuss the role of anxiety disorders in pregnancy and the frequency of post-traumatic stress disorder (PTSD) that can occur for women as a result of a traumatic childbirth (Brockington et al., 2005). Despite the claim that anxiety plays a significant role in postpartum distress, I have chosen to remain focused on depression for the purpose of this study due to my sense from the literature that depression is more widely recognized as a potential difficulty for women. I therefore believe it is more likely that women who are choosing whether or not to have children are liable to be more preoccupied with the possibility of experiencing depression as opposed to anxiety.

In summary, the literature supports the presence of an important and complex interaction between the early life experience of a mother and her subsequent capacity for attachment. Poorly formed attachment, in turn, may increase both the possibility of experiencing depression during pregnancy and a woman's reaction to such an experience. A woman who has had prior depression seems more likely to have a conflicted view of herself, motherhood, and her own mothering capacity. It would not be surprising therefore that such women would have conflicted feelings, or perhaps negative feelings about becoming pregnant and having children.

Decision Making

Eija Sevon states "more than a destiny, motherhood has become a choice, a possible way of life" (Sevon, 2005, p.461). In an empirical, qualitative study, Sevon examines the experience of four pregnant women and their decision to become mothers. Sevon looks at this issue from a feminist perspective and clearly states that various factors impacting the transition to motherhood, such as fears concerning the well-being of

the unborn child have not received enough attention (Sevon, 2005). According to Sevon's findings, timing and the quality of the relationship between partners was crucial to a woman's choice to have a child (Sevon, 2005). This is a very small sample which limits the generalizability of the study so the results can be taken only as heuristic. Nonetheless, these are useful insights into the decision-making processes of women who are already pregnant and the author also points to a need for more in-depth research to be done around the transition to motherhood.

Akker (2005) in a brief review paper, refers to studies in which personal fulfillment was cited as the main reason couples choose to have a child. The author also addresses the impact of this reasoning on new mothers, stating that some women who seek fulfillment from motherhood experience negative emotionality during pregnancy (Akker, 2005).

Langdridge, in an empirical study, reported that the main reasons expectant couples wanted to have children were "to give love", "enjoyment", and "a part of both of us" (Langdridge, 2000, p.7). Motivations to have children include personal fulfillment and shared experience. But these expectations are not always met which can lead to disappointment and depressive feelings. The presence of prior depression may also impact the ability of women to imagine themselves in these idealized scenarios. This is supported by a more general idea of depression. Depression may cause an increased sense of risk which may lead to atypical decisions (Pietromonaco et al., 1987).

There is also evidence to suggest that depression can increase the level of regret one feels after making a decision (Monroe, Skowronski, Macdonald, & Wood, 2005). Depression is believed to bring about a general negativity (Stone, Dodrill, & Johnson,

2001) which could impact decision making and perceptions of the future. It is well known and well recognized that depression can lead to social withdrawal (DSM – IV). Depression also distorts ideas of self, other (i.e., the world) and the future. Pietromonaco and Rook, in an empirical, quantitative study, assert that people experiencing depression are more apt to make decisions that lead to greater social isolation and withdrawal (Pietromonaco & Rook, 1987).

Psychodynamic theory views depression as a maladaptive response to significant stressors such as anxiety (Milgrom & Beatrice, 2003). In their empirical, quantitative study, Milgrom and Beatrice (2003) state, “according to both cognitive and psychodynamic theory, a person’s habitual way of processing information and responding to stressors can represent an important vulnerability factor leading to depression in the presence of stressors” (Milgrom & Beatrice, 2003, p.282). Blatt and Maroudas (1992) affirm that significant disruptions in interpersonal relationships and in the establishment of a positive sense of self result in depression. Beck (1967) discussed what he termed a “negative cognitive triad”, meaning that a depressed individual views experiences in a negative manner and anticipates unhappiness and hardship. As a result, relationships can become distorted. The implication of this theory could result in women asking themselves, “If I am a mother, how will I interact and manage with my child? How will I manage the relationship?”

Effects of Postpartum Depression and Interventions

Peindl, Zolnik, Edmund, Wisner and Hanusa (1995) examined the relationship between postpartum depression and family planning for women who already had children and whether action was taken to prevent further children. The authors found that 32% of

the subjects altered their plans to have children after experiencing postpartum depression (Peindl, et al., 1995). Reasons for altering family planning included fear of recurrence, effects of the illness on both the family and the baby, and cost of treatment. They also indicated that an increased awareness of postpartum disorders and the types of treatment available are vital in order to help women make decisions about family planning (Peindl, et al., 1995). This study clearly illustrates the profound impact that a depressive episode (in this case in the postpartum period) can have on a woman's view of herself and her future. Women may have more trouble viewing themselves as a capable parent and be unable to effectively take on maternal responsibilities (Hart & McMahon, 2006). This could directly impact a mother's ability to bond with her child, especially if she begins to develop a negative attitude towards her newborn as a result of postnatal depression (Hart & McMahon, 2006).

Murray, Cooper, Wilson and Romaniuk also examined the effect of postpartum depression on the relationship between the mother and child and assert that postpartum depression has a harmful effect on both the relationship between the mother and child as well as on the emotional development of the infant (Murray, et al., 2003). Buist, Ross, and Steiner point to the harmful effects of mental illness in both pregnancy and postpartum depression on women, familial relationships and on the newborn infant (Buist et al., 2006). Many women either do not recognize their symptoms as abnormal in the postpartum period, or they neglect to seek treatment due to feelings of shame or fear (Buist, et al., 2006). Perinatal depression is also severely under diagnosed (Buist et al., 2006).

Many women remain hesitant about using antidepressant medication during pregnancy and many healthcare providers continue to be reluctant to prescribe antidepressants during pregnancy despite evidence that this medication is relatively safe (Bonari, et al., 2005; Thomas, S.P., 2005). In fact, women who discontinue use of antidepressants during pregnancy have a significantly greater risk of relapse (Cohen, Altshuler, Harlow, et al., 2006). Bonari et al. found that women's fears about antidepressants were influenced by advice from family and friends, the Internet, and the order in which advice was dispensed (Bonari, et al., 2005). The authors also found that women were far more likely to stop taking antidepressant medication than other types of medication such as antibiotics (Bonari, et al., 2005). It leads me to question whether women's beliefs about antidepressants being harmful have an impact on their feelings about becoming pregnant, especially if they are currently taking or have taken antidepressants. Do women consider the risks of ceasing their antidepressant medication? Are women provided both the benefits of continuing with their antidepressants as well as the risks? Are they informed that there are substantial risks associated with prenatal and postpartum depression as well, including risk to the fetus and infant? (Bonari, Pinto, Ahn, Einarson, Steiner & Koren, 2004). This evidence points to a need for further education for women who are pregnant or are considering becoming pregnant. I also wonder whether women's emotional states are given the credence they deserve by health professionals and whether there is an awareness by the health profession of the impact of depression on the mother, the infant and the family system.

Murray et al. point to a number of potentially helpful interventions for postpartum depression including supportive counseling, CBT and brief psychodynamic

psychotherapy, with non-directive counseling and CBT being the most beneficial (Murray, et al., 2003).

Since my research will examine the effects of previous depressive episodes on women who have not yet given birth, I do not consider treatment for postpartum depression a significant factor in determining the answer to my particular hypothesis. However, available treatment options may impact women's feelings and possible concerns about pregnancy and motherhood. It could be important to examine the actual treatment options for postpartum depression and compare them to what women perceive to be options for treatment which could be an area for further exploration.

Summary

After reviewing the literature, it is clear that there is a wealth of literature on maternal and infant health, and maternal mental health issues including women's experiences with depression during pregnancy, postpartum depression, intervention and treatment options for women experiencing depression and anxiety during pregnancy, and the effects of depression on the mother-infant relationship including the impact on mother-infant attachment and object relations. The amount of research done in this area leads me to believe that depression and child-bearing are central and essential areas of study.

After reviewing the literature, it has become evident that women who suffer from depression may have also suffered from poor parenting as infants and lacked the opportunity to form strong attachment relationships to their own caregivers. Since depression and negative early attachment relationships are linked, it could be that women who experience concern over their ability to be effective parents are in fact unconsciously

experiencing a fear or worry over their ability to attach to their children and provide the type of care they themselves did not receive.

