Sensemaking Through the Storm: How Postpartum Depression Shapes Personal Work-Family Narratives

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Abstract

Many women experience psychological and emotional challenges during their transition to becoming a working mother. Postpartum depression (PPD) is one common, salient aspect of motherhood that can serve as a work-life shock event and profoundly shape women's work and nonwork lives, yet has evaded discussion in the organizational sciences. Taking a grounded theory approach, we interviewed 41 women who experienced PPD as well as key informants who provided additional insights about PPD (e.g., an obstetrician, women working for organizations that support postpartum health). Our analysis highlights how being diagnosed with PPD activates a complex sensemaking process in which women process an *imposing identity*—a concept we introduce to the identity and work-family literatures reflecting an unexpected, undesirable identity that imposes upon existing (e.g., work) and/or provisional identities that may or may not be fully elaborated (e.g., motherhood), ultimately shifting how women think about the intersection of work and family. We also delineate how supports and antisupports (i.e., overt acts dismissive of women's PPD) shape the aforementioned processes. Combined, our research aims to advance the discussion of PPD within organizational scholarship, rendering significant implications for both theory and practice.

Keywords: postpartum depression, maternal health, work-family, sensemaking, identity

The transition to becoming a working mother is among the more challenging periods in many women's lives (Grandey et al., 2020; Greenberg & Ladge, 2019; Little & Masterson, 2021). Notwithstanding the physical challenges of having a new baby (Hackney et al., 2021), women must manage new routines and roles across multiple life domains (Little & Masterson, 2021; Nichols & Roux, 2004). Moreover, the salient, observable nature of becoming a mother challenges ideal worker norms (Acker, 1990; Kelly et al., 2010; Reid, 2015) and work-devotion schemas in organizations which suggest that individuals should be constantly available for work (Blair-Loy, 2009; Padavic et al., 2020), perpetuating a stigma working mothers must overcome (Jones & King, 2014; Little et al., 2015). Because of this, it has been noted that organizations must strive to make the workplace more supportive for mothers to help manage work, family, and the blended demands that span both roles (Ladge et al., 2018; Little & Masterson, 2021; Nichols & Roux, 2004). From a practical standpoint, offering support to working mothers is critical, as 61% of women (i.e., 2.5 million women annually) in the U.S. alone who give birth are working postpartum (Little & Masterson, 2021; U.S. Bureau of Labor Statistics, 2017), with most citing inadequate workplace support as a key problem for protecting and promoting women's mental health and well-being postpartum (Grandey et al., 2020; Hackney et al., 2021).

Although attention has been paid to the challenges of reentry following childbirth (Gabriel et al., 2020; Ladge & Greenberg, 2015; Little & Masterson, 2021), research is lacking regarding how women cope with work after having been diagnosed with postpartum depression (PPD)[1]—a critical mental illness that occurs quickly after childbirth. This presents a significant

[1] We recognize that in our discussion of PPD, we will be detailing events from participants that may be distressing to read and challenging to engage with. This may be particularly the case for those who have also struggled or are currently struggling with mental illness and/or transient mental health challenges (e.g., Follmer & Jones, 2018). We offer this as a general disclaimer. For those who are currently struggling with PPD in particular, we recommend Postpartum Support International (https://www.postpartum.net) for up-to-date resources and offer our support.

limitation in our understanding of pregnancy and postpartum experiences at work. Per the American College of Obstetrics and Gynecologists (2019), PPD is a severe form of depression involving experiences of intense sadness, anxiety, and/or despair that interfere with women's lives, far surpassing the typical "baby blues" or fatigue that women may feel after birth (Mayo Clinic, 2018; O'Hara & McCabe, 2013).[2] At least 15% of mothers are diagnosed with PPD, making it "the most common complication" of childbirth (Post & Leuner, 2019, p. 417)[3]. Previous studies have positioned PPD as a distal outcome of work experiences during pregnancy (e.g., an outcome of social support, Jones et al., 2022; an outcome of pregnancy discrimination, Hackney et al., 2021), with little discussion of how PPD may affect women's experiences at work and at home. As such, there remains a limited understanding of the burden caused by PPD on women's work and nonwork lives, despite its possible—and likely significant—impact.

In the current investigation, we conducted an inductive qualitative study to *understand how the emotional, cognitive, physical, and behavioral symptoms associated with PPD affect and dynamically shape women's work and nonwork lives.* To explore this, we adopted a grounded theory approach, using interviews with 41 working women who had PPD[4], plus information from discussions with key informants (e.g., an obstetrician, a representative from a leading women's health online platform, leaders of a postpartum support group). Although we did not enter the project with a priori hypotheses, our familiarity with the literature on identity

[2] PPD is not synonymous with the "baby blues," postpartum psychosis, or general depression. For a review of the distinctions between PPD and these other diagnoses or experiences, see O'Hara and McCabe (2013).

[3] A major depressive episode may also occur postpartum in the non-birthing parent but does so at a substantially lower rate and later on than for the birthing parent (Scarff, 2019). As such, we opted to focus on the experiences of the birthing parent for this initial investigation and encourage future work to consider PPD in both partners.

[4] As detailed below, we hit theoretical saturation at 40 interviews, but still had one final interview to conduct. During this last interview, our participant described all of the symptoms of having PPD, noting that her doctor commented on the symptoms without giving a formal diagnosis. We have retained her in this study, as her experiences aligned with those with formal diagnoses. Future research on PPD should consider how symptoms associated with PPD manifest for working women when they receive the diagnosis, versus when they do not.

and sensemaking led us to assume that being diagnosed with PPD would affect women's views of themselves (i.e., their identities) at home and at work, as well as how women thought about the intersection of work and family. Aligning with broader conceptualizations of mental illness (Follmer & Jones, 2018)[5], we recruited women who reported receiving a formal diagnosis, as this ensured that participants had a shared experience and a common language around PPD, its symptoms, and its treatment. The formal diagnosis also allowed them to provide insight into the complexities of PPD and its intersection with work and family in a way that those without this common language and framing may not have been able to. Further, and critical to our theoretical contribution, this allowed us to understand how being diagnosed with PPD (and the resulting imposing nature of having PPD) influenced experiences for women, both at work and at home.

Specifically, through our use of grounded theory, we investigate whether, and in what ways, the emotional, cognitive, physical, and behavioral symptoms of PPD drive women's sensemaking surrounding their diagnosis and treatment, as well as their experiences as working mothers. We present a theoretical model that sheds light on how PPD—a difficult, complicated, and unwanted shock for women—operates as an *imposing identity* (a concept we introduce to the identity literature) that drives women to shape their own *personal work-family narratives*[6], or the individual-level storytelling women engage in to craft their personal, work, and family lives in ways that suit their personal goals and that allows them to find strength in their storm.

