“BUYER’S REMORSE” OF “EVERYTHING SHE EVER WANTED:” NARRATING EXPERIENCES OF POSTNATAL DEPRESSION AFTER ASSISTED CONCEPTION

by

Nathan Michael Pope

A thesis submitted to the faculty of
The University of North Carolina at Charlotte
in partial fulfillment of the requirements
for the degree of Master of Arts in
Communication Studies

Charlotte

2019

Approved by:

____
Margaret M. Quinlan, Ph.D.

____
Christine S. Davis, Ph.D.

____
Bethany Johnson, M.Phil., M.A.

ABSTRACT

NATHAN MICHAEL POPE. “Buyer’s Remorse” of “Everything She Ever Wanted:” Narrating Experiences of Postnatal Depression After Assisted Conception (Under the direction of DR. MARGARET M. QUINLAN)

When I initially read the heartfelt stories of the many people who had battled depression during their child’s infancy after assisted conception, I was shaken by the complex emotions they expressed. They wrote about communication breakdowns that occur when discussing their lived experiences with family and friends who cannot relate. The breakdowns manifested as negative messages that reflected ridicule and presumption from others. After collecting relevant social media and online discourse, I discovered how this group uses storytelling to discuss their experiences with others. Even within the storytelling spaces of blogs and social media, the array of possible terminology to label their experiences caused confusion and strained communication. What was evident is that storytelling acted as a valuable tool for individuals who experienced postnatal depression after assisted conception. They worked together to make sense of their experiences.

Inspired by this powerful storytelling, I set out to share their stories in a way that depicted both diversity and similarity of experiences. After using thematic narrative analysis to analyze the data, I constructed a set of fictional and fictionalized narratives. The narratives take the form of stream-of-consciousness monologues from six characters who are demographically diverse but have similar lived experiences. The characters in the monologues are composite – they’re a compilation of characters from similar stories. Through these fictional and fictionalized narratives, we can take a glimpse into the lives of people who are different than ourselves, or in some cases, people we can

easily relate to. The monologues help us to better understand lived experience of people who live with postnatal depression after assisted conception.

As one person emptied their glass, a group of others attempted to refill the glass and replenish their spirit using love and support through comments and responses.

ACKNOWLEDGEMENTS

I cannot eloquently express the gratitude I owe to these people:

My best friend, partner, and wife, Sarah. Next to you, I can do anything.

My advisor, friend, and confidant, Dr. Maggie Quinlan.

My mentor, Prof. Bethany Johnson.

One of the scholars who inspired me to tell stories, Dr. Christine Davis.

Dr. Erin Basinger.

My parents and grandparents.

My sisters.

My friends.

TABLE OF CONTENTS

CHAPTER 1: INTRODUCTION

He got really depressed after the birth of our girls.
We just didn't know it was a thing that could happen.

The discourses that surround parents living with symptoms of depression or anxiety during their child's infancy are complicated by the many terms and labels used by lay and technical voices. These terms include "postpartum depression," "postnatal depression," "perinatal mood and anxiety disorder," "baby blues," and "sad dad." In American health sciences, the definition and criteria for caretaker depression during the child's infancy period after birth has evolved, but slowly and with scant progression (Segre & Davis, 2013). Those who are living through this depression are without terms and labels that explain the uniqueness of their experience while health practitioners are without terms and labels to diagnose their symptoms with legitimacy.

The American Psychological Association (APA) (2017) recognized postpartum depression as a mood disorder, consisting of depressive symptoms, that women experience after their baby's birth. Similarly, the Centers for Disease Control and Prevention (CDC) (2016) referenced postpartum depression as symptoms similar to clinical depression that occur after having a baby.

Many individuals have found a voice through the blog *Postpartum Progress*; the blog, which is targeted specifically to postpartum and postnatal parent health has been featured on popular news outlets and awarded honors from several health organizations (Postpartum Progress, 2019a; 2019b). People explain that they have struggled to find an outlet to express their feelings because of a lack of social support, the surrounding presence of uncontrollable stigma, and misconceptions among their peers through comments to blog posts and a section of the blog's website titled "Find Stories Like Yours" (Postpartum Progress, 2019c). Katherine Stone (2011), the blog's curator and lead writer, reported there is a common misconception that only women who have given birth experience postnatal depression. Prior research fails to fully recognize specific groups who could be aided with a better understanding of postnatal depression – parents of newborn adoption, parents of children born via surrogacy, and even parents who did not give birth such as cis-gender fathers and partners of the parent who delivered. In addition, it is often assumed that individuals who undergo fertility or assisted conception treatments before becoming parents are so passionate about having a child they are not at risk of postnatal depression, according to *Postpartum Progress* (Stone, 2011). The APA (2018) estimated as many as 1 in 7 new mothers experience postpartum depression and the CDC (2016) reported 12% of women in the US used infertility services on average between 2011 and 2015, displaying the inevitable intersection of these two groups. These statistics suggest there are a considerable number of women who were treated for infertility and later experienced postnatal depression. Fisher, Hammarberg and Baker (2005) found postnatal depression is more likely after undergoing assisted conception (a term some use to encapsulate biomedical therapies and treatments that seek to aid the reproductive process). Thus, the importance of recognizing and understanding the misconceptions, stigma, and lack of social support associated with postnatal depression after assisted conception is evident.

The sometimes-unfathomable, silencing, isolating experiences of living with postnatal depression, more specifically postnatal depression after assisted conception, make this a complex, sometimes difficult to discuss topic. Subsequently, it is an exemplar topic for narrative research. Narratives are storytelling mechanisms that allow individuals to organize, unpack, and reconstruct their experiences in a way other research methodologies do not (Willer et al., 2018). The strength of narrative does not prevent the challenges that go along with verbalizing pain by participants and researchers, nor does it always prevent the uncomfortable vulnerability that goes along with sharing one's personal story. Fictional and fictionalized narratives, such as those I have created as part of this research offer a poignant opportunity for representation without a crisis of identity (Davis & Warren-Findlow, 2012). Further, artistic expression is shown to be therapeutic for researcher and participant when studying experiences of postnatal depression (Perry, Thurston, & Osborne, 2008) and those who underwent REI treatments (Johnson, 2016; Johnson & Quinlan, 2019; Pope et al., 2017).

1.1 Rationale

In 1994, "Major Depressive Disorder with postpartum onset" was first recognized in the DSM-IV (Segre & Davis, 2013). The addition of this disorder signified formal medical recognition of the relationship between early parenthood and depressive symptomology, but this classification may be limiting and exclusionary. The timescale for major depressive disorder with postpartum onset defined "postpartum onset" as "within four weeks of delivering a child," differing from the organization Postpartum Support International's (PSI) consideration of postpartum as the immediate six months to one year after birth (Segre & Davis, 2013, p. 4). Postpartum Support International (PSI) (2018a) formed in 1987 at the first annual Women's Mental Health Following Childbirth conference. The organization is a task force of sorts, focused on promoting awareness, prevention and treatment of postnatal women's mental health (Postpartum Support

International, 2018). At the October 2010 meeting of the Marcé Society, members of PSI bravely presented arguments during the "question and answer" session of a panel discussing DSM-V revisions (Segre & Davis, 2013). Prior to the "question and answer" portion, the panel had concluded the DSM-V would not include revisions, especially not extensions, of the onset period of postpartum depression because they had not found persuasive evidence that postpartum depression differed from other depressive disorders (Segre & Davis, 2013).

In 2017, an update to the DSM-V included a revised description of "Major Depressive Disorder with peripartum onset" that added considerations of depression during pregnancy, but maintained onset was "the four weeks following delivery," thereby excluding many new parents who experience depressive symptoms during the longer postnatal period of the first six months to one year after the child's birth (APA, 2017). Given these exclusions and omissions, I use the label "postnatal depression" (PND) to refer to parental depression during the first year of their child's life. The term postnatal depression more effectively reflects the experience of the community represented by *PSI* while also including parents of varying biological and genetic relation to their children, such as parents who adopted, parents who used a surrogate, egg or sperm donor, or parents who are partners of the parent who biologically gave birth. Parents who use a sperm or egg donor do not have full genetic relation to their children, but if one of the partners carries a child with a donated gamete, it is their biologic child (Breitkopf & Rubin, 2015). Surrogates carry the couple or individual's genetic child, but the child is not the surrogate's biological child in this case (Breitkopf & Rubin, 2015).

Parents who do not biologically deliver their children themselves are often treated by a Reproductive Endocrinology and Infertility (REI) clinic or specialist while trying to conceive (Pope et al., 2017). Assisted conception therapies are not exclusively administered in REI clinics, but often times patients receive assisted conception therapies at an REI clinic. REI clinics administer treatments through Assisted Reproductive Technology (ART).[1] According to the Centers for Disease Control and Prevention (CDC) (2017), "ART includes all treatments in which both eggs and embryos are handled." Other REI treatments that are not considered ART include hormonal treatments for reproduction assistance, such as women taking medications to stimulate egg production or treatments during which sperm is handled such as intrauterine insemination (CDC, 2017).

Through feminist lenses, health communication scholars have explored communication phenomena between patients undergoing assisted conception and their social contacts (Bute, 2009; Chester, 2003; Johnson, 2016; Johnson & Quinlan, 2016; Johnson & Quinlan, 2017; Johnson & Quinlan, 2018; Willer, 2014). Their research revealed there are communication breakdowns between individuals undergoing REI treatments and members of their social circles (Pope et al., 2017). Recent discussion (blog and social media posts) suggested, for many individuals, communication breakdowns with others extend beyond REI treatment and into postpartum life (Stone, 2011). The experiences of individuals living with postnatal depression (PND) after

---

[1] 1 Reproductive Endocrinology and Infertility (REI) is the medical sector that specializes in treating fertility and reproductive health matters, Assisted Reproductive Technologies (ARTs) are the various medical advances and therapies that are utilized for treating fertility or reproductive health matters, and "fertility/infertility treatments" refers to each. The terms are often used interchangeably by those within the population of interest.

assisted reproduction is under-observed and under-discussed and the social support that surrounds this occurrence is under-researched.

