Altered Perceptions of Personal Control About Retained Weight and Depressive Symptoms in Low-Income Postpartum Women

Bobbie Sue Sterling a; Eileen R. Fowles a; Alexandra A. Garcia a; Sandra K. Jenkins b; Susan Wilkinson c; Minseong Kim a; Sunghun Kim a; Lara Latimer a; Lorraine O. Walker a

a The University of Texas at Austin, Austin, Texas b Prairie View A & M University, Houston, Texas c Angelo State University, San Angelo, Texas

Online Publication Date: 01 July 2009


To link to this Article: DOI: 10.1080/07370010903034524
URL: http://dx.doi.org/10.1080/07370010903034524

Full terms and conditions of use: http://www.informaworld.com/terms-and-conditions-of-access.pdf

This article may be used for research, teaching and private study purposes. Any substantial or systematic reproduction, re-distribution, re-selling, loan or sub-licensing, systematic supply or distribution in any form to anyone is expressly forbidden.

The publisher does not give any warranty express or implied or make any representation that the contents will be complete or accurate or up to date. The accuracy of any instructions, formulae and drug doses should be independently verified with primary sources. The publisher shall not be liable for any loss, actions, claims, proceedings, demand or costs or damages whatsoever or howsoever caused arising directly or indirectly in connection with or arising out of the use of this material.
Altered Perceptions of Personal Control About Retained Weight and Depressive Symptoms in Low-Income Postpartum Women

Bobbie Sue Sterling, Eileen R. Fowles, and Alexandra A. Garcia

The University of Texas at Austin, Austin, Texas

Sandra K. Jenkins

Prairie View A & M University, Houston, Texas

Susan Wilkinson

Angelo State University, San Angelo, Texas

Minseong Kim, Sunghun Kim, Lara Latimer, and Lorraine O. Walker

The University of Texas at Austin, Austin, Texas

Postpartum weight retention and depressive symptoms have a high prevalence among low income women. This qualitative study describes low-income women’s experiences of weight changes and depressive symptoms during the late postpartum period. Women (n = 25) who were either overweight or had depressive symptoms, or both, at 12 months postpartum participated in an ethnically-congruent focus group. Women’s experiences indicated altered personal control related to retained postpartum weight and depressive feelings. Retained weight negatively affected self-esteem and family functioning. Depression left women feeling isolated yet reluctant to seek help. These findings could provide the basis for health promotion interventions relevant to this population.

New motherhood has been called a health transition for women (Walker & Wilging, 2000). In addition to psychosocial and physical health problems common during this transition (Cheng, Fowles, & Walker, 2006), low income women in the United States may experience these more acutely as they are exiting the health care systems at 6 weeks postpartum, the usual end-point of postpartum health care. Postpartum weight retention and depressive symptoms are two leading health conditions that are important for community health care agencies to address because of their high prevalence among low income women (Walker, Timmerman, Kim, & Sterling, 2002; Walker, Timmerman, Sterling, Kim, & Dickson, 2004).

This study supported by grant RO1 NR04679 through the National Institute of Nursing Research.

Address correspondence to Eileen R. Fowles, University of Texas at Austin, School of Nursing, 1700 Red River Street, Austin, TX 78701–1499. E-mail: efowles@mail.nur.utexas.edu
Numerous studies show that women with low socioeconomic resources compared to more advantaged women are at greater risk of postpartum weight retention (Olson, Strawderman, Hinton, & Pearson, 2003; Parker & Abrams, 1993; Wolfe, Sobal, Olson, Frongillo, & Williamson, 1997). As a result, prevalence estimates indicate that at 6 weeks postpartum, in excess of 80% of low income women retain weight carried over from pregnancy (Walker, Timmerman et al., 2004). Having limited socioeconomic resources is also associated with greater risk of depressive symptoms (Petterson & Albers, 2001). Prevalence of elevated depressive symptoms at 6 weeks postpartum has been reported as 60% in low-income women (Walker et al., 2002). Postpartum depressive symptoms may decline over time, but 36% to 51% of low-income mothers continue to report elevated depressive symptoms when their children are 6 months to 3 years of age (Boury, Larkin, & Krummel, 2004; Petterson & Albers, 2001). Although studies report mixed results on whether postpartum retained weight or depressive symptoms increase risk of each other (National Research Council & Institute of Medicine, 2007), the high prevalence of each condition during the postpartum period means that community-based programs for low-income new mothers that are focused on weight loss or managing depressive symptoms are likely to have a substantial number of women with both conditions.