However, despite the abundance of research done in this area, and despite statistics that illustrate the increased risk of postpartum depression for women who have suffered a previous depression, I have not, to date, uncovered any literature on the topic of the relationship between depression and women's attitudes towards having children. This is a clear gap in the research and literature which leads me to believe that this is a subject worthy of further exploration and study. The lack of research done in this specific area is surprising considering the rising incidence in depression among women and the population in general, and the growing focus on maternal and infant mental health. Women considering motherhood who have suffered from depression would likely benefit from research in this area, particularly if this research leads to further understanding and insight by medical doctors, mental health professionals, families and women themselves.

CHAPTER III

METHODOLOGY

“Not life, but good life, is to be chiefly valued” – Socrates

I would like to answer the question: Does a history of depression influence women’s feelings about having children? Specifically, given the damaging effect of postpartum depression on both women, children and families, does a history of depression influence women’s feelings about having children? I would also like to examine whether a history of depression is associated with increased fear of postpartum depression. This chapter discusses the research design, sample population, procedure and data collection, method, ethics and safeguards, and data analysis procedures.

Research Design

Almost no research has been done regarding the particular question of whether a history of depression impacts women's feelings about having children. Therefore, I chose to use a quantitative research method in order to try and glean as much initial information as possible regarding this issue. My hope is that by exploring this issue more broadly and attempting to gather as many responses as possible up to a maximum of 100 using a quantitative online survey, I may be able to shed some light on the significance of this issue and demonstrate a need for further examination and study. However, I also recognize the depth of understanding that can come from qualitative research and how

crucial that can be when beginning to explore an issue such as this one. Therefore, I chose to include two open-ended questions in order to yield more detailed and personalized accounts of the experiences of the women who participate in this study.

Sample

I used a mixed method online 16-item survey to gather information. 14 questions were multiple choice and two were open ended, fill-in-the-blank questions for participants to include more detailed thoughts and/or reactions.

Inclusion criteria for the study involved women who were between the ages of 20-35, have no children, are not currently pregnant, have never given birth and are able to read and write in English. Participants must have either been previously diagnosed with depression by a therapist or medical doctor, or have felt themselves to be significantly depressed without any previous formal diagnosis. The purpose of this study is to examine attitudes towards pregnancy and depression for women who have experienced themselves to be depressed at some point in their lives; therefore I did not require a formal diagnosis of depression for inclusion in the study. However, I recognize the importance of participants having experienced significant depression in order to maintain the validity of the study. Therefore, in order to ascertain whether participants had suffered a significant depression without having been formally diagnosed, I turned to the depression criteria of the DSM-IV.

The formal definition of major depressive disorder, as defined by the DSM-IV-TR is “a clinical course that is characterized by one or more Major Depressive Episodes without a history of Manic, Mixed, or Hypomanic Episodes” (DSM-IV, p. 369). The DSM-IV-TR defines a Major Depressive Episode as “a period of at least 2 weeks during

which there is either depressed mood or the loss of interest or pleasure in nearly all activities...The individual must also experience at least four additional symptoms drawn from a list that includes changes in appetite or weight, sleep, and psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating, or making decisions; or recurrent thoughts of death or suicidal ideation, plans, or attempts” (DSM-IV, p.349). The survey includes five diagnostic questions to determine whether women have experienced significant depressive episodes, including whether the depression lasted for two weeks or more, significantly interfered with their functioning including loss of interest or a desire to withdraw from people or activities, whether there was a change in appetite or sleep patterns for two weeks or more, and whether participants ever received treatment for depression.

Exclusion criteria included a history of successful childbirth, an inability to read and/or write in English, and no prior history of significant depression as determined by the questionnaire. Successful childbirth and experience with raising children may have a bearing on a woman's attitudes towards depression including if they have already experienced a post-partum depression.

The questionnaire yielded a 90% response rate from those who began responding. 73 respondents viewed or began the questionnaire and a total of 66 complete responses were collected. Of those, 60 (N=60) described themselves as having experienced a significant depression. Therefore, only data from those 60 participants was used in the analysis.

Procedure and Data Collection

Initially, I had hoped to recruit participants through a number of Toronto hospital clinics specifically aimed at women's mental health issues. Two hospitals in particular – Women's College Hospital and Mount Sinai Hospital – offered programs specifically geared towards maternal and infant mental health. However, after contacting Ethics Review Board staff at both hospitals, I was informed that it would not be possible to conduct research at these institutions without being supervised directly by staff members. I did speak with several staff members at Mount Sinai Hospital who conduct large-scale research projects who suggested that I use Facebook, a free social networking website, to recruit participants as they have found this recruitment method to be extremely successful. As a result, I decided to recruit participants using Facebook as well as through email.

In order to recruit participants for the study and distribute the survey, approval was needed from the Smith College School for Social Work Human Subjects Review (HSR). Requirements for application approval included:

- 1) A statement of the project purpose and design, including research questions and methods, justification for the study, potential usefulness of findings and how the research will be used

- 2) The characteristics of the participants, including inclusion and exclusion criteria, and desired sample size

- 3) The recruitment process, including screening, location and efforts to achieve diversity

4) The nature of participation, including procedures, data collection, nature of personal contact if applicable, estimation of how long participation will take, and how data will be gathered and processed

5) Risks of participation, including confidentiality

6) Benefits of participation

7) Informed consent procedures including how the informed consent will be obtained and explanation of the participants' right to refuse

8) Precautions taken to safeguard confidentiality and identifiable information

I submitted my initial application to the HSR committee three times before receiving approval in December, 2007 (Appendix B). Changes I was asked to make throughout the process included clarifying who is eligible to participate and clarifying characteristics necessary for participation particularly related to level of depression. I was asked to make sure that participants were aware that only those who fit inclusion criteria would be included as part of the study. I specified the inclusion criteria in the introductory email as well as the online consent form. I was also asked to explain that despite my residing in Canada, the HSR Committee with which I was working was governed by US Federal standards. I was asked to clearly describe my project design and specify that while my particular area of study has not been researched, there has been an extensive amount of research done in the area of maternal and infant mental health. I was asked to clarify my recruitment process and told that I would not be able to contact Smith alumni since I was inquiring about personal information and my research was not related to social work policy or practice. I was also informed that in order to formally contact current Smith social work students, I would need to receive approval from the Dean of

the SSW program at Smith. I decided not to attempt to formally contact current students since I felt confident I would likely be able to recruit enough participants using email and Facebook.

Method

Potential respondents were contacted either through Facebook or through email. They were sent an initial contact letter stating inclusion criteria for the study, what was involved in participation, and informed about the possible risks and benefits. Those who received an email were asked to click on the link at the bottom of the message if they were interested in participating. The link directed them to the survey which was posted on Survey Monkey. They were immediately directed to a formal consent form which gave participants the opportunity to read a more detailed overview of the study, what was involved in participation, possible risks and benefits, and inclusion/exclusion criteria. After reading the form, they were given the option of providing an electronic signature, meaning that by clicking the “next” button, they effectively agreed to participate and give their consent. This is a commonly used method of obtaining consent for online surveys.

Recruitment from Facebook started with a request sent to members of my own Facebook page asking those interested to click on the link. They were then directed to the same formal consent form. Facebook has 57 million active members worldwide. With this in mind, my Facebook page was created for the express purpose of recruiting participants for the survey. In the accompanying email describing the survey, recipients were asked to forward the email to others who they felt may be interested in participation even if they themselves were not eligible or did not wish to participate. By distributing the survey over Facebook, I was able to gather an increased number of respondents using

snowball sampling. Since I recruited participants over the Internet, I had no way of knowing how diverse the respondent population would be.

Participants first completed the consent form (Appendix C) followed by questions to gather demographic information. These questions were derived from the demographic survey used by Statistics Canada in the 2006 Census which includes race, culture, ethnicity and religion. Participants filled out a brief Internet based electronic survey which asked participants about their experience with depression and their feelings about pregnancy, motherhood, and post-partum depression. The survey, which utilized a 5 point Likert Scale, was limited to face validity. Participants had the option of answering: Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree, and Not Applicable. There was no personal contact whatsoever since the survey was completed online. Participation, meaning the completion of the 16-item survey, should have taken no more than 15 minutes, however participants were given as much time as was needed to complete the survey.