With our research, we aim to contribute to scholarship on identity, sensemaking, and mental health/illness at work by highlighting PPD as a unique work-life shock event (Crawford

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[5] Although mental illness and mental health are related, we view them as distinct. Per Follmer and Jones (2018), mental illness captures disorders that are formally diagnosed by a medical provider (such as PPD), with mental illness ultimately shaping individuals' affect, cognitions, and behaviors. Mental health, on the other hand, captures more transient fluctuations in psychological health and well-being, such as fleeting feelings of depression or anxiety.

[6] Here, we distinguish *personal* work-family narratives from *organizational* work-family narratives, which are often centered around organizational norms to be available for work 24/7 (e.g., Padavic et al., 2020).

et al., 2019). Specifically, we explain that PPD can be influential for working mothers in ways that extend beyond responsibilities related to caring for a child. We also suggest that, while other mental illnesses such as generalized depression can be difficult (Follmer & Jones, 2018; Kensbock et al., 2022), PPD renders unique challenges in that it onsets quickly after childbirth, making it an acute, life-altering shock that reflects "emotional turmoil" occurring during a time that is described as joyful and celebratory (Corrigan et al., 2015, p. 48). Importantly, while theory tied to identity, sensemaking, and mental health/illness helped inform our understanding of how PPD impacts working women, it does not fully explain the dynamic process through which women come to terms with their symptoms and diagnosis, and the ways in which having PPD shifts—perhaps positively—how women shape their work and family lives. As PPD symptoms can drive women to reevaluate their personal and professional demands (O'Hara & McCabe, 2013), understanding these experiences is critical, as the imposing identity represents an unwanted identity compared to the volition of professional and personal identities. Thus, we seek to explore how women cope with these identity dynamics and how they may impact their ability to maintain and protect their health, well-being, and relationships at work and at home.

Postpartum Depression and Theory Informing Our Research

The onset of PPD—the accumulation of symptoms and the diagnosis—is a significant experience or series of events that many women must grapple with in their motherhood journey (Corrigan et al., 2015; Crawford et al., 2019). Per the American College of Obstetrics and Gynecologists (2019), the development and diagnosis of PPD typically occurs within 1-3 weeks following childbirth, though PPD can be diagnosed up to one year postpartum. Although many factors can contribute to PPD, the American College of Obstetrics and Gynecologists (2019) pinpoints changes in hormones, a prior history of depression, feelings of doubt associated with

pregnancy/motherhood, fatigue, and lifestyle factors (e.g., stressful events at birth) as potential contributors. Women with PPD can experience symptoms related to depression for years; for others, symptoms wane in the first few months (Goodman, 2004; Uguz et al., 2009). Regardless of the severity of PPD symptoms, the timing of the formal diagnosis often occurs during maternity leave—which in the U.S. (where we conducted our research) typically lasts through the first 6-12 weeks after childbirth (Little & Masterson, 2021)—and before work reentry.

What makes PPD pernicious as a mental illness is that it can manifest emotionally, cognitively, physically, and behaviorally, affecting women's ability to engage effectively with their roles and demands in both the work and family domains (Office on Women's Health, 2019; O'Hara & McCabe, 2013). These symptoms make PPD a pervasive experience that has the potential to not only affect women in a multifaceted manner, but also affect women's children, partners, family members, and others they must engage with (e.g., Mandl et al., 1999; O'Hara & McCabe, 2013). In this way, being diagnosed with PPD reflects a work-life shock event—"a disruptive, novel, and critical event that necessitates additional resource investment in the domain the shock originated from" and "triggers a reevaluation and potential change of the status quo" (Crawford et al., 2019, pp. 195 and 198, respectively). Indeed, being diagnosed with PPD has the potential to serve as a significant shock to women that engages a reevaluation process (i.e., sensemaking) and ultimately influences resource investment in work and family domains. Such an impact of PPD would be crucial, as such work-life shocks are particularly challenging for women during earlier career stages when motherhood occurs (e.g., Gloor et al., 2023).

Critical to our work, studies of PPD have largely happened outside the organizational sciences in gynecology/obstetrics and clinical psychology (e.g., O'Hara & McCabe, 2013; Stowe et al., 2005). Of the research that has looked at its work-related implications, PPD has often been

an *outcome* of organizational processes (e.g., lack of support or pregnancy discrimination, Hackney et al., 2021; Jones et al., 2022). Thus, the impact of PPD on working women and their identities is not well understood. As a starting point to guide our thinking around PPD and its intersection with work and family, we briefly review two literatures as a starting point: the literature on identity and sensemaking, and the literature on mental health/illness at work. In so doing, we shine a spotlight on areas where theory and research fall short in fully explicating how PPD unfolds across work and family domains, necessitating the current research.

Identity and Sensemaking

Identity has been defined as the "self-referential description that provides contextually appropriate answers to the question 'Who am I?'" (Ashforth et al., 2008, p. 327). Identities can be socially constructed and based on group membership, roles, or unique traits and—pertinent to the current investigation—can also include unwelcome identities such as those related to illness and health diagnoses (Charmaz, 1991; Flowers et al., 2006; Goffman, 1963). As reviewed by Follmer and Jones (2018), having a mental illness such as PPD represents "a unique type of concealable social identity" that "creates a unique perspective through which individuals interact with the workplace, and such a perspective is markedly different from that of individuals without mental illness" (p. 329). Such ideas fit with classic work from Charmaz (1994; see also: Flowers et al., 2006), who noted that those with mental illnesses or mental health challenges face identity dilemmas resulting from "losing valued attributes, physical functions, social roles, and personal pursuits *through illness and their corresponding valued identities*, i.e., positive definitions of self, including socially conferred and personally defined positive identities" (pp. 269-270; italics added for emphasis). Thus, having PPD is likely a distinct social identity for working mothers, though the ways in which this identity manifests and affects women is not clearly delineated.

More specifically, individuals often hold multiple identities (e.g., mother, architect, swimmer), which can influence one another, intersect, and blend as they are revised and refined over time (Ladge et al., 2012; Ladge & Greenberg, 2015). As it relates to the experiences of becoming a mother, research also points to how the adoption and transition to new identities can lead to shifts in already established professional or personal identities (e.g., Ladge et al., 2012). Over time, as individuals take on new roles and/or have challenging personal or professional experiences, their overall sense of self will likely adapt and change as well (Conroy & O'Leary-Kelly, 2014; Ladge et al., 2012; Shepherd & Williams, 2018). This suggests that being diagnosed with PPD may be one such challenge that could facilitate identity adaptation and change across multiple life domains (e.g., Crawford et al., 2019; Ladge & Little, 2019).

