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Moving After Baby: Developing Informed Dance/Movement Therapy Interventions for Symptoms of Postpartum Depression

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Abstract

This thesis was a phenomenological study, which investigated the lived experience of four women who had changes in mood and behavior postpartum. The purpose of this study was to fully understand the actual experience of women going through the changes instead of basing interventions off of a list of symptoms in a book. The study culminated in the development of three client centered dance/movement therapy interventions to treat the changes in mood and behavior that the participants experienced in hopes of preventing a formal diagnosis of postpartum depression. This study expanded the literature related to the treatment of postpartum depression, which is primarily limited to cognitive behavioral therapy (CBT) and the use of exercise. This study also laid the foundation for future research on the use of dance/movement therapy as an evidenced based modality for postpartum depression.

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Chapter 1: Introduction

Though I never experienced PPD I found the transition to motherhood difficult and disorienting. It required me to find myself again; a task that is ever continuing in my identity as a mother. In the beginning, I remember sitting around my house after giving birth to my own children, being told by my doctor that I could not exercise. I am typically a rule follower, so I did not question why. I was also too tired from being awake all night with each new baby to do much movement. My emotions would fluctuate quickly between being happy and being sad to the point of tears. I always wanted an adult with me in part for company and comfort, and in part because I was afraid to be left alone with a new human that was my responsibility. I believe that simple movements would have helped me regulate my emotions. When I had energy I wanted to get up and do something, like move my body or be creative. My body felt peculiar as it was healing from an experience unlike any I had previously had, and I wanted to get the depressed energy out and feel more comfortable in my own skin.

I had always used exercise and dance to cope with stress in the past, and that means of coping was taken away. I now know that there are some dance/movement therapy (DMT) techniques, which could have given me a little bit of movement as well as an outlet for all of the different emotions that I experienced after bringing home my babies for the first time: the excitement of one's family growing, the nervousness of realizing one's responsibility for raising this new innocent human, and the sadness and the happiness of how one's life changes. This made me curious about other women's experiences after giving birth and how DMT could possibly help them.

My hypothesis was that DMT can help a woman explore her new identity and feelings about her new identity in a creative and non-threatening manner because it incorporates both verbal and non-verbal components. DMT can also help women gain a sense of self and an awareness of their body through using their body as a tool to heal. The American Dance Therapy Association (American Dance Therapy Association, 2016) defines DMT as "the psychotherapeutic use of movement to further the emotional, cognitive, physical and social integration of the individual." DMT adds a kinesthetic level to the relationship, which can help to minimize feelings of being alone. DMT espouses looking at and treating the interconnected mind, body, and spirit (American Dance Therapy Association, 2016). It offers a unique perspective as—like exercise—DMT brings in the aspect of movement; however, DMT utilizes this movement-based perspective to create a shift in the woman's state of mind and create cohesion between the woman's mind, body, and spirit. Finally, DMT can facilitate an effective interaction between mother, baby, and partner (Hurst et al., 2011)

Postpartum depression (PPD) has seemingly only become a well-known phenomenon in the past 20 years. Despite its apparent rise, there were gaps in the literature at the time of this study. First, DMT was not researched as a treatment for PPD; rather, the literature focused on cognitive behavioral therapy (CBT) and exercise. Therefore, I wanted to know more about the relationship between DMT and treating symptoms of PPD. Second, although 8-19% of women are diagnosed with PPD (Center of Disease Control and Prevention [CDC], 2013), the women's experiences of the symptoms were never discussed (Flynn, O'Mahen, Massey, & Marcus (2006; Mendelson, Leis, Perry, Stuart, & Tandon, 2013). Instead, a list of known symptoms were presented in the literature (Brandon et al., 2012), which sparked my curiosity and led me to use phenomenology as the methodology for my research. Furthermore, I wondered what it was like

for those that experienced the symptoms of PPD, but did not meet the full criteria for a formal diagnosis. I was curious about what these women needed at that point in their lives in general, but more specifically in terms of how to help them through the transition and diffuse some, if not all, of their uncomfortable changes in mood and behavior. I wanted to take that information and create informed interventions, in hopes that the interventions would meet the women's needs.

My theoretical framework is a combination of several different approaches. I fold concepts from CBT, humanistic/person-centered theory, Internal Family Systems (IFS), Chacian DMT, and Schoop DMT into my own worldview to create my theoretical framework. CBT focuses on what behaviors people do and why those behaviors were created based on clients' perspective of the world and how they interact with their environment. To change an undesired behavior, the therapist and the client work together to change perspective or thinking patterns, and therefore change the behavior, or vice versa (D'Andrea, Ivey & Ivey, 2012). As an emerging dance/movement therapist, I use movement behavior in part to change a person's thoughts while also bringing awareness to how an individual's thoughts are reflected in their movement.

The aspects of the humanistic tradition that are folded into my own theoretical framework are the explicit emphasis on the use of empathy, the focus on the relationship between the client and the therapist, and the promotion of individual choice (D'Andrea & Ivey, 2012). Clients know themselves better than I do, and therefore I cannot dictate how a session can go but look to them for guidance, and then I can facilitate the session to help them reach their goal. Rogerian person-centered theory does this through the use of empathy and building rapport between the client and the therapist (D'Andrea & Ivey, 2012). Empathy is used to enter into clients' worldviews so that therapists can further help clients with what they want to accomplish

(D'Andrea & Ivey, 2012). The relationship is looked at as one between two equal humans, both benefitting from the interaction (D'Andrea & Ivey, 2012). I prefer this perspective, because it gives clients control over their lives and places value on the interaction. It takes the therapist off the pedestal and shows the client that the therapist does not have all the answers, but that together they can create change. In my research, this led me to include interviews of participants, honoring them as experts in their experience of the uncomfortable changes in mood and behavior after giving birth.

I also value honoring each part of an individual, which is supported by the IFS model. IFS looks at a person's behaviors and personality as broken into three autonomous parts, creating an individual's internal system. The exiles, who contain the pain, fear, and sadness from hurtful past experiences; the managers, who try to keep the exiles locked away because they make people vulnerable to being hurt again; and the firefighters, who take over when the exile part gets out by putting out the fires of feelings that emerge when the exiles take control by dousing it with something such as food, drugs, etc. Looking at each part individually can often give it the recognition it needs and allows the client to fully understand what that part's role is and why it is there. The parts system allows clients to look at certain aspects of their personality, not the entirety of their personality, which is simply less overwhelming and often gives the clients the distance they need to approach an issue (Goulding & Schwartz, 1995). I believe that we are all made of parts and it is easier to look at issues from a parts perspective at times. In my research, I referenced the participants' parts at times as I would paraphrase what they stated, allowing for a deeper understanding of their experience. I also used this perspective when creating one of the interventions.

Marian Chace was one of the pioneers of DMT, creating a new field that combined dance and psychology (Levy, 2005). Chace's theory was based on two assumptions: one, that dance is communication, and two, that communication is a basic human need (Levy, 2005). Chace would seek out and engage those aspects of a client's personality that were available, no matter how minimal (Levy, 2005). When facilitating a session, I encourage clients to speak as little or as much as they want, allowing the same for movement. Often clients will make little movements. I watch for them and then use the little movements to facilitate bigger movements. In my research, I looked for any sign of movement, and at times, asked my participants to move or pose to show me how they felt. I observed how they were communicating through their bodies and then asked them if my interpretations of their movements were accurate.

Trudy Schoop, another DMT pioneer, believed that what happens in our mind has a reaction in our bodies and vice versa (Levy, 2005). Schoop was unique in her use of humor and performance when facilitating DMT (Levy, 2005). Her use of humor was specific and intentional in that she used humor to help people be more comfortable with movement and in acknowledging their own inner conflicts. She used it as a tool to help clients, as she used her own body as tool through modeling behaviors and movement processes (Levy, 2005). I was drawn to Schoop's method of DMT, because it appeals to and works with the majority of client populations. I use humor to build the therapeutic relationship and bring people into movement, an activity not many are comfortable with. I used this piece of Schoop's style in my research to help the participants be comfortable with doing movement as well as being taped and sharing personal information.

The purpose of this study was to create informed DMT interventions to improve women's experiences of uncomfortable changes in behavior and mood after giving birth.

Currently 8-19% of women who give birth are diagnosed with postpartum depression (CDC, 2013); however, a study showed as many as 20.4% of women in a single U.S. state self-identify as having symptoms of postpartum depression (CDC, 2013). To be diagnosed, the women have to meet specific criteria pertaining to the number, severity, frequency, and duration of the symptoms. However, many women do not receive a formal diagnosis of postpartum depression, yet still experience uncomfortable changes in behavior and mood. Changes in their behavior and mood after giving birth may be less intense, fewer in number, or shorter in duration than what qualifies for a diagnosis, but still affects their lives. The purpose of this study is to create informed ways of responding through DMT to address these changes, alleviate any discomfort or distress in relationship to these changes, and prevent a diagnosis as a result of worsening of changes. In this study, I did not interview women with a diagnosis of major depression, but rather interviewed women who had experienced at least two uncomfortable change in their mood or behavior after giving birth.

Chapter 2: Literature Review

This literature review looks specifically at six different forms of treatment for PPD: mother and baby courses, group psychotherapy, cognitive behavioral therapy, interpersonal psychology, exercise, and listening visits. The review also incorporates how DMT has been utilized in the treatment of PPD and creating a cohesive family. Even though there are several different names for PPD, such as, peripartum depression, post-natal depression, and antenatal depression, in this literature review will use the term PPD. The term PPD is used in most of the literature that is referenced, and it is the most common term used in the general public.

Postpartum Depression

PPD has seemingly only become a well-known phenomenon in the past 20 years. It is common for women to experience feelings of irritation, tearfulness, and anxiety in the first few weeks after childbirth, known as the "baby blues;" however, if the "baby blues" do not subside after a week or two, or if symptoms occur one or more months after childbirth, then it is considered PPD (National Library of Medicine, 2012). PPD is a specifier under Major Depressive Disorder in the *Diagnostic and Statistical Manual of Mental Disorders 5* known as peripartum onset (American Psychiatric Association [APA], 2013). Specifically, PPD encompasses the symptoms of a major depressive episode, such as agitation and irritability, changes in appetite and weight, feelings of worthlessness or guilt, and diminished sense of pleasure or interest in most, if not all, activities (APA, 2013, pp. 160-162). However, the symptoms extend to those that are specifically related to having a baby, such as feeling numb or disconnected from the baby, having scary or negative thoughts about the baby, and worrying about hurting the baby (CDC, 2013). There are schools of thought stating that the changes in hormones cause PPD, but there is no hard evidence to prove such thinking. Today, PPD affects

between 8-19% of women (CDC, 2013). In its wake, PPD could leave a family in ruins. The aftermath of such a depressive episode could have continued effects on the child throughout his or her life due to the potential for poor attachment developed in infancy as well as the impact it has on the spouse and extended family (Bennett, 2014).

Prevention

Society and the medical world in general may still solely believe in the hormone theory, but many other causes or risk factors for PPD have been identified, such as stress, low social support, preterm labor and delivery, pregnancy and birth complications, and low economic status (CDC, 2016). By knowing these risk factors and others, researchers can now take a proactive look at PPD and study prevention methods. I found three such studies that all looked at different aspects of prevention. A study done by Flynn, O'Mahen, Massey, and Marcus (2006) showed that women were simply uneducated about what depression was and how to seek treatment, yet early detection was essential in order to curb the attachment affects that could ensue, essentially right after birth (Bennett, 2014). Finding a way to identify women with PPD and encourage them to get treatment was the first hurdle for Flynn et al. (2006). Flynn et al. (2006), as well as Mendelson, Leis, Perry, Stuart, and Tandon (2013), attempted to find a solution to this problem. Flynn et al. (2006) went into a university hospital obstetrics clinic and added the Edinburgh Postnatal Depression Scale (EPDS) to the new patient paper work for women's first prenatal care visit. The doctors then spoke to the patients about depression and ways to seek treatment. These two minimal steps increased the percentage of patients who sought out and received treatment.