Multiple contributors to the blog *Postpartum Progress*, wrote in posts that many people interpret the experience of living with postpartum depression after receiving infertility treatments negatively. Stone (2011) discussed how others referred to postnatal depression after assisted conception as “buyer’s remorse,” and noted a story where a woman was criticized for feeling depressed after “getting everything she wanted.”

There’s a lack of public understanding and a lack of compassion in regards to postnatal depression after assisted conception That combined with a lack of scholarly study of this unique lived experience brings forth a need for qualitative exploration. Qualitative exploration can lack of understanding and its coinciding lack of compassion strain the relationships between new parents and others, including their child, and complicate if not omit the social support need and deserve.

1.2 Literature Review

Changing terminology, definitions, and social attitudes concerning postpartum or postnatal depression suggest cultural and medical hegemony. The terminology currently used by health organizations is exclusionary because it is not representative of a large number of individuals who may be experiencing postnatal depression. In this literature review I will discuss postnatal depression, postnatal depression in media and culture, and the intersection of infertility and postnatal depression before transitioning to my guiding theoretical perspective, narrative theorizing. By doing so, I will examine the limited medical and social understanding of depression during the infancy period, discuss the illness in modern culture by exploring media representations, and explain the unique relationship of infertility and postnatal depression.

Postnatal Depression

Postpartum Support International admirably faced an uphill battle as their work began after nearly two centuries of misclassification of illness and lack of formalized diagnosis for postnatal depression. Even today there is limited data on the prevalence of postnatal depression because of a lack of standardized illness naming and diagnostic considerations, however; the APA (2018) estimates as many as 1 in 7 new mothers experience depression during baby's first 6 weeks of life and roughly 10% of new fathers experience depression during baby's first 3 months of life (Da Costa et al., 2017).

Discourses around postpartum depression can be traced to the mid 19th century, when mental and physical disturbance during and after pregnancy was labelled as, "puerperal mania," defined in a case study by Poole (1847) as "unsoundness of mind occurring in the puerperal state, and most frequently from three to ten days after delivery" (p. 346; Perry, 1842). Poole (1847) argued puerperal mania originates from a "peculiar irritation of the uterus derived from its previous impregnated condition," associating a change in mental state with the change in physical state that occurs during and after delivery, which reflected the science of the day around the womb as the source of all female ill-health (p. 346). In 1842, Dr. Richard Perry shared his observations of a woman who "became restless and delirious" three days after delivery of her seventh child (p. 394). Perry (1842) described ordering medications such as laudanum, a strong sedative made from opium, popular with doctors for the treatment of many different ailments during the 19th century, particularly for women. Neither blistering nor sedatives relieved Perry’s patient, and she died a few days after onset of care (Perry, 1842; The Recovery Village, 2019). Perry (1842) performed a postmortem examination of the body and commented on several physical markers of the woman’s suffering but, like many doctors through history, did not adequately consider her psychological state during or after she was in his care.

Reflecting present-day definitions of postpartum depression (APA, 2017) another patient experienced onset of symptoms two weeks after birth including lethargy, discomfort, and what West (1854) described as “mania” and “hysteria” (p. 717). West (1854) argued very confidently that in several cases he felt women’s psychological symptoms were unrelated to their body’s weakened state after delivery, differing from today’s accepted stance that the body’s altered physical state after delivery can negatively impact emotional health (APA, 2017).

The definition, diagnostic criteria, and even an agreed-upon name assigned to parental depression during the infancy period has experienced a slow, rigid progression for nearly two centuries. After reviewing hospital medical records for information about women who experienced mental illness after giving birth, researchers found the terminology used to describe the women’s illness led to ineffective and sometimes unnecessary treatments (Hamilton, Harberger, & Parry, 1992). Poole (1847) wrote of his diagnoses of puerperal mania for women experiencing “irritability” or “unsoundness of mind during the puerperal state,” a phrase that may refer to distress felt by women during the postpartum period, which he argued is medically accepted as the three to ten days immediately after delivery (pp. 346-347). Poole (1847) argued puerperal mania likely occurs because of uterine inflammation after “impregnation” (p. 346). As mental health diagnostics and treatments changed throughout the early and mid 20th century, a formalized understanding of postpartum depression surprisingly did not follow. The first edition of the DSM (1952) did not include any mention of mental health issues after childbirth, and by 1972, Seward believed women experienced “postpartum psychosis” because they are “unable to withstand the emotional burden of childbirth and develop a psychosis” (Hamilton, 1962, p. 13). “Major Depressive Disorder with postpartum onset” was recognized in the DSM for the first time in the manual’s fourth edition released in 1994 (Segre & Davis, 2013). PSI worked actively to encourage revision of the DSM-IV, asking for a clearer view of postpartum depression by assigning the illness a name rather than have it exist as an asymptomatic consideration of another illness, and lengthening the postpartum period from DSM-IV’s four to six weeks immediately after birth to the immediate six months to one year after birth (Segre & Davis, 2013). In APA’s (2017) fifth edition of the DSM (DSM-IV), the section now reads “Major Depressive Disorder with peripartum onset” with “peripartum onset” defined as “onset during pregnancy or within 4 weeks postpartum” (p. 7).

Feminist and critical views of the power of naming suggest there is intrinsic power in naming because the *namer* maintains power over the *named* (Brown, 2000; Laclau, 2005; Phillips, 2006). From a feminist perspective, the power to classify the health of another is an act of paternalistic control (Brown, 2000). Lerman (1986) proposed eight assumptions for feminist modeling of a disorder or illness. These eight assumptions are that the model (a) is clinically useful, (b) encompasses human diversity and complexity, (c) represents women in a positive, central way as opposed to comparison to the dominant group, (d) arises from the experiences of women, (e) follows the data of the experiences of both client and clinician, (f) recognizes the feedback loop of internal realities and external experiences, (g) avoid obscure and particularistic terminologies so that terminology is accessible to both client and clinician, and (h) supports feminist modes of medical practice.

The current medically accepted definition of postpartum depression has failed to meet these feminist considerations. Horwitz (2017) argued biological and sociological forces act in conjunction to influence both the social and medical definitions of a disease and ultimately the social and medical experiences of someone living with that illness. Following Lerman's (1986) assumptions, the DSM-V's definition has been minimally clinically useful, is exclusionary, has been developed not by women but by centuries of gendered hegemonic medical assumptions, and is complicated by obscure and particularistic terminologies (APA, 1994; 2017; Hamilton, 1962; Poole, 1847). Modern health organizations have adapted their own considerations of postpartum depression; the CDC (2018) follows a model of "Depression During and After Pregnancy," noting severity, symptoms and timeframes vary for every woman. The National Institute of Mental Health (2018) also noted severity, symptoms, and timeframes vary for every woman. While efforts similar to these – generic terminology, removing time and severity limitations – have effectively made the social and medical definition of parental depression during a child's infancy more inclusive, it is still exclusionary to parents who did not deliver their baby.

The term postnatal depression is more inclusive than postpartum depression when discussing parental depression socially and scientifically (Dalton, Holton, & Dalton, 2001; National Health Service, 2016; Postnatal Depression, 2007). The term postpartum depression implies that only women who have given birth are at risk for depression during a child's infancy, a possible source of historical "weak female body" social constructions of reproduction discussed by feminist researchers such as Lerman (1986), Brown (2000), Johnson (2016), and Johnson and Quinlan (2016).

Terminology has the power to deprive patients of the right to legitimize aspects of their health, cause patients to feel othered in social contexts, and even lead to an identity crisis because of the conflict of signifier and lived experience (Butler, 1993; Hamilton, Harberger, and Parry, 1992; Jack & Ali, 1970). Use of the term *postnatal depression* has the potential to limit or eliminate concerns of othering, identity, or misrepresentation of experience for many parents who have lived with depression during their child's infancy.

Postnatal Depression in Media and Culture

Discourses of postnatal depression in popular culture has led to shifting attitudes concerning those who are affected. Cultural discussion of "the baby blues," a term commonly used to refer to postnatal depression experienced by partners or adoptive parents and "sad dad syndrome," a term used to refer to paternal postnatal depression show that individuals are attempting to create and disseminate a signifier they feel is representative of their experience (Baby Blues, 2009; Hiremath & Mohite, 2016; Laclau, 2005).

People experiencing depression often feel silenced if they are without an outlet to discuss their experience (Jack & Ali, 2010). Individuals who have experienced postnatal depression seem to have found an outlet for discussion of their experience online through social media and blogs. Others have found community in representations of postnatal depression in popular media, such as celebrity narratives. Serena Williams, Chrissy

Teigan, Adele, and Brooke Shields have all discussed their experience with postnatal depression publicly (Dubriwny, 2013; Yagoda, 2018). The TLC show *OutDaughtered* features the Busby family who, after using in vitro fertilization (IVF)[2] to assist conception, became pregnant with quintuplets (Niz, 2017). Adam Busby opened up about his experience with depression after the birth of his daughters (Niz, 2017). Beck, Chapman, and Simmons (2015) and Bute, Quinlan and Quandt (2016) argued celebrity health narratives are indicative of mobilization of shifting public opinion and increasing awareness of health concerns.