Postpartum weight retention and postpartum depressive symptoms are of concern for their effects on women and children. Postpartum weight retention may contribute to women’s lifetime weight gain (Linne, Dye, Barkeling, & Rossner, 2004; Rooney, Schaubberger, & Mathiason, 2005) and becoming overweight (Gunderson, Abrams, & Selvin, 2000) with attendant weight-related complications including perinatal risks and diabetes (Cedergren, 2004; Cedergren & Kallen, 2003; Field et al., 2001; Must et al., 1999). Having elevated postpartum depressive symptoms is associated with less healthful early parenting practices, such as not breastfeeding and not putting infants to sleep on their backs (Chung et al., 2004; Paulson, Dauber, & Leifer, 2006), as well as less favorable developmental outcomes for young children (Beck, 1998; Civic & Holt, 2000; Petterson & Albers, 2001). As a result, interventions to reduce postpartum weight retention and depressive symptoms are an important part of health promotion and prevention strategies targeting low-income childbearing women and young children.

Solidly grounding such intervention approaches for low-income women depends on reliable knowledge not only of the health conditions themselves, but also women’s experiences of them. This study augments existing qualitative studies pertaining to the experience of postpartum weight retention (Kieffer, Willis, Arellano, & Guzman, 2002; Lambert et al., 2005; Setse et al., 2008) and depressive symptoms (Amankwaa, 2003; Beck, 1993, 2002) by considering both in an ethnically diverse sample (African American, Hispanic, and Anglo/White) of low-income postpartum women. The aim of this study was to develop an understanding of the meanings of weight changes and depressive symptoms during the extended postpartum period among low-income women as the basis for future development of community-based weight loss and health promotion interventions relevant to this population.

METHODOLOGY

Design

Semistructured focus group methodology (six focus groups; two per ethnic group) was used to obtain descriptions of the mothers’ experiences and concerns related to weight and depressive symp-
toms within their life context during postpartum (Krueger & Casey, 2000). The focus groups were conducted in a comfortable, private room located in a women’s wellness center administered by a large university School of Nursing in the southwestern United States. Institutional Review Board approval was received for this study. Before each focus group, women signed a letter of informed consent for participation in the study and agreed to be audiotaped. Participants were encouraged not to use personal names during the discussion, and any names used during introductions were redacted from the printed transcripts.

Participants

Participants were a purposively drawn sample of women who participated in a longitudinal study of psychosocial correlates and postpartum weight retention (Walker, Freeland-Graves et al., 2004). Inclusion criteria for the earlier study required that women be over 18 years of age; have a medically uncomplicated pregnancy; delivered term, healthy, singleton newborn; had received Medicaid reimbursed perinatal care by private physician; and were able to read and write in English. (For a complete description of the sample from which the focus group participants were selected, see the report by Walker, Freeland-Graves et al., 2004.)

Women were invited to participate in the focus groups if they had completed the longitudinal study and, at 12 months postpartum, had either a body mass index (BMI) of 25 or greater (indicative of being overweight, \(n = 10\)) or a total score of 16 or greater on the Center for Epidemiologic Study-Depression Scale (CES-D; suggestive of elevated depressive symptoms, \(n = 3\)), or both (\(n = 12\)). The mean age of focus group participants (\(n = 25\)) at enrollment to the original longitudinal study was 24.3 years (SD ± 4.3; see Table 1 for additional sample demographic information). Three women reported being pregnant again at the time of the focus group meetings.