Theory from Crawford et al. (2019) suggests that work-life shock events—such as having PPD—trigger a reevaluation or a sensemaking process through which people work to understand situations that are novel or ambiguous (Weick, 1988). Sensemaking is particularly pronounced following major challenges to the self and one's identity, serving as a core process in meaning-making (Maitlis & Christianson, 2014; Maitlis & Sonenshein, 2010; Weick, 1988). Further, sensemaking is a dynamic process triggered when "members confront events, issues, and actions that are somehow surprising and confusing" (Maitlis, 2005, p. 21). Research has suggested that sensemaking is the mechanism through which identity work occurs as it follows major challenges to oneself (Janoff-Bulman, 1992; Neimeyer et al., 2002; Vough et al., 2020). Moreover, sensemaking has been found to be important in the work context when individuals experience an event that undermines their ability to do their work (e.g., Maitlis, 2009).

Thus, when it comes to the study of PPD, a key question that remains is how having PPD as a socially constructed identity manifests to shape working women's lives. For example, it is

unclear if such a diagnosis would be subsumed within one's nonwork identity (i.e., a mother), change and/or shift one's identity at work (i.e., a working mother), or be viewed as a separate identity (i.e., a person with PPD). Follmer and Jones (2018) suggest that PPD is likely a social identity; yet their work stops short of detailing the identity-related impacts of such a diagnosis. Crawford et al. (2019) suggest that work-life shock events, such as experiencing PPD, influence reevaluation and resource investment in work and family domains; yet we have little information as to what that sensemaking (i.e., reevaluation) process entails, and what type of identity work people may engage in during a work-life shock event. In short, the internal identity experiences linked with having PPD are not clearly explicated from related literatures we have reviewed.

Mental Health and Mental Illness in Organizations

Compared to research on identity and sensemaking at work, the literature on mental health and mental illness in organizations is comparatively smaller despite the importance of these topics in affecting individuals' workplace well-being, performance, and retention (e.g., Follmer & Jones, 2018; Kelloway et al., 2023). Generally speaking, it has been presumed that the presence of mental illnesses in organizations is detrimental to both individual and organizational functioning (Kelloway et al., 2023; Kensbock et al., 2022). As reviewed by Kelloway et al. (2023), leaves of absence for mental health challenges are often quite lengthy (i.e., roughly 100 days), suggesting that the cost of mental health issues at work is close to $300 billion USD per year due to productivity and absenteeism costs (National Alliance on Mental Illness, 2019). For employees experiencing mental illness, there are well-being costs (Follmer & Jones, 2018) as well as interpersonal costs. Scholarship has suggested that mental health disclosures are often met with stigma from social others (Keyes & Shaman, 2022), particularly at work (Stuart, 2006).

The stigma identity management literature suggests that managing stigmatized social

identities (e.g., PPD) is a complex process of deciding whether to pass, reveal, or conceal. After disclosure, individuals with stigma still need to actively manage their identities, perhaps even more so. Little et al. (2015) found that women use image-maintenance strategies before and after pregnancy disclosure at work, which should also apply to those with PPD. Yet the broader literature on mental illness suggests that there can be benefits, or "silver linings," associated with a diagnosis. Research on autism (Johnson & Joshi, 2016) and bipolar disorder (Delmas et al., 2011) diagnoses highlights that having a diagnosis offers clarity and relief, allowing individuals to find productive and potentially positive ways to move forward. In calling for future work on mental illness in the workplace, Follmer and Jones (2018) remarked that such research should focus on "employees' lived experiences with mental illness, including the ways in which it disrupts, modifies, or enhances the job" (p. 343). Thus, while we assume that having PPD is detrimental—particularly due to its symptoms and its sudden onset—it also seemingly has the potential to be transformative in how people navigate their work and family lives.

In sum, given that these areas of scholarship could inform the study of PPD, but not fully explain the effects of such a diagnosis, and given the nascence of studying PPD in organizational research, we elected to take a grounded theory approach to explore this critical phenomenon.

Method

Transparency and Openness Statement

Below, we detail the research design, sample, and analysis plan, including a visual representation of our study's analysis and evolution for added transparency. Given that we took a grounded theory approach, no part of our study was preregistered; due to the sensitive nature of the interview content, raw transcripts of the data are not available. Finally, we followed the methods checklist for best practices surrounding qualitative reporting as detailed by the journal.

Our protocol is in our OSF repository (see Appendix A), along with additional participant quotes (see Appendix B): https://osf.io/d6x9g/?view_only=b68ebd627635499e966e5fbdcc2c7e89.

Research Design

We followed an inductive, qualitative approach based on principles of grounded theory (Corbin & Strauss, 1990; Glaser & Straus, 1967). We first conducted four pilot interviews using an open-ended interview protocol that was developed based on our understanding of PPD and women's health in the workplace, as well as personal experiences that a member of the author team had with being diagnosed with PPD. We revised the protocol as we iterated between our data, emerging themes, and existing research (Charmaz, 2014). Although we followed the basic guidelines of grounded theory, we chose not to be tied to one methodological template that might inhibit our design, data collection, and findings (Pratt et al., 2020). We also drew from multiple sources (e.g., personal experiences with PPD, interviews, practitioner experts who reacted to our model) to triangulate our findings and ensure generalizability in our key themes.

We initiated the project with a general research question: *How do women navigate PPD at work and at home—specifically, how do the symptoms associated with PPD and the treatment that follows contribute to sensemaking processes that affect how women experience work and family?* Prior to conducting our interviews to explore this question, we first engaged in a deep dive into literature that exists in other academic domains that specifically addresses PPD. Much of this existing research resides in the nursing, medical, and clinical psychology literature, which we acquainted ourselves with before developing our interview protocol. A member of the author team also had a personal experience of being diagnosed with PPD and had access to several support groups, which guided our generalized thinking about what kinds of questions would be appropriate and gave us some insights into our participants' experiences. We also read about the

topic in various practical outlets and forums to gain further insights into these experiences.