The purpose of the study was clearly stated to any potential participants. There may have been a risk to participants of experiencing emotionally disturbing thoughts when asked to reflect on past experiences of depression or personal feelings. It was made clear that the survey questions would be asking about specific experiences with depression which might lead to remembering or even re-experiencing painful, upsetting, or uncomfortable emotions. It was also clearly stated that the survey questions ask directly about attitudes and feelings about their history of depression, risk of future depression, and motherhood. Women were informed of their right not to participate or to cease participation at any point.

Participants were also informed that their personal information would not be used for any purposes outside those of the study and that their information will be kept strictly confidential apart from myself and, to a limited extent, my research advisor. Any and all personal information will be kept in a locked file cabinet and retained for the three years before being destroyed. Although I currently reside in Canada, the study is being conducted through a US academic institution and is being reviewed by a Human Subjects Review (HSR) Committee governed by US Federal standards.

Participants were informed that they may benefit from knowing that they have contributed to the further knowledge and understanding of women's experiences with depression and their decision of whether or not to have children. They may also gain an increased and fuller understanding of their own feelings about child-bearing, motherhood, and family. They may benefit from being able to tell their story and having their perspective heard. Participation may help social workers or other health care workers to have a better understanding of how to approach these issues with clients, better serve women who have had experiences similar to their own, and work effectively in collaboration with women, couples and families. It may be of some comfort that someone is concerned enough about this issue to research it and that they are contributing to an increased understanding of this issue.

Since the surveys were distributed using Survey Monkey and names were not requested, each respondent is identified only by a number and is not known personally to the investigator. Survey Monkey does not allow names or identifying information to remain in the system, meaning that it is not possible for anyone, including myself, to trace where the responses came from. In this way, anonymity and confidentiality were

guaranteed. The consent form also clearly stated that all survey responses will be kept confidential and secure for a minimum of three years. Once the data is no longer needed, it will be safely destroyed.

Ethics and Safeguards

The purpose of the study was clearly stated to any potential participants. The benefits and risks of participation were also detailed, including the potential benefit to women who may fear being at risk for postpartum depression, as well as the risk of writing about upsetting or emotionally difficult information. Women were informed of their right not to participate or to cease participation at any point. They were also informed of issues around confidentiality including the fact that their personal information will not be used for any purposes outside those of the study and their information will be kept strictly confidential apart from myself and, to a limited extent, my research advisor.

Any and all personal information will be kept in a locked file cabinet and will be kept for the required amount of time before being destroyed. Since I will be in Canada, I will keep records based on Canadian and Ontario law as governed by Ontario privacy legislation. Any participants were also given my contact information as well as the contact information for the Smith Human Subjects Review Board if they felt the need to make contact for any reason.

Data Analysis Procedures

I decided to use a quantitative research design for this study mainly because little to no research had been done in this particular area and in order to establish whether this was an area worthy of further study, I thought it was important to utilize a research

method that would gather information from a larger sample. However, I recognized the possible significance of narrative responses to such a potentially sensitive and personal topic. For that reason, two qualitative questions were included in the survey in order to help illuminate the quantitative data.

Quantitative data was gathered and analyzed using descriptive statistics. Data was used to decipher whether there was a correlation between a history of depression and negative feelings about having children. Qualitative data was examined for themes and used to elucidate the quantitative information. For a response to qualify as a theme, it had to be mentioned at least four times in the open response portion of the survey.

Limitations of the study included language (the study needed to be conducted in English since this is the only language I speak), and economic status since participants in the online survey needed to have access to a computer and the Internet. Participation was also limited to those who received a direct email or visited my Facebook page, which means that certain demographics of the sample population may have been under or overrepresented. The following chapter will more fully examine and analyze the descriptive statistics gathered.

CHAPTER IV

FINDINGS

“The strongest principle of growth lies in human choice” – George Eliot

The question addressed in this research project was: Is there a relationship between a woman's history of depression and her feelings and attitudes about having children? Because little has been written on this topic, the survey was intended to discover whether there is in fact a correlation between a woman's history with depression and her feelings about having children. Therefore, the statistics presented in this chapter are descriptive and meant to illustrate the findings, which were mixed.

73 women began the survey and 66 completed it (N=66), meaning that there was a response rate of 90.4%. Of the women who completed the survey, 60 (N=60) defined themselves as having experienced a significant depression at some point in their lives. Since the study was intended to survey those who had experienced depression, only the data of the 60 participants who specified that they had been depressed were included in the findings.

This chapter provides descriptive statistics of the quantitative data gathered from participants. Qualitative data was also collected in order to help illuminate the quantitative information. Qualitative data was gathered at two points in the survey: the first qualitative question asked participants why they chose not to have children if they

had indicated that this was their decision, and if they could explain, in their own words, their feelings about having children.

Demographics of Participants

66 women completed the survey and of those, 60 had experienced a significant depression. Demographic data including age, race, ethnicity, culture, religion, sexual orientation are outlined in Table 1.

Table 1

Demographic data for study participants

Age	Frequency	Valid Percent
20-24	6	10
25-29	36	60
30-35	18	30
Race/Ethnicity/Culture	Frequency	Valid Percent
Black	2	3.5
Korean	1	1.8
South Asian	1	1.8
White	53	93.0
Jewish	1	1.7
Multiracial – White/Latina	1	1.7
West Indian	1	1.7
Religion	Frequency	Valid Percent
Buddhist	1	1.7
Christian	17	29.3
Jewish	17	29.3
Other	23	39.7
Anglican	1	1.7
Sikh	1	1.7
Sexual Orientation	Frequency	Valid Percent
Bisexual	4	6.7
Lesbian	4	6.7
Heterosexual	50	83.3
Queer	1	1.7
It's a long story	1	1.7
Current Place of Residence	Frequency	Valid Percent
Canada	45	75.0
United States	15	25.0

Questions one through five of the survey inquired about history of depression. Of the women who completed the survey, 84.4% indicated that they have had a significant depression at some point in their life. Of those, 88.3% said this depression had interfered with their functioning for at least two weeks, 88.3% experienced a significant change in appetite and/or sleep patters for two weeks or more, 66.7% had a formal diagnosis of depression and 73.3% have had treatment for depression. Details are presented in Tables 2 through 6.

Table 2

Experience with significant depression

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	60	100	100	100

Table 3

Depression and interference with functioning

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	57	95.0	96.6	96.6
	No	2	3.3	3.4	100.0
	Total	59	98.3	100.0	
Missing	System	1	1.7		
Total		60	100.0		

Table 4

Depression and interference with sleep and appetite

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	53	88.3	88.3	88.3
	No	7	11.7	11.7	100.0
	Total	60	100.0	100.0	

Table 5

Participants who have had a formal diagnosis of depression

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	40	66.7	66.7	66.7
	No	20	33.3	33.3	100.0
	Total	60	100.0	100.0	

Table 6

Participants who have received treatment for depression

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	44	73.3	73.3	73.3
	No	16	26.7	26.7	100.0
	Total	60	100.0	100.0	

The majority of women surveyed (86.4%) did express a desire to get pregnant despite their history with depression, as illustrated in Table 7.

Table 7

Interest in childbearing

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	51	85.0	86.4	86.4
	No	8	13.3	13.6	100.0
	Total	59	98.3	100.0	
Missing	System	1	1.7		
Total		60	100.0		

Of those women who said they would not like to have children, 10 elaborated on their decision. Two women worried about passing on defective genes and unresolved issues to their child. Three women said they felt mixed about the prospect of having children and have not made a definitive decision. Two women worried about dying prematurely and leaving their child without a mother. One woman was concerned about developing post-partum depression which would interfere with motherhood. Two women did not specify what their reasons were other than to say they had decided against having children. The full narratives can be found in Appendix F.

Most of the women surveyed wanted to have children despite their history with depression, and felt that being depressed had no impact on their desire to get pregnant. However, approximately half of the women surveyed fear getting pregnant and worried that their depression would harm their child. Tables 8 through 10 illustrate these findings.