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anglo</td>
<td>6</td>
<td>24</td>
</tr>
<tr>
<td>African American</td>
<td>9</td>
<td>36</td>
</tr>
<tr>
<td>Hispanic</td>
<td>10</td>
<td>40</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partial high school</td>
<td>8</td>
<td>32</td>
</tr>
<tr>
<td>Completed high school</td>
<td>10</td>
<td>40</td>
</tr>
<tr>
<td>Some college</td>
<td>7</td>
<td>28</td>
</tr>
<tr>
<td>Family income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; $15,000</td>
<td>11</td>
<td>44</td>
</tr>
<tr>
<td>$15,000–29,999</td>
<td>7</td>
<td>28</td>
</tr>
<tr>
<td>&gt; $30,000</td>
<td>7</td>
<td>28</td>
</tr>
<tr>
<td>Married</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>13</td>
<td>52</td>
</tr>
<tr>
<td>No</td>
<td>12</td>
<td>48</td>
</tr>
</tbody>
</table>
Data Collection

Participants self-selected into one of two available ethnic-specific focus groups that were held after the completion of the longitudinal study. Women were 12 to 24 months postpartum at this time. Each group consisted of 3 to 6 women and met once for approximately 2 hr. The project manager, experienced in group process, and a staff member (one of the authors) of the same ethnic background as the focus group members served as facilitators. Each focus group discussion was audiotaped using a nonintrusive multidirectional microphone linked to an out-of-sight recorder. The women were told that the purpose of this discussion was to understand the experiences and health-related problems that some women face in the later postpartum period. Participants were not told that their selection was specifically based on weight status and/or presence of depressive symptoms at 12 months postpartum. Women in each focus group were asked to respond to similar questions. Several postpartum health-related global questions were included in the focus group discussion. However, results reported here focus exclusively on questions dealing with pregnancy-associated and resultant postpartum weight changes and experiences with stress or depression after the delivery (see Figure 1).

Data Analysis Approaches

Established guidelines for analysis of focus group qualitative data (Morgan, 1997; Speziale & Carpenter, 2006) were followed in data analysis. Verbatim transcripts were prepared from each audiotape. Before data analysis began, we reviewed and discussed guidelines to facilitate bracketing individual beliefs and to identify procedures to isolate experiences described by participants in the narratives. Data for analyses included the verbatim transcripts, facilitators’ field notes, and memos from multiple discussions among research team members.

Individuals (B.S., M.K., A.G., S.J., S.W.) experienced in qualitative data analysis reviewed each transcript separately and classified comments regarding weight changes and depressive symptoms. Soon after each focus group discussion, two members of the research team listened to the audiotape, read the transcript simultaneously, and made detailed notes of common experiences and preliminary themes. Another member of the research team (S.K.) analyzed the narrative solely from the written transcript. Members of the research team met on multiple occasions to

1. How has your weight changed since becoming pregnant and having your baby?
2. How do the weight changes in this recent pregnancy compare to the weight changes in previous pregnancies?
3. How do you see those weight changes affecting you?
4. How do you think those weight changes are affecting your children and your family?
5. What were your experiences of feeling stressed or depressed during pregnancy or during postpartum?
6. How did those periods of stress or feelings of depression affect you and your family life?

FIGURE 1 Specific weight and depression related questions asked in focus group.
identify representative textual examples describing women’s experiences, and to establish consensus on component and overarching themes. This was done as a measure of credibility to insure the phenomenon was accurately identified and described.

To enhance dependability of the findings, two focus groups were held with members of each ethnic group. Descriptions were included using the participant’s words and phrases to represent developing themes (Denzin, 1998). A measure of trustworthiness was confirmed when similar themes emerged from each of the six focus groups.