Unlike Flynn et. al. (2006), Mendelson et al. (2013) chose to study people who were already seeking help and look more specifically at the preventative program called The Mothers and Babies course (MB). MB was originally designed to be given in a group setting, and taught

women how to modulate negative thoughts, increase supportive and enjoyable contacts with others, and increase pleasant activities through cognitive behavioral theory. The MB course always emphasized the relationship between the women and their babies both during pregnancy and after birth. The MB course consisted of six two-hour modules, which contained didactic instruction, activities, and discussion. In this particular study, the MB course looked at 78 low income, predominantly African-American women that were already participating in one of four *home visiting programs* (HV) (see Appendix A). The HV program consisted of a clinical psychologist or social worker visiting the women in their homes. The women participating in this study were randomly grouped into the control group, who continued to receive the HV program, and the intervention group, who received the MB course in the group setting and then also received a one on one home visit after the first five sessions where group material was reinforced. In the end, they found that the MB program did help in stabilizing mood regulation and increasing feelings of support (Mendelson et al., 2013). These two studies showed that reaching women early in their pregnancy can lower the risk for PPD, allowing for a healthy transition into parenthood.

Pessagno and Hunker (2012) looked at a third method of prevention. These researchers studied the effects of a psychotherapy group in preventing PPD in those at risk. Unlike Flynn et al. (2006) and Mendelson et al. (2013), Pessagno and Hunker (2012) looked at prevention after the baby was born instead of prior to birth. Similarly to Flynn et al. (2006), they went to the hospital where the women gave birth. Pessagno and Hunker (2012) then had all women who gave birth within a three week period fill out the EPDS. Those that scored an 11 or higher and were first time mothers were offered to participate in an eight week short term psychotherapy group. The eight, 90-minute, sessions began after the women were discharged from the hospital,

making it difficult for many of the women to attend the group therapy sessions. This limited the number of participants to those who had the capability to get to the facility; however, childcare was provided for those who participated. Out of the 202 women who took the EPDS, 16 women participated in the study. The eight sessions utilized an interpersonal theoretical framework, focusing on relationship issues and identifying resources. They found their method to be effective in reducing the women's depressive symptoms (i.e., lowering their EPDS score), which showed the efficacy of women in a group setting experiencing peer support, emotional universality, and professional guidance. However, this study also highlighted the limitations created by a non home based program that many mother's face and that providers have to take into consideration, regarding the number of women that can logistically participate (Pessagno & Hunker, 2012).

Treatment

Cognitive behavioral therapy and interpersonal psychology. In addition to studies that examine the prevention of PPD, several studies explore treatment methods after symptoms have manifested. Although risk factors are helpful predictors of PPD, some women are not informed or are exceptions to the rule (Rosenquist, 2010). In general, the literature revealed three main categories of treatment: cognitive behavioral therapy (CBT), interpersonal psychology, and exercise. As the researchers who conducted the MB study hoped to accomplish improved mood and interpersonal relationship between the mother and baby (Mendelson et al., 2013), Vliegen et al. (2013) also used CBT to accomplish this. However, Vliegen et al. (2013) explored hospitalization as a means to provide a "holding environment" (p. 152). Vliegen et al. asserted that mothers are often exhausted right after childbirth, which further increases the psychological breakdown that occurs with PPD. They, therefore, attested that the hospital is the best place for

those with severe PPD, because it provides a supportive and emotional container. The staff created this container by being supportive and emotionally available 24 hours a day. The mothers also had the ability to sleep, because the babies slept in separate rooms for this study, rather than in the hospital room with the mothers, as is typical. Seemingly, the intention behind this was to promote rest and recovery for the women. Once those basic needs were met the women could more aptly focus on rediscovering themselves in their new roles. The rest and recuperation also allowed the women to establish a secure attachment with their babies. This study clearly showed the importance of a safe environment for the mother to explore her PPD symptoms, as well as the importance of rest for the mother to overcome her symptoms.

Just as the MB program was utilized in an HV program, Serge, Stasik, O'Hara, and Arndt (2010) connected home visits with listening visits (LV), also utilizing CBT. Similar to what Flynn et al. (2006) did by using the obstetrics office and having the doctor, a person the client trusted, speak about the need for treatment, Serge et al. (2010) used providers that the clients already had a rapport with to encourage them to obtain treatment and then conducted the treatment. In LV, the provider facilitated active listening and reflected back what the patient said. Both parties then collaborated to solve problems. This intervention specifically targeted the dilemma of reaching those people who needed the treatment, but refused to obtain it due to the negative stigma or low economic status. They also sidestepped the issue of time and childcare by having the intervention HV. This was a valuable intervention, as depressive symptoms decreased over and following the study period showing the significance of creating a trusting relationship for the intervention to be successful (Serge et al., 2010).

Although the LV intervention happened in the family space, as it was HV, and Vliegen et al. (2013) allowed the partner and other family members to enter the hospital as they pleased,

without restraint, neither study specifically addressed the aspect of the family. Brandon et al. (2012) brought this lack starkly into view as they focused on the relationship between the mother and her partner through interpersonal psychotherapy, creating a partnership in therapy. Brandon et al. (2012) incorporated elements of Emotionally Focused Therapy and focused on the attachment needs between mother and partner. Just as attachment theory looks at the attachment of a caregiver and their baby, here Brandon et al. (2012) used research on adult attachment to create the basis for study. They found that studies in adult attachment show that romantic partners want to be together, derive comfort and security from one another, and get upset when the other is unavailable. With this in mind, by having the partners included in the treatment, the mother could express her needs and the partner could learn how to show they are receptive and then meet the mother's needs. It brought the therapy beyond the psychotherapy session and into the world, as the couple took what they learned in a session and practiced/used those tools at home. This was determined to be a safe method, meaning no participant's symptoms worsened and no adverse events occurred. It was moderately successful in that it decreased the mother's EPDS score marginally (Brandon et al., 2012). This study showed the importance of including at least the women's partner in treatment.

Exercise. Exercise has long been known to have positive effects on mood and depressive symptoms; consequently, a number of studies have been done on the effects that physical activity has on depression in general (Da Costa et al., 2009; Demissie et al., 2011; Songoygard, Stafne, Evensen, Salvesen, Vik, & Morkved, 2012). More recently, researchers looked at the effects of exercise and physical activity on women who had PPD, but the results indicated that the exercise was not significantly beneficial for this population (Da Costa et al., 2009; Demissie et al., 2011; Songoygard et al., 2012). Songoygard et al. (2012) found that participating in aerobics and

strengthening exercises between week 20 and week 36 during pregnancy only prevented PPD when the women did not exercise prior to their pregnancy. Conversely, in 2009, Da Costa et al. found that participants' depressive symptoms decreased during a HV exercise program compared to the control group. However, by the three-month follow up, the two groups had no differences in symptom levels (Da Costa et al., 2009).

The lack of encouraging data about exercise relieving PPD could be due to the domain in which the exercise occurs. As Demissie et al. (2011) found, the odds doubled for clients to have increased depressive symptoms when they exercised at work or at home. However, when the exercise was done in a recreational or outdoors environment, there was no association between an increase in depressive symptoms and the exercise (Demissie et al., 2011). This pointed to the idea that environment had a significant impact on the outcome of the treatment. It also hinted to the concept of some interventions, i.e. CBT and exercise, being temporary solutions to PPD.

Dance/Movement Therapy. DMT is founded on the idea that the body, mind, and spirit are inseparable. Therefore, people's experiences live in their bodies. DMT views and utilizes movement, creative or functional, as a way to reflect inner emotional states. DMT uses the body as a healing tool that is always available to help people change their psyche through changing their movement behavior (Levy, 2005). For these reasons, DMT seems like it would be a productive form of treatment for PPD. PPD effects the mind, body, and spirit of a woman and DMT utilizes a tool she always has available, her body.

Though the use of DMT as a treatment of PPD has not been specifically researched, there is some research that connects DMT being utilized to treat major depression. Meekums, Karkou, and Nelson (2015) conducted three small randomized studies on the effects of DMT as a treatment for depression. A total of 147 people participated in the study, 74 participated in the

DMT group and 73 participated in the control (standard care) group. The studies included male and female participants, as well as inpatient and outpatient participants. They found some evidence that DMT was more effective than standard care for adults, but not for adolescents, as the participants' score decreased on the Heidelberger Befindlichkeitsskala depression scale but not an amount considered clinically significant. However, their findings were not clinically significant due to the low quality of data and low participant number.

Pericleous (2011) conducted a review of case studies where dance/movement therapy was used to treat people with major depression. Unlike Meekums, Karkou, and Nelson's (2015) findings, Pericleous (2011) found that in the four case studies she reviewed, dance/movement therapy was an effective form of treatment. The first looked at a man in his twenties, who had panic attacks and "feelings of unreality." The dance/movement therapist had him move around as he wanted and talk while he did so. Consequently, he was able to identify his feelings and realize he had been depressed for many years. Through this realization he was then able to confront his depression head on. In the second case study a 40 year old woman had overwhelming feelings of powerlessness and immobility. By using expressive therapies, mostly movement of her arms, she was able to rewrite her story and get in touch with her inner-self. The third case study was an exploration study on the efficacy of ballroom dancing on geriatric depression. There were 20 participants broken into two groups who participated in eight 45 minute dance session once a week. In the end, their depressive symptoms decreased. The final case study in this review was about a twenty year old artist who was insecure and depressed but also had trouble admitting it. The dance/movement therapist had him whirl through space. Through this specific movement and the sensations that arose from it, the client was able to admit to his depressive feelings and therefore work through them. Though the ages and

circumstances of the clients in every case were different, in each one, DMT helped them resume their normal interpersonal relationships if not improve them. In three of the four, the dance/movement therapist was able to help the clients identify their feelings and therefore work through them, and they were able to break down antisocial barriers that had previously been unbreakable.

Mala, Karkou, and Meekums (2012) also did a review of studies, these being mostly quasi experimental, and found that in seven out of the nine studies reviewed, DMT significantly improved the participants' depressive symptoms. Between the two reviews and one quasi-experimental study, DMT is shown to be an effective treatment for major depression.

Even though there is no specific research on using DMT to treat PPD, there is some literature, and there are some people using DMT to treat PPD. Gabrielle Kaufman is one such person. She has been a practicing dance/movement therapist for over 20 years and has spent much of her time focusing on PPD (Kauffman, n.d.). Similar to the MB intervention, the LV intervention, and Flynn et al. (2006), Kauffman went into the community, as she is a member of the Perinatal Mental Health Task Force in California, which advocates for PPD awareness and de-stigmatization. The organization facilitated a community campaign to instill awareness and take the stigma out of the diagnosis (Perinatal Mental Health Task Force, 2014). In treating PPD, Kauffman (n.d.) utilized CBT and interpersonal psychology as several of the aforementioned studies discussed. However, Kauffman added DMT to each intervention which deepened the experience by focusing on the movement behaviors that were created through the therapeutic alliance. She looked at and developed expressive, communicative, and adaptive movements to explore, assess, and then create change (Kauffman, n.d.) Movement as simple as

walking toward one's baby or learning how to adjust one's swaying tension flow rhythm to soothe the baby added another facet in the treatment of PPD (Kauffman, n.d.).