Table 8

Depression and impact on desire to become pregnant

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	1	1.7	1.7	1.7
	Agree	14	23.3	24.1	25.9
	Neutral	8	13.3	13.8	39.7
	Disagree	22	36.7	37.9	77.6
	Strongly Disagree	11	18.3	19.0	96.6
	N/A	2	3.3	3.4	100.0
	Total	58	96.7	100.0	
Missing	System	2	3.3		
Total		60	100.0		

Table 9

Depression and impact on the desire not to become pregnant

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	11	18.3	19.0	19.0
	Agree	15	25.0	25.9	44.8
	Neutral	6	10.0	10.3	55.2
	Disagree	19	31.7	32.8	87.9
	Strongly Disagree	6	10.0	10.3	98.3
	N/A	1	1.7	1.7	100.0
	Total	58	96.7	100.0	
Missing	System	2	3.3		
Total		60	100.0		

Table 10

Fear of becoming pregnant

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	8	13.3	13.6	13.6
	Agree	18	30.0	30.5	44.1
	Neutral	9	15.0	15.3	59.3
	Disagree	9	15.0	15.3	74.6
	Strongly Disagree	13	21.7	22.0	96.6
	N/A	2	3.3	3.4	100.0
	Total	59	98.3	100.0	
Missing	System	1	1.7		
Total		60	100.0		

Those who answered in the affirmative to "I fear getting pregnant" were then asked to label the fear more specifically. Many women feared that they would have a postpartum depression, their depression would harm their child, that they would not be able to control their depression, and that they would have difficulty caring for their baby. Responses were mixed regarding whether they felt their relationship with their partner or spouse would suffer and about whether they felt that their depression would harm their child. Few women worried about having to take medication while pregnant and very few worried about not being able to get effective treatment.

Table 11

Fear of developing postpartum depression

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	4	6.7	8.7	8.7
	Agree	21	35.0	45.7	54.3
	Neutral	9	15.0	19.6	73.9
	Disagree	6	10.0	13.0	87.0
	Strongly Disagree	3	5.0	6.5	93.5
	N/A	3	5.0	6.5	100.0
	Total	46	76.7	100.0	
Missing	System	14	23.3		
Total		60	100.0		

Table 12

Worry that depression will impact relationship with partner/spouse

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	3	5.0	6.7	6.7
	Agree	14	23.3	31.1	37.8
	Neutral	7	11.7	15.6	53.3
	Disagree	11	18.3	24.4	77.8
	Strongly Disagree	7	11.7	15.6	93.3
	N/A	3	5.0	6.7	100.0
	Total	45	75.5	100.0	
Missing	System	15	25.0		
Total		60	100.0		

Table 13

Fear of having to take medication while pregnant

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	3	5.0	6.7	6.7
	Agree	7	11.7	15.6	22.2
	Neutral	13	21.7	28.9	51.1
	Disagree	13	21.7	28.9	80.0
	Strongly Disagree	5	8.3	11.1	91.1
	N/A	4	6.7	8.9	100.0
	Total	45	75.0	100.0	
Missing	System	15	25.0		
Total		60	100.0		

Table 14

Fear of depression harming the child

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	5	8.3	11.4	11.4
	Agree	16	26.7	36.4	47.7
	Neutral	10	16.7	22.7	70.5
	Disagree	8	13.3	18.2	88.6
	Strongly Disagree	3	5.0	6.8	95.5
	N/A	2	3.3	4.5	100.0
	Total	44	73.3	100.0	
Missing	System	16	26.7		
Total		60	100.0		

Table 15

Fear of loss of control over depression

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	5	8.3	11.1	11.1
	Agree	20	33.3	44.4	55.6
	Neutral	7	11.7	15.6	71.1
	Disagree	8	13.3	17.8	88.9
	Strongly Disagree	3	5.0	6.7	95.6
	N/A	2	3.3	4.4	100.0
	Total	45	75.0	100.0	
Missing	System	15	25.0		
Total		60	100.0		

Table 16

Fear of not being able to care for the baby

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	4	6.7	8.9	8.9
	Agree	15	25.0	33.3	42.2
	Neutral	8	13.3	17.8	60.0
	Disagree	10	16.7	22.2	82.2
	Strongly Disagree	6	10.0	13.3	95.6
	N/A	2	3.3	4.4	100.0
	Total	45	75.0	100.0	
Missing	System	15	25.0		
Total		60	100.0		

Table 17

Fear of not being able to receive effective treatment for depression

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	1	1.7	2.3	2.3
	Agree	4	6.7	9.1	11.4
	Neutral	9	15.0	20.5	31.8
	Disagree	18	30.0	40.9	72.7
	Strongly Disagree	9	15.0	20.5	93.2
	N/A	3	5.0	6.8	100.0
	Total	44	73.3	100.0	
Missing	System	16	26.7		
Total		60	100.0		

Despite the fears these women expressed regarding depression, pregnancy, and caring for their child, almost all felt that these fears would not prevent them from having children.

Table 18

Fear of depression would not impact decision to have children

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	8	13.3	14.3	14.3
	Agree	25	41.7	44.6	58.9
	Neutral	3	5.0	5.4	64.3
	Disagree	12	20.0	21.4	85.7
	Strongly Disagree	4	6.7	7.1	92.9
	N/A	4	6.7	7.1	100.0
	Total	56	93.3	100.0	
Missing	System	4	6.7		
Total		60	100.0		

Table 19

No worry about having children

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	6	10.0	10.7	10.7
	Agree	11	18.3	19.6	30.4
	Neutral	10	16.7	17.9	48.2
	Disagree	22	36.7	39.3	87.5
	Strongly Disagree	6	10.0	10.7	98.2
	N/A	1	1.7	1.8	100.0
	Total	56	93.3	100.0	
Missing	System	4	6.7		
Total		60	100.0		

Table 20

Worries do not impact decision to have children

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	15	25.0	26.8	26.8
	Agree	25	41.7	44.6	71.4
	Neutral	3	5.0	5.4	96.8
	Disagree	11	18.3	19.6	96.4
	Strongly Disagree	1	1.7	1.8	98.2
	N/A	1	1.7	1.8	100.0
	Total	56	93.3	100.0	
Missing	System	4	6.7		
Total		60	100.0		

Table 21

Decision not to have children as a result of depression

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	1	1.7	1.8	1.8
	Agree	3	5.0	5.5	7.3
	Neutral	6	10.0	10.9	18.2
	Disagree	19	31.7	34.5	52.7
	Strongly Disagree	26	43.3	47.3	100.0
	N/A	0	0	0	0
	Total	55	8.3	100.0	
Missing	System	5	8.3		
Total		60	100.0		

Table 22

Participants have talked to someone about concerns

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	0	0	0	0
	Agree	13	21.7	23.2	23.2
	Neutral	2	3.3	3.6	26.8
	Disagree	17	28.3	30.4	57.1
	Strongly Disagree	10	16.7	17.9	75.0
	N/A	14	23.3	25.0	100.0
	Total	56	93.3	100.0	
Missing	System	4	6.7		
Total		60	100.0		

A little over half of the women surveyed (51.8%) indicated that they thought it would be helpful to talk to someone about their worries or thoughts regarding depression and having children.

Qualitative data was gathered in order to elucidate the quantitative data. The qualitative results enrich the quantitative research. At the end of the survey, participants were asked to explain, in their own words, their feelings about having children. When examining these responses, a number of themes emerged. However, for the purposes of this study, a theme had to appear at least four times in order to be included in the analysis. Given this criteria, there were five clear themes that emerged in the qualitative responses: 1) Fears of genetic predisposition or passing on depression to children; 2) inability to raise children or fear of being a "bad" mother; 3) concern over repetition of past trauma, pain, loss or abuse; 4) fear of postpartum depression and/or experiencing repeated depressive episodes; and 5) concerns regarding relationship status and ability of

partner to help care for child if the mother became depressed. Full responses are outlined in Appendix G.

CHAPTER V

DISCUSSION

“Be not ashamed woman...you are the gates of the body, and you are the gates of the soul” – Walt Whitman

This chapter examines the results and conclusions of this study which was designed to examine whether there is a connection between women who have a history of depression and attitudes towards having children. Included in this chapter are key findings starting with demographic information, the main findings from the surveys, strengths and limitations of the study, implications for social work practice and policy, and topics for future research.

Overview of the Study and Demographics of Participants

An online survey was created and distributed to women who self-identified as having experienced a significant depression at some point in their lives. Survey questions were both quantitative and qualitative designed to gain an understanding of women's attitudes towards having children and whether or not these attitudes were linked to their experience with depression.

66 women completed the online questionnaire and of those, 60 defined themselves as having experienced a significant depression at some point in their lives.

