Coping Strategies as a Manifestation of Resilience in the Face of Postpartum Depression: Experiences of Women in Northern Ontario

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Abstract: In the last decade, a growing body of research on resilience among women has emerged in the disciplines of social work, nursing, psychology and sociology. Myriad conceptualizations of resilience may be found within the research literature. One such conceptualization equates resilience with coping strategies leading to successful adaptation or positive outcomes under stressful or adverse circumstances. Among women, resilience has largely been studied in the context of physical and mental health issues, violence, abuse, poverty, immigration and geographic isolation. An extensive review of the literature has revealed that there is limited research on resilience among women who experience postpartum depression (PPD) in the underserviced communities of Northern Ontario. The current study addresses this knowledge gap by exploring coping strategies as a manifestation of resilience among women in the City of Greater Sudbury who are experiencing postpartum depression (PPD). Utilizing purposive sampling techniques, women were recruited from the Perinatal Mental Health Program of Sudbury Regional Hospital and various community agencies (e.g., mental health, parenting and peer supports and health services). The women were included in the study if they met key criteria such as (i) being 18 years or above, (ii) having experienced depression within one year after the birth of a live infant or within the previous five years, and (iii) being able to recall and articulate conscious experiences of resilience in the English language. The women were invited to take part in individual semi-structured interviews which were tape recorded and transcribed verbatim. The interview guide encompassed demographic details, experiences of PPD and coping strategies. This paper presents major themes delineating the coping strategies as a manifestation of resilience among twelve women experiencing PPD while living in an underserviced community within Northern Ontario. The findings are interpreted in the light of an eclectic theoretical framework consisting of Frankl’s meaning-making existential philosophy, Miller’s cultural-relational theory, and key principles of feminist standpoint theory. Coping strategies congruent with this theoretical framework include making meaning of one’s suffering (e.g., being philosophical about PPD, connecting with God, accepting the reality of motherhood), seeking support (e.g., sharing motherhood responsibilities, accessing services), nurturing oneself (e.g., participating in professional and recreational activities, developing positive outlook), and advocacy work (e.g., bringing awareness about PPD, providing support to other women). Other strategies such as connecting with and deriving strength from nature go beyond the assumptions of the theoretical framework. The findings have implications for the development of strengths-based interventions for women experiencing PPD.

Keywords: Resilience, Coping, Postpartum Depression
THE CONSTRUCT OF resilience has drawn the attention of researchers across various disciplines. This interest appears to derive from the view that resilience emphasizes the strengths of human beings rather than the deficits (Fergusson & Horwood, 2003). There are large variations in the definitions of resilience including its functionally equivalent terms such as invulnerability or stress-resistance and its polar opposites such as risk or stressor (Kaplan, 1999).

Among women, resilience has largely been studied in the context of physical and mental health issues, violence, abuse, poverty, immigration and geographic isolation (Anderson & Danis 2006; Bachay & Cingel 1999; Campbell, 2008; Kafanelis, Kostanski, Komesaroff, & Stokanovska, 2009; Kennedy, 2005; Leipert & Reutter, 2005; Notter, MacTavish, & Shamah, 2008; Shaffer, Coffino, Boeleke-Stennes, & Masten, 2007). An extensive review of the literature on resilience has revealed that there is limited research on resilience among women who experience postpartum depression (PPD), specifically within the context of underserviced and rural geographic locations, although some studies have touched upon the notions of personal strengths, agency and coping (Amankwaa, 2003; Beck, 2002; Chan & Levy, 2003; Chen, Wang, Chung, Tseng, & Chou, 2006; Nahas, Hillege, & Amasheh, 1999). Indeed, a common conceptualization equates resilience with coping strategies leading to successful adaptation or positive outcomes under stressful or adverse circumstances.