At the ADTA's annual conference in 2012, Becky Engler Hicks presented her concept of early parenting through DMT. Resembling Kauffman's DMT style, Hicks (2012) utilized various movement behaviors of the mothers to create a shift in their bodies, minds, and spirits to create a stronger sense of self and a stronger bond between mother and baby. Hicks (2012), like Flynn et al. (2006) and Mendelson et al. (2013), can also be looked at to help prevent PPD. Hicks (2012), referencing Kestenberg's work (Amighi, Loman, Lewis, & Sossin, 1999), stated that attuning to one's baby begins in the uterus, which creates a smoother transition into parenthood and consequently a better attachment between baby and mother. Once the baby was born, Hicks (2012) addressed the issue of sleep deprivation, as did Vliegen et al. (2013). One way Hicks (2012) proposed to help this issue, while at the same time addressing the attachment issues, was to have parents enter into resonance through breath, rhythms, feelings, and movements. For example, breathing together or creating a rhythm together. This created a sense of harmony between parent and baby, helping the parent to learn how to reflect back subtle movement and authentic feelings to the baby. This helped the mother know what the baby needed in each situation, allowing the baby to be satiated and sleep better, which allowed the mother to sleep better. Hicks (2012) demonstrated that DMT can address prevention, attuning, and attachment, a few of the core issues of PPD. My study differs from these and most others in that the emphasis is usually on the mother-baby relationship, whereas my study emphasizes the self of the mother.

Like Hicks (2012), Suzie Tortora (2006) also addressing the issue of attachment and attuning in her book *The Dancing Dialogue*. Tortora's (2006) work focuses on how adults can

attune (see Appendix A) to children through movement. She calls her technique ways of seeing, where the adult watching the movements of the child and then mirrors the child. This brings the adult to a place where they can attune to the child which helps with attachment because the child feels that the adult is with them (Tortora, 2006).

At the 2011 annual ADTA conference, Hurst, Lengerich, and Welling explored the concept of using DMT to give and receive through life transitions, addressing specific issues such as identity and uncomfortable changes through people's lived experience, which are a few of the aspects that my study addresses. Hurst et al. (2011) utilized *Laban's relationship taxonomy* (see Appendix A) to move in and out of relationship and explore such concepts as grief. An example of this would be moving in and out of relationship with another person through mirroring each other and then moving on their own or moving in and out of relationship through touching and then not touching. Although Hurst et. al. did not explicitly address birth or PPD, these concepts can apply to PPD as they address a core aspect of the relationship between the mother and baby or mother and partner and grief of the mother's previous lifestyle. This, combined with the use of pedestrian movement for marital therapy, also presented at the 2011 ADTA conference by Nesser, would bring in similar aspects of the family, as Brandon (2012) did with bringing the partner into treatment while using interpersonal psychology.

PPD in Society

Although, more research is being conducted (Group, Kendall-Tackett, & Taylor, 2010) and a better understanding of what PPD is, what causes it, and how to treat it has been gained there are, unfortunately, several myths being perpetuated. Group, Kendall-Tackett, and Taylor (2010) claim that society sees depression in new mothers as not serious and that it will go away on its own. Many people still think that PPD is solely caused by shifts in estrogen and

progesterone or that we do not know what causes PPD. The final myth that Group, Kendall-Tackett, and Taylor (2010) discussed was the misperception that PPD is more common in middle class Caucasian women. Pam Belluck points out in her New York Times article (2014) that this last myth came to be and is in fact perpetuated by the fact that it was White celebrities that helped put a spotlight on PPD through telling the public of their struggles. Celebrities are upper class; however, since those first few celebrities, the media has put a spotlight on Caucasian middle class women, who are actually combating postpartum psychosis (Rosenquist, 2010).

In the book *Conquering Postpartum Depression, a Proven Plan for Recovery*, Rosenberg, Greening, and Windell (2003) state that PPD is viewed from a perspective that sees it as an emotional problem that is separate and unrelated to the physicality of pregnancy and childbirth. The authors conclude that therefore, doctors and nurses do not know a lot about PPD. The authors go on to say that because PPD is not seen as having to do with the physicality of pregnancy and childbirth, only minute parts are addressed in the medical world. Like Group, Kendall-Tackett, Taylor's (2010) list of myths, Rosenberg et al. (2003) stated PPD is viewed in the medical world as similar to the baby blues and will go away on its own, as well as PPD is not serious unless the woman is suicidal. Whereas this may not be as true as it once was, there is still a long way to go in the education of all people about PPD.

The UpToDate online medical journal (2016) gave a shortened list of symptoms and a brief list of treatment options, consolidating pertinent information into one page. However, the same journal published a seven-page article about depression (UpToDate, 2016), going into depth about symptoms, types, risk factors, and a brief mention of treatments, attaching a sample depression questionnaire for readers. Not once on the seven pages was PPD mentioned, not even as a subtype. However, in a nursing text book (Dunphy, Porter, Thomas, & Winland-Brown,

2011) PPD is mentioned a few times, including once where a grounded theory study describes how the women experiencing PPD described their own experience. The study included 12 women who participated in an in-depth interview. The researcher found that the women described their experience as "teetering on the edge" and that they felt between sane and insane. The researcher also identified three stages the women went through: encouraging the terror, where they had overwhelming feelings that came and went in an unpredictable manner; the dying of the self, where they felt isolated and were withdrawn; and struggling to survive, where they began to deal with their feelings and seek out help (Beck, 1993). Today there is no federal law that mandates doctors' offices to screen for PPD; however, at least 12 states have passed legislation to mandate screening, develop awareness campaigns, or convene task forces (Postpartum Support International, n.d.). However, on November 30, 2016, the Bring in Postpartum Depression Out of the Shadows Act passed in the House of Representatives and on December 7, 2016 it passed in the Senate (Bologna, 2016). This piece of federal legislation will authorize the Secretary of Health and Human Services to provide federal grants to states for screening, assessing, and treating PPD; allowing states to create, improve and maintain programs for maternal mental health (Bologna, 2016). Hopefully, this is the first step in the right direction for helping, and possibly preventing, many women from experiencing PPD.

Conclusion

In reviewing the literature, some important concepts surfaced. A few of the studies found that locating the women who needed help and creating a relationship with them was the first step to treatment. Flynn et al. (2006), Meldelson et al. (2013), and Pessagno and Hunker (2012) found a few ways to identify women with PPD and connect them to providers. Going into the hospitals and doctor's offices, as well as finding a way to create a trusting relationship before

treatment is needed, as Serge et al. (2010) did with their LV intervention, were effective options for getting to the people that need help. Kauffman (n.d.) also found a solution by going into the community and creating a campaign to create awareness.

In terms of the actual interventions, CBT, as much as it has been shown to work in improving depressive symptoms and was employed in the majority of the aforementioned studies, focuses on the symptoms rather than underlying issues or the whole person. Exercise improved mood and alleviated depressive symptoms, increasing endorphins, but did not treat the underlying issues. The studies on exercise proved it improved PPD symptoms in the short term, but the benefits did not last for the long term. Pessagno and Hunker (2012) showed that the socialization aspect of a group therapy session does help PPD, but the limitations of the clients needing to find a babysitter, transportation, and time have to be considered when creating a program. DMT can be used in prevention and treatment, individually and in a group, as both Kauffman (n.d.) and Hicks (2012) showed.

DMT uses the body as a means to reach the originating issue and create a shift in the whole person, not simply one aspect of the person. DMT espouses using the connection between the body, mind, and spirit and treating the whole person, not simply the symptoms. As of now, there is no research at all on using DMT to treat PPD. I began to wonder about both the experience of the whole person these studies were discussing and if DMT could be a more effective treatment for PPD. This led me to my research questions of: What is the lived experience of individuals who have had symptoms of PPD? How does the lived experience of PPD inform dance/movement therapy interventions? This study is the first to methodically research using DMT to treat PPD. It will further the knowledge known about the women who have had uncomfortable changes in mood and behavior postpartum and about how DMT can

help prevent and treat women before their symptoms are severe and numerous enough to qualify for a full diagnosis.

Chapter 3: Methods

Methodology

This study examined the lived experience by women having uncomfortable changes in mood and behavior after giving birth to generate effective DMT interventions. The methodology used to conduct this study was phenomenology, which is part of the constructivist paradigm and puts an emphasis on an individual's subjective experience (Mertens, 2005). Phenomenology takes into account the individual's perspective and places value on their perceptions of the phenomenon being studied. I chose phenomenology because it gives a voice to the participants by understanding their lived experience, an aspect that is lacking in the literature on treatment for PPD thus far. Phenomenology refers to a person's lived experience and how "members of a group of community themselves interpret the world and life around them" (Mertens, 2005, p. 240). This methodology utilizes qualitative methods, including semi-structured interviews, movement responses, and member checking to provide the researcher with a glimpse into the participants' experience (Mertens, 2005). I added using the participants' embodied experience as a method because I am writing a dance/movement therapy thesis. I saw the women's bodies as an integral part of the interview as it showed me clues to what interventions I could utilize and what happened in their bodies through their challenging times. I also used *kinesthetic empathy* (see Appendix A) to help conduct the interview.

Just as the participants bodies gave me clues as to what interventions to utilize, the information shared by the participants influenced the interview by allowing for the flexibility to change, add, or rearrange questions. This created a discussion rather than a traditional interview, where each participant is asked the same questions and treated the same way. It created an authentic feel to the interview and the data. Interviewing and being immersed in a discussion

about the participants' experiences, where I could feel the tightness of their muscles and see their physiological changes as they spoke, and then analyzing the transcripts, gave me a bigger picture perspective. The use of semi-structured interviews gave me the opportunity to learn the details of each participant's experience and physically see the bodily manifestations of those experiences. It also allowed me to adapt my questions so I could learn what their actual experience was and not have the questions based on my assumptions or biases. Phenomenology yields an in-depth understanding of a specific phenomenon, which supported my inquiry into women's lived experience of postpartum changes in mood and behavior. This deep level of understanding led to the development of interventions that fit the women's actual embodied experience of living as a new mother, instead of interventions based on a prescribed list of symptoms.

Participants

Four women participated in my study. Three were Caucasian and one was African American. All four women were between the ages of 30 to 35. Three of the women lived in urban areas in the Midwest and one woman lived in a small town on the east coast. Two participants had two children, one had one child, and one had four children. Two experienced uncomfortable changes in mood and behavior postpartum with their first child, one experienced it with her second, and one with her third. Two participants were Jewish, one was Christian, and one was religiously unaffiliated. The women were selected based on the following criteria: lived in the United States, spoke English, were over 18 when they became pregnant and were in a consensual relationship, conceived without medical intervention, parented their baby after giving birth, experienced at least two changes in behavior or mood after giving birth (decreased appetite; difficulty sleeping; irritability and anger; overwhelming fatigue; loss of interest in sex; lack of joy in life; feeling low, shame, guilt, or inadequacy; mood swings; difficulty bonding

with their baby; withdrawal from family and friends), were not currently experiencing changes in behavior or mood after giving birth as listed above, and had not been formally diagnosed with PPD.

Recruitment Procedure

I recruited the participants through my personal network and through the Creative Arts Therapies Department research participant list via email using a recruitment flier (see Appendix B). Recipients from the department list were asked to either reach out to me directly if they qualified or were interested, or forward the recruitment flier to their extended social network. My personal contacts were instructed to simply forward the email on to maintain ethical boundaries. I also placed a recruitment announcement on the American Dance Therapy Association (ADTA) forum and the Illinois Chapter of the ADTA listserv, posting both the email and the flier. The flier was also sent to a therapist who conducts a PPD support group, and one was posted to an online PPD support group through a member of the group.