Six women were between the ages of 20-24, 36 women were between the ages of 25-29, and 18 women were between the ages of 30-35. When asked to identify their race, two women identified as Black, one as Korean, one as South Asian, 53 as White, one as Jewish, one as Multiracial, and one as West Indian. When asked to identify their religion, one participant identified as Buddhist, 17 as Christian, 17 as Jewish, 23 as Other, one as Anglican and one as Sikh. When asked about sexual orientation, four women identified as bisexual, four identified as lesbian, 50 as heterosexual, one as queer and one answered with "it's a long story". Forty-five women reside in Canada and 15 in the United States.

Main Findings

The question asked in this study was: Is there a relationship between a history of depression and feelings about having children? This research was conducted to support the theory that there is a link between a history of depression and attitudes towards having children in women between the ages of 20-35. The results were mixed, with the data supporting a clear link between previous depression and concerns about having children for approximately half the women surveyed.

The sample of participants was significantly depressed, with 95% of participants affirming that their depression had interfered with their functioning for at least two weeks and over 88% stating that they experienced a change in appetite and/or sleep patterns for two weeks or more. Over 66% had been diagnosed with depression, and over 77% had treatment for their depression.

Substantial numbers of participants who were or are depressed indicated that this made them reluctant to get pregnant. 44% of respondents said they were afraid to get

pregnant, which suggests that this is a complex, vital issue for some women.

Interestingly, fears and worries about depression does not prevent most of the sample from deciding to have children in the future with over 85% affirming that they would like to have children at some point in their lives. Clearly, there is a lot of internal emotional conflict about these issues. Interestingly while many agreed that they fear becoming pregnant, most affirmed that this fear would not stop them from having children. These anxieties included a fear of passing on a genetic predisposition for depression, fear of postpartum depression and/or experiencing repeated depressive episodes. Such woman, who clearly approach pregnancy with uncertainty and anxiety about depression, may benefit from assistance, support, education and/or therapy in the pre and postpartum periods as well as during pregnancy.

A number of respondents stated that their experience with depression had no impact on their decision to have children. Rather, they indicated an array of other variables that would impact on their decision, including fears of being a "bad" mother to their child, concern over repetition of past trauma, loss, pain or abuse, and concerns regarding relationship status. While fears around motherhood may not be directly related to experiences with depression, it is possible that women who experience any type of fear or concern in relation to motherhood would need similar support as those whose fears focus on depression.

It is also possible that certain fears surrounding motherhood may have been influenced by a history of depression. For example, some women cited fear of repeating trauma, loss, and abuse as reasons for being reluctant to have children. It is well known that trauma and abuse can lead to depression. These experiences could have led to

depressive episodes for these women and informed their sense of self-worth and capacity to be an effective parent. If these women are reluctant to have children because of a history of trauma and abuse, it is possible that depression may have played an indirect role in their decision whether or not to have children in the future.

How This Study Relates to the Current Literature

As discussed in Chapter II, there has been a wealth of research written on the subject of depression, and the likelihood that women who have suffered from depression prior to becoming pregnant are at a greater risk for developing postpartum depression (Bernazzani, et al., 1997). There is also a vast amount of literature regarding the negative effects of postpartum depression on the relationship between a mother and her infant (Buist, 2002) and the importance of attachment in the development of the infant (Bowlby, 1969; Ainsworth, Blehar, Waters & Wall, 1978; Ainsworth & Wittig, 1969). It has been noted that there is indeed a connection between insecure attachment and depression (Scharfe, 2007) and a lack of early secure bonding with a parent can lead to poor attachment style in adulthood (Scharfe, 2007; Acklin, Sauer, Alexander & Dugoni, 1989). As mentioned above, a substantial number of women indicated that their experience with depression impacted their feelings about having children. The literature did not directly assist in clarifying this issue even though it seems to be a significant issue for some women.

However, though the literature does not help in specifically identifying this issue, it is very helpful in illuminating some of the psychodynamic issues that may be present. A number of women discussed fear of being a “bad” mother, fear of repeating abuse, loss, and trauma, and worries regarding relationship status and the strength of their

relationship with their partner. As mentioned in the literature review, depression is connected with early disturbance and a deprivation of needs by primary caregivers. Many women indicated that they feared repeating previous traumatic experiences and loss with their own children. A substantial number of participants also indicated that they feared that their depression would harm their child and that they would have difficulty caring for their baby. If some of these women experienced depression as a result of early trauma, loss, or abuse, their sense of whether or not they will be a fit parent could have been impacted as well. They may not have felt safe in the world and may not have been provided the crucial support needed to effectively manage their fears and concerns as adults. These women may have internalized a distorted image of what it means to be a parent and may now fear that they do not have the ability to be the successful parent they wish to be.

Implications of Study Findings

According to the sample surveyed, there appears to be a clear link between a history of depression and feelings about having children for a substantial number of participants. Since the majority of respondents indicated that they plan to have children despite their concerns, the implication is that support may be needed for this particular group and additional research should be done in order to gain a more complete understanding of this issue and the possible needs of this population of women. Studies that target attachment style and feelings of vulnerability as a parent might be appropriate. Prospective studies could examine women who are conflicted about pregnancy because of depression and how they fare as mothers. Research could also be done on the impact of early trauma and abuse on feelings towards having children. It might also be

important to examine whether the loss of a parent impacts women's feelings about becoming parents themselves and if so, in what way. There could be research looking at the difference in attitudes towards childbearing between women who lost a parent at an early age and women who did not, and whether this loss impacts experiences with depression.

Limitations

There were a number of limitations in this study. Since snowball sampling was used, the responses were not a representative sample. Almost all the respondents were White and heterosexual and participants who identified their religion as Jewish were over represented in the study at just over 29%. There were also some limitations when searching for appropriate literature. For example, no literature was found on the link between attachment style and decision making, or depression and decision making in regards to having children. Literature of this nature would have increased the understanding of this topic and further informed the development of the survey as well as the interpretation of the findings.

The survey also failed to inquire as to the timing of the depression experienced by participants. The length of time since they experienced their depression may have influenced their feelings about the impact depression had on their decision making and feelings about childbearing. Moreover, if participants experienced depression during adolescence versus adulthood, their feelings about having children may again have been altered as a result. They may feel less concerned about depression if they experienced it at a younger age, or alternatively, they may be more concerned about passing on their depression to their child if they were a child themselves when they experienced

depression. A few of the participants spoke to this issue in their qualitative responses, stating that they had experienced depression some time ago and no longer felt it to be an concern for them.

It may have also been important to inquire about whether participants felt that their depression was related to a particular incident or experience and if so, what this experience was. This information could have had led to a fuller understanding of why some women felt that depression was not a concern for them in relation to childbearing while others remained fearful and apprehensive.

Implications for Social Work Practice

This study highlights the need for further research to be done in the area of women's attitudes towards childbearing, particularly related to a history of depression. The research, in this preliminary stage, indicates that there may be a link between a woman's history of depression and concerns about having children for at least 50% of women surveyed. This study opens an area of discussion and training in clinical practice.

The results of this study could impact a clinician's work with this particular group of women and could attune the clinician to the possible connection between their client's prior depression and their concerns and fears regarding pregnancy, postpartum depression, relationships with partners, and ability to effectively bond with and nurture their child.

In addition, more intensive therapy could be effective when problems are more deep seated. For example, if difficulties arise from disrupted early relationships with a woman's own parents, more focused therapy could be valuable in helping to alleviate fears surrounding the transition to motherhood.

Implications for social work policy

There is a gap in the social work knowledge in what is probably substantial population that struggles with issues important to every woman. There appears to be significant conflict around this issue, however there is nothing known about it. Once more research has been done that proves that indeed this is a substantial issue, it would be prudent for social work research policies to incorporate the findings of this research. Education for practitioners and physicians could be implemented and incorporated into existing programs for practitioners who are working with this population.

There are many views of the dangers of depression implied in the data. Hence education about depression, the actual risks of passing it on, the management of depression during pregnancy, medication use, parenting and peer support groups could be valuable.

Certain preventative measures could also be explored, such as programs aimed at assisting women who may be at risk or screening measures that could be utilized by clinicians or physicians working with women who may be considering motherhood.

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Appendix A

Human Subjects Review Proposal

Investigator Name: Beth Sadavoy

Project Title: Does a personal history of depression influence women's attitudes about having children?

Project Purpose and Design

I would like to examine whether or not there is a link between a history of depression and women's attitudes and/or feelings about having children. Specifically, given the damaging effect of postpartum depression on both women, children and families, does a history of depression influence women's feelings about having children? I would also like to examine whether a history of depression is associated with increased fear of postpartum depression.

