



DOCENCIA - INVESTIGACIÓN

Experiences and meanings of post-partum depression in women in the family context

Vivências e significados da depressão pós-parto de mulheres no contexto da família

Experiencias y significados de la depresión postparto de mujeres en el contexto de la familia

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ABSTRACT

Objectives: To understand the experiences and meanings of maternal post-partum depression for the woman and her family; To develop a theoretical model representative of the woman and her family's experience.

Method: Qualitative study that had as a guiding theoretical referential the Symbolic Interactionism and as a methodological referential the Grounded Theory. The participants of this study were women who had post-partum depression and their families, recruited through public hospitals and basic health units in the municipality of Cuiabá-MT. The data were collected through in-depth interviews with the woman and family.

Results: The theoretical model "Oscillating between the support and the need to maintain control" represents the perceptions and strategies present in the experience of the woman and her family aiming at adapting family life to the circumstances of life affected by depression.

Conclusions: Control and support constitute the core symbolic elements of how the woman with post-partum depression and her family deal with the experience from the onset of the symptoms until the results of the diagnosis.

RESUMO

Objetivos: Compreender as vivências e significados da depressão pós-parto materna para a mulher e sua família; Desenvolver um modelo teórico representativo da experiência da mulher e da família.

Métodos: Estudo qualitativo com referencial teórico o Interacionismo Simbólico e a Teoria Fundamentada nos Dados como referencial metodológico. Os participantes foram mulheres que tiveram depressão pós-parto e seus familiares, recrutados em Hospitais Públicos e Unidades Básicas de Saúde do município de Cuiabá-MT. Os dados foram coletados por meio de entrevistas em

profundidade.

Resultados: O modelo teórico “Oscilando entre o apoio e a necessidade de manter o controle” representa as percepções e estratégias presentes na experiência da mulher e da família visando à adaptação da vida familiar às circunstâncias da vida afetadas pela depressão.

Conclusões: Controle e apoio constituem os elementos simbólicos centrais de como a mulher e a família maneja a experiência desde o início dos sintomas até a constatação do diagnóstico.

RESUMEN

Objetivos: Comprender las experiencias y significados de la depresión materna después del parto para la mujer y su familia; Desarrollar un modelo teórico representativo de la experiencia de la mujer y de la familia.

Métodos: Estudio cualitativo tuvo como guía de referencia teórica el interaccionismo Simbólico y la teoría referencial metodológica basada en Datos. Los participantes de este estudio fueron mujeres que han tenido depresión postparto y sus familiares, reclutados a través de hospitales públicos y unidades básicas de salud de la ciudad de Cuiabá-MT. Los datos fueron colectados a través de entrevistas en profundidad con la mujer y la familia.

Resultados: El modelo teórico “Oscilando entre el apoyo y la necesidad de mantener el control” representa las percepciones y estrategias presentes en las experiencias de la mujer y de la familia dirigidas a la adaptación de la vida familiar, a las circunstancias de la vida afectadas por la depresión.

Conclusiones: Control y apoyo son los elementos básicos simbólicos de cómo las mujeres y la familia manejan la experiencia desde el inicio de los síntomas hasta la confirmación del diagnóstico.

INTRODUCTION

Over the past twenty years, there has been increasing recognition that for some women, pregnancy and post-partum can be accompanied by many disorders, especially depression and this knowledge runs contrary to the widely spread popular belief that this is a period of happiness for all women⁽¹⁾. For fear of being misunderstood, many women do not reveal feelings of sadness, since they feel guilty for having depressive symptoms at a time that should be of happiness⁽²⁾. Obsessive thoughts about the care and health of the baby are frequent, with discord in the interaction being the earliest symptom, even before the depressive symptoms emerge. The symptomatology begins in the first weeks or months after birth and about two-thirds of the cases resolve themselves during the first year⁽³⁾. Symptomatology and manifestations do not differ from depression experienced by people in other phases of life, characterizing by sadness, loss of interest in activities and decrease of energy, loss of confidence and self-esteem, unjustified feeling of guilty, ideas of death and suicide, decrease of concentration and disturbance of sleep and appetite⁽⁴⁻⁵⁾.

The international literature has been indicating in its results that post-partum depression (PPD) has appeared as a public health problem. Hence, one of the priorities of the Brazilian Ministry has been to encourage research related to mental health of women in the pregnancy-puerperium cycle, with focus on the magnitude, dynamics, understanding of mental disorders post-partum, as well as studies of prevalence and incidence of mental disorders in pregnant women⁽⁶⁾.

AIMS

Understand the experiences and meanings of maternal post-partum depression for the woman and her family; develop a theoretical model representative of the experience of the woman and her family facing maternal post-partum depression.

METHODS

Qualitative study guided by the Symbolic Interactionism as a theoretical referential and the Grounded Theory as a methodological referential. The participants were 10 women who had PPD confirmed by medical diagnosis, psychological or self-reported and 10 family members who lived with them at the time of the onset of depression. Inclusion criteria were: age over eighteen; not be going through the depressive process at the time of the interview; be at least two years past the experience; have at least one member of the family, besides her child, present in her daily life during the experience of depression; have one or more children (when they had PPD) and these children are alive and healthy; have experienced PPD. The participants were recruited in Public Hospitals and Health Care Units in the city of Cuiabá-MT, Brazil. The data were collected through interviews with the woman and family and analyzed according to the principles of the Grounded Theory.

The data analysis procedure followed the recommendations of the constant comparative method ⁽⁷⁾. Thus, the data collection and analysis occurred simultaneously, that is, after each interview, the transcript content was analyzed. The initial coding was done line by line, word by word, incident by incident. In the process, the excerpts from the interviews were examined and coded with words which reflected the action. Each incident enabled the identification of the first properties of the experience and received a name, according to its meaning, called code. After the initial coding, we went on to the focused and selective coding phase, where the codes went through a process of comparison with each other and were grouped by their similarities, forming categories which sought to convey the meanings present in the codes. Each of these categories received a conceptual name more abstract than the code.

Considering that a characteristic of the constant comparative method is the temporality of the categories, during the process of analysis until its end, the name of the categories was modified many times, until we got to a more representative denomination of the concepts that grouped them making them definitive. Throughout the collection process, coding and categorization of data, questions were asked to the data and hypotheses about the possible relations established among the data. These ideas were recorded and organized and formed the bases for the elaboration of memorandums or memos.