Infertility and Postnatal Depression

The diversity of those at risk for postnatal depression extends beyond fathers such as Busby (Niz, 2017). Many people, for various reasons, seek assisted conception therapies in order to become pregnant (Bell, 2010; Breitkopf & Rubin, 2015; Sandelowski, 1993). The Centers for Disease Control and Prevention (CDC) (2016) defined infertility as occurring when 12 months of unprotected sex between two hetero, cis partners doesn't lead to pregnancy. They currently estimate 12% of women aged 15-44 years will experience infertility (CDC, 2016). The National Institute of Child Health and Human Development (NICHHD) estimates 9% of men and 11% of women will experience infertility (NICHHD, 2018). The technical definitions of infertility provided by many organizations (such as CDC and NICHHD) maintain a heteronormative, cis-gender focus that excludes the experience of LGBTQQIA+ couples or individuals who may seek infertility treatments for assisted conception (Breitkopf & Rubin, 2015). People

---

[2] In vitro fertilization (IVF) is an assisted reproductive technology (ART) that involves assisting conception by extracting eggs, retrieving a sperm sample, combining them in a laboratory setting, then transferring the resulting embryo to the uterus (Medline Plus, 2019).

who experience infertility often seek fertility treatment from a Reproductive Endocrinologist and Infertility (REI) specialist or clinic. Unfortunately, it is uncommon for the first fertility treatment an individual receives to successfully achieve a pregnancy, leading to a journey of multiple attempts and physical, mental, and monetary strain (Johnson, 2016; Pope et al., 2017). Further, previous communication studies research has found there are often social support communication breakdowns between those attempting to conceive and their peers (Johnson, 2016; Johnson, Quinlan, & Marsh, 2018; Pope, et al., 2017). Some of that research effectively utilized a narrative framework to display the lived experiences of this marginalized group, suggesting narrative presents an opportunity for further exploration (Johnson, 2016; Pope et al., 2017).

Narrative Theorizing

Polkinghorne explained narrative at the most basic level – narratives allow people to understand human experience (Polkinghorne, 1988). Communication Studies scholars have found that narrative can be a useful tool in exploring the experiences of marginalized populations (Novak, 2010). Narrative acts as a valuable framework for individuals to make sense of self and other (Harter, Japp, & Beck, 2005; Somers, 1994).

Humans are storytellers and are storied, and that is why narratives can act as a sense-making tool for many (Burke, 1969; Polkinghorne, 1988). Narratives embody lived experiences while existing within institutional and cultural scripts (Wood, 1994). Through narrative, we assess our own actions and the actions of others, and narrative research presents the opportunity for both participant and researcher to make these assessments (Ochs & Capps, 1996; White, 1981). According to Garro and Mattingly (2000), narrative is the human way of giving meaning to experience as storytellers mediate between their inner world of thought and feeling and their outer world of observations. Most importantly for many, narratives help to make experiences meaningful (Bochner, 2002). With concern to infertility research, Chester (2003) and Johnson (2016) used narrative to explain the experience of infertility effectively. Willer (2014) found narratives to be an efficient tool for understanding women's infertility stressors.

Narratives, like all stories about humans, are socially constructed. They are manifestations of our understandings of that which fills and surrounds us. Narrative presents the opportunity for empathy, which could lead to a whole new understanding of another's lived experience by simply sharing stories (Buber, 1965, 1970).

New stories – stories that have not been told before -- disrupt existing, socially embedded stories. In the process, new stories help people recognize and interpret their role in social constructions (Harter et al., 2006). By hearing or reading another person's story, audiences may question how they could have possibly perpetuated constructions that negatively impacted others. From the questions audiences draw, they can develop understanding and partake in interactions of support and acceptance (Israelite et al., 2002).

1.3 Study Purpose and Objectives

In this study, I analyzed publicly available online discourse surrounding the unique experience of living with postnatal depression after undergoing infertility treatments. By doing so, the project could potentially increase public understanding and compassion while contributing vital scholarly research about marginalized health populations. In this study, I provide information that will aid family, partners, friends and health professionals alike as they support individuals who experience postnatal depression. Using narrative analysis, I analyzed data in and used it to construct fictional and fictionalized narratives that are representative of this unique experience.

Communication Studies scholars are uniquely equipped to explore the narratives and social discourse of marginalized populations, because of their training in textual and rhetorical analysis of critical and cultural matters. The possibility for narrative methods and products to be both informative and impactful, as seen in previous communication studies research (see Harter, Quinlan, & Shaw, 2016; Novak, 2010; Willer et al., 2018), suggests these methods could become valuable tools to the academy to perform translation and community-centered research. Additionally, will hopefully provide information to aid practitioners in supporting individuals who experience PND.

In order to gain this insight this thesis explores this Research Question (RQ):

RQ: How do individuals living with postnatal depression after assisted conception treatments narrate their experiences?

CHAPTER 2: METHODOLOGY

My study is a narrative analysis of stories people previously shared about living with postnatal depression after undergoing assisted conception therapies. I collected online discourse from publicly available social media and blog posts using the social media monitoring tool Radian6 and topic-specific web searches on Google. I analyzed the collected data using narrative analysis by reviewing the data multiple times and performing thematic narrative analysis (Reissman, 2008).

On February 1, 2019, UNC Charlotte's IRB deemed that this study "does not constitute human subjects research as defined under federal regulations [45 CFR 46.102 (d or f) and 21 CFR 56.102(c)(e)(l)] and does not require [Intuitional Review Board] IRB" from University of North Carolina at Charlotte (see Appendix A for IRB Decision Notification and Appendix B for IRB Application). Because possible data existed across the Internet, it would have been difficult if not impossible to maintain a record of participants. For that reason, I did not collect any identifiers, and subsequently this study had no participants. I redacted any possible identifiers from messages using pseudonyms, fully maintaining the privacy of original posters.

2.1 Researcher's Role and Reflexivity

The researcher is "the primary instrument for data collection" in qualitative research (Merriam, 1998, p. 7). There are many roles the qualitative researcher can adopt, and all of these roles involve the researcher contributing a part of themselves – their experiences and their beliefs – to their research (Glesne & Peshkin, 1992). The researcher can limit the presence of their experiences and beliefs but cannot observe and report experience with total objectivity.

I maintained a reflexive stance throughout data collection as I learned from the same feminist scholars who inspire this project (e.g., Johnson & Quinlan, 2016, 2019; Norander, 2011). My reflexive position allowed me to examine how I was interpreting and framing the messages I collected and analyzed (Harding, 1998; Norander, 2011). The emotional nature of the messages required that I ponder and understand the ways my interpretation of the messages could have been influenced by my personal lived experiences.

I used fieldnotes as a space for my reflexivity. I took note of my status as a white, heterosexual, cisgender, able-bodied man who lives day-to-day with a lifelong mental health condition. I recognize that I am not a parent or caregiver to an infant nor have I ever been. Additionally, I have never been diagnosed as infertile nor has my partner. I share these personal identifiers because I believe that I should subject myself to the same vulnerability that is expressed in the messages I collected. Naples (2003) explained:
"If we fail to explore our personal, professional, and structural locations as researchers, we inevitably reinscribe race, class, and gender biases in our work. Feminist scholars rely on social research methods that challenge dualities" (p. 13).

2.2 Data Collection

Over a 14-day period from February 18, 2019 to March 4, 2019, I collected 96 publicly available social media and blog posts and comments to posts were collected using Radian6 and topic-specific Google searches. Radian6 is a social media monitoring tool that can perform keyword searches of millions of publicly available online discussions and report to the user posts which have been identified as containing relevant information. Keywords used for Radian6 searches in this study were: postnatal depression, postpartum depression, perinatal mood and anxiety disorder[3], PND, PPD, PMAD, sad dad, and baby blues. I used the same terms for Google searches and Google alerts I received during the 14 days of data collection. Messages came from Twitter, Facebook, Instagram, Tumblr, and blogs from across the Internet. They included both posts and comments to posts.

2.3 Data Analysis

After collecting posts, I analyzed each narrative through thematic narrative analysis. Thematic narrative analysis places emphasis on the "what" rather than the "how," "who," or "why" and the "told" rather than the "telling" (Reismann, 2008). Thematic narrative analysis is especially useful for analyzing stories that develop through conversation, such as the conversations that take place in the comment sections of social media and blog posts (Reismann, 2008).

My first read of each message was one of relevance. There are many posts on caregiver mental health during the infancy stage and many posts on assisted conception, but there are fewer posts on the intersection of these two. During the first read of the post, I determined whether the message laid at the intersection of these topics. Messages that contained mention of both assisted conception and caregiver depression during a child's infancy stage were kept as possible data.

During the second review of the data, I determined the presence of storytelling elements within the message. Some posts contained technical information rather than storytelling elements; these posts were omitted. After this review, 87 transcribed messages remained within a 19-page, single-spaced document. 51 messages were

---

[3] Perinatal mood and anxiety disorder (PMAD) is an umbrella term that encapsulates depression or anxiety experienced by parents before, after, or during pregnancy.

extracted from social media posts and comments to posts and 36 were extracted from blogs and the comments section of blog posts.

Using thematic narrative analysis as a guide, I reviewed the messages a third time and took notes on the "what" of each message (Reismann, 2008). I strived to read the stories with the same passion that had inspired their existence by examining what the speaker was saying as opposed to the tools and elements they were using to say it. I immersed myself into the stories of the members of this group so that I could learn from the characters, plot lines, settings, and conflicts they shared. I took notes on the similarities and differences.