**FINDINGS**

The major overall theme that emerged from the data was that of altered perceived personal control in postpartum. Even though perceived personal control, as a phrase, was not verbalized as such in each group or by all participants, comments regarding weight retention and depressive feelings overwhelmingly reflected their persistent feelings that life, decisions, and personal environment were being controlled by someone or something else.

**Altered Perceptions of Personal Control About Postpartum Weight**

Even though a BMI of 25 or greater was one of the two criteria for participation in the focus group, not all of the overweight women perceived themselves as having a weight problem at the time of the focus group discussion. However, for others, their current weight status or their postpartum weight changes were a source of concern, frustration, anger, and self-depreciation. Common experiences describing postpartum weight gain and retention were consolidated into four subthemes: actual pregnancy-associated weight changes; factors influencing weight changes; effects of weight on self, family, and other relationships; and stimuli and activities for taking control of weight status. These subthemes are explained in the following section.

*Actual pregnancy-associated weight changes.* All participants discussed experiences of weight gain during pregnancy and varying success stories with losing that weight during postpartum. The actual weight gained during the recent pregnancy varied. Only a few women gained within the range of normal or ideal recommendations and then lost the pregnancy associated weight. The majority of women gained above the recommended amount for their BMI and retained excess weight after the initial early postpartum weight loss.

> When I got pregnant with my first one I was at 105, and I gave birth at 198 and then I went down to 150, now I am about 175 and I hate all this up and down.

I’m like probably 80 pounds more now, probably close to 200 pounds right now.

*Factors influencing weight changes.* Participants described factors and situations that they believed were causes of weight gain and retention. These factors were primarily seen as external factors over which they had limited perceived control and included “my metabolism,” “hormones,” “my genetics,” and “breastfeeding.”

> I come from a family where all my sisters are really big…

> “I lost the weight but then she really started breastfeeding and I just started gaining.”
During pregnancy you get to gain weight and your metabolism slows down and then you have the baby and think you're going to lose it and it never happens.

I just started gaining weight just rapidly. I don’t know what happened.

Women frequently compared weight changes with different pregnancies, but all agreed that multiple pregnancies in a relatively short time resulted in cumulative weight gain and retention and resulted in an overweight status simply from the pregnancy associated weight changes.

After my first son I did lose a little weight, but after my second son, I didn’t lose, I gained weight and now it is really bad.

My first son, I lost a lot of weight. On my second son, I didn’t lose, I kept gaining weight; I ended up gaining more and more.

Another factor influencing weight over which participants felt they had no real control was that of knowing healthy ways to lose weight. Even though most participants were eligible for federally funded health care services, the majority did not utilize these services throughout the first postpartal year. When the women did have contact with health care providers, nutrition and weight loss strategies were not discussed.

Sure I went to their classes, but it’s nothing about teaching the mothers, you know, about nutrition and weight loss, and how to stay healthy.

Participants elaborated on three areas that they identified as powerful barriers to weight loss over which they also had limited perceived control: time to prepare healthy foods, time to exercise, and control over mindless eating. Inadequate time for nutritional food preparation or exercise was identified in each ethnic group as a major barrier to healthy eating and weight loss. Even though only a small percentage of women indicated that they were working outside the home, they identified time management as a major barrier to weight loss. Participants frequently stated they felt they had limited personal control over this.

I don’t have time to myself to do the things I want to do, which is lose weight and exercise.

For me it’s time. I don’t have time to prepare like this really good healthy meal or go exercise.

I don’t feel there’s enough time in the day to cook a meal.

Even women who had not retained excess weight or were at a more normal weight agreed that inability to manage their personal time to be organized were significant barriers to improved health.

Several participants identified emotional eating as the cause of weight gain or their inability to lose weight. These women readily acknowledged their awareness that eating was a response to feeling the stress that generally followed an adverse interpersonal event, yet they perceived that they did not have control over their stress response at this time.

I can’t change it [eating practices] because I have no control.