The phase following the characterization of data, that is, the theoretical Coding consisted in regrouping the categories which referred to the same phenomenon and the connections between them and their subcategories. Thus, the category properties consolidated and the categories became integrated with others. This regrouping of the categories generated several attempts of graphic representation of the connection between them, as a way to understand the experience. The last phase of the analysis was carried out with the identification of the central category **Oscillating between support and the need to keep control** and allowed the development of the theoretical model representative of experience.

The research project was approved by the Research Ethics Committee of the Nursing School of the University of São Paulo (CEP/EEUSP) according to process n°1105/2011CEP-EEUSP. This research followed the guidelines of resolution 196/96 of the Conselho Nacional de Saúde ⁽⁸⁾ (National Health Council) which regulates research on human beings.

RESULTS

Oscillating between support and the need to keep control represents the theoretical model of experience. The experiences and meanings of maternal PPD for the woman and her family were understood as a psychosocial process; in which control and support are central symbolic elements of how the woman with PPD and her family handle the experience from the onset of the symptoms to the finding of diagnosis and implementation of the treatment. This model integrates three categories which represent the perceptions and strategies that are present in the experience of the woman and her family aiming at the adaptation of the family life to the circumstances of life affected by depression.

I. Struggling with maternity represents the initial time of the theoretical model. It is the beginning of the process which focuses on the woman having to deal with the new condition of mother, experiencing frustration and fear by the inability to perform simple tasks to attend the needs of her newborn. The woman defines the situations which involve her child as without control and, when identifying that some situations of relatively simple management get out of control by the woman, the family without realizing the reason for her behavior, tries to normalize her reactions, supporting her and cooperating in meeting them.

Problems related to breastfeeding and the baby's cry, sometimes come together, interconnect, overlap each other and sometimes go separate. However, difficulties with breastfeeding are one of these events faced by the woman since the first contact with the baby.

Observing the behavior of dissatisfaction of her child, her body in response to breastfeeding and of others that breastfeed leads her to infer that something is wrong, leaving her stressed for not being able to satisfy her son with her own milk, and sees herself Struggling with breastfeeding. She is also confronted with her own inability to handle breastfeeding and with her nervousness to face the problem that emerges. In the interaction with her husband, who is sensitive to her physical status and shows the desire to alleviate her suffering, a behavior which comforts her and makes her feel accepted to continue breastfeeding. However, after a certain period of time of her struggle with breastfeeding, she starts to realize that her child presents insufficient weight gain. Rejecting the observation of normality attributed to the event by others, the woman embarks on a path trying other solutions to feed her child with the support and participation of family members who engage with her acting to resolve the problem that is presented, ignoring future consequences for the success of exclusive breastfeeding. Sometimes the woman is reluctant to offer another kind of milk to her child and in these situations, the husband in interacting with the woman and child, evaluates her status and her child's and decides to feed him with formula milk, communicating his decision to the doctor and at the same time seeking guidance on the type of milk to offer.

[...] at the very beginning she was not giving him milk because of her post-partum anxiety, so, he was starving, so she said: "I'm not going to give him anything, otherwise he won't be healthy!" But I said: "no, my son is starving!" She said: "no, if you give him bottle feeding he will not want breastfeeding and won't be healthy!" (Man B).

These actions are supported by the members of the family, but are accepted with restrictions by the woman and are disregarded by the husband, who finds himself struggling to put them into practice, as well as worried; prioritize meeting the feeding needs of the child.

Decisions to resolve the son's feeding problem with another milk are permeated by several feelings, including frustration, guilty, depreciation of themselves in their competence as mothers, especially when they compare their performance to that of other women around them who, in their evaluation, would have more obstacles to effectively breastfeed and do so without problems. These feelings become stronger when she prepared herself and had already knowledge about breastfeeding before her child was born, and this disappoints her deeply.

Yet, the daily struggle with her son also extends to struggle with his crying, which is the way he has to communicate that something is not good and it is necessary that people can decipher and accept it, until he is capable through language of expressing what he feels and wants. Thus, Struggling with the son's crying, refers to the woman and her family's behavior in relation to the baby's crying and strategies used to solve it.

The son's crying face the symbol of the provider for the needs of the child triggers thoughts that refer to care. It is a message that something is bothering the baby and awakes ideas of solution. It affects some members of the family that start to have problems to sleep at night, especially the woman who is consequently overburdened by the accumulation of functions attending the newborn's needs and other people in the family.

The feelings the woman experiences when she hears the baby's crying, range lack of control, breakdown and despair, mediated by the difficulty of identifying and consequently solve it, culminating with her own crying for feeling helpless and also with the desire to put an end, in a drastic way to what bothers her. She sees herself physically distant from her son when he cries, as a strategy to avoid intense nuisance she feels, to self-preserve, collect her, consequently returning to the situation after solving the problem. In some situations, she can identify that her son becomes more agitated by her presence, senses that he absorbs her emotional state and tries to be far from him as a way to ease the situation. In these moments, with frequency she counts especially and, for a relatively long period, with the help of other women of the family, with whom she feels more secure and where she realizes temporarily swapping roles in meeting the child's needs.

[...] because I lost control when he cried. I lost control! If I held him, then he would cry even more, because of course he felt that I was very nervous. Then my mother held him, then I thought that he was well cared by her. I had to wait to pull myself together. Sometimes, my role was to pass the washcloth (warm), to put medicine, prepare, these things. So, I did all this, then by the time he stopped

crying, then I held him. But, when he cried, I would lose control; it was with my mother that I thought he was well cared for (Woman D).

Some newborn weeping is temporarily solved through domestic practices, but when it becomes difficult to be solved, the woman, together with husband and family find themselves seeking medical help. However, this quest becomes a long and stressful journey, which causes in women, insecurity and disorientation, mainly due to the different and not always consistent professional conducts concerning baby care.

Finding the reason for the baby's crying may take from days to months, and the consequences of an identified specific problem may have caused suffering to him, leave her oversensitive and desperate. However, the family, although unhappy and perplexed with the situation, try to reassure her by searching for information, and trying to make her understand that the problem despite having cause pain and discomfort in the child, soon will be resolved.

Besides the loss of emotional balance when the child cries, she feels unable to take care of him and this is noticed more significantly when it is the first child. The fear of not knowing and not being able to look after the child increasingly looms, mainly due to the possibility of being alone with him, a fact which she resists. The inability she feels about her performance as a mother is realized in the care of the child and together will be outlining the disappointment with herself that becomes more obvious when she sees the ease with which other family women meet the needs of their children.

Faced with the inability that she feels to care for her child, the woman has the support of family members, who organize themselves around her and the child, accompanying, supporting, evaluating and with her seek strategies to resolve the problems that arise. The behavior of women so far is considered normal and typical of the stage where she is, a phase of adaptation to events considered inherent to the situation. The diagnosis of depression has not yet been made by then.