The birth of a child creates dramatic changes in the lives of women. During this period, many women experience emotional turbulence which is often described as “postpartum psychiatric disorder”, “postpartum depression” or “postpartum mood disorder” (Chrisler & Johnston-Robledo, 2002). A large number of qualitative studies have attempted to elucidate the lived experience of PPD through the personal accounts of women in different cultures and contexts (Amankwaa, 2003; Beck, 2002; Berggren-Clive, 1998; Hall, 2006; Nahas et al., 1999). These studies have revealed several features of PPD which include clinical symptoms (e.g., sadness, anxiety), family dynamics (e.g., altered relationship with the partner, ambivalent feelings towards the baby), moral dimensions (e.g., struggle to live up to the ideal of a “perfect” mother, PPD as a sign of internal weakness), socio-cultural dimensions (e.g., withdrawal from friends and family, threatened self-identity, cultural taboo on mental illness) and structural dimensions (e.g., gendered division of labour, unemployment and financial worries, geographic isolation in rural areas, perceived lack of power in the feminine world of motherhood) (Behnke, 2004; Chen et al., 2006; Edhborg, Friberg, Lundh, & Widstrom, 2005; Martell, 1990; Templeton, Velleman, Persaud, & Milner, 2003).

Researchers have explored women’s care seeking experiences, preferences for different treatment modalities, perceived etiology of PPD, and support needs (Dennis & Chung-Lee, 2006; Letourneau, Duffett-Leeger, Stewart, Hegadoren, Dennis, & Rinaldi et al., 2007; McIntosh, 1993; Sword, Busser, Ganann, McMillan, & Swinton, 2008; Ugarriza, 2002). Moreover, there is a large body of quantitative research on PPD which focuses on the risk factors, screening procedures, treatment interventions, prevention, effects on partners and children, and self-care strategies for the mothers (Ross, Dennis, Blackmore, & Stewart, 2005). However, there is a dearth of research on coping strategies viewed as a manifestation of resilience among women experiencing PPD while residing in the underserviced and rural communities. Consequently, the present study addresses this knowledge gap by exploring coping strategies among women who had experienced PPD while residing in underserviced and rural communities in Northern Ontario, Canada.
Method

Sample and Recruitment Procedure

Purposive sampling was used to recruit twelve women between the ages of 24 and 39 years who had experienced depression within one year after the birth of a live infant and no more than five years prior to the study. Seven women were Anglophone Caucasians from European backgrounds, three had Francophone heritage, and two were either of mixed ethnicity or did not identify their cultural backgrounds. The cultural backgrounds of the participants reflect the composition of the general population in Northern Ontario, except that there were no Aboriginal women in the sample (since none volunteered to participate). Participants were living in the district of Sudbury, district of Parry Sound, or the Red Lake/Ear Falls region in Northern Ontario when they experienced PPD. Participants were recruited with assistance from staff at a hospital, health unit, a peer support group for women with PPD, various social service agencies, clinical practitioner offices, and college and university campuses. The broad recruitment strategy ensured that the participants included women with a psychiatric diagnosis of PPD and women who self-identified as having suffered from PPD. The rationale for this broader inclusion criterion was that psychiatric diagnosis based on DSM-IV-TR criteria is often restrictive and does not capture the full spectrum of symptoms or experiences reported by women (Letourneau et al., 2007).

Data Gathering Technique

Following ethics approval, narrative data were collected from the participants about their coping strategies. Semi-structured open-ended interviews were conducted in a conversational style at a location chosen by the women. Probing was carried out in a non-threatening, respectful and non-coercive way. The interviews were tape recorded and transcribed verbatim.

Analysis

The narrative data were subjected to thematic analysis involving the steps described by Cohen, Kahn and Steeves (2000). Each transcribed interview was read in its entirety to acquire a sense of the whole dataset. In the next step relevant statements and phrases in the text were underlined and tentative theme labels identified. Passages with similar themes and sub-themes were extracted. All possible perspectives and dimensions emerging from the data were included in the portrayal of each theme.

Theoretical Framework

The present study drew on an eclectic theoretical framework constituting the meaning-making existential philosophy of Viktor Frankl, the relational-cultural theory of Jean Miller, and certain principles of feminist standpoint theory to guide the data collection and analysis processes. Viktor Frankl espoused the view that individuals who demonstrate resilience in the face of multiple psychological and physiological forms of trauma are able to construct meaning and the purpose of the human existence, by drawing upon their personal sufferings and their own lives (Frankl, 1968, 1970). This study is influenced by existential philosophy
in that coping strategies as a manifestation of resilience among women who experienced PPD would constitute this meaning-making experience.