My husband upset me a couple of days ago. The first thing I wanted to do was run to the convenience store and eat a funnel cake.
I just want candy. When I’m upset, it’s the first thing I want to do.

Mindless eating, the practice of unplanned eating when not hungry and when engaged in other activities, was also identified as a cause for weight retention. Many mothers described frequent instances of eating food left by children in addition to their full individual meal and their habit of snacking on calorie-dense foods while watching television or engaged in light activity childcare.

Yea, and then when you’re bored, it’s a never-ending cycle. I wasn’t like this before pregnancy.

Eating out of boredom, or when stimulated by other emotions, was identified in all ethnic groups, but particularly by Anglo and African American women.

**Effects of weight on self, family, and other relationships.** The experience of retained pregnancy associated weight was described in negative, frustrating, and hopeless terms. Excessive weight gained during pregnancy that was retained after the birth had a pervasive negative influence on women’s perceptions of personal control. The majority of women wanted to lose the weight they either retained following pregnancy or had newly gained during postpartum.

The absolute amount of weight was a source of extreme frustration for many women and was evidenced in comments about self-concept, body image, and interactions with their spouse or partner and family. Women talked almost wistfully of wanting to have their lives and bodies revert to the original nonpregnancy state.

I wish I could be like I used to be before I got pregnant, smaller, feel good inside about myself. I wasn’t like that before I had her.

Several women expressed extreme displeasure with their self-concept and body image resulting from retained weight.

Weight is a horrible, horrible thing.

None of my clothes fit. I hate the fact that my stomach is sitting on my lap. It’s driving me crazy.

Women also felt that their weight had a significant negative influence on daily activities and on their overall family functioning. There was a sense of “missing out on” the child’s growing experiences because excess weight frequently prevented full involvement in play activities. Some participants felt they were relinquishing their responsibilities as mothers not to be able to play with the children because of the weight, yet chose not to be more active or were not able physically to engage in these play activities.

Because of how much I weigh, I just don’t have the energy for the children.

My kids want me to play with them, but I don’t feel like moving. I let my husband play with them.

I hate being so big, because I don’t have energy for the kids.

Relations with the participant’s husband/partner changed during postpartum because of excess weight.
When I didn’t lose the weight he (husband) started staying up later than me and not coming to bed.

My boyfriend used to put me down saying I wasn’t losing my weight fast enough for him after the birth.

I kept my weight for so long because he left me emotionally.

Mothers frequently talked about a double standard for tolerance of weight gain with men, especially with their husbands, as opposed to weight gain for women.

It’s OK if he gains a few pounds and gets a little belly—but boy, because I have this weight from the pregnancy, boy that’s a different story.

It’s terrible why we put so much emphasis on our physical size.

Participants frequently discussed instances of feeling talked about or silently ridiculed because of their weight, particularly in public eating situations.

I hate that feeling that if I’m eating a candy bar that people are looking at me and questioning, “Why are you eating that candy bar?” I just hate the whole thing.

So I was really big and when we go to the store, everyone’s staring at me, just that feeling of insecurity.

Stimuli and activities for taking control of weight status. Participants also shared experiences in which they did begin to assume personal control over events leading to weight changes. When prompted to identify the timing and particular stimuli for taking steps to lose weight, several women described specific events that served as triggers to take the initiative to be more conscious of healthy eating and physical activity. Some participants identified experiences of seeing themselves in a recent picture or on a family video; others described situations with the children that served as personal stimuli. Participants saw these events as triggering a “new beginning.” For some mothers, the events occurred earlier (e.g., around 2 to 3 months after delivery).

“Maybe about 3 months. I had a C-section but I wanted to get back to doing everything as soon as I could.

About 2 months or at least I remember wanting to do this right away—the problem is, that feeling didn’t last.

For others, the triggering event coincided with the ninth or tenth postpartum month, when the child began to eat table foods. When the women realized that, “He’s eating the same thing I’m eating,” it resulted in a “new beginning” and renewed commitment to individual self-care.