Over time, she begins to exhibit behaviors that are alien to her and the family, and that are externalized in relation to the child, extending and reaching her relationship with her husband and other family members who are surprised by her behavior and do not understand what is happening to her. These behaviors concomitant with the ones towards the child are gradually taking over the woman and she finds herself lost in the middle of feelings.

II. Getting lost in the middle of feeling in the fight with the unknown represents the second time of the theoretical model. This phase in which the woman dives into the depressive process is composed of strange and unfamiliar feelings. The situations she is undergoing are increasingly beyond her control; she does not notice very well and her ability to function as a mother varies a lot. In this phase, the family must fight very much to deal with her variable functioning and attempts in every way to support her and keep up with the child's care. It becomes evident the behavior and feelings experienced by women in the interaction with herself and with family where the lack of control is more present and family support assumes a protective dimension, as much of hers but also the family unit, many times threatened. The loneliness the woman experiences comes from her difficulty in expressing and having her feelings and fears recognized by her family.

Excessively caring for the child is related to the behavior that the woman starts having in the care of the child, which is considered by the family as excessive and unnecessary. The interaction with the child, the woman feels insecure to care for him, and as a strategy she increases the care that she dispenses as a way to ensure his physical integrity and also her own security in relation. In the excessive delivery of care to the child she is observed by the family, especially the women, who warn her about her attitudes and their repercussions in the future.

And I used to give him a bath with mineral water! I spent one month giving him a bath with mineral water and my mother used to say that there was no need and would say "no, are you mad?" I thought she was crazy, you know? Today I know I was crazy, but at that time I thought it was normal all the care I had with him, right? (she laughs a lot) (Woman I):

The excessive care she provides to her son works as a guarantee that she is not failing in the role that she sets herself to. Even if prompted by family women, who in the interaction with her and the care she provides to the child, bring their experiences to the situation, the woman does not understand and rejects their perceptions about it. In other situations, the lack of control over the excessive care that provides to the child is justified by the sense of normality that she has in her actions, that is, she does not perceive her behavior as exaggerated, as perceived by the family. At other times, she realizes and agrees that her care for her child is exaggerated, but cannot help them.

In the interaction with the family, she has her behavior with the child explicitly rejected, especially by the other women, who try to lead her to a path of motherhood less intense, smoother and practical. They also realize and alert her of the consequences of her behavior in the child's life and her own. However, over time she finds herself being consumed by the care for her child and sees her life, her time and her look entirely towards his care.

However, the pace of life the baby dictates is not accepted passively. She finds herself constantly fighting, wanting her life back and that is when she takes time to move away from the child's routine, distancing through the opportunities that she perceives and within the possibilities she has to do it. The return to work after maternity leave and even during, for financial necessity, is welcome. However, in some situations the depression is still ongoing, although in its mild form, spontaneously. However, if the return to work means the distancing of what causes her discomfort, return to the home environment and maternal activities at the end of the day signals the re-immersion in a reality that she rejects.

The routine care of the child is taking increasingly the format of a painful function, and extremely tiring, and it becomes worse when some health problems begin to manifest in the baby, such as respiratory problems (bronchitis) and gastroesophageal reflux making her feel extremely tired and required. A time to be alone becomes her greatest desire, although occasionally this desire is tinged with guilt as noticed, especially when she compares her behavior with the child of the other women who she takes as reference concerning maternity and when she is pressurized by her family in relation to dedication to her child.

The families through the women try to continue their way of taking care of children, presenting behaviors that sometimes soften motherhood and others make it heavy for the woman. The way the family deals with motherhood is not always accepted by her,

who longs to distance from the demands of the child and the control from the women in the family in relation to her way of taking care of the child.

I wanted to have to spend a few days in the hospital (alone) just to get out of that excruciating routine of worrying all the time, having to stay alert all the time, being able to sleep without anyone criticizing me for that (women in the family). (Woman G).

Her behavior with her son is controlled by the family, that is, it is rejected when she exceeds in the cares, when she does not want to take care of him or when she wants time for herself. The family and especially the women of the family have their established way of caring and mother-son relationship and try to make the woman fit to it. However, not always the symbol that the family has to motherhood is the same as she has and is meant for herself, then the symbols issued by the family in relation to maternity are not significant, because she does not recognize them.

Rejecting the child relates to the behaviors in which a woman refuses to take care of the child, perceived by family and herself and behaviors that although she cares for him, she perceives herself rejecting him, but mutes that feeling that goes unnoticed by the family. The behavior is perceived by family members when she seeks concrete ways to not care for the child through the early resumption of formal paid work, and the explicit refusal to meet the child's needs. This causes for the people around her the need to meet the demands of the child, especially at night, when he cries. This is often done by the man who also tries to stay with the baby and also be able to sleep and rest.

[...] sometimes, the child cried for a long time at night and I was like: ah, children do not feel hungry during the night, I'm not getting up to pick him, it will soon stop! Then, before I realized, I was nursing him in my arms (Woman A).

The refusal to care for the child does not escape the watchful eye of the family, especially of the women. That look, sometimes understands when it perceives the lack of maternal physical condition and sometimes reproaches when women have coarse attitudes with the child. The family then, attentive to what happens in the mother - child interaction tries to protect the child from maternal behaviors considered inappropriate and also gives him the care that he does not get from the mother. When she expresses the desire to free herself and get away from the child is made public, she is called to the fact that she has a son, and this is done by family members, that lead back to the situation, hindering any possibility of her moving away.

[...] I had a great desire to go away, you know? I'll drop everything and I'm leaving for anywhere, for nothing you know? I'll just walk out the world Where I stop I stop! (Woman C).

Older women of the family, through their experience, are placed in the woman's perspective, recognizing and validating the problems and difficulties that she expresses. The exercise of motherhood for women in the family is understood as a task that is not easy, and so the desire to get out of the situation and abandon it is understandable. However, we must stand firm in its execution, because the situation is irreversible, the child is real, the woman became a mother and there is therefore a greater responsibility that must be met with firmness and resignation, despite the problems that arise ahead.

In some situations, even when she assumes the care with her son, she finds herself rejecting him in her thoughts. The woman sees herself expressing the desire to have not had children and thinking about possibilities of how her life would be if he did not exist. The feeling of rejection does not get to culminate in the child abandonment; she thinks about the possibility, but does not perform the thought action, and nevertheless still blames herself for the thoughts she had. However, she finds herself thinking in a comprehensive way about other women who have abandoned their children and had their cases exposed in the media.