We developed an initial interview protocol, dividing our questions into four parts about the participant: (1) personal and family history; (2) work history; (3) becoming a mother and PPD diagnosis and treatment; and (4) their experience of PPD and its intersection with work. Before seeking IRB approval, we conducted an initial pilot interview (not included in the findings) to see how the protocol held up and make any changes to our guiding research question and protocol. After obtaining joint IRB approval across the authors' institutions (University of Arizona [with ceded approval from Northeastern University and University of Georgia]; IRB #2104687260: "Understanding Postpartum Depression in the Workplace"), we conducted three more interviews and further adjusted our protocol, merging redundant questions and adding new questions as they related to women's diagnosis, identity, coping, and work-related experiences tied to PPD. A consolidated version of our interview protocol can be found in OSF Appendix A.

Sample and Access

The author team and one research assistant conducted the interviews, each 45-90 minutes in length. Interviews were conducted over Zoom to allow for face-to-face communication to help build rapport, though participants had the autonomy to turn their camera on/off as they preferred. We recruited participants over professional networks (e.g., LinkedIn), blog posts, online support groups geared toward new mothers, and through Ovia Health—an organization that works with pregnant women and new mothers whom we partnered with for this project to help ensure that we had a diverse sample of mothers. Participants were offered a $25 gift card to a retailer of their choice at the conclusion of the interview. All identifying information was removed from the interviews before being transcribed verbatim by a third-party digital transcription service (Temi); the transcripts were then reviewed by another research assistant to ensure accuracy.

Demographic and background information for each of the participants can be found in Table 1. To be eligible, we asked participants to have had a formal diagnosis of PPD within the last five years, be at least 18 years of age, and have worked full-time or part-time in the U.S. at the time of their diagnosis. Most participants (27) worked in a salaried position (one of whom was part-time); the remaining were in hourly positions. Most participants (36) worked full-time hours at the time of the study; five women were working part-time, which was (as detailed below) a choice made in part due to their PPD diagnosis. The average age was 34.8 years (range = 26-45). While the majority of participants were White (30), we sought to gain diversity so that we did not generalize experiences in a way that may not represent all women. Thus, we recruited women who identified as Black (3), Asian (2), Hispanic (5), and Middle Eastern (1); one woman did not self-disclose. Most were married (36), with fewer divorced (3; one woman was married at the time of diagnosis and since divorced), engaged (1), or in a self-described co-parenting family structure (1). Women had an average of 1.85 kids (range = 1-3), three women also had stepchildren (range = 1-2), two women experienced miscarriages or ectopic pregnancies, and one woman had a child who passed away. Sixteen of the women had experienced PPD with more than one child. On average, participants were diagnosed with PPD at around 12 weeks postpartum, and it had been about 3-4 years since participants' most recent PPD experience, with five participants receiving their diagnosis just a few months prior to our interviews.

Finally, during and after the interviews, we sought feedback from four experts who had insights into PPD: a researcher from Ovia Health who helped access participants, an obstetrician, and two founders of a support organization for PPD. The purpose of talking to expert informants throughout our process was to further develop our understanding of PPD, ensure the questions in our protocol were appropriate, and elucidate whether our findings and theoretical model were

clear and resonated with their understanding of how women experience PPD. We spoke to expert informants at two points in time—first, when we were developing our interview protocol; and second, after we had conducted multiple interviews and began developing our theoretical model. These expert informants enabled us to engage in credibility checking (Creswell & Miller, 2000; Lincoln & Guba, 1985), a critically important technique for determining the credibility, transferability, and dependability of conclusions stemming from qualitative research designs.

Analytic Process

A visual depiction of our process as it unfolded in this study is shown in Figure 1. To begin, we analyzed four interview transcripts at a time. After this step, we developed a start list of codes with the most common themes, as well as emergent themes that were of interest. We also refined the interview protocol to further probe into the more common and emergent themes. We then continued the coding process following the same pattern, in which we coded four additional interviews at a time and collectively discussed emergent and recurring themes, at times consolidating and redefining them. We continued this process until no new recurring themes emerged, which occurred after 28 interviews. However, we continued to conduct additional interviews, focusing on diversifying our sample with participants from a broader range of racial backgrounds so that we could compare our participants' experiences and ensure the themes applied across different contexts. After 40 interviews, we reached a point at which we felt confident that no additional codes could be generated based on these comparisons, which we considered to be our point of theoretical saturation. We did, however, complete one additional interview as it was already scheduled; this woman did not recall receiving an official diagnosis, but discussed symptoms of PPD with her medical provider and had similar themes to the other women. As such, we proceeded with the full sample of 41 women that we spoke to.

After all the interviews were conducted, we continued to meet bi-monthly to review and refine our coding and engage with existing literature on identity and sensemaking (e.g., Maitlis, 2009; Petriglieri, 2011; Vough & Caza, 2017), mental health/illness (e.g., Follmer & Jones, 2018), and organizational work-family narratives (e.g., Ladge & Little, 2019; Padavic et al., 2020) to explain the common themes. By revisiting the literature, we could process the coding into higher-order themes. We also began modeling themes based on relationships we saw in the coding. It was at this point we began to glean novel insights indicating that PPD represents what we term an imposing identity that, once validated and treated, can have a positive impact on existing (e.g., work, self) and emerging (e.g., mother) identities. For example, we began to see connections between different aspects of PPD sensemaking that can help bring work and family in and out of focus for women (a crucial implication of an imposing identity occurring for women against their wishes, as we describe in detail below). We also began to see connections surrounding how PPD triggers sensemaking that ultimately led women to establish personal (i.e., individual-level) work-family narratives reflecting a newfound ability to thrive at work and at home, all while prioritizing themselves. This conclusion led us to research on post-traumatic growth (Maitlis, 2009; Williams & Shepherd, 2016) and on loss and restoration orientations associated with traumatic events (e.g., Conroy & O'Leary-Kelly, 2014) and grief (e.g., Stroebe & Schut, 1999), all of which helped to further inform our grounded theoretical model.

Based on these ideas, we began to develop our theoretical model to summarize the key themes, as well as the relationships that linked those themes together. Finally, we conducted "credibility checks" with our identified experts to determine if our model represented the aggregate experiences. We also ran cross-checks across different demographic groups within our study to determine if there were differences in PPD experiences based on distinct backgrounds,

family structures, and workplace dynamics. Although none fundamentally shifted the key themes that emerged for our model, ideas for future research did arise. To further address the reliability of our aggregate themes, we enlisted the help of two independent research assistants who were trained in qualitative analysis. We provided them the codebook, along with transcribed blocks of text from four of what we believed to be our most representative interviews. Using the coding comparison feature in NVivo, they independently coded the data. From this, we calculated an average agreement rate of 80%, with a weighted Cohen's kappa of .74 (Cohen, 1960).