Furthermore, relational-cultural theory states that resilience is a developmental, relational and contextual phenomenon (Jordan & Hartling, 2002). This means that coping strategies among women who have experienced PPD would involve a process of seeking and developing mutual connections and relationships with others. Self-imposed isolation characterizing PPD, cultural beliefs emphasizing joyous motherhood, personal expectations of self-reliance, stigma attached to mental illness, fear of child protection services, and lack of privacy in the underserviced and rural communities of Northern Ontario make it difficult for women to seek out connections and support (Amankwa, 2003; Beck, 2002; Dennis & Chung-Lee, 2006). Therefore, establishing mutual connections and seeking support within this larger socio-cultural, medical, political and geographical context was considered to be a coping strategy indicating resilience.

Additionally, existential and relational coping strategies were explored through the feminist notions of constrained agency and structural conditions including power relations, gender issues, health programs/social services, economic conditions and geographic location (Hallstein, 1999; Wood, 2005). Hence, the theoretical framework was three tiered as it sought to integrate individual (e.g., meaning making exercise, constrained agency), social (e.g., mutual connections) and structural (e.g., power relations, geographic location, health services/programs) levels while exploring coping strategies and resilience among the participants of this study.

**Major Findings**

The major themes along with the sub-themes delineating coping strategies are described in the order shown in Figure 1. All names have been changed to pseudonyms in order to ensure confidentiality.
Meaning Making

Meaning-making coping strategies involved being philosophical about PPD, coming to terms with the reality of motherhood, and connecting with God or being spiritual.

Being Philosophical about PPD

Mothers attempted to make sense of their experience of PPD as it completely defied the expectations regarding motherhood and proved to be a period of pain and misery which robbed them of the first few months of their babies’ lives. However, gradually they realized that PPD provided an opportunity for growth and self discovery as they made a journey towards recovery. The experience changed their perceptions of themselves, of people with mental health issues and of the world around them. Women who were working in health and social service sectors stated that PPD made them better clinical practitioners as they were able to relate to their clients in more meaningful ways from then on. Lindsay explained that the illness provided an opportunity for personal growth. She felt that it was liberating to experience PPD and recover from it. Anna described a positive aspect of PPD related to her work:

I was able to be better in my job because I had gone through depression and anxiety.... I was able to counsel people who were going through similar things. So it made me a better counsellor. [Anna]

Thus participants acknowledged that PPD enabled them to acquire new strengths and become better human beings.

Accepting the Reality of Motherhood

Participants approached motherhood with the expectation that it would be a beautiful period of life where they would be able to bond instantly with their baby, understand every behaviour of the baby, easily breast feed, and meet the “supermom ideal” which involves perfectly balancing child-care responsibilities with household chores. These expectations were shattered as women’s actual experiences differed considerably from the societal portrayal of an “ideal” mother. A way to cope with the contradiction between their expectations and their actual experience was to change their understanding of the motherhood role and to come to terms with the reality of it. Rose explained the adjustment process:

I was too hard on myself when he first came out, like [I thought] I need to know every cry, I need to always know what is wrong with him. Well, sometimes it will take a month before you get to know each other and know exactly what he needs...and dinner might be an hour late. I knew that I wouldn’t have time for everything every single day. And that was okay. [Rose]

Connecting with God

Some women turned to God or spirituality and sought solace in prayer as they attempted to cope with PPD. Talking to God involved praying for strengths and questioning why their lives were miserable. Alison and Anna reflected on the use of this strategy:
Certainly for a long time afterwards, I was definitely mad at God. I felt like why would you do that? ...So I mean we would pray a lot… And I just kept believing that God will get us through it somehow. [Alison]
I just try to be spiritual in a way that I look at the beauty in my existence, beauty in people and just nurturing my spirits. [Anna]

**Seeking Support and Connections**

The second major theme, seeking support, is divided into three subthemes relating to sharing motherhood responsibilities, accessing services and connecting with other mothers.