The rejection of the child as well as being something that she keeps for herself, shows camouflaged by the exercise of the maternal role related to child care, which she performs with perfection in the vision of a man, to the point that is not perceived by him. Among the reasons given by the man for not perceiving the rejection of the woman to her son, is her exemplary involvement as helpful and zealous mother in his care. In this situation, the man describes the affectionate mother-child relationship as acceptance, and consequently cannot identify some behaviors as signs indicating the child rejection, even when she voices it, he refuses to accept the fact.

Now one thing I discussed with her about this idea of rejection ... Because I never understood this as rejection. She was always a caring mother, too much sometimes ... I even fought with her ... No, not like that ... You have to let ... she always spoke, crying "is rejection, yes ..." . (Man E).

So the mother-child emotional relationship is linked to the way she dedicates to him that is, the greater the care of him, the more she is linked to the caring mother figure, zealous and dedicated to her children, and therefore she is in the eyes of her husband far from the distant mother who rejects her son, a fact that he does not believe though it is by it commented.

Losing control of herself in their interaction with the child refers to the behavior of aggressiveness that the woman begins to exhibit with him, the fear that she feels of being unable to contain them, her struggle and family to maintain control over these reactions as well as child protection. Aggression takes physical contours, psychological and does not depend on the age of the child. The woman finds herself losing control of herself in his care, including care related to some health problems he goes on to present and where she sees herself with the addition of one more task in their day-to-day, that somehow overwhelms her.

Aggression also occurs when she does not get the child to understand and meet her requests as he grows and is carried away from other people where probably she feels no control of the watchful gaze of others and where to her, aggression seems to be allowed. But she feels after the act, invaded by repentance and fear that everything will be repeated again.

I fought with him to take the medicine, and then I shoved the medicine once in his mouth, doing these stupid things, gross, coarse, thing of stupid people. I was afraid of that. (Woman L).

The woman reproaches herself, is rejected, is scared and afraid of her behavior with the child, especially the extent of it in terms of aggressiveness and the fact that she practices them hidden from others. By hiding to attack him, she is aware it is wrong; she knows that is contrary to what is expected of her as a mother and is afraid of being

singled out as a bad mother. Her actions in their interaction with her child in her perceptions are incorrect and dangerous because she notices herself letting go of all the aggressiveness controlled when in public when alone with her son is.

When she notices she is being aggressive with her son, and with difficulties in controlling herself, she finds herself trying not to be alone with him, in an attempt to protect him from her and her reactions. Among the strategies are to maintain the husband longer inside the house with her, demanding his return to work when she is in better condition; to distance herself physically from the child when she realizes she is on the verge of beating him and seeking contact with people from her surroundings, close to her home, in the hope that through these contacts, she will get rid of bad thoughts and attitudes towards him. The aggressiveness towards the child is perceived by relatives trying to protect her from maternal attitude and this is done by the older women trying to understand the reasons that lead her to have such behavior and at the same time provide conditions for her to distance herself from the child and return at a later period in a better position to deal with him.

The aggressive behavior and the lack of control shown are also manifested and are directed to other people of her family circle like her husband and other children, as well as to other people outside of her family.

Losing control of herself in the interaction with others refers to relational difficulties of the woman with her husband and other family members and her fear to repeat such behavior with the child. She realizes that her aggressiveness grows inside her every day and makes her feel more and more afraid of not being able to contain it, especially in her contact with the child. The feeling of having another one within her makes her realize something very intense and monstrous, to perform increasingly powerful in her relationships, and the possibility that it manifests itself in the care of the child makes her afraid of being alone with him.

[...] Because I was afraid that my inner monster could do any harm. I never had ... I never did any harm to him (son), I never gave up, never stopped caring, never anything. But I was afraid of being affected, you know that awareness, the imposter there, that it would take me by surprise like this, you know? To lose control of it, you know? (Crying a lot) (Woman E).

The woman looks at herself in her interaction with the child and his eyes pointing her as a caring mother, but when she looks at herself in the interaction with other people, perceives herself as a woman without a care, aggressive, angry. She evaluates her actions in these interactions and is afraid to repeat the same behavior she has with other people with the child. Thus, the fear of not being able in her interaction with the child to have the same self-control and when she interacts with others, causes great suffering, because she feels threatened by something that she does not recognize as part of her and that at any moment can manifest in her interaction with him. The aggressive behavior is perceived by the family that suffers to see her trying to physically assault other people in her environment and also sees herself struggling to contain these events.

Both physical and non-verbal aggressive behavior of women cause discomfort and suffering for the family and especially for the man who besides being targeted, does not recognize that there is presented as part of the personality of the woman who, in

his eyes becomes another person who he does not recognize. That aggressiveness, however, extends to other children, that is, her behavior affects other family members.

[...] There was a day even if she (eldest daughter) was... I spoke to her and looked like she was not listening. Then she began to cry, I talked to her and she wasn't listening to me. Then, you know that nervousness like, suddenly? Then the feeling I had was that I would get her (older daughter) and throw her from up there (lives in a townhouse of 03 floors) (Woman J).

There are situations in which she exposes the aggressiveness as a call for help she longs, but it does not come soon enough, despite the various signals given. So she decides to trigger the aid in order to make public her aggression in an attempt to force the family to worry about and engage with her. The woman manipulates the situation to achieve the goal of drawing attention to herself, to what happens with her and cannot make herself understood; that practiced action is significant for the family who decide to give more attention to her needs.

In this environment soaked in aggressiveness, the man also becomes a target, especially of verbal abuse and finds himself wanting to escape the maternal behavior. Among the flight strategies are the detachment of the situations through leaving the family environment for short periods and the desire to go away from home. Feeling rejected by the partner's behavior, the man starts to feed the idea of abandoning the family and consequently starts to evaluate the possibilities he has and future consequences. However, his decision to stay is reconsidered especially when he thinks about the responsibilities of being a parent, when he thinks about his spouse's future that will bring up the children alone, in the love he has for his children and also the fact that he realizes he still loves his wife. Oscillating between going away and not being able to go away, the man also visualizes the possibility that moments of difficulties in the marital relationship that he is experiencing will one day have an end. Besides the desire of going away from home, he takes refuge in himself in face of the aggressive behavior. This decision comes as a strategy not to increase the friction and preserve the marital relationship. Thus, he continues to hear the aggressions without refuting them, even if this brings him emotional impairment.