I took the first four women who responded and self-identified as meeting the criteria to participate in the study. Once potential participants were identified, I sent follow up emails or made follow up phone calls to solicit and answer any questions they had, and ask if they were comfortable receiving the informed consent form (see Appendix C) via email, as I could not guarantee confidentiality due to the lack of security of email. All participants approved of using email. Upon receiving the signed informed consent form, which included the use of video recording, I corresponded with participants to find a mutually convenient time to meet over Skype. All interviews took place within two weeks upon receiving their informed consent form.

Though I had the potential for 15 participants, most of them dropped out of the study. This mostly happened once the informed consent form was sent out or even after it was signed; most people did not respond to inform me they could no longer participate due to the time commitment or unstated reasons. Out of the 15 people who originally contacted me, only four followed through and participated in the interview.

Setting and Data Collection

All interviews took place over Skype, as my participants were from different areas of the country and could not meet me in person to conduct the interviews. When conducting the interviews, I was in my home office with a closed door so to ensure privacy.

The data was collected through in-depth, 60-90 minute, semi-structured interviews, which included both verbal and movement responses by the participants (see Appendix D) and me. Participants were asked to describe their experiences of uncomfortable changes in mood and behavior through being prompted by predetermined questions. The questions were then adapted based on the participants' responses, experiences, and willingness to share. The participants were always in control of the pace of the interview and could stop or pause the interview at any time or refuse to answer a question. Verbal and movement components of the interview were video recorded through the software DVDVideoSoft. This is a software add-on that allowed me to video record the entire interview. As with the other information that was on my computer, it was password and firewall protected.

The verbal section of the interview was transcribed before the next interview occurred, allowing me to adapt my questions for the next interviewee. The movement was included in the data collection process, so that I could more effectively develop DMT interventions to address

the women's needs. The participants' movement responses occurred throughout the interview in two forms. The first was as a response to questions, such as, "what body sensations do you remember from when you experienced the uncomfortable changes in mood and behavior after giving birth?" or "Can you show me in a statue, pose or movement?" Here they were showing me one movement that summarized their experience. Most participants chose a movement that highlighted where they felt the sensations the most in their bodies. The second was in my observations of how their bodies responded or moved through postures and gestures during the course of the interview. A third form of movement data was my own movement response during the interview. My movement responses occurred throughout the interview, as I mirrored certain movements I observed in the participants and took on their movement qualities or postures. I noted these movement responses as they happened, as I was not able to be in the video due to the nature of the interview. This informed my own felt response, which influenced the interventions I created. In other words, my interventions were informed by how my own body felt in the moment: the sensations, muscle intensity, and postures.

Immediately after each interview session, I did my own movement response to the interview, which was recorded on my computer. I did a movement response to give my body felt response to the interview. This gave me an opportunity to move and then analyze the salient movement themes that I experienced during the interview, giving me insight into the four common themes that were found between all participants. It also gave me a place to release any residual tension or emotions I was holding onto in my body from the interview. I moved until I felt finished, when my body did not want to move anymore, and I had released all the held emotions and residual symptoms from the interview, moving between one and two minutes. Then I wrote a journal entry that recorded my reactions to the interview, including what I

observed, heard, and moved. The journal worked in two ways: it gave me a place to record my experiences of the interview and also functioned as an epoché journal, so that I made sure to keep my bias out of the data (Clark Plano, Creswell, Hanson, & Morales, 2007). According to Clark Plano, Creswell, Hanson, and Morales (2007), the goal of the epoché process is to suspend judgment. In phenomenological studies, an epoché journal is utilized by researchers to capture their thoughts, so that they can identify what their biases are and how they manifest. Once bias is acknowledged, it can be better excluded from the research (Clark Plano et al., 2007). For example, through engaging in the epoché process, I found that I expected the participants' symptoms to only last a year, but some lasted up to four years. In addition, I anticipated that most participants would have experienced sadness, but there was more anger than sadness.

Data Analysis

Forinash's data analysis method (Cruz & Berrol, 2012) was utilized to analyze the verbal, movement, and journal data. This is a method of analyzing qualitative data in a six-step theme development process. The six steps, as defined by Forinash, are reviewing the data, marking significant or meaningful parts, organizing the marked data into themes, member checking the themes, constructing a description of the phenomenon, and presenting the findings. I identified key content (or themes that were referred to several times throughout the interview) and then clustered the content that had the same focus. I then compared the clusters from the different interviews to discern overarching themes. The key content was information that was either referred to several times or most emphasized by the participants.

Verbal Response

Directly after transcribing the interviews, I used the first five steps of Forinash's data analysis (Cruz & Berrol, 2012): I marked the key aspects in the transcript to organize it into themes, member checked the themes by asking the participants via email if the verbal themes were accurate, and described the phenomenon for each interview. In addition, I used themes from previous interviews to adapt my questions. For example, when a couple of participants mentioned absent fathers or unsupportive mothers, I made it a point to ask later participants about their relationships with their partners and mothers as well as their emotional support system in general. After each interview was transcribed, I then analyzed across interviews for common themes that led to a common description of the phenomenon and informed the interventions I created.

Movement Response

For the movement responses, I watched the video and noted when and how the participants' movements changed in the transcript. I looked specifically for the four *Effort elements of movement (space, time, flow, and weight), gestures and postures* (see Appendix A), as well as extreme changes in movement (Moore & Yamanoto, 2012). I then analyzed the movements in the transcripts as well as in my journal using Forinash's (Cruz & Berrol, 2012) data analysis: I completed the first five steps to identify the movement themes reflected in the individual interviews and then compared them across interviews. This showed me the salient and common movements and movement qualities that spanned across the participants, so that I could create dance/movement therapy interventions that addressed those aspects. Due to the

participants' limited knowledge of *Laban Movement Analysis* (see Appendix A), I did not member check the movement themes.

Validation Strategies

I utilized triangulation and member checking as validation strategies. Triangulation is using three different methods to collect data so as to self check that the results are consistent. The triangulation consisted of verbal interviews, movement responses from the participants and me, and my journal entries. Member checking (Cruz & Berrol, 2012) happened throughout the interview, as well as during the analysis and final revision process of the completed thesis: I asked the participants in the interview if my understanding was accurate through questions, paraphrasing, summarizing, and reflective listening. I then sent—through email—the theme analysis of their interview upon completion of the first five steps of Forinash's data analysis, giving them a week to review it and send it back. I invited them to provide feedback, clarifications, and/or additional information they felt was relevant to the research data. At the end, once all the data was analyzed I sent a draft of my findings to all the participants. My journal entries and movement responses were also analyzed using Forinash's method.

Ethical Considerations

There were a few ethical considerations that I was aware of before starting my research. First, some of the participants may have known someone whom I knew. There was also the ethical consideration of having a close personal relationship to the person I was initially contacting through my personal network that needed to be considered. To minimize this ethical dilemma, I did not interview someone I knew personally and made sure referents were anonymous because they reached out to me directly. However, there was the consideration that

shared details of interview transcriptions, narratives, and quotations in written findings may un-intentionally reveal a participant's identity or the identity of others mentioned in her interview. To minimize these risks, the participants' information was dis-identified and the data was synthesized so no one participant stands out in the thesis. Part of a phenomenological study is including anecdotes from the interviews in the findings to support the themes found. All participants had a choice to allow this or not. If they allowed the anecdote to be used, a dis-identified participant number was assigned to them I assigned a pseudonym for any people they mentioned in their interview. I also kept all of my paper research data in a locked filing cabinet in my basement in a secure and locked room. Any digital data on my computer was password and firewall protected, and I deleted all the videos once the participants confirmed that my findings were accurate.

In addition, the women I worked with disclosed personal and difficult information that may have felt stigmatizing. To minimize the risk of causing emotional distress or harm, I did two things. First, I discussed with the participants, before the interview began, that this may be a difficult interview and may bring up strong emotions. Secondly, I informed the participants that they had full control over the pace of the interview; they could stop the interview at any point, take a break when needed, or continue the interview at a different time. There was a need to make sure the participants felt safe and sought outside help if they needed it. Though I could not ensure that participants sought outside help, I encouraged it and provided resources. The resources consisted of a national resource for finding a local counselor and online postpartum depression support groups (see Appendix E). I stated in the beginning of the interview that I am a mandated reporter, so any neglect, abuse, or self-harm that was shared would need to be reported. Finally, I used my dance/movement therapy lens to monitor if the interview was causing any stress so as not to trigger the participants in any way. To minimize the risk of

causing the participants to feel stigmatized, I normalized the experience by stating that many women have experienced uncomfortable changes in mood and behavior after giving birth.

Chapter 4: Results

The purpose of this study was to understand the lived experience of individuals who went through uncomfortable changes in mood and behavior after giving birth, to create informed DMT interventions to target the alleviation of any discomfort or distress in relationship to these changes and prevent a diagnosis as a result of worsening of changes. I arrived at this purpose after reviewing some of the literature on postpartum depression. I noticed that much of the treatments for PPD are based in CBT approaches or exercises (Serge, Stasik, O'Hara, & Arndt, 2010; Songoygard et al., 2012), but that the literature supporting these treatments never explain why the therapists chose specific interventions or how the interventions corresponded to the changes in behavior and mood that the women were experiencing. Therefore, I was interested in understanding the women's lived experience of the uncomfortable changes in mood and behavior. Thus my two research questions arose: What is the lived experience of individuals who have experienced uncomfortable changes in mood and behavior after giving birth? How does the information I gather about these experiences inform the creation of DMT interventions?

Through this study, my two questions were answered. Through the semi-structured interviews, a picture of the women's lived experience of changes in mood and behavior after giving birth became clear. After each interview, I transcribed the interview and then read through the transcript one or two times, marking the major statements each participant made. I then extracted the main idea from each statement. From the main ideas, I found general themes. As I added on interviews, I compared the themes I found, resulting in seven common themes: lack of support, frustration, guilt, expectations vs. reality, being/ feeling alone or isolated, no self-care, and identity. My journal responses showed similar themes as they reflected a lot of anxiety and fear, which interestingly began to grow into sense of advocacy for this population.

Table 1

Verbal Themes

Theme	Sample of Supporting data
Lack of Support	*Participant 1* "My husband was working all the time." "I was like really in a bad place, and I was concerned that my mother would think I was stupid for get pregnant again." *Participant 2* "My own relationship with my mother, I think that my mother's inability to sit with her own feelings, she is only able to identify joy… feeling that my mother was not able to mother me the way I feel would have been best." *Participant 4* "My husband wasn't coming home at night, he works four jobs." "She just looks at me and says G-d you need to take a chill pill, I just looked at her like what, I was so just like, seriously? I think she meant it in the sense like you need to take a step back but it was just the most unsupportive thing she could have said."
Frustration	*Participant 1* "I think I just felt wound up, just tense, like waiting for the other shoe to drop, like, just tense and frustrated and, nothing." *Participant 3* "When he's crying and you pick him up, it's not aww. You have those moments, but you're frustrated. You're frustrated with yourself and you're frustrated at him. You are angry at him, the baby is just a baby and he's crying, but you're frustrated at yourself that you can't take it in stride, so I found myself frustrated my myself and that was the relationship for a little while." *Participant 4* "I just remember being like I can't deal with this."
Guilt	*Participant 1* "I would try to pump, with goals. I am not good at pumping so that did not last very long—which is one of those guilt things you give yourself." *Participant 2* "Weighted guilt feeling that doesn't seem to have a place."