Certain aspects of postpartum depression are well identified, including that women may be afraid of passing on genetic vulnerability to children, afraid of harming their children or themselves, and that a history of depression increases a woman's chances of developing postpartum depression (Bernazzani, Saucier, David and Borgeat, 1997). Much has been written on the subject of maternal and child mental health including information regarding the link between a history of depression and the risk of developing post-partum depression, the effects of depression on perinatal women, and the effects of depression on the child as well as the mother/infant relationship. However, a search of the literature using PsychInfo, Medline Plus, MayoClinic, Academic Search Premier (EBSCO) and Health Reference Center did not reveal any literature on the specific issue of women's feelings and attitudes towards pregnancy before they become pregnant and the impact of depression on women's feelings about becoming pregnant. The lack of information seems to extend to a more general lack of data/research on women's decision-making around childbirth regardless of mental health issues. Research in this area would assist clinicians in working with this population of women. Clinicians would be able to assist women to explore conflicts, self-perceptions about mothering, issues related to bonding and attachment behavior and perhaps become a basis for defining who is vulnerable to mothering conflicts, depression and anxiety. Preventive strategies may then follow. This research will also help to define key ideas and attitudes involved in decision making for women who have a history of depression and may be contemplating pregnancy and motherhood. It would allow therapists to hone in on the conflicts and assist in working them through. Benefits to spouses may also indirectly emerge as therapists may be able to educate couples not only about the risks but also help them talk in a deeper way about the conflicted areas of contemplating pregnancy and motherhood.

Quantitative research data will be collected using an anonymous online survey administered by Survey Monkey. Survey Monkey allows the researcher to create and widely distribute entirely anonymous online surveys. A link to the survey can be sent to and easily accessed by potential participants.

The research will be used towards my Masters of Social Work thesis and will be presented to the Smith College community upon completion as well as for possible presentation and publication.

The Characteristics of the Participants

Inclusion criteria:

- female
- age 20-35
- a history of significant depression
- do not have children, are not currently pregnant and have never given birth
- English literacy

Exclusion criteria:

- history of successful childbirth
- no prior history of significant depression as determined by the questionnaire. Successful childbirth and experience with raising their children may have a bearing on women's attitudes towards depression, including if they have already experienced post-partum depression.

Sample size: A minimum of 50 respondents is the desired sample size. This is the minimum number of participants required by Smith for quantitative research projects. All appropriate and completed questionnaires will be included in the findings up to a maximum of 100 questionnaires.

The Recruitment Process

Initially, I had hoped to recruit participants through a number of Toronto hospital clinics specifically aimed at women's mental health issues. Two hospitals in particular – Women's College Hospital and Mount Sinai Hospital – offered programs specifically geared towards maternal and infant mental health. However, after contacting Ethics Review Board staff at both hospitals, I was informed that it would not be possible to conduct research at these institutions without being supervised directly by staff members. I did speak with several staff members at Mount Sinai Hospital who conduct large-scale research projects who suggested that I use Facebook, a free social networking website, to recruit participants, as they have found this recruitment method to be

extremely successful. As a result, I decided to recruit participants using Facebook as well as the Smith network. I also hope to post links to the survey on various mental health websites if possible. I plan to use snowball sampling as well since I am anticipating that participants may tell other women they know about the study.

I will send out a request on the Smith email network through the SSW Office of Academic Support Services asking for participants to click on the survey link. I hope to be able to access current Smith College SSW students. The link will direct them to the survey which will be posted on Survey Monkey. A formal consent form will be the first screen and participants will have the opportunity to read the form and give an electronic signature, meaning that by clicking the “next” button, they have effectively agreed to participate and given their consent. This is a commonly used method of consent for online surveys

Similarly, recruitment from Facebook will start with a request sent to members of my Facebook page asking for interested participants to click on the link. They will then be directed to the same formal consent form. Facebook has 57 million active members worldwide. With this in mind, my Facebook page was created for the express purpose of recruiting participants for the survey. In the accompanying email describing the survey, recipients will be asked to forward the email to others who they feel may be interested in participation even if they themselves are not eligible or do not wish to participate. By distributing the survey over Facebook, I hope to gather an increased number of respondents using snowball sampling.

Through Facebook, women will be sent an email stating characteristics necessary for participation. It will be clearly stated in the email that they should participate only if they meet inclusion criteria.

Since I will be recruiting over the Internet, I will have no way of knowing how diverse the respondent population will be.

The Nature of Participation

Participants will first complete the consent form followed by questions to gather demographic information. These questions are derived from the demographic survey used by Statistics Canada in the 2006 Census which includes race, culture, ethnicity and religion. Participants will fill out a brief (approximately 20-25 question Internet based electronic survey which will ask participants about their experience with depression and their feelings about pregnancy, motherhood, and post-partum depression. The survey will utilize a 5 point Likert Scale. Participants will have the option of answering:

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

Not Applicable

There will be no personal contact since the survey will be completed online. Participation, meaning the completion of the survey, should take no more than 20 minutes.

Risks of Participation

The purpose of the study will be clearly stated to any potential participants. There may be a risk to participants of experiencing emotionally disturbing thoughts when asked to reflect on past experiences of depression or personal feelings. It will be made clear that the survey questions will be asking about specific experiences with depression which might lead to remembering or even re-experiencing painful, upsetting, or uncomfortable emotions. It will also be clearly stated that the survey questions will ask directly about attitudes and feelings about their history of depression, risk of future depression, and motherhood. Women will be informed of their right not to participate or to cease participation at any point. Participants will also be given a list of support services should they feel the need for help.

Participants will also be informed that their personal information will not be used for any purposes outside those of the study and their information will be kept strictly confidential apart from myself and, to a limited extent, my research advisor. Any and all personal information will be kept in a locked file cabinet and retained for the required amount of time before being destroyed. Since I will be in Canada, I will keep records based on Canadian and Ontario law as governed by strict Ontario privacy legislation. However, although I currently reside in Canada, the study is being conducted through a US academic institution and is being reviewed by a Human Subjects Review (HSR) Committee governed by US Federal standards.

Benefits of Participation

Participants may benefit from knowing that they have contributed to the further knowledge and understanding of women's experiences with depression and their decision of whether or not to have children. They may also gain an increased and fuller understanding of their own feelings about child-bearing, motherhood, and family. They may benefit from being able to tell their story and having their perspective heard. Participation may help social workers or other health care workers to have a better understanding of how to approach these issues with clients, better serve women who have had experiences similar to their own, and work effectively in collaboration with women, couples and families. It may be of some comfort that someone is concerned enough about this issue to research it and that they are contributing to an increased understanding of this issue.

Informed Consent Procedures.

Surveys will be sent via the Internet. When participants click on the survey link, the first page they will see will be the informed consent form. Participants will have the opportunity to read the form and give an electronic signature, meaning that by clicking the “next” button, they have effectively agreed to participate and given their consent.

Precautions Taken to Safeguard Confidentiality and Identifiable Information

Since the surveys will be distributed using Survey Monkey and names will not be asked for, each respondent will be identified only by a number and will not be known personally to the investigator. Survey Monkey does not allow names or identifying information to remain in the system, meaning that it is not possible for anyone, including myself, to trace where the responses came from. In this way, anonymity and confidentiality are guaranteed. It will be stated in the informed consent that my Research Advisor will have access to the data.

The consent form will also clearly state that all survey responses will be kept confidential and secure for a minimum of three years. Once the data is no longer needed, it will be safely destroyed.

Investigator’s Signature: _____ Date: _____
Advisor's Signature: _____ Date: _____

Appendix B

Human Subjects Review Approval Letter

December 29, 2007

Beth Sadavoy

Dear Beth,

Your second revisions have been reviewed and all is now in order. I would think that your fellow students are also professionals and I have the same concern about involving them. In any event, you would have to get permission from the Dean's office before you approached the student body. You can see how there has to be some review of this, as repeatedly involving our students in their fellow student's research could really become problematic. But, you can certainly approach the Administration and see what they think. We are happy now to give final approval to your project.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain signed consent documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your recruitment and your study. Your findings could certainly be of considerable interest and use.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Joseph Smith, Research Advisor

Appendix C

Informed Consent Form

My name is Beth Sadavoy and I am conducting a study to learn more about the impact of depression on women's feelings about having children. The study is being conducted in partial fulfillment of the requirements for the Master of Social Work degree at Smith College School for Social Work.