However, the couple's disagreements are also provoked by the refusal of the man in accepting the way the woman is harsh with herself and dedicates to the child's care. He observes that she has behaviors of excessive care to the child related to the hygienic protection of the child and in the exaggerated concern with his health. These behaviors give her discomfort and intolerance, especially because of its repetition day after day.

I felt suffocated! Sometimes I think that has already passed, but I also think that I wouldn't bear to hear and see all that again ... I was traumatized with that, wasn't I? That was suffocating me. Today if I see, I go elsewhere. I can't see that! ... That obsessiveness! (Man B).

He observes the behaviors presented and classify them as obsessive, feels annoyed for struggling not being able to get out of this movement that repeats many times and leaves him in his limit of tolerance, creating great discomforts and marital misunderstandings. The woman's behaviors and reactions provoke detachment and silence of the spouse and other members of the family, who cannot understand what is

going on with her. In contrast, the woman, unable to make herself understood, begins to feel alone even with the presence of the family and her child.

Feeling very lonely refers to the feeling of loneliness experienced by the woman due to the difficulties to be understood by the family and of the perception that the family does not value what she feels. Thus, regardless of the number of people that are around her and that helps her to take care of her child relieving herself from his demands, she feels alone.

[...] in fact, I felt alone because actually nobody was able to understand me. It didn't matter how many people were there. It is as I say everybody tried to help me, in the care with the child, everybody always near, but I felt alone all the time, this I remember! [...] I think that even for the lack of understanding of what was happening to me, that I didn't even know what it was, isn't it? (Woman I).

The woman associates the lack of understanding of the family to what happens with her, to the fact of not being able to voice what is happening. She struggles with her own inability and lack of knowledge to describe in words what she perceives of herself and in herself to the others that surround her and although she is in disagreement with what is expected from her as a mother, she does not know how to express it. However, the loneliness that she feels, in the interaction with her family is also attributed to the perception that they don't give any importance to what she feels.

Besides feeling alone in relation to her birth family and her husband's family, she also feels alone because of her husband's frequent absences of his domestic environment. This, besides provoking the feeling of loneliness, gives the sensation of abandonment. She perceives that the man goes on with his normal life, with his work and leisure activities at the weekend out of the house, leaving her alone or even excluding her from these commitments so, even after signaling her need to have him beside her. For the woman, it is not staying at home that makes her feel bad, but to be disadvantaged by the husband in favor of his other needs, which is not always understood by him, who proposes to leave her in the home of other family members when he is out for leisure activities, attitude that is firmly rejected by her that feels that she is treated like an object to be transported.

When the frequent absence of her husband from the home environment persists, besides causing her the feeling of loneliness and abandonment, it also makes her realize that the family they proposed to build is already being born in an inappropriate manner, that is, separately. The woman, seeing her husband continuing with his previous life as before the birth of the child, she sees herself and the child excluded from his life and feels abandoned by him in relation to the development of care to the child, who day after day develops in solitude.

However, regardless of the reasons, the man's detachment from the home environment becomes stressful for her, when she has another son who depends on her care. When she is alone with the children, she gets stressed for not being able to care for them properly at the same time, depending on the age, needs and level of understanding of the eldest son, who demands a completely different attention she devotes to the newborn. In this situation, in the midst of loneliness and anxiety of having to give account to look after them together, strives to maintain control.

[...] I was in a way I did not know what to do, it was making me stressed out because I could not cope with two babies alone at night and he lecturing at night. And a thing that I realized is that I think he (the husband) got this lot of classes, to get away from us. I'm not talking as guilt no, because he could not manage to stand it (his constant crying) and I was so alone (Woman H).

At the same time she points to the disadvantaged situation she finds herself in regarding her husband, she ponders his behavior, emphasizing the difficulty he has to bear the crying manifestations that she displays. To perceive herself she sees immersing increasingly strange feelings herself and losing her own control over herself.

Losing control of herself refers to the woman's perception of herself where she sees herself in constant and progressive disconnection with herself, imprisoned and trapped by depression. She also realizes she is careless of her appearance, which reveals itself in the abandonment of the care with her body that she used to have, the routine hygienic care of her body and also care for the proper nutrition of it. However, not only the physical changes resulting from the PPD bother her and are perceived. The feeling that she is entering a state of prostration, apathy, and that is disconnecting from herself and the environment in which she lives is present and in the process, the woman feels discouraged and unwilling to perform any activity, including care of the child.

However, she is not alone in the perception of herself; the man also notes her apathy; but this perception is taken by observing that it is the interaction with her son, where he notes little interaction with the child, specifically in relation to physical contact. However, family members and her husband observed that the woman's behavior starts swinging.

The woman's behavior is perceived by the family permeated by fluctuations living and not be present in the situation, in a coming out of and a returning to herself, and these comings and goings presented by the woman in the course of the disease, repeatedly bring and take away the hope of the family in their recovery.

Impregnated by something she does not know and that is not part of her, the woman realizes she is trapped by depression and increasingly losing her strength. Concurrently she feels being pushed down and this takes concrete contours of a deep, dark place where the possibility of finding support for the getting over it becomes nearly impossible. In addition, the care that she gives her child seems increasingly drain her energies that she could save to get out of there. This situation may worsen when she finds herself without the birth family support to share the care with herself and the child, which makes her feel lonely and worthless.

Thinking of the situation in which she is, she feels herself as someone who must act to get out of the situation of being dominated to having self-control again, and one of the ways of escaping from the imprisonment in which she lives is to face the PPD. However, other ways are in her thoughts which are that she feels that she can end her suffering through suicide as one of the possibilities of gaining freedom. The husband is the person to which she expresses her desires and he, realizing the seriousness of what he is hearing has the delicate and difficult task of maintaining his own self-control, the control of his wife and of the situation.

The time came when she talked of killing herself, of throwing herself under a car. She talked and then I talked to her and everything. And I said "It's not like that, and gave her advice and everything...[.] I kept calm, kept calm and talked to her a lot, kept calm, said that it wasn't like this, that she had to change. I prayed with her, talked about God to her, and she would listen to me, but there were moments when she would react [...] I was very worried, I saw this wasn't normal, I wanted the cure and the total recovery.[man B]

The confirmation of the seriousness of what he hears makes the man seek for support in the Divine and bring to his wife the effort to find other ways out such as professional help. However, at the same time, that she thinks she transcends the immediate situation in which she is living in the present and transports to the future, imagining her son an orphan and the consequences that her act would cause him. The love for her son, along with the worries about his future and the religious principles is what holds her to continue living. However the man is worried when she says that she doesn't want to be alone with the baby and associates this to a possibility of suicide bringing to the situation something that happened to a person known by the couple.