Findings

As shown in Figure 2, we present a theoretical framework in which we delineate how PPD symptoms reached a turning point (i.e., hitting "rock bottom") where women sought help. Although some PPD symptoms began as minor, women eventually experienced a buildup of extreme symptoms and intrusive thoughts. This resulted in a turning point which triggered PPD sensemaking, an interrelated process in which women: (a) recognized that there was a problem violating their expectations of themselves/motherhood—what we term discrepancy recognition; (b) received a diagnosis of having PPD that ultimately served as an imposing identity[7]—an unexpected and undesirable identity that interferes with existing identities (e.g., work) and/or provisional identities (e.g., motherhood); and (c) developed ways to cope with the above discrepancies and diagnosis, partly via formal treatment (i.e., antidepressants, therapy).

Indeed, PPD sensemaking gave way to a second turning point, leading to crucial identity work that better served women's professional and personal goals. Here, identity work—the work

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[7] The majority of women internalized to varying degrees their PPD identity via diagnosis, which facilitated their sensemaking process. To confirm this, we engaged in deviant case analysis, looking for instances where women did not internalize their diagnosis. Although we did not find any instances where women disconfirmed, we found four cases where participants were a bit more matter-of-fact about the diagnosis and did not view it as a major shock; these cases were tied to women having pre-existing histories of mental health/illness challenges, or having other conflicting work-life shock events occurring (e.g., caring for a parent who had a terminal cancer diagnosis). Still, we theorize within our model that women internalized to some degree that having PPD was, in fact, an identity.

associated with constructing, maintaining, or changing identities (e.g., Sveningsson & Alvesson, 2003; Vough et al., 2020)—that stemmed from PPD sensemaking contributed to the creation and/or revision of women's personal work-family narratives. Indeed, PPD as a work-life shock event allowed women to recast who they were as a person, worker, and/or mother, often in ways that went against typical organizationally and societally derived work-family narratives surrounding being constantly available for work (Acker, 1990; Padavic et al., 2020). For many, this involved cross-domain reprioritization (i.e., gaining a clearer understanding of what was important in terms of work, family, and self-care) and cross-domain compassionate responding (i.e., recognizing that a core part of their existence involved self-compassion toward themselves and compassion toward others at work and at home). We provide quotes illustrating each of these themes and the underlying relationships; additional quotes can be found in OSF Appendix B.

Culminating Symptoms of PPD as a First Turning Point: Hitting Rock Bottom

As we reviewed, PPD manifests in emotional, cognitive, physical, and behavioral ways, affecting women's ability to effectively engage with work and family if not diagnosed and treated (American College of Obstetrics and Gynecologists, 2019; Office on Women's Health, 2019). Emotionally, women reported feeling sad, hopeless, and/or overwhelmed, often crying excessively throughout the day. Serena, a public health teacher, described this experience:

> *"I tried to be happy, and I tried to feel what everyone kept telling me I was supposed to be feeling [as a new mother]. But I just didn't. I was miserable. I would go to my office every day and put my head on my desk and cry."*

Cognitively, women reported feeling dissociated from their baby in ways surpassing the typical questioning mothers can have of their ability to be a "good" mother, particularly in light of their work status (Buzzanell et al., 2005; Johnston & Swanson, 2006; Ladge & Little, 2019). Many women reported having intrusive thoughts about hurting themselves or their child—one of the

more severe PPD symptoms (American College of Obstetrics and Gynecologists, 2019). Valeria, a program officer for a grant agency at the time of her diagnosis who was in higher education at the time of her interview, experienced the deeply painful manifestations of this PPD symptom:

> *"I still remember vividly telling my daughter bye, because I had plans [to harm myself]."*

Beyond the emotional and cognitive symptoms, physically women reported sleep issues. For some, this involved needing to sleep constantly; for others, there were experiences of postpartum insomnia on top of the night-wakings that were already occurring with the baby. Women also reported a number of psychosomatic complaints (e.g., headaches, general aches, gastrointestinal problems) and lack of appetite. Finally, behaviorally, women reported avoiding activities they once enjoyed or found themselves withdrawing from family and friends. Daphne, an early childhood teacher, described such physical and behavioral challenges with PPD:

> *"I felt like something was sitting on my chest all the time and I couldn't take a deep breath. I would hyperventilate over [little things]. Like I couldn't find my car keys, not that I was going anywhere. . . I was so worried that my youngest was going to stop breathing. And I couldn't move on from that. I didn't want to even go outside."*

Importantly, all women described various combinations of these symptoms, resulting in feeling that they hit an all-encompassing "rock bottom"—the first turning point for women's PPD sensemaking. More specifically, prior to an official PPD diagnosis, women's symptoms often culminated in a very negative experience—or set of negative experiences—that led them to feel as though they were hitting rock bottom. Often, this included statements that reflected intrusive thinking, where women began to ask themselves questions such as: "What is wrong with me? Is my experience 'normal'? Would the world be better off without me?" For most women, hitting rock bottom included destructive or suicidal thoughts interfering with all aspects of their lives. Such feelings are described below by Haley (who worked in students affairs in higher education) and Felice (who was a mechanical engineer), respectively:

> *"I was having a really hard time… having really scary, bad thoughts. I really hate guns, and all I could think about was, 'If I could go to Cabela's and buy a gun…'. [It] was really frightening because I know I wouldn't even touch a gun [previously]. So lucky for me, I feel like I have a lot of agency, and my husband's a psychologist, so I'm aware that that's not normal. That's something I probably need some help for. I should not be embarrassed about asking for help there. I feel kind of embarrassed about it now."*

> *"The biggest symptoms I had were the self-harm thoughts, and then the ultimate thought of these kids would be better off without me in their lives. I kind of think it was at rock bottom where I was like, 'I'm on the verge of losing my husband. I am on the verge of like shaking up my kids' lives.' I was like, 'I have to fix this. This has to be fixed.'"*

Some women during this time also recognized that they did not feel like themselves—what many women described as not feeling "normal"—and experienced an overwhelming sense of sadness, isolation, and panic. As Jessica, a first-grade teacher, explained:

> *"It was a lot of tears—a lot of panic about really strange things. I was absolutely convinced my child was going to die. I thought she was going to like fall off the bed, or I would fall asleep with her in my arms, and I would crush her… I thought I was going to have a psychotic break… It was a lot of being very worried about very specific things. I didn't like being touched. I didn't like being hugged. And a lot of it had to do with the lack of sleep, but I mean, a lot of it was also hormonal, I believe as well."*