I am interested in whether or not a history of depression alters women's feelings about having children and whether these women have a greater fear of developing postpartum depression. You are being asked to participate in this study if (a) you are female (b) you are between the ages of 20-35, (c) you have experienced a significant depression at some point in your life, and (d) you do not currently have children or are pregnant.

As a volunteer in this study you will be asked to complete an online questionnaire.

Questionnaire items will ask for demographic information as well as focus on your own understanding of when you felt you were depressed, if and when you were diagnosed with depression, what that experience was like for you, and whether you feel that this experience impacted your feelings about having children or of post-partum depression.

The questionnaire should take less than 15 minutes to fill out.

Your participation is completely voluntary. You will receive no financial compensation for your participation in this study; however you may benefit from knowing that you have

contributed to the further knowledge and understanding of women's experiences with depression and their decision of whether or not to have children. You may also gain an increased and fuller understanding of your own feelings about child-bearing, motherhood, and family. You may also benefit from being able to tell your story and having your perspective heard. Your participation may help social workers or other health care workers to have a better understanding of how to approach these issues with clients, better serve women who have had experiences similar to your own, and work effectively in collaboration with women, couples and families.

The potential risks of participating in this study are the possibility that you might feel strong or uncomfortable emotions while writing about your experiences. In case you feel the need for additional support after participating in this study, you may contact me at any time and I will provide you with a list of resources for counseling services in your area.

Strict confidentiality will be maintained, consistent with Canadian regulations and the standards of the social work profession. Confidentiality will be protected by coding the information by number only. The study is completely anonymous. Your name will not be requested and there will be no way to trace your responses back to you. Because there will be no way to identify you, there will be no way to withdraw once you have completed the questionnaire. Data will be stored for a minimum of three years. The data may be used in other educational activities, professional and popular publications, as well as in the preparation for my Master's thesis.

This study is completely voluntary and you are free to refuse to answer specific questions. If you have any questions, please do not hesitate to contact me by email at bsadavoy@email.smith.edu. You may also contact the Chair of the Human Subjects Review at Smith College at (413) 585-7974.

BY CLICKING “NEXT” AND SUBMITTING THIS SURVEY, YOU ARE INDICATING THAT YOU HAVE READ AND UNDERSTAND THE INFORMATION ABOVE AND THAT YOU HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY. THANK YOU.

Appendix D

Interview Guide

Demographic Information:

Please check each that apply

Age:

20-24

25-29

30-35

Race/Ethnicity/Culture:

Please check all that apply

Arab

Black

Chinese

Filipino

First Nations

Japanese

Korean

Latin American

South Asian (e.g. East Indian, Pakistani, Sri Lankan, etc.)

Southeast Asian (e.g., Vietnamese, Cambodian, Malaysian, Laotian, etc.)

West Asian (e.g., Iranian, Afghan, etc.)

White

Other – Please specify

Religion:

Buddhist

Christian

Hindu

Jewish

Muslim

Other – Please specify

Sexual Orientation:

Bisexual

Lesbian

Heterosexual

Other – Please specify

Current place of residence

Canada

United States

Other – Please specify

To the following questions answer options are:

Yes

No

1. I have experienced significant depression at some point in my life
2. This depression has interfered with my functioning for at least two weeks, for example loss of interest or desire to withdraw from people or activities
3. During the depressed period I experienced a significant change in appetite and/or sleep patterns for two weeks or more
4. During the depressed period I experienced feelings of hopelessness and low self-esteem
5. I have had a formal diagnosis of depression
6. I have had treatment for depression
7. I would like to have children at some point in my life
8. If you answered “no” to the previous question, please explain what led you to this decision.

To the following questions answer options are:

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

Not Applicable

9. My experience with depression has made me reluctant to get pregnant
10. Being depressed has had no impact on my desire to get pregnant
11. I fear getting pregnant

I fear getting pregnant because:

- a. I will have a postpartum depression
 - b. My relationship with my partner/spouse will suffer
 - c. I will have to take medication while pregnant
 - d. I feel my depression will harm my child
 - e. I feel I will become depressed and will not be able to control it
 - f. I will have difficulty caring for my baby
 - e. I won't be able to get effective help or treatment
-
12. My fears or worries about depression prevent me from considering having children
 13. I am worried about getting depressed but that worry will not stop me from having children
 14. I do not worry about having children
 15. My worries about depression do not prevent me from considering having children
 16. Because I have been depressed I do not want children

17. I have talked to someone about my concerns about depression and having children
18. I think it would be helpful to talk to someone about my worries or thoughts about depression and having children
19. Please explain, in your own words, how you feel about having children.

Appendix E

Qualitative Responses to Question 8:

If you answered “no” to wanting children, please explain why

- 1.** My career is unstable and I am somewhat nomadic with a strong desire to spend much of my life travelling. I have rotten genes (lots of cancer, diabetes, alcoholism etc.). I don't feel it would be fair to a potential child.
- 2.** I have step-children... it made me realize just how much you have to give up in order to have kids! Plus having step children makes it complicated and difficult to have your own children.
- 3.** Yes and No - I need a maybe box! Part of me wants kids but my fiancée and I are looking around at most of the kids right now and wonder can we really handle this and/or do we want to handle all of this. I think we are just going to let nature take its course and see what happens.
- 4.** Many things, but mostly, no strong, natural pull to mother. I have seen women get swallowed up by their identity-as-mother, and I am scared this would happen to me. I would also be worried about passing on my own issues and unresolved internal conflicts onto the child.

5. My partner and I have decided to not have children.

6. My answer to the previous question is maybe towards having children. I have mixed feelings about it.

7. I have next to no desire to raise and care for a child for their entire life. I also don't know if I would be able to remain partnered and would not want to die early in life and leave my child alone.

8. I lost a parent at a time in my life when I felt I was becoming who I was supposed to be. I feel now that I could never do that to my child.

9. I am not sure I want to have children, but I am leaning towards not having children. I am not convinced that it would be the best thing for me to have children.

10. Would actually like to answer "not sure." Am not sure at this point in my life whether I want to have children or not. Do have some worries about post partum depression and depression interfering with motherhood.

Appendix F

Qualitative Responses to Question 19:

Please explain, in your own words, how you feel about having children

- 1.** I think my real fear is passing along depression to my children and being unable to raise them, or recognize when they exhibit signs of depression as I did, when I was younger. I worry that because of me, and my family's genetics, I will be unable to save them from themselves. I think that's a strong reason why I'm also thinking about adopting children, so that at least I'll know someone in my family doesn't have my loaded genetics.
- 2.** I adore children. I spend a lot of time with my friend's children and occasional baby-sitting and hope to always have strong relationships with the children in my life but feel that I should not have my own children because of a lack of stability in my life. I have a genetic pre-disposition to cancer and having lost my mother at a young age would not want to risk putting my own child through that pain.
- 3.** I know I will be an amazing mother and my experiences have made me more empathetic and stronger. I see the world around me in a much more sensitive light. My mother was depressed and yet I watched as she put her own feelings aside to care for her children. It was selfless love.
- 4.** I can't wait! I think that it is the best thing that will happen in my life! I am worried about post partum and further depression in my life, but I know that my doctor can help

me. I am afraid to be overwhelmed, because it's when I am overwhelmed by life that my depression and anxiety kicks in big time. I just want my child to have a healthy life and I will take care of myself to stay healthy. My family is helping.

5. It would change my life forever.

6. I have had several bouts of depression - but it is not a factor in my decision to not have children. My stepfamily issues and the large amounts of support we pay - it just isn't really feasible.

7. I am currently not ready to have children due to timing and relationship status. I do feel a bit of anxiety about dealing with so many changes once having a child. Emotional change and responsibilities that would ensue could be overwhelming.

8. I feel as though it will be the most rewarding part of my life.

9. I feel that having a child is not something to be taken lightly. Although there is no "formula" for effective child raising, it would probably benefit the child to have a solid way of coping with feelings of depression. My depression has never been debilitating, but it has lessened my ability to care for myself, let alone trying to care for others. However, I feel that having children is something I greatly look forward to in the future.

10. Rather than depression being the cause of my concern regarding having children, I am concerned that my experiences as a child, which has largely precipitated my depression, will also be what my children face. Ultimately, I fear I will be an insufficient parent and damage their impressionable minds.