Another situation in which the woman notices she is losing control is related to her crying which is constant, but her decision of looking for help to stop it is increasingly postponed until she sees herself crying several times a day. However the husband even knowing that the woman cried very much sees the crying as part of her behavior. This happens because he brings to the current situation past experiences, where the crying of the woman was present and defines the current situation as normal, making it difficult to perceive the problems that have been happening for some time and consequently the decision to seek for help.

Nonetheless there are situations in the behavior of the woman that the man perceives that her crying is not normal, but has difficulty in dealing with it. Thus he uses strategies to maintain the control of the situation and also to escape from it. To escape the man works more hours and stays away from home longer, at the time when she cries, coming back when she has stopped. He tries to control her crying calming her and avoids talking about it, because he perceives that she becomes nervous.

Sometimes if I talked, the more I asked the more she cried so I avoided being worried, asking her things, so I would say don't cry, I talked about other things [man G]. To me it was as if he wasn't interested [woman G...interrupting]

The behavior presented by the man, of escaping when the woman was crying, brings to them feelings of loneliness and abandonment, and also the perception of lack of interest on his part with what was happening to her, making it clear then that the man and the woman give different interpretations of the fact. However other members of the family, especially other women when they see the mother crying, try to stop it with reprehension and this can be justified because of several things, among them the most frequent is the lack of reason for crying because of the perfect physical and physiological health of her son. This attitude silences the woman and makes her accuse herself and stops expressing how she feels so she will not be censured and rebuked by the others.

If she does not notice any morbid thoughts and other behaviors in herself, she rejects the possibility of PPD, and diminishes what she feels and continues trying to live her "normal" life context. The exclusion of the possibility of PPD is also reinforced by the

man as he analyses the interaction of the woman with her son as it is impregnated by the PPD conception associated to the behavior of rejection of the child and by the cultural conception of behaviors that are considered "normal" for the post-partum that the woman has in some moments. In some situations the perception that something is not well is noticed first by the husband, indicating that the husband is observing the changes in the woman and perceives them before she does, although he does not link them to PPD.

In his interaction with the family he notices that she is different from before, but has no idea of what is really happening to her. However, for some families, the identification of the woman as having PPD is complex because they associate situations and maternal behavior that do not follow the rules in their idea of what is considered post-partum depression.

In this way the mothers' behaviors are perceived sometimes as normal, sometimes as different and strange and associated to other kinds of psychic manifestations, and so the possibility of PDP is contemplated neither by the family nor by the husband. However, the strangeness that the woman feels about her behaviors, mainly related to her interaction with her child that she shows in public or that she keeps to herself in what she thinks serve as an impulse for her to seek for help, through reading of material from the media that describes the post-partum condition.

Through the search for information, she finds hints about her perception of being a stranger to herself, to her family and in her group that has a reference of what maternity is. As she perceives similarities in what she feels with what she hears from other people outside her family circle and through the reading of articles she begins to act upon her suffering and to decide to seek for professional help. In this quest, she receives support from her family and husband and together begin the process that will take them to take over the control of the situation and recovery of the PPD.

III. Taking control represents the third round of the technical model and refers to the stage of the return to the surface and struggles to recover the control of life itself. It is marked by the diagnosis of PPD and by the interaction directed by the treatment. The family is involved in this stage supporting, protecting the woman and managing situations that are difficult for her, without depending so much on her.

The family in some moments tends to diminish the importance of the illness and its impact on the woman and the family itself. With the perception that there is more control of the situation, her hope of recovery also becomes more real. The treatment is supported by the family when it defines it as a resource that can improve the woman's performance and the life quality of the family.

After identifying what is happening with her in the information she gets in the media that describe the psycho emotional condition of the post-partum and through contacts with other people (friends, co-workers) that alert her to the possibility of depression, the woman decides to seek for expertise help to relieve her sufferings.

Seeking for professional help. At first the woman goes to doctors that already take care of her such as homeopaths, physicians, obstetricians and psychologists and the depression is diagnosed. The decision in the choice of a psychiatrist is in most cases postponed and is done basically when she perceives that her suffering is growing

through her behavior when she cannot control them, when they do not go away and are not solved by the treatments mentioned above.

[...] So, when four or five months had passed that I was taking homeopathic medicines. I had controlled a little the crying. But I saw that the anguish, the anger, the irritation, the feeling of being trapped...right? Of being shut up in a situation... Of seeing a monster inside me, ready to bite anyone at any moment. That hadn't passed. I said, no this isn't right. And then when I was talking to a friend that had had depressions, not post-partum but... She said, look, you have to take the medicine to hold on, you have to go, not have prejudice, because we stay in this natural medicine thing I don't know what but you can't be prejudiced you have to help yourself too until when are you going to stare at this monster? Then I said. That's it. [Woman E]

She perceives that her evolution is slow during the treatment that she sought for at first and this she verifies observing that some signals and symptoms that she had before had not disappeared with the therapy. So, she looks for other ways to get out of the situation seeking for other experts such as the psychiatrist and sometimes the decision to see him is taken after talking to other people outside the family circle.

The search for psychotherapy occurs when she finds herself in new events during the depressive process that seem to contribute for the worsening of her situation, among them the impossibility of breastfeeding her child and the coming of another child that, consequently put her in a situation in which she has to make efforts to attend their needs. Thus, the search for treatment with a psychologist happens when she perceives that alone she cannot deal with other elements and situations that appear and leave her in conditions worse than before because of the burden she carries trying to cope with her condition and situation added up.

However, the help with the psychologist can be given later also, when she goes back to work, after the end of the maternal leave. She perceives that she is rejecting and fearing having to go back home after the end of the work period when she inevitably has to go back to take care of her son. The perception she has when she finds herself crying because of this, is that this is not normal and that she needs help.

However, the search for psychoterapic help is done by the woman who presents better financial conditions and that understands the importance of this treatment for her recovery.

Seeking for spiritual help: The search to relieve the sufferings using religion is through daily prayers with her husband and members of her church. This search is made when they perceive the worsening of the signs and symptoms of depression and the frequent expressing of wanting to die. The family seeks for the inclusion of religious practices to relieve the woman suffering and at the same time condemn and reject them when they perceive that the woman gets involved with them in an irrational way having typical religious fanatical behavior. Besides, the family worries about the physical harm to the child and the woman when they see her going to church daily.

It is that there we start to get involved with the pastor's words. In sermons, they say a little about what we are going through and so we start to get involved with that (Woman F).

These observations are rejected by the woman who keeps practicing her religion, going to the church that she belongs to, because through this practice she can identify herself and feel involved by the words she hears in the services, that brings relief to her sufferings.