The most notable variations between the stories were the characters' diverse identities. Characters sometimes discussed their identity as part of their experience. I noted that race, gender, and sexuality often contribute to the conflict between those experiencing postnatal depression and their peers. Further, characters frequently described varied manifestations of their symptoms. For example, some noted feelings of helplessness, others expressed anger and rage, and some wrote of worry or fear. It became evident that the narratives I constructed needed to represent a diverse group of characters to represent the intersectionality of this group effectively.

Interestingly, there were abundant similarities that existed alongside the differences. Thematic narrative analysis calls on the researcher to place minimal focus on the "local" and considerable focus on the "societal" context of a story (Reismann, 2008); more specifically, on how the speaker and their experience fit into society. Observing the social interactions that storytellers narrated, I discovered trends that display how this group of storytellers interpret themselves and their experience in society.

CHAPTER 3: FINDINGS

It is important to note the collected stories were admirably reflective. Individuals poured out their experiences to their audience and displayed a vulnerability that welcomed others to disclose. Parents wrote of the woes of parenthood, including the surprise or shock of suddenly being responsible for the life of another human, the anxiety associated with worrying about their baby at night while they're in another room, or the horrific possible outcomes that a parent is warned about prior to their child's birth.

With each sharing of a story, an array of comments containing stories from others would follow. Comments and responses were filled with support, encouragement, and commendation. Commenters empathically provided support by complimenting a parent's strength and commending their courage. There was a shared recognition of the empathy shown by people who read the stories, and a shared recognition of the compassion felt among participants as they allowed themselves to be vulnerable and share stories from their own life. The stories were beautiful and heartfelt, but often the exchanges even more so. An inspiring presence of collaboration, interpersonal awareness, and comradery was displayed through simple sharing of stories within this community. Participants in these exchanges did not seek to co-opt the experiences of other storytellers. They did not "one-up" or attempt to create a hierarchy by competing with the stories of other posters. Participants did seek to engage in meaningful conversation for their benefit and the benefit of others.

Connections were made and likeness was identified with each comment. While each individual shared a different story, their experiences are surprisingly similar.

“That happened to me, but my husband was more worried than frustrated” (Twitter user)

These similarities allow participants to identify their shared understandings.

“I felt so much better after I found that out, too…” (Facebook user)

Similarities provide assurance of the legitimacy of their experiences, assurance of their membership in an understanding community, and positive assurance that their decision to speak publicly was a beneficial one.

3.1 An Amalgamation of Stories

I humbly present the following stories as manifestations of the experience of postnatal depression. These narratives are both fictional and fictionalized; some aspects have been created and some aspects are retold. The characters in these monologues are not identifiable people, but the stories we see are stories shared by real people. Each stream-of-consciousness monologue is an amalgamation of similar stories and the characters who perform them are an amalgamation of storytellers. Each of these stories and the characters they depict are composite – they were developed by combining similar stories to create representational narrative.

Individually, each monologue represents a different perspective. Collectively, however; they represent the experience of postnatal depression after assisted conception. The following five characters unpack their experiences with Dr. Branch, a clinical psychologist who often works with new parents. Each monologue is told while the speaker is in a session with Dr. Branch, from within Dr. Branch’s office.

3.2 Alex: Mom #2, The Adoptive Mother

Alex adopted her daughter as an infant through a planned adoption. She sought adoption after unsuccessful infertility assisted conception. Here, she speaks to Dr. Branch during an early appointment when she has first begun to unpack her experiences.

I feel like people are thinking "she took this child in and promised her a healthy life and now she can't get her shit together." I can feel them walking through the steps in their head —

Years of trying
All those infertility treatments
Multiple almost pregnancies
The adoption process
Waiting some more
And now she has a baby she doesn't want.
Maybe she wasn't ready…

[Dr. Branch tilts her head to the side as she jots something on the legal pad she's been holding since the two sat together.]

The assumption that a mother doesn't want her child or doesn't care about her child is the single most disgustingly judgmental assumption another person could make. I'm not one to call someone an awful person, but if you say that shit…the shoe kinda fits, ya' know?

[Dr. Branch lets out a small grin as she nods in agreement.]

I definitely "want" my daughter. I love my daughter. She is the most beautiful gift my husband and I could have ever been given. You know how people talk about the way the top of a baby's head smells? They're right. It's magnificent. It's the most comforting thing. It's so relaxing to just sit and rock her while just enjoying how cute her little fingers are, how soft her skin is, and the way her head smells.

But then she cries. *[Dr. Branch looks up from her notes]*

And I freak out – lack of a better term.

It's so hard to deal with the crying. It's loud, persistent, and she can't communicate with me about what's wrong. The guessing game can be infuriating — I wish she could just tell me what the hell she wants!

[Dr. Branch again scribbles in her notes and promptly returns to eye contact with Alex.]

Someone told me that since I'm an adoptive mother that I'm "kinda mom number two," so I'm "this baby's" — literally referred to my daughter as "this baby" — I'm "this baby's second chance to be loved."

"Number two?" F*** you.

I'm number one.

It's infuriating. If I really think about it, a lot of things have been getting on my nerves and making me angry the past few weeks. I just — I just have no patience for the nonsense that surrounds me. I don't want to take it out on her — she's just an innocent little baby. She doesn't understand.

So that's why I'm here — my husband thinks I'm depressed. Even referred to my feelings as "some form of postpartum depression."

But how on Earth could I have postpartum depression when I didn't give birth?

[Dr. Branch lays her pen and notepad on the table next to her as she locks her fingers together and begins speaking.]

3.3 Dave: The Sad Dad

Dave, a father of three, discusses his depression experience in retrospect with Dr. Branch. Already having attended therapy appointments, and already having unpacked some of his emotions, he looks back on his journey.

It's funny — I remember thinking my dad could pick up anything whenever I was younger because he could pick up my swingset. It was one of the ones with the metal frame that had two swings and a little slide and he would move it whenever he mowed the lawn. I really thought my dad was as strong as Superman. As I grew older, I began to realize my father's strength was inward and outward. When I would think of myself as a father, I realized that I wanted to be viewed as that strong too. I wanted to be able to impress my son or daughter with my ability to move the swingset and my ability to move past painful experiences.

I think maybe I started getting a little down in the dumps when my wife and I had to get infertility treatment because in a way, I blamed myself for our inability to get pregnant. I questioned my manhood daily.

The comments from others were kinda a culture shock — they would say things like "you guys just need to have fun and then you'll get pregnant" — do people really think about whether my wife and I "have fun" during sex? Like, is that any of your business? Then atop people's comments, you add the fact that I had to watch or assist as my wife administered drug after drug to her tired, hormonally confused body. I think maybe the anticipation and the pressure from others may have put me in an anxious mindset before we were even pregnant.

But we got pregnant with not one, but three babies.

We had triplets. All boys. *[Dr. Branch displays a gentle, empathetic smile]*

I was going to have a part in bringing someone into the world, which was the greatest feeling — I was so excited.

But I have to "lift the swingset" three times as much as my dad did. *[Dr. Branch maintains eye contact]*

People talk about becoming a father as if it's an accident — you just enjoy the sex and then suddenly — BAM — you have a baby. It was not an accident for my wife and I. It was very deliberate. So, I thought I was ready to take on anything parenthood could throw at me. *[Dr. Branch scribbles in her notes]*

When you go from being just a guy to being someone's dad overnight — it creates an entirely different feeling within. It is somewhat shocking to go from keeping yourself alive to being responsible for keeping multiple people alive. And it's hard. Taking care of a baby is hard.

And we had three.

The struggle made me sad. I started questioning myself again *[Dr. Branch again scribbles in her notes and Dave pauses to watch her. She nods at him assuring him he can carry on]* — first we struggled to get pregnant and now I'm struggling to be the dad that can lift the swingset. To compensate, I poured everything into my kids' lives. I didn't feel well, but I thought I was just tired and being tired wasn't an excuse. I can't even explain the absolute terror of wondering if your kids are going to make it at night. But as I poured more and more into my kids, I poured less and less into the rest of my life.

I didn't treat my wife like the beautiful, inspirational mother she is and I was cold to my family.

I was just kinda shitty and in denial that something was up. *[Dr. Branch tilts her head as she listens]*

My mother-in-law was the first to say it — “Oh he’s ok, he just has the baby blues, he’s just a man, he’ll snap out of it” The baby blues? I’m not sad that I have a child. I love my kids. I’m just terrified — what if I’m not good enough? What if something happens I can’t fix? What about SIDS? My boys were born preemie, do you have any idea how many health problems they’re at risk for? How can I be Superman if all the outcomes are kryptonite? *[Dr. Branch gives Dave an assuring nod in agreement]*

I only went to therapy because I promised my wife I’d start trying to feel better. *[Dr. Branch smiles – no offense taken]* Then I learned that dads can get postpartum depression, too. I don’t think that’s the right term, because dads aren’t technically postpartum, but the therapist helped me to understand that the way I was feeling was normal and that I could make it through it.

[Dr. Branch clicks her pen, uncrosses her legs and looks up from her notebook as she starts to speak]

3.4 Tina: The Black Goddess of Motherhood

I can look back at it now that I've had time to heal When it happened, I both couldn't accept what was going on, and denied it because of mom guilt.

[Dr. Branch jots down a quick note while Tina pauses to gather her thoughts]

"You're a beautiful Black goddess" my mother told me. "Your womanhood is not a curse, it's the greatest gift our Mother gave us" — the comment that set the tone for my experience with motherhood. Sisters are encouraged from a young age to be Mamas — we even call each other Mama. It's ingrained into our culture. I had to become a Mama. But when I couldn't get pregnant, the Black goddesses in my life made me feel isolated.