**Sharing Motherhood Responsibilities**

Some partners willingly helped to fill in the “mother” role for the baby and other children. These partners were engaged with the women and enabled them to receive rest, care and professional help to cope with PPD. Other partners struggled with child rearing responsibilities and household chores. This created marital discord as women expected their partners to assume child care responsibilities, while some men resisted any alteration in gender roles. Tanisha found ways to organize her partner’s contributions to household activities:

I told him like… he had to start helping me… like really helping me…I have a whiteboard in the kitchen and I put daily duties, weekly duties, monthly duties for him to do. You know it is like I had to tell him what to do. [Tanisha]

At times partners were occupied with their professional lives and women had to reach out to immediate family members who performed household chores, looked after older children, assisted with the care of the newborn baby, and provided emotional support to the new mother. Linda recounted her strategy for help-seeking:

We were living down the street from my mother. I just would jump in the truck and drive there all the time. Or she would come and get me… [Linda]

Not every woman had immediate family members available to help. Single mothers had to approach extended family members or friends for instrumental and emotional support. At times women partially disclosed their plight to others and sought help without revealing that they were suffering from PPD. Living in the Northern Ontario sometimes meant that friends were available at a distance but not in person, as Susan observed:

Well, a couple of close friends… I told them just whatever I was going through on phone and but the thing is they are all four and five hours away so I cannot just visit them. [Susan]

**Accessing Services**

Women approached professional service providers and navigated their way through the health and social service systems with or without the support of their partners and family members. Jane commented on a number of services that she had accessed:
The health nurse was phenomenal. She understood what I was going through. She gave booklets, pamphlets just on what PPD is all about. And how you could cope with it and... It is a home respite... They would come in and give me relief if I had a doctor’s appointment just for me... I am taking another parenting course through Our Children, Our Future. I go to Baby Steps every second Thursday. ...I go to Canadian Mental Health... [Jane]

At times women working in the health and social service sectors found it difficult to access certain resources as they did not want to be served by their own colleagues in the underserved and rural communities with limited resources. This required them to find alternate resources where their privacy and confidentiality could be maintained. Some women, including Mae, reported receiving beneficial services from unexpected sources.

And I know hospital runs a program, but one of my class mates is the assistance in running that program. So I did not feel comfortable going for that reason... But I went to see counsellor through EAP program. I always felt better after I saw her. [Mae]

Several women reported challenges including a shortage of family physicians, reliance on walk-in clinics for treatment, and a lack of privacy in small underserved communities of Northern Ontario. However, traveling to other cities to receive specialized services was not always considered a barrier as it afforded much needed privacy at the cost of convenience, according to Susan:

[I] had to come to the City every time had an appointment with a psychiatric nurse... The main hard part, Jamie [husband] had to rearrange his schedule, because most of the appointments with the psychiatrist were Friday afternoons... it was well worth it.... Living in a small town, there is a lot of gossip... you are labeled and that is the way it is. And that affects everything you do... So coming to the City is actually a lot easier for me”. [Susan]

**Connecting with Other Mothers**

Some women attempted to connect with other mothers at playgroups, at a peer support program, in the neighbourhood, or on the internet. Hearing stories of other mothers validated and normalized the feelings that these women were experiencing. Participants, like Alison and Mae, learnt coping strategies by interacting with other mothers:

Once I started to go to the playgroups, and listened to other moms speaking, I realized ‘wait a second, some of these moms feel some of the things that I feel too.’ ...I do not think they are bad moms because they say that. So why should I think I am a bad mom... Just started to realize that it is totally normal and real for people to feel these things. [Alison]

Mae used the internet to read the comments of mothers going through PPD, which helped her to understand that she was not alone and to accept her feelings. Whether the contact was face-to-face or online, participants learnt that others had similar experiences. This knowledge was empowering.
Nurturing Oneself

The third major theme, about nurturing oneself, included three subthemes dealing with involvement in professional and recreational activities, developing a positive outlook, and taking time for oneself.