Perceiving been taking care of: The woman sees that in several moments the family is worried and takes care of her. In this act of care the women of the family participate more, during the time they think is necessary and as when the woman asks for it. They get together not worrying about the tasks they have in the family and professionally and the long distances they have to cover. And more, to take care of the woman and her children they organize themselves sharing tasks among the members of the family. They distribute the cares among them, the cohesion becomes a facilitating element. The distribution of the cares varies between the direct care to the children and the woman and observing and protecting her in events that can potentialize the worsening of her state. The care depending on her condition becomes a priority for the family that tries to involve the largest number of people to attend the needs they identify in her.

[...] That the baby we knew that the mother-in-law would take care of the baby. We didn't have this concern right, after my mother gave the baby (to the mother-in-law), we knew that she (the mother-in-law) would take good care of the baby, we were worried about her, that she would get better soon right (Sister woman F).

So, the women of the family get involved in the situation, through the creation of a collaboration and solidarity network, where they act cooperating with each other, sharing and distributing cares, supplying their social and affective needs of medical attendance, aiming at her return to the behavior she had before the depression. However many cares given by the family through the women are directed to the care for the children but these in the end relieve the physical and psychic burden of the woman comforting her very much for she feels also cared for through the attention given to the children. The cares given by the women of the family extend to the protection of the couple's marriage through dialogues giving information to the man and or in the control of the intolerant behavior of the man towards the woman observed when there is a bad interaction between the couple.

I didn't know what to do, but I talked to her husband: "Y have a lot of patience with X! Don't ask too much of X she isn't well! Have patience with her. In what you can do to help, help, and don't get in the way. Because she isn't right!" That's how I could do for her... (Mother-in-law C).

The older women in the family allow themselves and realize through their own experiences the difficulties that women with newborn children may be having. All this care developed by the family causes in women, even temporarily, the sense of comfort, acceptance and balance.

In the interaction with psychiatrists and psychologists, she feels respected in her time of recovery from illness, and feels welcomed getting detailed information about what happens with her development and overcoming possibilities. Another source of support and care received is located in religious communities to which they belong as well as women who make up some societies internal to the churches. So the woman, family and husband feel, when they receive professional and spiritual help, comforted,

welcomed, guided and strengthened to move on. With time and recovery of the event, the woman begins to examine the past while trying a new way of walking.

Trying a new way of walking: In this new way of walking, the woman is seen struggling to build a good motherhood, which she reproaches herself for having been aggressive with the child, and is invaded by the feeling of compassion every time she remembers the attitudes which she had during the depressive process. After the depressive period evaluates herself as a mother who managed and can be a bad mother especially when reviewing explosive behaviors she had with her son and herself fighting to turn into a different mother from the current one and who disapproves and rejects, although she did not have full control.

Realizing that she might have been a better mother effectively with her child, she sees herself worrying about the possible consequences of depression on him. During the child's growth she begins to relate his behavioral responses as negative and problematic, linking them directly to the established interaction with him during the depression. In her fight to minimize in the child what she believes is a result of her illness, she finds herself in a search for changes in her own behavior that still has some of the traces it had when in depression, with those seen by her as harmful to the proper development of the child. She counts on the strong participation of the husband concerned about the relationship established between mother and child, often interferes in it to help them become independent.

Although she often feels herself in a mental condition where she considers herself recovered from postpartum depression, she perceives herself in certain situations threatened by some behaviors similar to those she had when depressed. These are also perceived in the interaction with her partners, who identifies them as the same as she had in the course of the disease, which are considered as a warning sign that she should keep in control of them.

Even for a good six months, I would get something like 'is this me?' (looks over shoulder) having the feeling that it (depression) can return.. Sometimes when irritation crops up, I say "no, wait, control this monster, this monster that is caged, right? Throw away the key, right?" (Woman E).

Married life also becomes the object of her care after the depression, where she tries to return to the previous pattern. The woman sees this process as something that caused intense changes and refers the situation she was in as the feeling that something very strong happened in her life causing disorganization of how " the things" of her life functioned, imposing a new functioning and in which she could not be located and have control.

Look, to me it seems like a hurricane in my life, you know? When something takes you, comes and changes everything and escapes your control? So, I felt it, it seems that my life was out of control and changed a lot and everything. And I could not place myself there (Woman D).

This lack of control affects the marital relationship marked by constant disagreements arising from their failure to understand the situations that occurred on a daily basis as they were put to her by her partner. In the interaction with her husband, her difficulty of understanding of the various issues that they had is well perceived by him.

Although considered as a time that causes great suffering, disruption and subsequent marital estrangement, both claim that after post-partum depression, they managed to reestablish the way their marriage used to work. For this, they also had to work out a new way to address themselves, where they started taking care of the communication process between them, to circumvent the problems that arose on a daily basis, together with the exercise of self-control and balance in times of marital tension.

DISCUSSION

This study shows that the uncontrolled behaviors present in the woman is not perceived by the family and they find themselves struggling to support her and control these events. The man, one of the targets of these behaviors tries, in the interaction with the woman, ways to control himself and to ease the tension that is established. Among the strategies sought by him is silence and physical distancing of the woman for variable periods of time, especially when she cries or loses control of what she says to him. However, the man's behavior contributes to the exacerbation of the woman's irritability and lack of control, because she sees his attitudes as undermining what she feels and express, besides feeling alone. These results are congruent with those of a study ⁽⁹⁾ in which women thought their partners spent too long away from home, worked too much, did not engage with them and the children, and did not help them with them. They felt very angry, irritable and disappointed with their husbands, saying that their behavior took much of the joy and happiness they expected to feel with the birth of their children ⁽⁹⁾. For women in another study ⁽¹⁰⁾, to be alone at home was perceived as a situation which they barely tolerated, especially when their husbands were absent for long periods because of work.

In our study, the detachment of the man from the turmoil caused by the depression, apart from being a way of trying to protect the family unity, it is also a consequence of the fact of not knowing how to handle the situation, due to ignorance, lack of preparation and difficulties in dealing with emotional aspects. In a study ⁽¹¹⁾, the men whose partners had PPD indicated the need of support from professionals, friends and families, and the last two with the intention to talk and share the burden that they perceived themselves carrying concerning the woman's illness.