Altered Perceptions of Personal Control About Postpartum Depressive Symptoms

One of the criteria for participant selection was a total score of 16 or greater on the CES-D at 12 months postpartum, suggesting that some participants had elevated depressive symptoms at that time. Even though the focus groups for this study were held up to 24 months after the CES-D measurement, participants shared vivid descriptions and personal stories of living with postpartum de-
pressive symptoms emphasizing the volatile, out of control feelings resulting from this debilitating experience. Three subthemes emerged from the group discussions: the experience of depressive symptoms on self, feelings of isolation, and a sense of altered personal control with the health care system. These subthemes are explained in the following section.

**Experience of depressive symptoms on self.** Participants described the unexpected, surprising, and extreme mood swings and erratic feelings they could not anticipate and over which they felt they had no control. Erratic mood swings resulted in either decreased physical energy or, conversely, a sense of “nervous energy all day” that negatively affected the participant’s ability for self-care and the ability to provide childcare.

Sometimes, you’re okay for a couple of days, and then you wake up in the morning and just start crying all day. I remember having to crawl into the bathroom because I could not face anybody.

One woman described her experience with excessive energy.

One of the symptoms is like making sure everything is in its place, and it’s like the nesting syndrome like before you have the baby, and how you clean everything. Well, I had nothing else to clean.

**Feelings of isolation.** Participants noted the negative cyclic impact of depressive feelings on spousal and family support and the difficulty resulting from a perceived lack of understanding by others in the family. This absence of anyone to talk to resulted in increased introversion and detachment that potentiated the feelings of being unable to control their own actions or responses to others.

I couldn’t talk with my mother about it. I couldn’t talk with my husband. He just could not grasp the idea that I had those feelings.

It was 4 months after I had my baby. I was feeling it, but I wasn’t saying anything to anybody. It was just coming on strong every day but I couldn’t say anything to anybody about it.

All participants expressed a sense of relief upon hearing that all the focus group participants experienced similar types of depressive feelings at some point after delivery.

I wasn’t sure if anybody else went through what I went through.

My fiancé said, “You are not the only one.” I said I know that I’m not the only one, but sometimes I feel like I’m the only one feeling this way.

**Altered personal control during interactions with the health care system.** Participants experienced a sense of altered perceived control over dealing with symptoms of postpartum depression because they left the hospital after delivery with minimal instruction in signs and symptoms of emotional stress. Furthermore, they did not know if their feelings could be considered within acceptable limits or if they needed to consult a professional.

I didn’t know what to expect. Nobody ever told me it was okay to feel this way after I had her. I don’t think I would have worried so much about not being a good mother if I knew that feeling this way was going to happen.
A significant contextual influence affecting many participants’ feelings of altered perceived control during interactions with the health care system was the pervasive fear of long-term repercussions for seeking care or receiving treatment for postpartum depression. Some participants equated depression with “being crazy,” and participants in all ethnic groups verbalized concern that the “wrong” medication would be prescribed, that the medication would “make me do way out things,” and that they could not trust themselves to care for the child “if I was on that stuff.” Several participants indicated that they had received a prescription for an antidepressant but postponed filling the prescription for weeks because of these fears.

When my daughter was about 6 months, I had postpartal depression and went to the doctor for that. He put me on a little medication, but I didn’t feel right about taking it, so I didn’t take it for a long time.

Some African American and Anglo participants expressed a fear that seeking treatment for postpartum depression, especially through community mental health clinics, would create a vulnerability to investigations by social workers or others who would have authority to remove the child from the home based solely on the mother’s diagnosis of postpartum depression.

I went (to the mental health clinic) and they said, “Do you want to talk to a social worker?” “Uh no.” “No … they try to bring all these people in the room. They might get the wrong idea. I’m not crazy. I don’t want them messing with me or my children.