Professional and Recreational Activities

Some women realized that returning to work would help them to cope with and to recover from PPD. However, this was not an easy decision to act upon when women were experiencing self-doubt and a lack of confidence. Therefore returning to work proved to be a period of transition during which some mothers gradually assumed greater responsibilities at work and regained their confidence. This activity subsequently enabled them to come out of the shadow of PPD. As another way to nurture themselves, participants described how they took part in various recreational activities such as playing soccer, swimming, or cross-country skiing. Mae and Maya explain how such professional and recreational activities were strategies for nurturing themselves:

I would say things really improved when I went back to work… I realized that it would be better if I went back to work….it would speed up my recovery. Forced myself to get back into my work… [Mae]

Last summer I played soccer and that got me out of the house and away from being a mom. I got to be myself. And that helped. It is a game that I like playing. I really enjoy it…and I would really feel good after that. [Maya]

Developing a Positive Outlook

A coping strategy that mothers like Susan utilized was to reflect on the positive aspects of her life despite the experience of PPD and the demands of motherhood.

For being in our early thirties, we are okay. You know, we have roof over our head, we have food in fridge, I am not too worried about having anything else anymore… [I’m] more peaceful, more peaceful I would say.[Susan]

Another strategy, described by Tanisha, was to turn to an inspirational speaker to gain a positive outlook towards life: I found this great speaker and he has a workbook... I started going through those home-works… [Tanisha].

Taking Time for Oneself

Participants learnt to take time for self-care which involved taking a shower, a nap or having a nutritious diet, going out for a walk, watching television programs and movies, and socializing with other women. Engaging in these simple tasks helped them to overcome feelings of guilt for “self indulgence” and isolation associated with residence in rural areas. Anitha explained how she came to understand the importance of self-care:
I was nervous about leaving the baby. I started to feel almost guilt at some point. Because I was going for a walk with a friend and I was not paying any attention to him…so it was hard in the beginning. But then I realized that that is normal. [Anitha]

A challenge for participants in remaining active and coping with PPD involved struggling against adverse climactic conditions during the long, cold winter in Northern Ontario. Maya commented on the need to find ways to stay active during the winter season:

Keeping active. I tend to hibernate if it gets below certain temperature. I would not go outside at all… unless it is pretty mild. Like -1 or -2 [degrees Celsius]. …That is hard to find here… [Maya]

At times the participants had to fight against the self-imposed social withdrawal characteristic of PPD; they forced themselves to go out and visit people. Certain activities that might appear to be part of a typical daily routine for most people required considerable effort on the part of women living with PPD, as the experience of Alison illustrates:

She would just call me up once in a while and say do you want to go for a walk? And even though I did not want to go for a walk, I would force myself to do it. And just get outside and then eventually, over time, I started saying ‘yeah, I need to be more social.’ [Alison]

**Advocacy Work**

The fourth major theme was about advocacy work, which involved two subthemes about raising awareness of PPD and providing support to other women.

**Raising Awareness about PPD**

Many participants were motivated to bring about awareness of the “taboo” topic of PPD and to work towards removing the stigma attached to it. Some mothers openly spoke about their experiences at playgroups and also at organized gatherings for disseminating knowledge such as at a symposium, forum or conference. Some participants served on a committee to organize a conference, participated in a research project on PPD or published articles in the print media (e.g., local newspaper, magazines). Anna explains the value of speaking out about PPD:

So I had reached out to the editor to say, ‘You know what? I am going through PPD, and may be it could help other people if I share my story’. So I actually wrote an article that was published in the Smithville Times... I was also introduced to the Canadian Family Magazine and my story was published in their magazine. So, that for me was rewarding. [Anna]

**Providing Support to Other Women**

Participants spoke of providing support to other women in-person or over the telephone. This type of support involved giving assurance to other women that—in the participants’
words—they were not “going crazy”. A central message was that there was a possibility of recovery from PPD. They encouraged other women to seek professional and interpersonal help while also discussing the fear of potential consequences such as the involvement of a child welfare agency. Anna found that it was rewarding to help other women:

I was really able to help out [a mother] because she started to have a lot of anxiety and depression. I recognized the signs right away and I just reached out to her, and she wanted to find out more about my story. So once I shared my story, I was able to help her; she went to get help and she did much better. And her whole life changed and she was very thankful. For me that was very nice. [Anna]