Expectation versus Reality	*Participant 1*"I expected he would be born, I'll see him, it'll be great. And I just didn't." *Participant 2* "This euphoria that was supposed to be happening wasn't there." *Participant 3* "I'm supposed to be so happy and I'm not." *Participant 4* "I had two kids before so I was kinda like just waiting. I'll get more use to it, things will start to go but it didn't."
Being/Feeling Alone or Isolated	*Participant 1* "We always hosted things and I don't remember hosting any people that year." "I think it's worse because you feel alone and with a husband at work all the time you are really on your own." *Participant 2* "Not talking about it, you sort of start to feeling like you have to put those feelings aside, and people come because everyone wants to come and see your baby—of course—so you get a lot of extra visitors, and everybody is happy, but you're just, like, well for me I was always like not quite matching that same level of joy so just feeling slightly on the outside, kind of like watching—like your perspective is slightly on the outside." *Participant 4* "I felt a little isolated also that year. It was just me and three little ones." "There were times in my life where it was like maybe a good 6 months where I didn't see people. I wouldn't like go out to dinner on a date with my husband or with friends."
No Self-Care	*Participant 1* "I went to work, did my work thing, went home." *Participant 2* "I got swooped into feeling like my entire existence centered around baby." *Participant 3* "I put him completely first and didn't think about myself at all I just kinda thought about him, him, and what he's going to do and I'm going to take care of him and not thinking about taking care of myself so there was no self-care there was just baby care." *Participant 4* "I just didn't feel like I had time to take care of myself" "It was always rushing to work. And then I would come home. I would get out of work at 5:00. By the time I got home, it was 5:45, you know, and then throwing food together, just bath time, and bedtime."

Identity	*Participant 2 "*I have always been connected to my body, and I had a natural birth. It all made sense while it was happening. My body was changing, and everything was going right, but then when the baby was out and I still had this body and all these hormones but there was no baby, and I think that connected so much to that initial depressed feeling. When you are pregnant, you identify as a pregnant woman and you are carrying a baby and you have a specific purpose and then it's just gone. That mourning piece; you mourn that you are not pregnant anymore and now you have plunge into the next thing." *Participant 4 "*All of a sudden, I'm going from like working and being out of the house all the time to being in the house all the time with the kids. I don't know. And then being alone in the house and I was a very social person but also I didn't know how to be social normally because that was also partying so then I was like are we just going to go to a restaurant like a grown up like a normal person, like I don't know. I didn't know myself socially without that kind of outlet."

Verbal Themes

All four participants admitted to a lack of support emotionally. All had complicated relationships with their mothers, who were thus unable to meet the participants' needs emotionally and sometimes physically. As seen when Participant 2 stated, "There was never that initial connection which I think plays a very valuable role, that connection with your own mother." Participant 1 stated, "I got a lot of flak for having my first child and that's part of the reason I didn't tell my mom, which like not being able to talk to my mother just kind of sent me downhill." Participant 3 stated, "Even though I had my mom she just didn't understand and I think, since she's from Haiti and the whole culture thing of understanding PPD, that's like get it together, put your big girl panties on and move on, you're a mom, and so she didn't understand." All four participants' husbands were also often gone from the house as they were all working late

hours. Participant 3 stated, “The way we communicated at the time wasn’t so helpful,” and “So as much as they could help is what they did, but if we were are just being candid some of the things were not so helpful.” Participant 4 stated, “He definitely was not with me a lot when she was first born,” and “I remember resenting him a lot because he’s like, ‘Oh, come relax, come watch something with me,’ and I couldn’t. He’s like, ‘what’s wrong with you; just come sit down.’ I’m like, ‘I can’t there’s toys everywhere.’”

The lack of support then contributed to the feelings of isolation and being alone. None of the participants spoke to anyone about what they were experiencing; if they started to, they were met with people who could not give them the emotional support they needed or point them in the correct direction. Participant 1 tried to talk to a friend but she was also going through a similar experience and so neither one could identify the problem: “I remember that I told her I was angry but like, she had her own kids at the time and it turns out that I think she had her own things going on with her son that is the same age as my son because I’m pretty sure that we both were kinda going through it together so we both kinda figured that it was normal, so we were not good for each other.” They also tended to stay home and not be around friends. Participant 3 stated, “I pushed them away.” Participant 2 remarked, “I didn’t really talk about what was going on at the time.”

All the participants experienced feelings of guilt and frustration. They each had different reasons for feeling frustrated, but the underlying emotion was the same. Participant 3 stated, “You’re frustrated with yourself and you’re frustrated at him [the baby].” The same occurred with the emotion of guilt. Participant 2 remarked, “There’s just like this guilt and not being able to identify why.” These emotions occurred in part because there was a disconnection between what each woman expected and what the reality turned out to be. For example, one expected to

just be in love with her baby from the first moment she was born. The reality was that she did not fall in love at first sight and in fact had to develop the relationship with a strong sense of intention and hard work. She said, "This euphoria that was supposed to be happening wasn't there." For participant 4, she had expectations that her mother would help both physically and emotionally, but the reality was that her mother was too focused on her own needs and was unable to see what her daughter needed. She remarked, "She has a lot of her own issues emotionally and stuff so she's very wrapped up in herself, you know what I mean. For the good or bad, it just has to be the way it is because that's who she is."

The women were also met with feelings of guilt and frustration in relationship to their identity; participants expressed that the idea of what kind of mother they planned to be was drastically different from the mothers they actually were. Each woman had a sort of identity crisis that occurred during the time she was experiencing the difficult changes in mood and behavior after giving birth. All had a hard time figuring out how to combine their pre-baby identity with their post-baby identity. As Participant 2 commented, "I think for me I kind of went into motherhood thinking this baby is coming along for my ride, I'm doing my life I'm going to have this baby and I'm going to accommodate as much as I can and when your older you will head off and lead your life but for now you coming along for mine." Even for the two participants who were already moms, they struggled with their identity of being a mom of multiple children, being a mom to this particular child because it looked very different, and being a mom to children of different ages. As participant 4 remarked, "I'm a very black and white person so it's hard for me to figure out how to take care of the big ones when I'm trying to nurse and that kind of juggling gets like hard." They all lost their sense of self in this struggle. They could only focus on their baby (and other children), forgetting about the activities they enjoyed

before. Participant 2 stated, "I got swooped into feeling like my entire existence centered around baby." They had to find that life-family balance, as well as a new family balance, and when they did, their uncomfortable changes began to dissipate.

The last theme was a lack of self-care. This related to the themes of identity and isolation, but was also its own theme as all four participants felt that they did not have the time, energy, or money to take care of themselves. They all said it was a time that they just survived; they pushed through and it was bad. Participant 4 stated, "It was just one of those times in your life where you're like, we just had to survive." Participant 1 remarked, "I just need to get through." They did not have the capacity for one reason or another to care for themselves.

Movement Themes and DMT Interventions

Throughout the interviews, there were six movement themes that arose as participants were remembering and discussing these difficult times; all participants sat with a concave upper body posture; they all used short, sharp, and sudden movements; their muscles were tight; they made circular motions with their hands and arms; most of their movements were gestural; and when asked where their symptoms lived in their bodies, all had symptoms that lived in their stomach and/or chest area. All the participants sat with a concave upper body posture, where the chest area was retreating, descending and enclosing as they spoke of their experiences, but would straighten when talking about the difficult changes dissipating. Many of these themes were also reflected in my own movement responses. When watching my own movement responses, I also had tight/bound movements, a concave upper body, made circular movements with my arms, made small, heavy, and sudden movements, and all of movement occurred with me on the floor, either lying down or sitting.

For my first DMT intervention, I would address their concave posture by having the women stand in the vertical dimension, reach their head as far up to the ceiling as possible with their feet firmly planted into the ground. To help with grounding the feet, the women could push on the tops of their feet helping the feet to feel the ground and be firmly placed. From this grounded position, I would invite them to stand up while continuing to feel the length in their bodies, grounding down through their lower body and lengthening through their upper body. They would then simply breathe. They would breathe with intention and focus their mind on only their breath. Breath connects oneself to one's inner world through the most fundamental pattern and rhythm of life (Hackney, 1998). The goals of this intervention are to increase their vertical posture, integrate their old and new identities/roles, and increase their self-care.

A second intervention that could be extended from the first would be to facilitate the execution of the *dimensional scale* (see Appendix A). The dimensional scale can have a grounding and calming effect as it promotes stability (Dalby & Newlove, 2004) through the body. It can also bring individuals into the present moment as they feel and move through the space around them (Moore, 2009). Here the goals are to increase the women's stability, increase their ability to be in the present moment, decrease their muscle tension. This can lead to cultivating internal support and provide a mechanism to self-care from which to accept and cope with one's reality.

For the third DMT intervention, I would facilitate the women in reaching out into the world around them through engaging their core-distal fundamental pattern of total body connectivity (Hackney, 1998). They would literally reach out into the space around from a standing or laying position, again making sure they are using their full vertical alignment, and then bring their limbs back into their bodies. For this intervention the goals are to increase their

ability to reach out to their baby and others, and decrease their unrealistic expectations as related to the disconnect between their expectations and their reality.

The fourth DMT intervention I would facilitate relates to the tightness the women felt and displayed in their bodies. For this, I would have the women exaggerate the feeling of tightness, meaning I would have them tighten every muscle in their body all at once and hold it as long as they could. Then I would have them release all the tension all at once. The feeling I got in my body from watching them and mirroring them was that there was tightness, but it was being ignored or they were trying to make it go away. Therefore the goal for this intervention was to increase their ability to more fully express their emotions, including feelings of frustration and guilt.

The circular and gestural movements I saw in the participants' bodies may stem from the same tension and could possibly be addressed by a fifth DMT intervention. Part of what the participants' experienced was a foggy blackout of time, which they identified as being in survival mode, and that became routine. I would want the women to use all the space around them, their full *kinesphere* (see Appendix A). I would bring attention to the circular movements they were doing, all with their hands. Then I would have them make the circles bigger; expanding them until they are reaching as far as they can with their arms. From there, I would have them use different body parts to make circles, expanding them again until they are reaching out. Then I would extend the intervention to using their entire body to make circles. Finally, I would have them do other movements while reaching out to their full kinesphere. Here the goals are to decrease muscle tension and increase their body awareness. More fully accessing their movement potential can offer increased opportunities for self-care including awareness of how and where they can seek support and connection to others.

All five interventions could help address the stomach and chest areas of the women's bodies, as that is where their difficulties after giving birth were felt. Utilizing the vertical dimension, which could help to ground the women, may give them the few minutes they need for themselves to recuperate. Exaggerating the tightness could help increase the sensations felt in those areas to an extreme point. They would then intentionally let all the tension go, allowing the stomach and chest areas to relax. Finally, expanding their circular movements could help them focus on other areas of their body in the present moment.

Chapter 5: Discussion

My first research question was what is the lived experience of women going through uncomfortable changes in mood and behavior? Through the four interviews I conducted, I got a clear picture of the four women's lived experiences. They described their day-to-day lives as they went through the uncomfortable changes in mood and behavior, and—as they did—they moved their bodies in various ways giving me an intellectual understanding of their experience as well as a visceral feel for their experience. This helped inform my second question: how does the lived experience of postpartum changes in mood and behavior inform DMT interventions? Through using kinesthetic empathy (see Appendix A), I could sense what recuperation my body needed. In addition, the questions I asked sparked memories and provoked thoughts leading to more information. Each of the women I interviewed gave me a better understanding of how different, and yet how similar, the postpartum experience can be.