Ultimately, any one symptom or combination of these symptoms associated with PPD (albeit pre-diagnosis) resulted in a catalyzing event that contributed to women *recognizing that something is wrong* (i.e., intrusive thinking) and *seeking help* (i.e., treatment and diagnosis), all of which comprised the beginnings of women's PPD sensemaking. This phase marked the first turning point for women on their journey with PPD in an attempt to shift what was a very negative experience (i.e., having PPD and its associated symptoms) into one that would allow them to move forward in their personal and professional lives. Catalyzing events represented a wide variety of experiences, ranging from a routine doctor's appointment where symptoms were assessed (e.g., using the Edinburgh Postnatal Depression Scale; Cox et al., 1987), comments from family members or friends encouraging them to get help, and/or an extreme incident linked with their symptoms (e.g., disturbing and/or suicidal cognitions). Shannon, a researcher

coordinator at a children's hospital, described this catalyzing process:

> *"I got hit with [thoughts] like, I don't want to kill myself, but I would much rather not be here. Like it would be okay if I died, I don't want a hand in it. I don't want to do it, but if I was dead, it'd be all right. My husband would survive. My kid would survive. Everything would be fine. And then [my husband] was like, 'Why don't we call the doctor?'"*

Discrepancy Recognition as PPD Sensemaking Initiates

Hitting rock bottom initiated a complex, nonlinear sensemaking process that began with most women recognizing that there was a discrepancy between how they thought motherhood would be and what they were actually experiencing—what we term *discrepancy recognition*. Specifically, hitting rock bottom amplified women's intrusive thinking regarding their unsettling thoughts and feelings about motherhood and their identity as a mother broadly (e.g., "Why am I not measuring up? What's wrong with me?"). It is important to note that some level of unsettling thinking or uncertainty is common for working women during pregnancy, maternity leave, and reentry (Greenberg & Ladge, 2019; Ladge et al., 2012; Ladge & Greenberg, 2015). However, the intrusive thinking experienced by women here was focused on questioning the legitimacy of their symptoms, feelings, and behaviors. Often, these thoughts were happening in the buildup to the formal diagnosis, with women asking themselves if what they were experiencing was "normal" (i.e., common thoughts for new mothers) or whether their symptoms indicated the existence of a more significant issue (i.e., having PPD). This experience was described by Chelsea, a high school teacher who ran the gifted and talented program at her school:

> *"I just exploded at the children about something and [my husband] was like, 'you're being way too hard on them.' And I said, 'look,' I said, 'I just think it's postpartum depression. The rage piece of it is not me. It's not how I normally act.' And so, he was like, 'well, I don't know, just call your doctor.' So, I guess for me that was that point, that low point, like, I don't like how I'm reacting to my kids, to my husband. He's noticing there's a problem. So obviously something's, you know, not right."*

Indeed, the women we spoke to tried to understand what they were feeling and thinking,

ultimately coming to terms with the fact that something was not right and that they required help. There were also some cases, however, where women assumed that their "rock bottom" was just their new normal, with others (e.g., family members) noticing the discrepancy and encouraging them to seek help and treatment (e.g., Shannon's husband in the quote above). Regardless of how it occurred, discrepancy recognition at this stage of sensemaking revolved around two central themes that we explain as *identity dissonance* and their felt *weight of responsibility*. *Identity dissonance* included overwhelming thoughts that created a "pile-on effect" due to the high level of uncertainty women were already feeling as a mother and a worker. Women expressed feeling as though they were not meeting expectations of motherhood, work, and other identities as a function of hitting "rock bottom." While having doubts about oneself as a working mother often occurs for women postpartum—especially new mothers as they create their new working mother identity (Ladge et al., 2012)—the experiences of women with PPD differed and were far more extreme in nature. Specifically, the women acknowledged that the symptoms they were experiencing were incompatible with ideal worker and motherhood norms. Particularly as it related to women's family lives, there was an acknowledgment that how they were feeling (i.e., extreme levels of depression) was misaligned with societal expectations of how they should be feeling with their new baby (i.e., joyful). Illustrating this tension triggered by these symptoms is Mona, an ultrasound technician, who described her feelings associated with identity dissonance when she started to transition back to work after having her baby while also having PPD:

> *"One of the hardest parts of the whole thing was having to go back to work and having to navigate still having these feelings and these emotions and feeling unstable, but having to put on a happy face for your patients and not let [others at work] know what's going on."*

At the same time, women expressed the *weight of responsibility* they were feeling in this part of their PPD sensemaking. This stemmed not only from being responsible for a new life but

also from hitting their personal rock bottom. Many, like Jessica below, described catastrophizing basic activities and recurring fears of inevitable doom associated with their child's health, with Jessica in particular noting that she was trying to seek relief from her own personally felt weight of responsibility by avoiding being home altogether and seeking solace in her work:

> *"I was so afraid that I was going to accidentally hurt my child or like let her roll over in her sleep or something that I was so thankful to go to work because I felt like, okay, if my child dies, that's not my fault. Like, you know, this inevitable looming, my child's not going to make it to, you know, four months or whatever, for whatever reason."*

PPD Identity: An Imposing Identity

Identity dissonance associated with discrepancy recognition helped lead women to diagnosis and treatment, though we recognize that this process was not always linear (i.e., multiple events tied to hitting rock bottom may have occurred before diagnosis). The diagnosis represented a critical part of women's sensemaking, as it gave them common language to explain the discrepancies they were experiencing and automatically gave them a *PPD identity*, if only in name at first. All women discussed how being diagnosed with PPD gave them a name for their symptoms and placed them into a category of mothers with PPD, affirming this newfound identity (Leisha: "I won't say it felt good because I hated being diagnosed with [PPD], but I mean… I know it is what it is."). As women discussed their PPD identity, they emphasized its unexpected, undesirable, and all-encompassing nature that imposed upon existing (e.g., work) and/or provisional (e.g., mother, working mother) identities. Kara, a postdoctoral fellow in the humanities, explained across two stories how her PPD identity interacted with both her emerging identity as a mother, her preexisting professional identity, and her overall sense of self:

> *"I mean—this sounds cliché—it's brought a certain softness to me [in my job]. I think that it's, it's changed the way that I'll do some things."*

> *"[Having PPD] was not something that people talked about and it just totally stripped my sense of who I was because I was like, I'm a happy person. And if I'm depressed, I can't be a happy person which now I get is like, nope, false… you can be a very happy*

person and also deal with depression."