11. I am very excited to someday have children and raise a family. I love kids; they bring me joy: especially b/c they see the world so simplistically and that helps me to focus on what's important. I do not plan to have children until I'm in a committed marriage and then I know that things will be ok.

12. Mostly I know it's genetic and runs in my family and it feels like an unfair burden.

13. I don't really like children so I don't really want to have any. I don't think I am responsible enough to have kids.

14. Well, as a fairly masculine queer woman, I'd probably not feel very comfortable being pregnant anyway. But I worry that I can't rely on myself to stay mentally well enough to look after kids. Plus, I think there's just too darn many North Americans already, so I think having more babies isn't the most ethical thing to do. But my partner really wants kids, and I like kids... so I feel ambivalent about it.

15. I want very much to have children, however, I currently take medication and am very concerned that coming off of drug therapy could be too risky for my mental health. I

would not want to be on anti-depressants during pregnancy or while nursing. Post-partum depression is also a strong worry as I have a family history. I wouldn't have a problem with adoption, but I am concerned that a potential partner would be opposed to this option. I am not sure having a biological child is a good possibility for me, or the child. However, my significant other has indicated that he wants biological children, and would not be comfortable with adoption. It is a difficult position to be in.

16. I am excited to have children and look forward to them enriching my life and theirs. I feel that my depression is a signal for things that need to be balanced or changed in my life and I will continue to work toward equilibrium.

17. I am very much looking forward to it.

18. I am currently too young and plan on having children when I am much older.

19. I do not have strong feelings about having children at this point in my life. I know I would like some in the future but not for at least a few years and perhaps this is why my recent depression has not affected my views of children - in my head the two events are well separated by time.

20. Excited about the future prospect.

21. See previous entry

22. It is not something I have 100% made up my mind about, but I feel very strongly that I will not have children. It is mostly for selfish reasons - that I will lose myself when I take on the role of mother - but also for less selfish reasons - not wanting to fail children due to inability to care, lack of patience, passing on my own issues, etc.

23. I have found that I am at my best when I am caring for children and that having someone else's needs to look after makes it much easier for me to stay motivated.

24. I am excited to have children but anxious of the idea of getting pregnant without planning for it. I'm anxious mostly because I would like to feel like my life is somewhat in order before I get pregnant, not because of being concerned about getting depressed.

25. I can't wait to have children, but I have feelings of anxiousness about when I will actually and realistically be ready to have them. I don't think these feelings have anything to do with my past experience of depression. My feelings of depression were during adolescence and concerns about my body, but they don't really affect me today.

26. I have always wanted to have children, but since being diagnosed with depression I definitely have moments of worry as it relates to post-partum depression, as well as what I may pass on to my children (i.e.: my mother has depression, I have depression, etc..)

27. Genetic conditions (including mental illness) in my family has made me considered that having children would not be the best option for me.

28. I would like to have children some day. However, I intend to ensure that my depression has been fully stabilized before that point, as I have some concern about postpartum depression and relapse.

29. My history of depression and current depressed moods makes me feel that I may turn out to a "bad" mother who can't put her feelings aside to be the "best" mother. I can already imagine the negative effects of depressed mood on my children. And I do not wish that for them.

30. Very mixed feelings. I don't see my potential future children as being good, I worry about them misbehaving or suffering from depression as I did.

31. Fear of having children has more to do with childhood abuse and repeating what occurred. My depression also stemmed from that experience. Being the youngest child and not growing up with kids around also makes me fearful as I have not had the chance to develop skills in taking care of kids.

32. Although I suffer from depression and have fears of developing postpartum depression, this does not sway my decision to have children one day.

33. Having kids is scary in it's own right. I don't believe my apprehension is related to previous depression. I do worry about passing on anxiety/depression-related genes, but that will not deter me from having a family.

34. I do not think about my depression often, especially because it has been several years now. Luckily I think my depression was brought on by an isolated incident and now that I am out of that phase, I rarely think about it. I think about having children now and again. But my worries are more related to, how good a mother I would be, how could I provide for them, what kind of world it will be.

35. I think the relationship between a parent and child can be one of the most amazing things ever. I'm just not sure it's for me. I'm afraid to care for the child and I'm afraid of having to leave the child.

36. My primary consideration where children are concerned is timing: being in a relationship and with a partner who wants children at a time when I am ready to have children.

37. I feel it an unnecessary course of action to bring a potentially unwanted child into the world.

38. I can't wait. I'm dying to be at a moment in life when it is possible. That moment will be when I achieve relative financial stability.

39. I feel that I would like to have children in the future, but am concerned about the following factors: depression during pregnancy, postpartum depression, difficulty caring

for a child/children while depressed, and the increased probability that my child or children will also suffer from depression in their lives.

40. There is so much to say here! I really look forward to having children someday, and to the love and enjoyment they will surely bring to my life and to my partner's. I'm sure they will inspire generosity and devotion to another that I've never before given, and I will feel baffled by their beauty, creativity, and brilliance. There is nothing about being pregnant that really worries me -- I don't have a fear of doctors, needles, or pills, and I look forward to my belly swelling and feeling the baby's first kicks. My main concerns with having children center around how good of a parent I will be (will my own ghosts interfere?), which includes my worries about developing postpartum depression or depression later in the child's development, and around my relationship with my partner. I am currently in a new relationship in which everything is new and exciting, and I know that this can't possibly last, but I would certainly like to maintain it as long as we are able. I understand that having children causes tremendous changes in intimate relationships -- that it is actually the least happy time in the lifetime of a partnership. I would never want my children to have to experience their parents divorcing, nor would I want them to grow up under the influence of an unhappy and unloving parental relationship. My own parents divorced when I was very young, and both became depressed as a result, and I never want my children to experience what I did and what my siblings did at that time.

41. I have decided that I will on adopt children vs. actually having children of my own. As for if I was to actually have children of my own then it is quite scary.

42. Depression was an experience that I had when I was in my 20s. Being 30 and somewhat removed from that time in my life, I feel less concerned about how depression affects my desire to have kids. While depression will not prevent me from having children, I do hold, in the back of my mind, the fear that I am more susceptible to postpartum depression or of becoming depressed more than typical new mothers. I hope to have children in a few years and expect that, when that time comes, I will need to talk with my therapist about my concerns. Thanks for doing this survey!

43. I hope I can. More worried about whether or not I can than depression.

44. I have never linked fear of depression and the thought of having children. I am worried about having children because of my career ambitions.

45. I do not want to have children; it is not an important priority for me and I do not want to have the change in my life that having a child will likely bring. I do not think I will make a good mother.

46. For many years I was unable to determine why I was ambivalent about having children. While I currently do not feel that I will never have children, my recurring episodes of depression do give me concern about my ability to handle motherhood in a consistent and healthy way. I also have some concerns about passing on depression to my children, as it can be a very painful way to go through life. It seems to me that I can only envision parenthood with a partner, because I do not know whether I could parent on my

own. I realize that many (non-depressive) women also want to find the right partner for parenting, but at no point in my life have I considered the idea of children separate from a specific relationship. This is a topic of much interest to myself and many others. Best of luck in your research.

47. Two schools of thought in my journey through depression: 1) that if only I had a child all my problems would disappear, & 2) I don't want a baby because my father will not be there to welcome them into the world (my father's passing was a major cause of my depression).

48. My experience with depression made me realize how important it is to have a support system in place before I undertake any life-changing decisions. It's made me more cautious and thoughtful about when in my life I would like to get pregnant. It has also made me careful to choose a partner who I feel will be able to give me the extra support I may need.

49. I feel pretty ambivalent about having children. I think this is partly because I am at a point in my life where I am young, in school, and not in a romantic relationship, so having children does not feel like a part of my current reality. I do not currently spend much time thinking about whether or not I want to have children. I do have worries about post partum depression and worries about my depression interfering with my ability to care for children. I think these factors will come up when I am at a point where I am more seriously considering having children.

50. Excited yet fearful. Not necessarily linked to the depression, but it being such a permanent life change and one with which you are stuck regardless of how it feels once you actualize that change.

51. I am mixed, but leaning towards it. Though I do think I will be a bad mother, especially in the winter when I suffer from seasonal affective disorder.

52. Excited, hopeful, somewhat nervous.

53. I want to have children. I am not afraid of depression; I have received good treatment for depression and see it as a treatable condition, not a foreign visitor who will take me over.