Each woman described a different emotional experience including anger, detachment, sadness, and anxiety, but the underlying themes of lack of support, frustration, guilt, expectations versus reality, being/feeling alone or isolated, no self-care, and identity were the same. The movement and verbal themes I extracted led me to five different movement interventions. All of the women sat in a concave posture when describing the uncomfortable changes. I wondered if it was connected to the theme of identity. This sense of identity that resulted went to an even deeper level than I had originally imagined. It was not simply their cognitive understanding of identity, but an *embodied* (see Appendix A) sense of identity. My intention was not to extract an embodied sense of their lived experience; yet, that is what happened. Their description of their lived experience extended beyond simply describing changes in mood and behavior to how it was manifested in their body, felt sensations, and roles. The women could not figure out how to

combine their old and new identities on both a cognitive and body level. Consequently, they left behind activities that they said were part of their identity and focused solely on the day to day tasks of caring for their families. This left the women with no time to care for themselves, which left them exhausted and with no recuperation. The study that Vliegen, et al. (2013) conducted using the hospital as a holding environment gave the mothers the time they needed to recuperate, decrease their exhaustion, rediscover themselves, and form a secure attachment with their babies. However, this positive result was contingent on the women being able to stay in a hospital, a feat most cannot accomplish. The goal of the movement interventions is to provide the women with a coping mechanism in any setting.

The vertical dimension is correlated to a sense of self, which is intertwined with identity (Hackney, 1998), one of the themes from my results. My first intervention addresses the exploration of embodying one's evolving identity. It focuses on lengthening and grounding in the vertical dimension while breathing. Breath is the first pattern of total body connectivity (Hackney, 1998), which supports one's relationship to oneself as well as others. In Peggy Hackney's book *Making Connections*, she goes through six fundamental patterns of total body connectivity, as defined by Irmgard Bartenieff, that are used to help people move with a full range of motion and efficiency. Going through the six fundamental patterns of total body connectivity helps one re-pattern the connections within one's body and therefore changes one's relationship with one's body. Hackney (1998) stated that being in relationship is fundamental and that relationship is connection. Here, she is talking about relationship in two senses. One sense is the relationship/connection one has with another person, and the second is the relationship/connection one has with one's own body. These two forms of relationship affect each other, and can be developed in similar ways.

The first fundamental pattern is breath. Breath is simply about breathing. It sounds simple because humans breathe without intentionality all the time; it is an automated system for us. However, breath is the foundation of all life. One cannot survive without breath and it is the first thing we learn to do, providing the foundation for our initial sense of self or experience of our own bodies and being in the world. Going back to breath could help us reconnect with our simplicity; as an infant, newly born, we only breathe. There is no reaching out into the world, just the self. Using breath in the first DMT intervention could help the participants come back to themselves, giving them the little bit of time to connect internally and literally take a breath. Furthermore, breathing with someone else can be a simple way to attune, creating an empathic connection between two people while still keeping one's boundaries (Hackney, 1998), as Hicks (2012) pointed out when discussing early parenting. Once the women, who are having difficulty after giving birth, find their own breath and begin integrating their new identity, they might be able to then begin to attune to their baby through breath, similar to both Hicks' (2012) and Tortora's (2005) theories. In addition, through gaining a better understanding of themselves, they may then be able to reach out to others by asking for the help they need.

Seeking support could also help to reduce isolation. The literature review examined exercise as a treatment for PPD (Da Costa et al., 2009; Demissie et al., 2011; Songoygard et al., 2012), which could also help to provide a means of connection with others. Demissie et al (2011) found that exercising outdoors or in a recreational setting decreased depressive symptoms; if the women are outside they are around others. They could exercise with other women and take this as a chance to connect with friends. Exercise could also be a good way for their bodies to acknowledge the tension and possibly find a release for it. Furthermore, exercise could help with

the lack of self care as it could give the women time to themselves while actively moving their bodies. However, the studies revealed that exercise did not always help to alleviate or prevent symptoms of PPD. There is also the potential that it could lead to the women feeling more guilt and shame if they skipped a day of exercise. DMT can incorporate movement as exercise does, while also examining thoughts, feelings, and behaviors, which are addressed in CBT. Thus, it combines the two standards for treatment into one intervention and adds the extra level of the kinesthetic relationship.

Building on the first intervention, the second intervention entails moving through the dimensional scale, which can have a grounding and calming effect. Through grounding themselves and attending to the space around them, the women could gain a sense of stability. The women could also use these interventions as a form of self-care, by taking a few minutes to create stability and calm in their bodies. The dimensional scale is looked at as a stable scale because it is easy to maintain one's balance as the body moves between the vertical and horizontal positions while always being supported by one leg (Dalby & Newlove, 2004). This could provide them with a moment to reflect and think more clearly, which could help in a time of transition. This could give moms a chance to reflect on their former identity as well as their new role, giving them an opportunity to look at their evolving identity. Again, this is similar to what Vliegen et al. (2013) accomplished.

These interventions that promote stability may even address the lack of support experienced by these moms. The lack of support stemmed from two main areas; the husbands not being home and the mothers not being able to meet the participants' emotional needs. All four husbands were not home as much as they had once been. They all worked late into the night, leaving the women to adjust and take care of the home on their own. The women all

struggled with this as they were having a hard time taking care of themselves, let alone a new infant and any other children. Brandon et al. (2012) looked at a similar aspect of the relationship between the mother and partner. By using interpersonal psychotherapy with the mother and partner, the two were able to work together, circumventing some of this struggle. The women I interviewed did not have this help; and in fact, expressed feelings of isolation and loneliness, which was in part due to their husbands' absence. They were not only isolated from friends due to having an infant and not being able to go out as easily as before, but they were also left alone at home. Moving through the dimensional scale could help increase their stability, possibly giving them the inner strength to help themselves, which might include reaching out to those that could help.

The second area in which all four women experienced a lack of support was from their mothers. They all had mothers who did not support them emotionally in a way that they needed. The mothers would offer support in ways that the mothers saw fit but it did not meet the emotional needs of the women. It seemed like all the mothers had good intentions, but they always fell short. The lack of support from the women's mothers may have been able to be replaced by the emotional support of those also struggling with uncomfortable changes in mood and behavior if they had participated in group therapy such as in Mendelson et al. (2013) or Pessagno and Hunker's (2012) studies.

When people have a lack of emotional support from others, one place they could find that support is from within themselves. By grounding themselves through moving through the dimensional scale and accessing the vertical dimension in particular, they may be able to rein in their own inner strength and stand on their own. That way, the lack of external support does not have the same effect. This may also give them the strength to reach out to others to find or ask

for the specific forms of help they need. Lastly, this grounding can bring them into the present moment, such that their thoughts are only focused on what is right now, not the past or the future. This has the potential to help with the incongruity between their expectations of being a mother and the reality they face. It would also give them a time out of their negative cycle, which may help alleviate some of the tension in their chest and stomach, as the tension stemmed from their situation.

The third DMT intervention utilizes the second fundamental pattern of total body connectivity, core-distal, which is about connecting to one's center (Hackney, 1998). Hackney (1998) says that the core-distal connection prepares individuals to move in the world with confidence from a place of knowing that their bodies are connected through their central core, which supports them. Once that sense of security in one's own body is present, one can reach out into the world, literally reaching arms and legs out, and then come back to the self. This is the first fundamental pattern of total body connectivity where the vertical through line in one's body is present. Physically, core-distal is about having the core support to reach out to one's six distal ends and then come back into one's center. It is literally reaching out into the world and then coming back into one's self. To do this, one has to be connected through the vertical dimension, reaching the head up and the feet down (Hackney, 1998). Gaining a sense of one's self, taking a minute to feel the support from the grounding of the feet through one's core and out one's head and arms allows for the security and knowledge that one can reach out to her baby or others and come back to herself. This is similar to the case studies Pericleous (2011) reviewed, where the clients discovered aspects of themselves through DMT and were then able to more aptly be in relationship.

The fourth intervention addressed the tightness experienced by the women, which may have been a reflection of their anger/frustration/guilt. Often when people are angry, their muscles tighten, as in punching or hitting when one is mad. The women's frustration grew out of a few different aspects of their postpartum experience, but all four were frustrated at the incongruence between their expectations and their reality as well as the fact that they were not feeling better. Each woman had expectations of how her life would be or what kind of mother she would be. The women got frustrated when their reality did not match their expectations. They all then felt guilty that they were not being "good" mothers.

It appeared to me that they did not feel they had the space or luxury to be angry or frustrated, so instead of acknowledging their emotions and their body's response, they were perhaps trying to avoid these strong feelings. Utilizing a similar concept to Kauffman's (n.d.), when she has her clients explore their movements to create change, I would invite the women to go as far into the tightness as they can. This can increase body awareness of the tension, and indulging in it can offer an opportunity to accept the emotional response to this tension. This may allow the women to feel the anger, frustration, or guilt and then release it, instead of holding onto it. This may also address the short, sharp, sudden movements, as the women were holding tension in their muscles when making those movements.

I was inspired by two sources to explore the tightness by having women go as far as they can into it and then releasing it. I brought Marian Chace's (Levy, 2005) idea of using the movements that people present and combined it with ideas from the counseling theory of Internal Family Systems (IFS) (Nichols & Schwartz, 1998). One of Marian Chace's main techniques was to watch for any movement that her clients would do and then help them to grow the movement and make it bigger. She believed that all movement was communication and that

communication was a basic human desire (Levy, 2005). In this case, the movement was the tightening of muscles. Following Marian Chace's method, having the participants exaggerate the tension would be growing the movement. Through growing the movement and continuing to make it bigger, the participants may be able to identify where the tension is coming from through symbolism (Levy, 2005).

IFS (Nichols & Schwartz, 1998) expounds that each person is made of different parts, each part maintaining a specific job. The exile part holds the pain, while the managers try to keep the exiles locked away and the firefighters douse the hurt feelings when the exiles get out. By acknowledging each part and knowing why it shows up, we can possibly integrate our experiences and lead our lives from our true selves and not one part. Each part needs to be acknowledged and understood instead of ignored. By ignoring the parts, we simply allow them to lead our lives instead of leading ourselves. By having the women go into the tightness that was already showing, the women would be acknowledging that part of their internal system and giving it the attention it needs. Only in acknowledging it can one then learn to understand and integrate it. It might also have been easier to look at the tightness, which could have stemmed from the frustration, guilt, and stress the women felt, as only part of their being. By saying this is a part of me but not all of me it could allow the women to gain a different perspective. Changing perspective through changing the way one thinks is also part of CBT, which was used in several of the studies I reviewed above such as Pessagno and Hunker (2012). Instead of possibly fighting the negative feelings they could allow them to be and then pass.

My fifth DMT intervention of starting with small circles and then having the women make them bigger, taking the circles to different parts of the body, was inspired by Marian Chace's theory. As stated above, she believed that dance is communication and that all people

need to communicate (Levy, 2005). Chace would watch for the smallest of movements and then facilitate the clients in growing that movement (Levy, 2005). The participants in this study were stuck. The circle may have represented the cycle of surviving and the gestural movements, instead of full body *posture gesture mergers* (see Appendix A), may be a representative of not being able to access their entire bodies as well as live their lives to their fullest potential. Growing the circles could potentially help the women break the cycle and reach their potential. Also, focusing their attention on the circular movement, could shift their focus away from the thoughts and feelings that are producing the tightness, and the resulting rhythm of this circular movement could be soothing, which might dissipate the tension.

This study is the first to address using DMT to treat uncomfortable changes in mood and behavior postpartum. When I began researching PPD, its symptoms, and the treatment, I noticed that there were two aspects that were never mentioned in the treatment literature; that of PPD occurring in conjunction with a major life transition, as well as the mother having to grieve the loss of her previous lifestyle. In a lifetime, people go through many major life transitions, such as moving, changing careers, getting married, becoming an adult, becoming a parent, and retiring. Each has an effect on the person or group of people going through the change, some bad and some good. Each transition has a different effect on each person. Transitions can be stressful, anxiety-provoking, and frustrating; they may also prompt depression and create an identity crisis (Gramotney & Lee, 2007).