Even though only a few participants verbalized this fear, other mothers in the group reinforced the pervasiveness of these concerns.

**DISCUSSION**

The theme of altered perceived control emerged from postpartum women’s conversations about weight retention and depression. Perceived control over weight retention was altered by the actual amount of weight retained, short intervals between pregnancies, lack of time to cook and/or exercise, lack of information about effective weight loss strategies, and mindless eating. Weight retention had a negative influence on the woman’s self-image and relationships with family. Women reported that the time when their infant began to eat table food resulted in an increased awareness of their weight retention. Postpartum mothers who experienced altered perceived control over depressive symptoms recalled the swings in mood and energy vividly, a sense of isolation, and fear of the response from community health care providers.

The findings from this study reinforces the “vicious cycle” of retained weight described by Krummel (2007, p. 37). Women were unable to lose the weight they retained from a past pregnancy before entering another pregnancy, which can significantly impact the course of the subsequent pregnancy (Edwards, Hellerstedt, Alton, Story, & Himes, 1996). Also, women who retained weight after childbirth often experienced an altered relationship with her child as a result of a lack of energy, which commonly occurs when women maintain extra weight.

Women in this study who engaged in mindless or emotional eating often retained weight. These findings are consistent with research reporting more emotional eating in women who were classified as obese 1 year postpartum (Nuss, Clarke, Klohe-Lehman, & Freeland-Graves, 2006). Life stress experienced by overweight and obese low-income mothers can trigger emotional eating and inhibit healthy eating habits during the postpartum period (Chang, Nitzke, Gulford, Adair,
Hazard, 2008). Identifying the time that infants start to eat table foods as a trigger for women to increase their awareness about their weight and eating habits is unique to this study. More research is needed to understand this phenomenon in more depth.

Depression and elevated depressive symptoms during postpartum has been termed the “most common complication of childbirth” (Beck, 2008, p. 122) and attests to their pervasiveness and negative impact on a woman’s life during the first year after delivery. Postpartum depressive symptoms including irritability, anxiety, inability to plan and maintain a healthy environment, and feelings of disorganization are frequently seen during the adjustment phase following childbirth (Beck & Indman, 2005). Prolonged or exaggerated feelings such as these, especially when experienced in a low resource and low support family environment, can adversely affect child functioning and development (Beck, 1998; Leiferman, 2002). Findings of being “the only one” suggest a persistent feeling of isolation in varying postpartum populations, changing relationships, and family misunderstanding or fear of mother’s depression and changed behavior (Kanotra et al., 2007).

This is one of the first studies in which women stated their fear of retribution if they sought treatment to manage their depressive symptoms after childbirth. Their concerns about being viewed as crazy or given medication that inhibited their ability to care for their children and, subsequently, that their children may be taken away, deterred women from seeking appropriate mental health services. Community health nurses must be sensitive to these concerns when seeking to refer women who may be experiencing depressive symptoms after childbirth.

Until recently, maternal health during postpartum has been researched in isolation with emphasis on the particular medical diagnosis of depression (Beck, 2002; Goodman, 2004; Howell, Mora, & Leventhal, 2006) or on maternal obesity and retained weight (Keller, Records, Ainsworth, Permana, & Coonrod, 2008; Linne, Dye, Barkeling, & Rossner, 2003; Walker, Freeland-Graves et al., 2004), often overlooking the implications of a combination of these factors. Although this study’s questions focused on understanding new mother’s experiences with postpartum weight retention or depressive symptoms, 44% of the low-income women in this study experienced both weight retention and depressive symptoms during the postpartum period, thereby highlighting the prevalence of these comorbid conditions. Although research suggests a positive relationship between prepregnant BMI and the development of postpartum depressive symptoms (LaCoursiere, Baksh, Bloebaum, & Varner, 2006), this is one of the first studies to examine women’s feelings about their postpartum body size and depressive symptoms. Although a relationship between weight retention and depressive symptoms during the late postpartum has been reported in a primarily Anglo population (Carter, Baker, & Brownell, 2000; Herring et al., 2008; Walker, 1997), this study explored this association in an ethnically diverse sample. Recent research (Cheng, Fowles, & Walker, 2008; Hung, 2004; Kanotra et al., 2007) is facilitating greater understanding of the entire experience of postpartum, thereby allowing researchers and health care providers an opportunity to develop and test interventions from an evidence-based perspective that address all aspects of this life-changing period in a woman’s life.