[Dr. Branch folds her hands atop her notepad to show Tina has her full attention]

"Girl, when you and Jay gonna have a baby? It's your turn." Well, easy to ask when something is going to happen if you just assume it *will* happen. MY road to pregnancy is different, so mind your business.

[Dr. Branch sits silently as Tina gathers her thoughts]

"Oh hunny, you just need to relax, God will give you a baby soon enough. Don't do all that to your body." Wow, so comforting. Definitely making me feel supported.

[Dr. Branch again waits as Tina takes pause]

After countless shots, medications, procedures, and tests, my rainbow baby happened.
I was pregnant.
Jay would be a daddy, I would be a Mama. I was gonna be somebody's <u>*Mama.*</u> *[Tina shakes her hands to emphasize mama]*

I started preparing. Black excellence has never seen motherhood done like this Queen was gonna do it. *[Dr. Branch smiles]* I read every book, talked to every Granny I knew — I soaked it all in. I'm an educated woman — I can easily sort through all this and not be overwhelmed. "No big deal," I said to myself. But in hindsight — maybe I was scared. *[Tina begins to speak quickly]* Maybe I was scared my rainbow baby would disappear. Maybe I was scared my gifts from Mother couldn't handle it. Maybe I was scared I would be a bad Mama -- I don't even know for sure. *[Tina takes a deep breath]*

What I do know for sure is that motherhood happens quick. One moment you're screaming out in pain from contractions, then the next the doctor on call is telling you you need an emergency cesarean or you may lose your rainbow baby before you've even held her in your arms.

[Dr. Branch's face drops as she and Tina look into each others' eyes and share a moment of understanding]

Can you even imagine? Having a drape in front of your face to shield you from seeing your body be cut in half and your sweet baby pulled from your body like an unwanted tumor? *[Dr. Branch maintains a flat expression as she loosens and tightens the tip of her pen]*

One day you go into the hospital, the next day a human being depends on you for life. Bottles, blankets, breastfeeding, baby monitors, onesies, diapers, wipes…
OH! And just by the way… You're *tired*. I mean TIRED. *[Dr. Grey scribbles in her notes]* Those all-nighters in undergrad, those are bullshit. Try sleeping in 3-hour increments *FOR A MONTH*. And then another month. And then another, and another.
[Dr. Branch returns her focus to Tina]

But I was a beautiful Black goddess. I couldn't tell anyone, especially my family, that I was feeling overwhelmed by my rainbow baby. And, Oh my God, if people judged my infertility treatments, they'd definitely judge this. I'm getting chills just remembering how alone I felt. *[Dr. Branch scribbles in her notes again]*

I didn't regret my rainbow. I didn't regret being a mother -- I was just overwhelmed. *[Tina pauses]* I needed someone to understand -- to look past their misconception of what motherhood *should* be and consider what motherhood *was* for me and what it *could* be for me.

3.5 Liz & Dina: Proving Maternal "Fitness"

Liz and Dina, moms who are in a same-sex relationship, maintain separate appointments with Dr. Branch that occur one immediately after the other. As Liz speaks with Dr. Branch, Dina waits in the practice's waiting room with their baby and vice versa. Their monologues are told in unison to reveal similarities and differing interpretations of experience.

Liz:

So, they call it a sock but it's more like a little foot wrap — it goes around his ankle and covers the top and bottom of his foot – it's called an Owlet. *[Dr. Grey nods]* Oh, it's also wireless — there's a little transmitter thing that looks like a hockey puck and you just leave it near their crib then the transmitter reports to the app. So, on the app I can track his heart rate and oxygen level while he's sleeping to make sure he's doing ok. We had one of those video monitors and I would watch it but my wife claims I was watching it way too much. *[Liz shakes her head in disagreement]* I couldn't handle just hoping that I'd hear him cry — I needed reassurance. Like, what if he stopped breathing? What if he spat up and got choked and I didn't hear him? There are just so many things, I could go on and on.

[Jump to Dina's appointment.]

Dina:

Liz had a twin sister. And unfortunately, I say had because she passed away when they were both 9 months old. SIDS. *[Dina pauses as Dr. Branch jots something in her notes]* Liz wore a heart monitor for a month after her sister passed away because pediatricians worried she and her sister had been born with a heart issue or something.

Her sister's little child-angel urn sat in Liz's bedroom throughout her childhood and is still sitting on the dresser that's in her old bedroom at her Mom's house. *[Dina locks her fingers and looks at at the ground. Dr. Branch writes in her notes]* Even when we started dating in our early 20s, it was evident that she had been really affected by the loss of her sister. On her 18th birthday she went and got a tattoo of her sister's initials under a tiny halo — it's on the top of her foot…she wanted to take every step with her sister. *[Dina looks at her hands as she fidgets with her ring]*

When we first discussed becoming moms, Liz was not on board *[Dina returns to eye contact with Dr. Branch]* — the thought of having a baby terrified her and I really think she was afraid what happened with her sister – or something similar – would happen to our baby.

[Return to Liz.]

Liz:

[Liz speaks without pause.] But anyway, the sock will detect and notify me on my phone if he's having trouble breathing or if his heart rate changes, so it's great. Sometimes it alarms when nothing appears to be wrong, but I'd much rather have it be very sensitive and pick up things that aren't there than not pick up something that is. I mean, I still have an alarm on my phone to wake up and check on him every 3 hours, but between that, the sock, and the app I told you about I can make sure he's doing ok. Is that him crying? *[Liz yells] Dina, is that the baby crying? Is he ok? [Liz turns to Dr. Branch]* I may need to go check on him, she may need help. *[Liz waits for Dina to respond…Dina doesn't, but the crying has stopped. Dr. Branch writes in her notes.]]* Oh, everything must be ok now. *[Liz begins to speak without pause again.]* So anyway, I'm using the

app to monitor how much goes in and how much comes out and his schedule. I'm not confident about the app, though because I'm pretty sure it deleted a day's worth of stuff last week. I just know I wouldn't forget to report things and there was only one feeding there So I started keeping a journal too just in case. It takes a lot of work and can be tiring, but it is so necessary. Hold on just one second, I'm going to just go and make sure they're ok. *[Dr. Branch lifts her arm to gesture Liz to sit, but her gesture is ignored.]*

***

Dina:

I tell you that because lately she isn't acting like herself, and I'm really concerned. *[Dina looks to Dr. Branch as if she's ensuring she has Dr. Branch's full attention.]* When I met Liz in college, she was so chill — easy going, never freaked out about anything, cool as a cucumber under pressure. So it's just really surprising to me that she's gotten so jumpy and worrisome. I feel bad because like, I'm really trying to be considerate of all the logging and checking over my shoulder when I do anything for the baby…*[Dina's eyes widen and she clasps her hand together.]* Like, I can read directions on a formula container. I can mix a bottle, I've got it. I don't need her to micromanage me while I do it. It's incredibly frustrating. *[Dina takes a deep breath.]*

***

Liz:

Ok, everything is fine. I was gonna just bring him in here with me but she insisted she watch him. I hope she logs this feeding. He didn't poop as much as he normally would so far today so he may not have eaten enough the past few times. I wonder if his stomach is upset. Oh my, I hope he doesn't get constipated. I'll check on what can cause that how I can tell in a bit.

***

Dina:

She's here because I insisted she come — after an extensive argument about her behavior — oh that's the other thing, the mood swings. She has mood swings. It happens so unexpectedly, too. One minute she's checking her apps and asking me questions, then the next she's clenching her fist and yelling at me. Like, why?

Ultimately, I want her to feel better. I knew she would be an incredible mom. That's why I wanted her to be the one to carry the baby. And I respect her for it. She showed an incredible amount of strength. First, she had to battle through fertility treatments, then she battled through pregnancy and childbirth. She battled through all that, and now she's still battling…battling to provide our son with the best possible life. I just don't want her to battle me. Up until a few weeks ago, having the baby was enjoyable, but now she is so in my face. Please don't take that the wrong way — I love my son more than words can describe. Being a mom to an infant while also trying to keep my wife sane is draining me. Sometimes I'll sit outside our house in my car just staring at the garage door because I'm afraid to go inside.

***

Liz:

Postnatal anxiety? What? I don't have anxiety. Did Dina tell you to say this? I'm not anxious, I'm just doing what's best for the baby. I have to show everyone we can do it. We're a lesbian couple with a baby — people already want to deny that we're fit parents, so I need to be the picture of perfect motherhood and no one will be able to question my ability to parent. Do you know what can happen to kids of LGBTQIA+ couples? *[Dr. Grey lays her pen down]*

***

Dina:

It goes without saying that I can’t be public about my feelings. Liz and I have to prove our ability to be parents just because we’re a lesbian couple. The instant one of us is slightly different than the ideal Instagram mom — [air quotes and an angry facial expression as she does an impersonation] this is why same-sex couples shouldn’t be parents. I don’t regret being a mother. But if I did it would be self-detrimental to share those feelings.

CHAPTER 4: CONCLUSION

4.1 Discussion

Through this research, people of all demographics can learn about those who fight postnatal depression. Not only do the results reveal overlooked diversity of those who live with postnatal depression, they also provide commentary about how these experiences are different and similar.

The themes that emerged from this data answer my previously stated research question, and those answers can be found within the poignant fictional and fictionalized monologues I have crafted. The monologues show the emergent themes of this research are life experiences; they are identities. Each story is a snapshot of the complex emotions and strained interactions an individual has experienced. They are a glimpse into another's world.

The themes identify the cultural differences, such as race, gender, or religion that contribute to communication breakdowns surrounding postnatal depression. They also display how certain terminology causes communication breakdowns; people sift through the array of possible terms to describe their feelings. They reveal the immense pressure parents feel to be the "ideal" parent after they undergo assisted conception. Most prevalently, the themes show parents' fear of judgement and internalized guilt if they experience difficulties such as postnatal depression after using assisted conception.