Gramotney and Lee (2007) examined the psychological effect on women during life transitions. They had 7,619 women conduct three self-surveys on four different life domains, one being parenthood. They found that the transitional symptoms of women who became mothers were similar to those who had a transition in employment; they both had higher levels of

stress, higher levels of depressive symptoms, and a decrease in life satisfaction. Those experiencing a relationship breakdown experienced a decrease in all of their mental health markers (Gramotney & Lee, 2007). These transitional symptoms that Gramotney and Lee described are similar to those of the four participants of this study. Feelings of sadness, isolation, and anxiety are often experienced during different life transitions as well as by those diagnosed with PPD. The *DSM*-5 outlines guilt, isolation, agitation, and feeling disconnected from your baby as symptoms of PPD (APA, 2013). Though the women I interviewed were not diagnosed with PPD, they did experience some of the symptoms.

The studies done on prevention (Flynn et al., 2006; Mendelson et al. 2013) began to look at PPD as a major life transition, focusing on how to prepare for this life event. However, most of the treatment studies I reviewed, such as Brandon et al. (2012), Serge et al. (2010), and Vliegen et al. (2013) only looked at specific symptoms. The addition of a child to one's life changes every aspect, from the clothes worn to the ability to leave the house. Bennett (2003), Rosenquist (2010), and Kendall (2010) all described the change that occurs when a new baby enters the family; there is a new life that depends on the parents for everything, to go out takes more thought and planning, and one's time is not only one's own but dictated by another. Furthermore, the mother's body is not even her own (especially if she nurses). Even if it was not the woman's first child when she experienced the uncomfortable changes in mood and behavior, growing a family is a vastly significant transition. Exploring that transition through Laban's taxonomy could allow the mothers the opportunity to viscerally move through it in a safe and supported fashion (Hurst et al., 2011), learning again how to give and receive in a healthy manner. Kendall (2010) described the expectations of a mom to be happy and care for the baby perfectly. Participant 2 had the expectation that her baby would seamlessly fit into her life and

go along for the ride of her life. Then, when the baby came along she found herself engulfed with the baby and only caring for the baby. She lost her sense of identity. She even stated a rite of passage would have helped in this transition.

This study was limited in the sense that I conducted all interviews over Skype. Thus, most of the time I could only see the upper part of the participants' bodies, limiting the amount of body movement I could see. There were also some technological difficulties, such as choppiness at times and losing internet connection. Another limitation was that there were only four participants, limiting my information as well as the diversity of the participant population. This was, in part, due to the difficulty I had with retaining participants. As stated before, I had several people show initial interest in participating, but many never followed through or dropped out. I know a few did not participate due to family situations that arose. I suspect others decided not to participate because they did not have the time to commit, even if it was only for an hour and a half, or because they did not want to rehash a difficult time in their lives. After all, I was asking busy moms, who may have isolated (as my research showed) and not spoken about their experience, to take time out of their lives to tell a stranger in detail what they perhaps would not tell their friends. I wonder if making the initial contact in person would have helped, as I would not simply be a faceless stranger asking for intimate details, but a fellow woman who cares. I also wonder if it would have been helpful to meet in person with child care provided, giving the women an opportunity to participate in the interview during the day instead of late at night when other family matters needed to be tended to. I also wonder if I had marketed my research in a different fashion and utilized a stop the silence approach if more women would have committed more strongly. Finally, I wonder how the findings might have been different if there had been more participants with more diverse ethnicities and cultural backgrounds.

This study looked at the lived experience of women who had uncomfortable changes in mood and behavior after giving birth. I asked what their lived experience was of the changes and used this information to create DMT interventions. I found seven verbal and six movement themes that crossed all interviews. I then developed DMT interventions to the movement and verbal themes that arose. Future research could be to conduct a study testing the DMT interventions I created to see if they help women who experience uncomfortable changes in mood and behavior. Therefore, the research questions would be: Do the DMT interventions alleviate the uncomfortable changes in mood and behavior that women experience after giving birth? Do the DMT interventions prevent their symptoms from getting worse and leading to a formal diagnosis of PPD? Further research into normalizing the experience and looking at the postpartum period as a major life transition could also be beneficial. How can this perspective help to prevent symptoms or diagnosis? I was personally fascinated by the fact that all four women had husbands who were not home as much as they been and mother's who were not emotionally supportive in the manner they needed. I am curious if these two specific aspects occur in more women and future research could address the question of whether there is a direct correlation between one's partner being absent and PPD or how the relationship between the new mother and her own mother relates to the development of PPD. Finally, my research was limited to four women, I would be interested in learning what similar or different themes might emerge if this research was done on a larger scale and only in person.

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Appendix A

Definition of Terms

Attune

Matching, though not exactly, a specific quality of another person's movement with the intention of connecting through that movement (Tortora, 2006).

Dimensional scale

A series of movements where one moves their arm moves up, down, the right arm crosses over the left, the right arm opens to the right, the right arm moves backward and then forward (Dalby & Newlove, 2004).

Dance/Movement Therapy

Dance/movement therapy (DMT) is the psychotherapeutic use of movement – the combination of talk therapy and movement – to integrate the emotional, cognitive, physical, and social aspects of a person (ADTA, 2016). DMT is founded on the idea that the body, mind, and spirit are inseparable. Therefore, people's experiences live in their bodies. DMT views and utilizes movement, creative or functional, as a way to reflect inner emotional states. DMT uses the body as a healing tool, that is always available, to help people change their psyche through changing their movement behavior (Levy, 2005).

Effort Elements of Movement (space, time, flow, and weight)

Effort elements are the dynamic aspect of movement. Space refers to a person's focus, either they are direct in their focus or indirect. Time refers to a person's timing, either

accelerating or decelerating. Flow refers to the degree of control a person has, either freeing/ lose or binding. Weight refers to the degree of pressure a person is utilizing, either increasing pressure or decreasing pressure (Moore and Yamamoto, 2012)

Embodied

Our own way of experiencing the world through unifying body, sensations, mind, perception, action, creativity, recognition, cognition, and emotion (Koch & Fischman, 2011).

Gestures

An action confined to one part of the body (Moore and Yamamoto, 2012).

Home Visiting (HV) Program

These are interventions done in the home either through the clinician going to the participant's home or the clinician calling the participant (Mendelson et al., 2013).

Kinesthetic Empathy

To viscerally experience and mirror back what the client was experiencing and trying to communicate (Levy, 2005).

Kinesphere

The personal space around a person that extents as far as they can reach in any direction (Dalby and Newlove, 2004).

Laban's relationship taxonomy

Analyzing, describing, or experiencing movement through relationship. This encompasses groupings, contact, facing, orientation, leading, following, relationship play, orientation, mirroring, echoing, synchrony, or asynchrony (Moore & Yamamoto, 2012).

Laban Movement Analysis

A comprehensive analytical system that examines, in detail, body part usage, spatial design, and movement dynamics (Moore & Yamamoto, 2012). It is a method and language for describing, interpreting, and documenting human movement (Moore, 2009).

Postpartum Depression (PPD)

PPD is a specifier under major depressive disorder in the *Diagnostic and Statistical Manual of Mental Disorders 5*, known as Peripartum onset (APA, 2013). Specifically, PPD encompasses the symptoms of a major depressive episode such as: agitation and irritability, changes in appetite and weight, feelings of worthlessness or guilt, and diminished sense of pleasure or interest in most, if not all, activities (APA, 2013, p. 160-162). However, the symptoms extend to those that are specifically related to having a baby, such as: feeling numb or disconnected from the baby, having scary or negative thoughts about the baby, and worrying about hurting the baby (CDC, 2013).

Posture

A position that is assumed by the whole body or an action the whole body participates in (Moore & Yamamoto, 2012)

Posture Gesture Merger

When a posture and gesture are combined to create a whole body movement (Moore & Yamamoto, 2012)

Appendix B

Recruiting E-Mail

To Whom it May Concern,

My name is Tonia Levison and I am a graduate student in the Dance/Movement Therapy and Counseling program at Columbia College Chicago. I am writing to extend a warm invitation to participate in my research study if you have experienced uncomfortable changes in behavior and/or mood after giving birth. I am seeking to interview participants to understand their experiences. From these interviews I will create participant centered dance/movement therapy interventions based on the experiences of participants as a means of alleviating symptoms and preventing a diagnosis.

In order to participate in this study, you must be a female who self identifies with the following criteria:

- Experienced at least two changes in behavior or mood after giving birth as listed below.
- Parented your baby after giving birth.
- Conceived without medical intervention.
- Was over 18 when you became pregnant and were in a consensual relationship.
- Has not been formally diagnosed with PPD.
- Is not currently experiencing changes in behavior or mood after giving birth as listed below.
- Speaks English and lives in the Untied State.

Uncomfortable changes in behavior or mood:

Decreased appetite; difficulty sleeping; irritability and anger; overwhelming fatigue; loss of interest in sex; lack of joy in life; feeling low, feelings of shame, guilt, or inadequacy; mood swings; difficulty bonding with your baby; withdrawal from family and friends.

If you are interested in participating in this study, please contact me at (614)565-9013 or e-mail me at tonia.levison@loop.colum.edu by December 15.

With Appreciation,

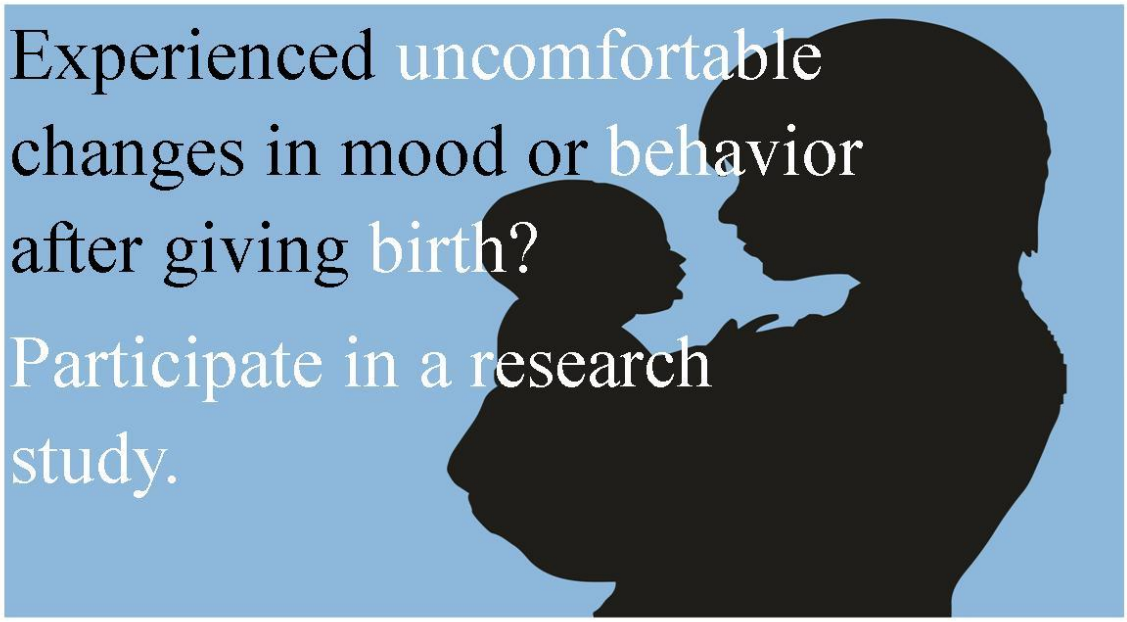
Tonia Levison

2015 MA candidate

Dance Movement Therapy and Counseling

Columbia College Chicago

Tonia.levison@loop.colum.edu



My name is Tonia Levison and I am a graduate student in the Dance/Movement Therapy and Counseling program at Columbia College Chicago. I am writing to extend a warm invitation to participate in my research study, if you have experienced uncomfortable changes in behavior or mood after giving birth. Based on your experience of these changes, I will create participant centered dance/movement therapy interventions as a means of alleviating uncomfortable changes in mood and/ or behavior.