Limitations

This study was limited to a small number of women who had completed all scheduled assessments in the larger research study of weight and thriving during postpartum. We purposefully invited women to participate in the focus groups that had retained pregnancy-associated weight or had elevated depressive symptoms, or both, at 12 months postpartum. With those characteristics, the
women had a heightened awareness of their weight status and experiences with depressive symptoms following the pregnancy. Because eligibility requirements dictated that women met specific criteria, these women may not have been characteristic of all low-income new mothers. Participation was limited to one time-limited focus group, which may not have allowed sufficient time to fully discuss concerns about postpartum weight retention and depression.

**Implications for Community Health Practice**

The results of this study can guide the enrichment of community-based health promotion programs directed to low-income women after childbirth. First, programs must be sensitive to meanings that low-income mothers ascribe to weight retention and depression and incorporate strategies, such as stress and time management activities, to increase perceived personal control. Interventions aimed at assisting new mothers to develop a sense of personal control, increase their knowledge of healthy eating and effective weight loss approaches, may strengthen their ability to lose excess weight, resulting in improved health. Second, community-based programs to foster increased personal control in new mothers should be built on congruent behavioral theories, such as those that address personal control or self-efficacy (see Rimer & Glanz, 2005).

Conducting community-based programs in a small-group setting that is family-oriented may decrease the feelings of isolation that many low-income women experience and increase their sense of support. Programs that focus on improving healthy eating patterns and increasing physical activity for partners and children, as well as for the individual mother, are more likely to be effective in supporting weight loss in African American and Latina women (Setse, et al., 2008; Thornton et al., 2006).

Community health nurses who monitor infant health are often the primary health care providers mothers encounter during the postpartum and could take advantage of the well-baby visits to assess unmet maternal health concerns (Kahn et al., 1999). For example, when anticipatory guidance is provided to mothers regarding the child’s developmental stage during routine well-baby visits, community health nurses should ask mothers if they are experiencing any health problems and could use validated screening tools to identify mothers suffering from postpartum depression. A mother could then be referred for further assessment and treatment if needed.

However, community health clinics may not have the resources to provide personal attention to an ever-growing number of low-income postpartum women, and subsequently may not detect the emotional and physical stresses that affect their health status. Furthermore, after childbirth, when the focus of attention for the community health nurse shifts from addressing maternal concerns to addressing the child’s health needs, weight retention concerns and maternal depressive symptoms may be inadvertently overlooked. Community health-based demonstration projects should be developed and tested that focus not only on providing family-planning information, but also on meeting the physical and emotional health needs of postpartum women in conjunction with current well-child programs. Such programs could enrich the child’s home environment, promote mother–infant interaction, and support appropriate infant development.

Evidence-based recommendations (McQueen, Montgomery, Lappan-Gracon, Evans, & Hunter, 2008) offer specific guides for nurses to use in identifying, assessing, and developing intervention strategies for women exhibiting signs of postpartum depression and weight gain or retention. These recommendations should be made available to all providers who interact with women and can include primary care practitioners in community health clinics and those in public
and private schools (Walker, Sterling, & Timmerman, 2005). Focusing interventions on one isolated condition, such as depression or weight retention, may fail to recognize additional areas of the new mother’s life that she perceives to be out of control. Exploring the context surrounding these perceptions may reveal the need for referral, unrelated to either weight or depression, and may offer needed support to the family undergoing this life transition.

REFERENCES