**Connecting with Nature**

In addition to the other themes discussed in this paper, certain coping strategies went beyond the theoretical framework employed in this study; one such theme included deriving strength and solace from nature. The geography of Northern Ontario provided ample opportunities for camping and hiking in the forests. Other examples of the connection to the northern landscape involved feelings of a special connection with pussy willows during the spring season, colourful leaves in the autumn and pine cones in the winter months. Christy explains how the natural environment can be a source of healing and coping:

In the fall I put her in the sling and went outside in the backyard and… picked up all nice colored leaves and I showed them to her…. I am looking for pussy willows now. [Laughing]. I walk with little clippers. I need that recharge when, specially when I am depressed. We had nice weather last week, I made sure we were outside getting that vitamin D. Because that is a happy vitamin. [Christy]

**Reflections**

In reflecting on the preliminary results of this study, it can be said that findings show an undercurrent of the key principles of feminist standpoint theory. Specifically the notion of constrained agency is highly relevant as is the need to recognize the structural conditions in Northern Ontario, or any other social setting. The coping strategies reveal the strengths, resourcefulness and resilience of women. But also, women were constrained by the gendered nature of their relationships and the limitations with regard to the availability of social services. The geography of Northern Ontario seems to pose special challenges such as a lack of privacy and limited resources or services. At the same time, it afforded opportunities for developing less conventional coping strategies—that may not be so readily available to women in large urban centres—such as bonding with nature and enjoying the natural environment.

Most participants were Anglophone or Francophone women of European origins, reflecting the dominant cultural groups within the population within Northern Ontario. Aboriginal women did not respond to the recruitment strategy for the study; it is likely that the involvement of program providers within agencies serving indigenous women would be required to include women in this cultural group in a study on PPD. Hence, the findings of the current
study are limited to non-Aboriginal women and further research is required to understand whether the results would differ with a more diverse sample.

Implications for Practitioners

The findings of this study suggest that practitioners need to recognize how the larger social and cultural expectations about motherhood play a significant role in the experience of PPD and the coping strategies that women employ. Practitioners need to recognize the power relations between men and women as they impact on women’s experiences in the postpartum period. Yet they must also acknowledge the individual differences between men in order to understand that engaged partners can facilitate women’s recovery from PPD. Practitioners also need to be cognizant of the role of geography in shaping the experience of PPD and coping strategies. Lastly, attention must be given to the personal meanings and interpretations of PPD and resilience as they are manifested in conventional and unconventional coping strategies.

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References


from women with signs of postpartum depression. Scandinavian Journal of Public Health,
33, 261-267.

Fergusson, D. M., & Horwood, L. J. (2003). Resilience to childhood adversities: Results from a 21-
year study. In S. S. Luthar (Ed). Resilience and vulnerability: Adaptation in the context of
childhood adversities (pp 130-155). New York: Cambridge University Press.

Touchstone Book.

American Library.

analysis. Community Practitioner, 79 (8), 256-260.

communication ethics. Western Journal of Communication, 63 (1), 32-56.

& L. S. Brown (Eds). Rethinking mental health and disorder: Feminist perspectives (pp, 48-

menopause: Mapping the complexities of coping strategies. Qualitative Health Research,
19 (1), 30-41.

Kaplan, H. B. (1999). Toward an understanding of resilience: A critical review of definitions and
models. In M. D. Glantz and J. L. Johnson (Eds.) Resilience and development: Positive life

Against Women, 11 (12), 1490-1514.

Leipert, B. D., & Reutter, L. (2005). Developing resilience: How women maintain their health in

Letourneau, N., Duffett-Leger, L., Stewart, M., Hegadoren, K., Dennis, C. L., Rinaldi, C. M., &

Nursing, 15, 90-93.

McIntosh, J. (1993). Postpartum depression: Women’s help-seeking behaviour and perceptions of


in rural trailer parks. Family Relations, 57, 613-624.

in women from black and minority ethnic communities in Wiltshire, UK. Ethnicity & Health,
8 (3), 207-221.

for front-line health and social service providers. Toronto, Canada: Centre for Addiction
and Mental Health.

Shaffer, A., Coffino, B., Boelcke-Stennes, K., & Masten, A. S. (2007). From urban girls to resilient
women: Studying adaptation across development in the context of adversity. In B. J. R.


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