In another study, spouses living with a depressed patient reported more depressed mood than the general population, this being closely linked to the increased burden of living with a partner in this situation ⁽¹²⁾. That same study revealed the presence of disharmony in the relationship, but the direction of causality between them was difficult to identify. The PPD of mothers is described in another study ⁽¹³⁾ as a difficult time, of great suffering for the couple, of pain and confusion for the man as well, who finds himself caught unawares in a situation that he had not foreseen, cannot control and has no idea how to resolve. They refer not to miss this time and describe family life as a real chaos, marked by fatigue and despair. Most men reported having felt perplexed by the partner's behavior, apart from the feeling of shock, misunderstanding confusion and disillusionment ⁽¹³⁾.

In a situation of illness the man can support the woman, but feels uncomfortable to deal with her sadness and emotional needs and that is because they tend to face the practical and instrumental aspects of coping and avoid the emotional side of their spouses and their own ⁽¹⁴⁾. They describe reactions and strong feelings in the initial period of the illness associated with the difficulty in understand what is happening to his wife, by defining the experience with them as full days of stressful reactions ⁽¹⁵⁾.

Results similar to the above study were found in this study, where the woman's lack of control causes discomfort, grievances and estrangements especially for the husband who besides being targeted, does not recognize what is happening as part of her personality. However, even though the spouse and other family members do not understand what is happening to the women, they seek to alleviate her suffering through support with child care, the woman herself and the running of the household.

The presence of depression in women can cause difficulties in the marital relationship⁽¹⁶⁾. Communication, especially regarding the means of resolving conflicts proves difficult, as couples struggle to express differences for fear that the conflict would increase and cause violence and marriage breakdown. In our study, although the man strives to protect the family unity, he also thinks about the possibility of marital separation at times when the tension is exacerbated and he sees no way out and losing control of the relationship. In contrast, the woman reported difficulties in communicating to the husband and also family what happens with her. This is linked to her own incomprehension of what is happening to her and the impossibility of revelations that confront the maternity model socially acceptable, which is reinforced in the attitudes of the women in the family, who warn her about the need for her to keep up with the tasks inherent to her duty.

The uncontrolled behavior of women in our study becomes more overwhelming, day after day and the fear of not being able to contain it is present, especially in her contact with her child, as she notices him manifesting without her consent in the interaction with other people in his surroundings; it scares her and it makes her constantly vigilant about herself. Similar results are noted in one study⁽¹⁷⁾ where women expressed shock, shame and guilt at the thought of wanting to harm their babies and although they say they had never done it, they said they were disappointed with themselves, surprised with their own thoughts and relieved when they disappeared.

The reassurance given by the presence of the husbands is reported in a ⁽¹⁰⁾ study where the women reported that the physical presence of the husbands in the house lessened their fear in relation to the PPD and was represented as an opportunity for them to verbally express their concerns and uncertainties, as well as being an opportunity to verbalize feelings and thoughts albeit selective, but possibly decreased the emotional turmoil and inner imbalance that they felt⁽¹⁰⁾. Regarding the presence of the father by the mother with postpartum depression, a study⁽¹⁸⁾ points out that the presence of the father was of great importance for the mother and the baby became of mutual responsibility of the spouses. The support from the father in baby care united the couple and helped them better understand the emotional turmoil in which the mother was immersed ⁽¹⁸⁾.

Scholars ⁽¹⁹⁾ say that the husbands of depressed women tend to become more involved with their children than fathers whose wives are not depressed, probably in an attempt to compensate for her difficulties with depression. Thus, the father could mitigate the possible impact on their children, by providing a model of sensitive interaction and responsive to the needs of the children, when his wife may be struggling to do it. ⁽¹⁹⁾.

In contrast to this idea, study⁽²⁰⁾ shows that men whose partners were depressed had scores of depression and stress significantly higher and presented decreased father-baby good interaction than men whose partners were not depressed, showing that

when a woman is having postpartum depression, the father-baby interaction is negatively affected. In our study, the detachment from his child and also from his wife in some specific times, is associated with the difficulties that the man has to deal with his wife's behavior and in those moments, the support of family eases the distancing, allowing him to recompose emotionally and return to the situation.

The fact that many women in our study present irritability and aggressiveness sometimes uncontrolled in their relations contributes for the people with whom they relate within the family context not to associate their behavior to PPD nor they themselves realize it. These behaviors, although not associated with PPD by the families of our study, were the ones that aggrieved them most. Study ⁽²¹⁾ draws attention to the variety of symptoms of PPD and among these, irritability that may vary in intensity from intolerance to even a destructive explosion of large proportions. ⁽²¹⁾

In this intense movement of relational difficulties with herself and with others, the woman begins to perceive herself losing self-control, and the ideas to put an end to the suffering she is experiencing through suicide start to become part of her thoughts. This behavior is what makes herself and her family realize that she needs expert help. However, behaviors such as prostration and withdrawal from the world around her makes the family more aware that there is something wrong with her and this is related to how the signs and symptoms of DPP are perceived by the family who relate her strictly to these behaviors.

The sensation of loss of strength makes the woman feel surrendered by the PPD, and this feeling takes contours of dread and terror, because she thinks about the possibility of ending her own life but conversely her responsibility to the child. At least two-thirds of postpartum depressed women in one study ⁽²²⁾ mentioned that they could not see a way out of the situation except by drastic means such as suicide and also through infanticide ⁽²³⁾. Another study indicates that one of the biggest difficulties for family members of women with PPD is when the signs and symptoms are exacerbated at times and the desire for suicide appears ⁽²³⁾. Husbands describe their wives having self-harming behaviours such as suicide, and they find this possibility tremendously frightening. ⁽¹⁴⁾

CONCLUSION

The findings of our study indicate the need to consider the implications of the PPD for the whole family, particularly including the fathers, in addition to the children, who due to their proximity to the women are more impacted by the postpartum depression. Marginalized by the perinatal health care, which focuses on the woman and the baby, the man, after the birth, finds himself having to support events related to his wife for which he was not prepared. Considering that depression mobilizes and affects everyone who lives with the woman, it is necessary to take the whole family as an object of care to be offered, in addition to being asked about the woman's odd behavior, as well as all the family context arising from the child's birth.

This study demonstrates that the PPD brings suffering to the woman and her family, and also weakens marital relations, thus the professionals who attend the pregnancy-puerperium cycle should equip the family with information that gives them skills in identifying and safely handling it.

Health care professionals often focus with the pregnant women on positive elements of the pregnancy-puerperium cycle; this practice can and should be preserved, but also touching the unpleasant elements such as emotional disorders postpartum, including postpartum depression, with all the behavioral aspects that women can present when faced with this event. The post-partum can be a period of gains, happiness, enchantment and fulfillment, but also can turn into a period with completely opposite experiences to these and the possibility of this happening should be revealed to the family.

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