4.2 Theme 1: We Get Depressed, Too

The people desire to become parents and subsequently seek assisted conception therapies are diverse (Bell, 2010; Breitkopf & Rubin, 2015; Niz, 2017; Sandelowski, 1993). Subsequently, the individuals who become parents and are at risk for postnatal depression are equally diverse. Shockingly, there was no social group unrepresented by stories of postnatal depression after assisted conception. A majority of their stories spoke of cultural factors they believed influenced their symptoms or their interpretation of their experience.

Tina, a Black woman, like many women of color, discussed the lack of recognition of postnatal depression within her community. Black social media users and bloggers explained members of the Black community often view motherhood as instinctual, and thus do not discuss it as a parental health concern. A social media user wrote:

> It’s just expected [Black women] don’t have that. We’re supposed to instantly be the mom they expect.

Black women expressed isolation within their community because of their use of assisted conception, and postnatal depression made them feel even more like an outsider.

Dave, the father of triplets who lives with postnatal depression during their infancy, was inspired by men and women alike who wrote about men battling postnatal depression. “Dads get depressed too,” wrote a social media user who told the story of her husband’s battle with depression after the birth of their children. Dave’s monologue is an example of the men who are not warned of postnatal depression and are unaware they are at risk. In Dave’s monologue, we hear the story of a man who pictured himself becoming an example of strength and masculinity as a father. When he battles postnatal depression, he questions his ability to be a superhero dad.

4.3 Theme 2: But I'm Not Postpartum

In American health sciences, postpartum depression (termed Major Depressive Disorder with postpartum onset by the APA (2017)) is a widely diagnosed type of depression during the infancy period, but this illness is exclusively a health concern for women, specifically women who have given birth (Segre & Davis, 2013). The terminology used to explain depression during the infancy period for people who are not women that have given birth (e.g., adoptive parents, cis-gender fathers, co-parents), however; is not widely accepted because it is both expansive and confusing according to the data. Messages online often expressed a lack of technical terminology, which is a barrier to explaining symptoms in a legitimate, inclusive, respectful way.

Depression experienced by fathers is sometimes referred to as "sad dad syndrome" or "baby blues," while other times postpartum depression was used as part of another phrase, such as "paternal postpartum depression." There is, at this time, no widely accepted term for this situation. In his monologue, Dave echoes online expressions of feeling helpless and feeling a lack of control. He presents the stories of others as he explains he felt he should keep to himself because he didn't think there was an explanation for men who have these symptoms. There was no terminology to legitimize his symptoms.

Alex represents concerns of parents who have adopted their child and experience depression during the child's infancy period. The term postpartum depression is indicative of hormonal changes in the female body after giving birth, and thus excludes her because she did not experience birth (APA, 2017). Though Alex adopted, other women, such as those who use a surrogate, also become parents during the infancy stage and are susceptible to depression. People who did meet current definitions of postpartum depression expressed concern over the negative connotation of the term.

By using the term postnatal depression, we can play a role in limiting the communication breakdowns experienced by people like Dan and Alex. As a label, postnatal depression is more inclusive and provides legitimacy to symptoms and risk of symptoms (National Health Service, 2016). The stories in the monologues I have presented illustrate how postnatal depression is a label that is more inclusive by removing restrictions set by gender and birth role, and subsequently provides a better means for communicating about lived experience.

4.4 Theme 3: After All the Trying to Get Pregnant, I Must Thrive

In agreement with the literature (e.g., Postpartum Progress, 2019c; Stone, 2011), online discourse revealed people who elected assisted conception feared their status as a parent would be questioned if they did not prove themselves as exemplary examples of parenting.

Rather than reflect how the judgment made them feel, storytellers from the data often described how intensely they feel they must prove their ability to thrive as a parent. Members of the LGBTQIA+ community, as represented by Liz and Dina, a lesbian couple who used assisted conception in getting pregnant with their son, expressed feeling they must prove their fitness to parent by being a textbook example of proficient parenthood. Research by Johnson and Quinlan (2019) supported this idea, by noting messages throughout society lead to parents feeling they must meet a certain standard of parenthood. A blogger expressed her fear to reveal her depression because homophobes would possibly think their arguments against same-sex couples being parents would be proven:

> "So many people believe I shouldn't even have kids because I'm gay… I have to prove that I should…"

Through the monologues of Liz and Dina, we can experience a storied example of these experiences. Their monologues are told in unison but from separate settings in order to reveal the differences between their experiences – Liz gave birth to their son while Dina was the supportive partner – while also showing they feared discussing their feelings externally because of their sexual orientation.

4.5 Additional Reflections: Narrative Is Emotionally Involving

As a hetero-, cis-, male, neither postnatal depression or infertility were issues that existed within my purview prior to adulthood. Through this research, however; I was thrust into a space that would cause me to question the communications practices of myself and others. The stories I have read over the course of this research have created a new emotional space within. This emotion was my motivation to release these stories and allow them to be heard as they so desired (Coles, 1989).

I found myself living vicariously through the characters in these stories. I felt the exhausting anxiety of worrying about my child, the numbing sadness resulting from the overwhelming duties of caring for my child, I felt the panic of being unable to help my baby cope when it cried, and I felt the vulnerability of telling a story I feared would be criticized. As a researcher, I became vulnerable due to the same fear. Who am I to represent the pain of another? Who am I to be the representative of a group that I am only an advocate for, not a member of?

The individuals I represent in this study regularly turn to social media to discuss their experience, and because social media can be the most vulnerable of space, they often find social media to be a dilemma. While social media provides a storytelling space, and a catalyst for sharing with and relating to others, it can also be a space of ridicule and isolation, especially for new parents (Johnson & Quinlan, 2019).

From my emotional conflict, I used narrative to make sense of the experiences I had immersed myself in (Frank, 1995). I released the voices I could hear inside by writing a new kind of narrative – a narrative that could speak for many and for one at the same time, while at the same time remaining aware that a single voice couldn't always speak for an entire group (Frank, 1995). As stated prior, at the most basic level, narratives allow people to understand human experience (Polkinghorne, 1988). These narratives were my way of understanding human experiences.

Writing narratives has a therapeutic nature, as other scholars have discussed (Davis & Warren-Findlow, 2011; 2012; Ellis, 2004; Lalvani, 2011). I find hope that if these monologues can move a numb, emotionally confused man such as myself, they have the possibility to move others and help them understand the lived experiences of another. I made sense of the lived experiences of a diverse, yet closely related group by constructing narratives (Davis & Warren-Findlow, 2011, 2012; Harter, Japp & Beck, 2005). Now, these narratives can help others to make sense of lived experiences as well (Somers, 1994).

4.6 Practical Implications

To learn from these narratives, one must simply read them with an open mind. On a practical level, these narratives and their format know no bounds. My hope is that they are informative to professionals and the general public, whether familiar or unfamiliar with the experience of caregiver depression during the infancy period after assisted conception. By gaining a better understanding of the experiences of parents, medical professionals, health practitioners, educators, family, and friends can potentially be more supportive to parents during interactions.

People who are experiencing or have experienced postnatal depression after assisted conception can turn to these narratives to wade through the memories of their experience, organize them, and make sense of what has happened (Frank, 1995; Somers, 1994). Because narratives embody lived experiences while existing within cultural scripts (Wood, 1994), there are practical implications for those who have not personally experienced depression during the infancy period, especially those who underwent assisted conception therapies prior to becoming a parent.

These monologues are stories which can help family and friends to make sense of their loved one’s symptoms and overall experience by identifying and examining characters and conflicts (Burke, 1969; Polkinghorne, 1988). The characters in these monologues are different from us, yet similar to us. Their emotions are jolting, but relatable. Their words are new, but familiar.

Healthcare practitioners, such as therapists, gynecologists, and REI specialists can examine the characters and conflicts to obtain insight of the lived experiences of their patients (Burke, 1969; Charon, 2001). Using narrative medicine, a patient’s doctor can look deeply at their experience, effectively humanizing a body and associating an identity to what is possibly seen as a medical case (Charon, 2001). Health practitioners often get a very short snapshot of a patient’s life, but with narrative there’s potential for gaining more understanding of an individual (Charon, 2001). By reading the stories of people who have lived with the same illness, the humanistic aspects – those that go beyond biology – of a person's lived experience is placed at the forefront (Davis & Warren-Findlow, 2011, 2012). Health practitioners can use stories to see realities they may not have learned from a medical textbook (Charon, 2001). The stories provided in this thesis may encourage health practitioners to use their expertise to educate prospective parents on the risks of postnatal depression. Further, they can help practitioners to not make assumptions about people who seek assisted reproduction therapies and to not make assumptions about people who are living with postnatal depression. Lastly, the evidence of the need for more inclusive terminology and diagnostic criteria in order to provide adequate care may encourage practitioners to carry out scientific research that will lead to a broader acceptance of postnatal depression in the medical community.

4.7 Limitations

This project is limited by representation; the narratives are representative rather than reported. The content of each narrative fell on the shoulders of the researcher. It was my responsibility to represent them well. By writing fictional and fictionalized narratives, I protected the vulnerability of the people I observed, but curated their words. I was tasked with writing another person's story while having available only snapshots of the lives of people similar to them.

A reliance on text may be another limitation of this study. he stories that inspired these fictionalized narratives are so much more than just words, because people are more than just words. People are, in addition to communicators, rational and irrational. They are emotional. Therefore, the audience's communication competence and motivation to learn could minimize or maximize the poignancy of the narratives by preventing the audience from capturing and processing the emotion that is associated to the narrative.