In order to participate, you must be a female who self-identifies with the following criteria:

- **Experienced at least two uncomfortable changes in mood and/or behavior after giving birth as listed below**
- **Parented your baby after giving birth.**
- **Conceived without medical intervention.**
- **Were over 18 when you became pregnant and were in a consensual relationship.**
- **Speaks English.**

Uncomfortable changes in mood and behavior:

Decreased appetite; difficulty sleeping; irritability and anger; overwhelming fatigue; loss of interest in sex; lack of joy in life; feeling low, feelings of shame, guilt, or inadequacy; mood swings; difficulty bonding with your baby; withdrawal from family and friends.

If you are interested in participating in this study, please contact me at (614)565-9013 or e-mail me at tonia.levison@loop.colum.edu by December 15.

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Appendix C

Informed Consent Form

Columbia
COLLEGE CHICAGO

Approved
IRB STAMP REQUIRED

Informed Consent Form

Consent Form for Participation in a Research Study

Title of Research Project: Moving after Baby: Developing Informed Dance/Movement Therapy Interventions for Symptoms of Postpartum Depression

Principal Investigator: Tonia Levison, M.Ed., MA DMT candidate, tonia.levison@loop.colum.edu

Faculty Advisor: Jessica Young, MA, BC-DMT, LCPC, GL-CMA, jyoung@colum.edu

Chair of Thesis Committee: Laura Downey, BC-DMT, LPC, GL-CMA, ldowney@colum.edu, 312-369-8617

INTRODUCTION

You are invited to participate in a research study to discuss your experience of uncomfortable changes in mood and/ or behavior after giving birth. This consent form will give you the information you will need to understand why this study is being done and why you are being invited to participate. It will also describe what you will need to do to participate and any known risks, inconveniences, or discomforts

that you may have while participating. You are encouraged to think this over. You are also encouraged to ask questions now and at any time. If you decide to participate, you will be asked to sign this form and it will be a record of your agreement to participate. This process is called 'informed consent.' You will receive a copy of this form for your records.

You are being asked to participate because you have self-identified as having experienced uncomfortable changes in mood and/or behavior after giving birth. The uncomfortable changes include: decreased appetite; difficulty sleeping; irritability or anger; overwhelming fatigue; loss of interest in sex; lack of joy in life; feeling low, feelings of shame, guilt, or inadequacy, mood swings; difficulty bonding with your baby; or withdrawal from family and friends. These uncomfortable changes can begin during pregnancy or up to a year after giving birth. In addition, you self identify that you conceived without medical intervention and parented your baby after giving birth. You were over the age 18 when you conceived and were in a consensual relationship. You have not been formally diagnosed as having PPD and you are not currently experiencing changes in mood and/ or behavior that are associated with PPD. By signing this form you are certifying that you meet the above criteria.

PURPOSE OF THE STUDY

The purpose of this study is to create informed ways of responding through DMT to address uncomfortable changes in mood and behavior that occur after giving birth, alleviate any discomfort or distress in relationship to these changes, and prevent a diagnosis as a result of worsening of changes. This study illuminates the experience of women who have had uncomfortable changes in mood and/or behavior after giving birth. The information I gather from your experiences will then inform the interventions I create.

PROCEDURES

If you agree to participate in this study, you will be asked to do the following:

- Participate in an hour to hour and a half interview that will explore your experience of uncomfortable changes in mood and/or behavior after giving birth.
- Answer open ended questions about your experience of these uncomfortable changes and what you think would help.
- Participate in movement responses to questions that arise during the interview as well as have movements observed by the researcher to inform the creation of DMT interventions.
- Consent to video recorded interview with a standard video recorder in the corner of the room or through Skype. The hard copies will be stored in a locked filing cabinet and the copies on my

computer will be protected by a password and deleted after the final version of the thesis is approved.

- Grant permission for portions of your interview to be included and possibly quoted in the final presentation of the research study. You will remain anonymous in the study.
- Provide feedback to the researcher. About a week after your initial interview, you will be contacted again to review the transcript of your interview as well as the theme analysis of your interview, provided to you by the researcher. You will be invited to provide feedback, clarifications and/or additional information you feel is relevant to your research data. You will have two weeks to provide this feedback.

POSSIBLE RISKS OR DISCOMFORTS

The risk(s) in this study is(are):

- The interview process may bring up physical, emotional, psychological, and social discomfort as you are reflecting on uncomfortable changes in mood and/or behavior that you experienced after giving birth. These risks may occur immediately, before, during, or after the interview process. The role of the researcher is not intended to provide clinical and therapeutic support. In order to minimize these risks, you will be provided with a list of resources of support that are readily available to utilize, if you feel you need it. You will have permission to choose what you do or do not want to share, and if/when you wish to stop the interview or take breaks.
- You will participate in an hour to hour and a half interview that will be conducted at Columbia College Chicago or through Skype. You will have to consider the time and expense it takes to commute to and from Columbia College Chicago as well as the time for the interview. You will also need to consider the time it takes to review the data analysis and results. You will have two weeks to review the data analysis, which should take about an hour or two to review. You will also have a week to review the final results section, which should take about an hour to review and then send back.
- Shared details of interview transcriptions, narratives, and quotations in written findings may un-intentionally reveal your identity or the identity of others mentioned in your interview. To minimize this risk, your information will be de-identified and the data will be synthesized so no one participant stands out in the thesis. If the researcher wants to use a direct quote from your interview, you will have the choice to allow this or not. If you allow a direct quote to be used, a pseudonym will be assigned to you and any people you mention in your interview. Video recordings and written interview data will be protected via secure laptop password and firewall protection, while backup copies will be stored in a locked home filing cabinet. All information will be deleted or shredded after the final thesis is accepted.

POSSIBLE BENEFITS

There are no direct benefits from participating in this study, the indirect benefits may include:

- Contribution to the increased acknowledgement and understanding of uncomfortable changes in mood and/or behavior after giving birth.
- Contribution to the increased knowledge of the role of the body in the experience of uncomfortable changes in mood or behavior after giving birth.

- Contribution to future research and treatment development for PPD.
- Contribution to the development of DMT interventions to alleviate uncomfortable changes in mood and/or behavior after giving birth.

CONFIDENTIALITY

Confidentiality means that the investigator will keep the names and other identifying information of the research participants private. The investigator will change the names and identifying information of research participants when writing about them or when talking about them with others, such as the investigator's supervisors.

- To protect your information I will be the only one transcribing the audio section of the video recordings and analyzing the movements.
- All transcriptions and any Skype recordings will be stored on a password protected laptop with a firewall in place. All hard copies of the transcripts or video recordings will be kept in a locked home filing cabinet, designated only for the research materials. All transcripts and video recordings will be kept for the duration of the research project and then deleted or shredded upon the completion of the thesis.
- In situations during which reports of child abuse or neglect are disclosed, or harm to self or others is disclosed, confidentiality cannot be guaranteed as I am a mandated reported and am obligated by law to report the above stated incidents.

The following procedures will be used to protect the confidentiality of your information:

1. The researcher will keep all interview, narrative, and study records password and firewall protected, and in a secure, locked home filing cabinet.

2. Any video recordings will be destroyed after the final thesis is accepted.

3. All electronic files containing personal information will be password and firewall protected.

4. Information about you that will be shared with others will remain anonymous to help protect your identity.
5. No one else besides the researcher will have access to the original data.
6. At the end of this study, the researcher may publish their findings. You will not be identified in any publications or presentations.

RIGHTS

Being a research participant in this study is voluntary. You may choose to withdraw from the study at any time without penalty. You may also refuse to participate at any time without penalty.

Thoughtfully consider your decision to participate in this research study. I will be happy to answer any question(s) you have about this study. If you have further questions about this project or if you have a research-related problem, you may contact the principal investigator, Tonia Levison at 614-565-9013 or the faculty advisor, Jessica Young at jyoung@colum.edu or (312)369-6893. If you have any questions concerning your rights as a research subject, you may contact the Columbia College Chicago Institutional Review Board (IRB) staff at 312-369-8795 or IRB@colum.edu.

COST OR COMMITMENT

- You may incur minimal fees from your involvement in this research study, such as parking fees, public transit costs, or cell phone charges.
- The time commitment includes the travel time to and from potential interview location, 1-1.5 hour interview time, and additional time for future data review.

COMPENSATION FOR ILLNESS AND INJURY

If you agree to participate in this study, your consent in this document does not waive any of your legal rights. However, in the event of harm arising from this study, neither Columbia College Chicago nor the researcher are able to give you money, insurance, coverage, free medical care or any other compensation injury that occurs as a result of the study. For this reason, please consider the stated risks of the study carefully.

PARTICIPANT STATEMENT

This study has been explained to me. I volunteer to take part in this research. I have had opportunity to ask questions. If I have questions later about the research or my rights as a research participant, I can ask one of the contacts listed above. I understand that I may withdraw from the study or refuse to participate at any time without penalty. I will receive a copy of this consent form.

_____	_____	_____
Participant	Print Name:	Date
_____	_____	_____
Principal Investigator	Print Name:	Date

Appendix D

Interview Questions

Warm-up Questions:

1) What race do you identify as?

2) How old are you?

3) How old were you at the time you experienced uncomfortable changes in mood and/or behavior after giving birth?

4) Are you currently working?

5) Were you working when you experienced these changes?

6) What support did you have while experiencing these symptoms?

7) What support do you have in your life today?

8) Was your partner around when you were experiencing these changes?

Must Ask Questions:

9) How did you experience your day to day life after the first year of giving birth?

10) When/ how did you learn or figure out that the changes you were experiencing were related to the birth of your baby? What do you think contributed to experiencing these changes in mood and/or behavior? What are some of the qualities or traits/features (feelings, thoughts, body postures, sensations, images) that you think you had during your experience of these changes in mood and behavior? Invite participants to embody these through statues or movement.

11) What body sensations do you remember from when you experienced these changes in mood and behavior? Invite participant to embody this through statue or movement.

12) What body sensations are you experiencing right now? Show me in movement.

13) When you think back to when you were experiencing these changes in mood and behavior what might have been helpful?

14) What changes in mood and behavior seemed to stay with you the longest? What was the most challenging part of your recovery?

15) How did you know when you were feeling better?

16) How did you experience your relationship with your baby during this experience, what would have been helpful. Same with partner.

17) In what ways would working with your baby in therapy have been helpful if at all?

18) In what ways might it have been unhelpful?

19) In what ways would working with your partner in therapy have been helpful if at all?

20) In what ways might it have been unhelpful?

Appendix E

Resource List

National resource to find a local counselor

Nbcc.org

Support Groups and Hotlines

PPD Hope

877-PPD-Hope (877-773-4673)

PPD Moms

800-PPD-MOMS (800-773-6667)

408-279-8228 (Crisis Hotline)

Chicago Support Groups and Hotlines

PPD IL Alliance Support group

http://www.ppdil.org/#

847-205-4455

Amanda Mitchell (PPD Support Group)

312-257-8550

Online PPD support group

http://www.ppdsupportpage.com/

Postpartum support international

1-800-944-44773