4.8 Future Research

It is my anticipation that qualitative researchers will find value in the use of fictionalized narrative. Fictionalized narrative is not a recent research innovation. Other researchers have been using fictionalized narrative to share the lived experience of another for three decades (see Angrosino, 1998; Holman Jones, 1999; Pecanowsky, 1988), but according to Davis and Warren-Findlow (2011) there is still some denial of this method's capabilities among qualitative researchers. There are many areas where fictionalized narrative can be used to represent the lived experiences of a group without compromising their identity.

As a feminist, I believe there is a wide array of marginalized intersectional groups who all deserve to have their story told. Researchers should challenge themselves to tell more stories. Some researchers are understandably fearful of doing so – creative writing requires one to think and feel in a way not often researchers are not trained to do. The researcher should not fear fiction and should not fear releasing a story. Every story is fiction and every story desires to be told (Coles, 1989; Kleinmann, 1988).

4.9 (Concluding) Moment of Reflexivity

I grew up in a society that predicates masculinity on men denying or hiding their emotions (Barnes, 2014). To complete this thesis, I had to release myself from those constructs and further develop my emotional awareness. I had to teach myself it is ok to cry it out, I do not need to fear sharing my feelings, and most importantly I should allow myself to feel the pain of others if I want to understand their experiences and represent them to the best of my ability. I learned this from the people I studied, who tell their stories with courage and bravery, and whose stories I have shared. My worldview has broadened and changed.

REFERENCES

American Psychological Association (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: American Psychological Association.

American Psychiatric Association (2017, October). *Supplement to diagnostic and statistical manual of mental disorders, fifth edition.* Retrieved from https://psychiatryonline.org/pb-assets/dsm/update/DSM5Update_October2017.pdf

American Psychological Association (2018). Postpartum depression. Retrieved from http://www.apa.org/pi/women/resources/reports/postpartum-depression.aspx

Angrosino, M. C. (1998). Opportunity house: Ethnographic stories of mental retardation. Walnut Creek, CA: AltaMira

Baby Blues. (2009). The penguin dictionary of psychology. Retrieved from http://search.credoreference.com/content/entry/penguinpsyc/baby_blues/0

Barnes, L. W. (2014). *Conceiving masculinity: Male infertility, medicine, and identity.* Philadelphia, PA: Temple University Press.

Beck, C., Chapman, S., & Simmons, N. (2015). *Celebrity health narratives and the public health*. Jefferson, NC: McFarland & Company, Inc.

Bell, A. V. (2010). Beyond (financial) accessibility: Inequalities within the medicalization of infertility. *Sociology of Health & Illness, 32*, 631-646. doi:10.1111/ j.1467-9566.2009.01235.

Bochner, A. P. (2001). Narrative's virtues. *Qualitative Inquiry*, *7,* 131–157.

Bochner, A. P. (2002). Perspectives on inquiry II: Theories and stories. In M. Knapp & G. R. Miller (Eds.), *Handbook of interpersonal communication* (3rd ed.) (pp. 73-101). Thousand Oaks, CA: Sage.

Breitkopf, E., & Rubin, L. (2015). (Re)productive disorders: The expanding marketplace for infertility medicine. In M. C. McHugh, & J. C. Chrisler (Eds.), *The wrong prescription for women: How medicine and media create a "need" for treatments, drugs, and surgery* (pp. 37-59). Santa Barbara, CA: Praeger.

Brown, L. S. (2000). Discomforts of the powerless: Feminist constructions of distress. In J. D. Raskin & R.A. Neimeyer (Eds.) *Constructions of disorder* (pp. 297-308). Washington DC: American Psychological Association.

Bute, J. J. (2009). "Nobody thinks twice about asking:" Women with a fertility problem and requests for information. *Health Communication, 24*, 752–763. doi:10.1080/10410230903265920

Bute, J. J., Quinlan, M. M., Quandt, L. K. (2016). Informing or exploiting? Public responses to Guiliana Rancic's health narrative. *Health Communication*, *31*(8), 1008-1018.

Butler, J. (1993). *Bodies that matter: On the discursive limits of "sex."* New York, NY: Routledge.

Centers for Disease Control and Prevention (2016, July 15). FastStats - Infertility. Retrieved from https://www.cdc.gov/nchs/fastats/infertility.htm

Centers for Disease Control and Prevention (2017, February 7). What is Assisted Reproductive Technology? Retrieved from https://www.cdc.gov/art/whatis.html

Centers for Disease Control and Prevention (2018). Depression during and after pregnancy. Retrieved from https://www.cdc.gov/features/maternal-depression/index.html

Chester, D. H. (2003). Mother. Unmother: A storied look at infertility, identity, and transformation. *Qualitative Inquiry*, *9*(5), 774-784. doi: 10.1177/1077800403254887

Clark-Ibanez, M. (2004). Framing the social world with photo-elicitation interviews. *American Behavioral Scientist, 47*, 1507-1527.

Coles, R. (1989). *The call of stories: Teaching and the moral imagination.* Boston, MA: Houghton Mifflin Company.

Da Costa, D., Zelkowitz, P., Dasgupta, K., Sewitch, M., Lowensteyn, I., Cruz, R., Khalifé, S. (2017). Dads get sad too: Depressive symptoms and associated factors in expectant first-time fathers. *American Journal of Men's Health*, *11*(5), 1376–1384. doi: 10.1177/1557988315606963

Dalton, K., Holton, W., & Dalton, K. (2001). *Depression after childbirth: How to recognize, treat, and prevent postnatal depression* (4th ed.). New York, NY: Oxford University Press.

Davis, C., & Warren-Findlow, J. (2011). Coping with trauma through fictional narrative ethnography: A primer. *Journal of Loss and Trauma*, *16*(6), 563–572. doi: 10.1080/15325024.2011.578022

Davis, C., & Warren-Findlow, J. (2012). The mystery of the troubled breast. Examining cancer and social support through fictional narrative ethnography. *Qualitative Communication Research*, *1*(3), 291-314. doi: 10.1525/qcr.2012.1.3.291

Dubriwny, T. N. (2012). *The vulnerable empowered woman: Feminism, postfeminism, and women's health.* New Brunswick, NJ: Rutgers University Press.

Ellis, C. (2004). *The ethnographic I: A methodological novel about autoethnography*. Walnut Creek, CA: AltaMira Press.

Fisher, J., Hammarberg, K., & Baker, H. W. (2005). Assisted conception is a risk factor for postnatal mood disturbance and early parenting difficulties. *Fertility and Sterility*, *84*(2), 426–430. doi:10.1016/j.fertnstert.2005.02.016

Frank, A. W. (1995). The wounded storyteller: Body, illness and ethics. Chicago, IL: The University of Chicago Press.

Garro, L. C., & Mattingly, C. (2000). Narrative as construct and construction. In C. Mattingly & L. C. Garro (Eds.), *Narrative and the cultural construction of illness and healing* (pp. 1-49). Berkeley, CA: University of California Press.

Glaser, B., & Strauss, A. (1967). *Discovery of grounded theory.* Chicago, IL: Aldine.

Greenhalgh, T., & Wengraf, T. (2008). Collecting stories: Is it research? Is it good research? Preliminary guidance based on a Delphi study. *Medical Education*, *42*, 242–247.

Glesne, C., & Peshkin, A. (1992). *Becoming qualitative researchers: An introduction.* White Plains, NY: Longman.

Harding, S. (1998). *Is science multicultural? Postcolonialisms, feminisms, and epistemologies*. Bloomington, IN: Indiana University Press.

Hamilton, J. (1962). *Postpartum psychiatric problems.* Maryland Heights, MO: Mosby.

Hamilton, J., Harberger, P., & Parry, B. (1992). The problem off terminology. In J. Hamilton & P. Harberger (Eds.), *Postpartum psychiatric illness: A picture puzzle* (pp. 33-40). Philadelphia: University of Pennsylvania Press.

Harter, L. M. (2013). The work of art. *Qualitative Communication Research*, *2*, 326-336. doi:10.1525/qcr.2013.2.3.326

Harter, L. M., Japp, P. M., & Beck, C. S. (2005). *Narratives, health, and healing: Communication theory, research, and practice.* Mahwah, NJ: Lawrence Erlbaum Associates.

Harter, L., Quinlan, M. M., & Shaw, E. (Producers) (2016). *Courage of creativity* [documentary film series]. United States: WOUB Public Media [Public Broadcasting Company (PBS) affiliate]

Harter, L. M., Scott, J. A., Novak, D. R., Leeman, M., & Morris, J.F. (2006). Freedom through flight: Performing a counter-narrative of disability. *Journal of Applied Communication Research*, 34(1), 3-29. doi: 10.1080/00909880500420192

Hiremath, P., & R. Mohite, V. (2016). Paternal postnatal depression: Sad dad syndrome. *Journal of Psychiatric Nursing*, *5*(2), 73–76. doi: 10.21088/jpn.2277.9035.5216.7

Holman Jones, S. (1999). Torch. *Qualitative Inquiry, 5*, 280–304.

Horwitz, A.V. (2017). Social context, biology, and the definition of disorder. *Journal of Health and Social Behavior, 58*(2), 131-145. doi: 10.1177/0022146517705165

Husbands, L. (2008). Blogging the maternal: Self-representations of the pregnant and postpartum body. *Atlantis*, *32*(2), 68-79.

Jensen, K. B. (2013). *A handbook of media and communication research: Qualitative and quantitative methodologies*. Abingdon, UK: Routledge.

Johnson, B. (2016). Personal, interpersonal, biomedical, textual: Vignettes on infertility and fertility privilege. *Departures in Critical Qualitative Research*, *5*(2), 76-100.

Johnson, B., & Quinlan, M. M. (2016). For her own good: The expert-woman dynamic and the body politics of REI treatment. *Women & Language*, *39*(1), 127-131.

Johnson, B., & Quinlan, M. M (2017). Insiders and outsiders and insider(s) again in the (in)fertility world. *Health Communication*, *32*(3), 381–385. doi:10.1080/10410236.2016.1138384

Johnson, B., Quinlan, M. M, & Marsh, J. S. (2018). Telenursing and nurse–patient communication within Fertility, Inc. *Journal of Holistic Nursing*, *36*(1), 38–53. doi:10.1177/0898010116685468

Kleinman, A. (1988). *The illness narratives: Suffering, healing and the human condition*. New York, NY: Basic Books.

Lalvani, P. (2011). Constructing the (m)other: Dominant and contested narratives on mothering a child with Down Syndrome. *Narrative Inquiry*, *21*(2), 276-293. doi: 10.1075/ni.21.2.06lal

Lerman, H. (1986). *A mote in Frued's eye: From psychoanalysis to the psychology of women.* New York, NY: Springer.

Merriam, S. B. (1998). *Qualitative research and case study applications in education.* San Francisco, CA: Jossey-Bass.

Naples, N. A. (2003). *Feminism and method: Ethnography, discourse analysis, and activist research.* New York: Routledge.

National Health Service, United Kingdom (NHS) (2016). Overview: Postnatal depression. Retrieved from https://www.nhs.uk/conditions/post-natal-depression/

National Institute of Child Health and Human Development of the National Institutes of Health (2017, January 31). *Infertility and fertility*. Retrieved from: https://www.nichd.nih.gov/health/topics/infertility

National Institute of Mental Health (2018). Postpartum depression facts. Retrieved from https://www.nimh.nih.gov/health/publications/postpartum-depression-facts/index.shtml#pub3

Niz, E. S. (2017). "Outdaughtered" dad reveals struggle with postpartum depression. *Parents Magazine*. Retrieved from https://www.parents.com/baby/all-about-babies/outdaughtered-dad-reveals-struggle-with-postpartum-depression/

Novak, D. R. (2010). Democratizing qualitative research: Photovoice and the study of human communication. *Communication Methods and Measures*, *4*(4), 291–310. doi:10.1080/19312458.2010.527870

Norander, S. (2011). Complicating empowerment and privilege. *Women & Language, 34,* 121-124.

Ochs, E., & Capps, L. (1996). Narrating the self. *Annual Reviews in Anthropology, 25,* 19-43.

Pacanowsky, M. (1988). Slouching toward Chicago. *Quarterly Journal of Speech, 74*, 453–467.

Perry, C., Thurston, M., & Osborn, T. (2008). Time for me: The arts as therapy in postnatal depression. *Complementary Therapies in Clinical Practice*, *14*(1), 38–45.

Polkinghorne, D. E. (1988). *Narrative knowing and the human sciences*. Albany: State University of New York Press.

Poole. (1847). Case of puerperal mania. *Provincial Medical & Surgical Journal, 11*(13), 346. doi: 10.1136/bmj.s1-11.13.346

Pope, N.M., Michalik, M., Maine, S., Rouse, M., Davis, C., Sadler, O., Cameron, S., Medlin, E. & Bataba, D. (COMM Graduate Student Producers), Quinlan, M. M., & Johnson, B. (Senior Researchers) (2017). *1 in 8: Communicating (In)fertility* (draft) Retrieved from https://youtu.be/7z9jfZjoS04

Postnatal Depression (2007). *Cambridge handbook of psychology, health, and medicine.* Cambridge, England: Cambridge University Press.

Postpartum Support International (PSI) (2018). History of PSI. Retrieved from http://www.postpartum.net/about-psi/history-of-psi/

Postpartum Progress (2018). About. Retrieved from www.postpartumprogress.com/about

Postpartum Progress (2019a). Postpartum progress in the media. Retrieved from www.postpartumprogress.com/postpartum-progress-in-the-media

Postpartum Progress (2019b). About. Retrieved from www.postpartumprogress.com/about

Postpartum Progress (2019c). Postpartum depression stories. Retrieved from www.postpartumprogress.com/find-moms-like-you

Pregnancy, Birth, & Baby (HealthDirect, AU) (2018). Postnatal depression. Retrieved from https://www.pregnancybirthbaby.org.au/postnatal-depression

Puerperal Mania (1830). *The Lancet*, *13*(338), 708. doi: 10.1016/S0140-6736(02)93734-7

Quinlan, M. M., & Harter, L. M. (2010). Meaning in motion: The embodied poetics and politics of dancing wheels. *Text and Performance Quarterly, 30*(4), 374-395.

Quinlan, M. M., Harter, L. M., & Okamoto, K. (2014). The communication potentials and challenges of arts-based programming in healthcare settings. In M. Brann (Ed.) (2nd ed.), *Contemporary case studies in health communication: Theoretical and applied approaches.*(pp. 269-282) Dubuque, IA: Kendall/Hunt Publishing.

Sandelowski, M. (1993). *With child in mind: Studies of the personal encounter with infertility.* Philadelphia: University of Pennsylvania Press.

Segre, L. S., & Davis, W. N. (2013, June). *Postpartum depression and perinatal mood disorders in the DSM.* Retrieved from http://www.postpartum.net/wp-content/uploads/2014/11/DSM-5-Summary-PSI.pdf

Seward, E. M. (1972). Preventing postpartum psychosis. *The American Journal of Nursing, 72*(3), 520-523. doi: 10.2307/3422144

Somers, M. R. (1994). The narrative construction of identity: A relational and network approach. *Theory and Society, 23*, 605-649.

Stone, K. (2011). Postpartum depression after infertility [blog post]. Retrieved from http://www.postpartumprogress.com/postpartum-depression-after-infertility

Van Maanen, J. (1988). *Tales of the field.* Chicago, IL: University of Chicago Press.

Wang, C. C. (1999). Photovoice: A participatory action research strategy applied to women's health. *Journal of Women's Health, 8,* 185-192.

Werner, O., & Schoepfle, G. (1987). *Systematic fieldwork: Foundations of mini-ethnography and interviewing* (Vol. 1). Newbury Park, CA: Sage.

White, H. (1981). The value of narrativity in the representation of reality. *Critical Inquiry, 7*, 5-27.

Willer, E. K. (2014). Healthcare provider compassionate love and women's infertility stressors. *Communication Monographs, 81*, 407–438. doi:10.1080/03637751.2014.940591

Willer, E. K., Droser, V. A., Drazner Hoyt, K., Hunniecutt, J., Krebs, E., Johnson, J. A., & Castaneda, N. (2018). A visual narrative of children's baby loss remembrance drawings. *Journal of Family Communication*. [published online] doi:10.1080/15267431.2018.1428608

Wood, J. T. (1994). *Who cares? Women, care, and culture*. Carbondale: Southern Illinois University Press.

Yagoda. M. (2018, May). Serena Williams, Chrissy Teigen, & more stars who've opened up about their struggles with postpartum depression. *People Magazine*. Retrieved from https://people.com/parents/stars-with-postpartum-depression/

APPENDIX

IRB Notice - 19-0026

Date: February 1, 2019 at 07:53

To: Nathan Pope, Communication Studies
From: Office of Research Compliance

Date: 2/01/2019
RE: Determination that Research or Research-Like Activity does not require IRB Approval Study #: 19-0026

Study Title: "Buyer's Remorse" of "Everything She Wanted:" Visually Narrating Experiences of Postnatal Depression After Assisted Conception

This submission was reviewed by the Office of Research Compliance, which has determined that this submission does not constitute human subjects research as defined under federal regulations [45 CFR 46.102 (d or f) and 21 CFR 56.102(c)(e)(l)] and does not require IRB approval.

Study Description:

This study intends to analyze publicly available online discourse surrounding the unique experience of living with postnatal depression after undergoing infertility treatments. By doing so, the project could potentially increase public understanding and compassion while contributing vital scholarly research about marginalized health populations. Results of this study may provide information that would aid peers and health professionals in supporting individuals who experience postnatal depression. Using narrative analysis, collected data will be analyzed in and used to construct a narrative that is representative of this unique experience. The study will utilize visual methods in conjunction with textual to yield a unique narrative that is representative of experience. The visual component of the project will be created/constructed by the researcher and act as an extension of the textual narrative. By using verbal/textual and visual products, individuals who view and read the researcher's (Nathan Pope) created narrative are given a greater opportunity to organize their experiences, reflect on them, and make meaning.

Discourse will be collected using the social media listening tool Radian6 and general web searches. Radian6 is an online tool that monitors publicly shared social media posts by searching text-only data from more than 150 million blogs, and millions of posts from social media platforms such as Facebook, Twitter, and Instagram. The searches Radian6 performs seek the appearance of keywords or phrases within individual posts. General web searches may yield relevant news or magazine articles or blog posts and comments. Radian6 does not collect personally identifying information or posts that are not publicly available and the researcher will not collect or seek out this information either.

Communication Studies scholars are uniquely equipped to explore the narratives and social discourse of marginalized populations, because of their training in textual and rhetorical analysis of critical and cultural matters. The possibility for visual research methods and products to be both informative and impactful, as seen in previous communication studies research, suggests these methods can be valuable tools to the academy as academics perform translational and community-centered research.

Please be aware that approval may still be required from other relevant authorities or "gatekeepers" (e.g., school principals, facility directors, custodians of records), even though IRB approval is not required.

If your study protocol changes in such a way that this determination will no longer apply, you should contact the above IRB before making the changes.