As such, we termed the PPD identity as an *imposing identity* due to its interconnectedness and influence on existing (i.e., work, self) and emerging (i.e., mother) identities, as can be seen in the quotes above about how Kara made sense of how PPD imposed upon all aspects of herself. Although the PPD identity and its imposing nature may shift and evolve in terms of its effects, the initial onset of the identity occurred around the diagnosis, which enabled women to name their struggle and make sense of how it was impacting them. Their newly imposed PPD identity stemming from this work-life shock event (Crawford et al., 2019) shaped both the sensemaking process and the identity work that followed as women overcame elements of their diagnosis.

Having a PPD identity, or imposing identity, contributed to two paradoxical feelings for women—*validation* and *stigma*. *Validation* included statements that legitimized their experiences (i.e., their symptoms were "real"), highlighting that the symptoms tied to hitting rock bottom were not their "new normal," nor common in motherhood. As Chelsea explained:

> *"For me, I think it was just [the] acknowledgment that… I'm not a bad mom with my temper, that [my behavior] is controlled somewhat by hormones."*

Beyond the recognition that symptoms were real, Valeria also talked about how being diagnosed by her therapist allowed her to recognize that she was not selfish, nor was she someone who could harm her children. Rather, it allowed her to acknowledge that what she was experiencing was something life-threatening that needed to be treated to help her and enable her to feel better:

> *"To have my therapist [who is] a medical provider legitimize [my symptoms], it just made me feel like this was real, and that I'm not a horrible person. This is just something that happens, and I need to get help because something bad could happen to me."*

Further, women also described the validation from their diagnosis as "freeing" in that it allowed them to move forward with their lives as they so desired. Celeste, a postdoctoral fellow working in neuroscience, recalled the following exchange she had with her child's pediatrician:

> *"One of the things that my diagnosis helped me [with] was I can feel less judged by myself. For instance, my child's pediatrician told me, 'You can go back to work. It's fine to have a career. Go back if that makes you happy.' And then I started to go back…."*

Although being diagnosed with PPD offered women much-needed validation, women still internalized *stigma* attached to their new PPD identity. Rosalind, who worked part-time as a high school teacher when diagnosed, recognized the stigma of her diagnosis.

> *"There's this idea [if you have PPD] that you're going to shoot [someone at] school or drown your children. You know—[it's] a stigma."*

However, as is clear in the previous quote from Celeste (i.e., "less judged by myself"), the women seemed to focus on stigma related to their own personal negative feelings about their PPD diagnosis (e.g., embarrassment, shame, fear), rather than external image management of this stigma (Mickelson et al., 2017). Stated differently, women perceived their own stigma, without being focused on managing the image others had of them (e.g., Little et al., 2015). Georgette, for instance, described her sensemaking around perceptions of PPD and the stigma she personally felt and was processing, noting the following experience with her sister-in-law:

> *"It was a shock [having PPD]. I told my sister-in-law. She was like, 'I mean, most people go through it. It's nothing to feel like you're stigmatized about.'"*

Interestingly, the stigma women internalized and felt was slightly different for women who had PPD across multiple births. Adina, who worked as a manager at a not-for-profit organization, described the stigma she felt tied to PPD during her first diagnosis compared to her second. Within her story, she highlighted that she struggled with accepting the first diagnosis because of the inherent stigma she thought it carried, based on her own perceptions of PPD. With the second diagnosis, she was able to give herself grace and more immediately get the help she needed:

> *"[The] first time [I was diagnosed with PPD], I was surprised just because I was thinking, 'Why would I have this?' It's the stigma behind it. I was just kind of in denial about it. But then the second time, I was just like, 'You know, this is a real thing. I'm not the only person that's experienced this, and this is completely normal, but it happens to women.' I was able to get help sooner, and I wasn't as surprised. And I just kind of knew*

that I needed to take steps to get the help that I needed."

Coping as a Means to Find a "Way Out"

The treatment that followed diagnosis set off a *coping* process that allowed the women to find a "way out" and successfully move forward with their work and family lives—an important starting point for managing their imposed identity and engaging in effective identity work. Drawing from literature on how people cope with and respond to trauma and identity loss, two coping orientations emerged as a function of the women's PPD identity and the sensemaking process: loss and restoration (Stroebe & Schut, 1999; Stroebe & Schut, 2010). *Loss orientation* involves "the concentration on, appraising and processing of some aspect of the loss experience itself" (Stroebe & Schut, 1999, p. 277). Here, loss orientation involved women processing the loss of their previous lives (e.g., identity as a person, professional, and/or spouse) and the loss of not having "ideal" motherhood experiences. Kelsey, who worked in communications, expressed how much she loved her children yet struggled to accept the loss of her former self:

> *"I love them [my kids]. I told my husband the other day, I kind of, I miss the person I was before I had kids. And I told him that it kind of makes me feel really crappy to say out loud. There are still like certain days that I really miss her."*

Similarly, Kara processed her losses related to her diagnosis and personal challenges she had in her family after diagnosis—namely, divorcing her partner and becoming a single mother. Kara described needing to "let go" of the unrealistic idea that she could overcome any challenge, including those from PPD and the symptoms that followed, with hard work:

> *"I did not anticipate how [having a child and PPD] would change myself and my sense of self. I feel like this might happen to women who have achieved a lot, either in their careers or their education, or maybe that doesn't even have to be the case, but it was one of the first things I had ever done in my life that I couldn't make better by working harder or like reading more. I could have read every book under the sun, but that wasn't going to make me better versed in being a mother. I could have pulled all-nighters, which I did. But that didn't accomplish any more. It was this really strange position."*

Further, for a subset of women, part of their sensemaking around the losses associated

with PPD focused on how they never wanted to be a mother. Given that PPD is happening at a time when women are expected to be joyful, such feelings likely further the sense of loss that women experience if they did not always see themselves as mothers. As noted by Celeste:

> *"I never wanted to have children. It was not on my to-do list in my life. I don't want to have that identity. So later when he was born, and I went to say, 'I love my child. He's great. He's fantastic. But I wish I was not the mother.' And that is how I feel about it."*

Restoration orientation, on the other hand, involves shifting focus away from losses and instead focusing on handling the "secondary stressors that accompany the loss" and "how to function in a changed world" (Conroy & O'Leary-Kelly, 2014, p. 69; see also, Stroebe & Schut, 1999, 2010). In our study, restoration orientation was exemplified with statements that implied a disconnect from the losses associated with PPD in favor of engaging in the new world they were now a part of—namely, being a working mother with PPD. For many women, this included immersion in work and/or taking on significant work assignments or goals to offset the experiences of PPD. One example of a woman reflecting a restorative orientation in her interview was Jocelyn. Jocelyn pursued a master's degree after her diagnosis and was back in her role as a teacher at the time of her interview. She described how her return to work aided her:

> *"Being back in a routine made it a lot easier for me. [It] made things more manageable for me. I don't know that it made the symptoms any better, but it made it easier to get through the day when it was like, you know, the bell's going to ring at these exact times, and this is when lunch is going to happen. I don't know that it helped with the symptoms, but it made kind of all the stuff that the symptoms cause a little bit easier to deal with."*

Jocelyn went on to note that being at work helped because it initiated structure in her day and helped her emotionally escape from the struggles she still had at home:

> *"When I was at work, I felt like I was really good at this, and it was something that I could handle, and it was something that I felt really capable of. And then I'd come home, and I had two [children] under two [years of age], and one was a newborn. It was just hard, and it was much more difficult. And then I was dealing with, you know, depression and anxiety on top of that."*

Sophia, a dentist, also described the importance of reengaging with her work role as part of her restoration orientation in coping with PPD, highlighting the helpfulness of her work routines:

> *"I don't know if I'm weird, or if [it's] a common thing, but it was really helpful to be able to go back to work to relieve the postpartum symptoms that I was having and to also feel that love and support from my coworkers and my friends… it just made life a little bit more normal."*

Beyond these examples of restoration, other women engaged in specific coping and recovery activities, such as practicing mindfulness, making sure they were exercising, limiting work emails during nonwork hours, and pushing back on work demands. These restoration activities were vital in helping them cope and reduce the impact of negative thoughts. Audrey was able to succinctly explain the value of these types of activities to us:

> *"Meditation and that sort of mindfulness stuff was huge for me because so much of my problem was just racing, racing, intrusive thoughts."*

Importantly, these coping practices were tightly coupled with another important element of restoration orientation: treatment. Receiving treatment was important for having a restoration orientation, as it was instrumental in helping women to learn about and lean into self-care practices—including rest, recovery, and relaxation—while simultaneously relieving the burden of feeling they needed to "do it all." Tara, a service sales coordinator, stated the following:

> *"[I realized that] I did need to reach out and get help and get on antidepressants and whatnot to balance things out, and I kind of focused on trying to do better self-care and taking that kind of time for myself so that I wasn't running on fumes all the time."*

Similarly, Haley, an assistant director of academic services, described her treatment process as a core aspect of developing and experiencing a restoration orientation, explaining:

> "*Zoloft was helpful, especially in the hormone equalizing time, but I felt like the talk therapy was much more effective for me. The ability to say, 'This is what's going on. This is what I feel like. Let's talk about some skills that I can do, [or] some coping mechanisms that I can do. Let me talk about what the issues are below these things, especially the obsessive part and the intrusive thoughts, what's driving [them], [and] what's making me feel that way. And what can I tell myself, what can I do with myself to*

> *not feel that way?' I think once I did the talk therapy and I really talked about what the underlying issues were there, I think that helped me a lot. I think the general, like breaking of perfectionism in me is, is something that's been very positive."*

As a critical caveat: loss and restoration orientations were not either/or experiences. Rather, women reported experiencing both as they engaged in PPD sensemaking. Indeed, the dynamic shift between loss-oriented coping, or dealing with the symptoms of PPD, and restorative-oriented coping, which focused on attending to the new realities of being a working mother with PPD, appeared to be central to how the women coped with different elements of PPD at different times. We can see this exemplified in the ultimate outcomes of our model.

A Second Turning Point: Identity Work Shaping Personal Work-Family Narratives

These interrelated PPD sensemaking processes gave way to a second turning point that we classified as identity work (Sveningsson & Alvesson, 2003). Here, women worked through changing and reconstructing their preexisting (i.e., worker) and newly developed (i.e., mother) identities as a function of the lessons learned from their PPD identity. We found this to be a fundamental characteristic of PPD as an imposing identity and an important area of resource investment for the women—because of its imposing nature, women were forced to make sense of their PPD identity and, ultimately, integrate it with other identities. Interestingly, we found that women almost exclusively discussed how they made sense of their own internal identity, rather than focusing on managing their image or externally oriented public persona (Roberts, 2005). This resulted in the crafting of personal—as opposed to organizational—work-family narratives that best served their professional and personal goals. We define personal work-family narratives as stories working mothers told themselves about their commitment to work and personal identities that had the potential to deviate from organizational or societal expectations.

In defining personal work-family narratives, we extend prior research that has defined

work-family narratives as an organizational culture-based narrative about what it means to be successful: "the job requires long hours and women's family commitments (but not men's) conflict with these time demands" (Padavic et al., 2020, p. 62). This also counters broader societal expectations about constantly being available for work (Acker, 1990). In contrast, as women developed personal work-family narratives, they identified what they believed it meant to be successful. Further, although these self-defined personal work-family narratives developed in light of societal norms about what is expected in order to be an ideal worker and parent, they are focused on personal needs and goals as opposed to societally driven narratives that working mothers feel compelled to live up to (Padavic et al., 2020; Thomason, 2022). We found these personal work-family narratives centered on two identity themes: (1) the prioritization of one's self, work, and family identities, and (2) the importance of compassionate responding to themselves and others. We label these as cross-domain narratives due to the identity blending that occurs as a result of holding an imposing identity that shapes other identities across domains.

Cross-Domain Prioritization of One's Self, Work, and Family Identities

PPD sensemaking led women to prioritize themselves and their relationships, clarifying their own narratives associated with their work and family identities. In terms of *cross-domain prioritization*, many women explained how having PPD led them to consider what was important to them in each domain, rather than relying on societal norms. This often meant putting their own self before their work and family so that they could focus on their mental health and well-being. Dana, an active-duty member of the U.S. military, described the following example:

> *"[The] bright side is I'm starting to realize my limits, and I've learned to start establishing more boundaries. Telling [people at work] 'no' has honestly made things a lot better for me because I've noticed that I used to always take a lot on that they would give me, and they only added more because I wasn't speaking up for myself. I wasn't establishing any boundaries."*

Working mothers often contend with societal expectations that make them feel guilty for putting their own needs before those of their family or work (e.g., Sanzari et al., 2021). Interestingly, the sensemaking tied to PPD made women realize that they could not be effective as a parent or as a professional if they did not take proper care of themselves, which offset any guilt that they felt.

Other participants explained how they had discovered better versions of their work selves while managing their PPD through diagnosis and treatment by engaging in more meaningful work, changing jobs or even industries. Chloe, who worked in higher education while having PPD symptoms but had since launched a private coaching business, shared the following:

> *"I think the bright side [of having PPD is] I'm at peace. I'm happy. I'm functioning at the best way that I want to show up and like the best version of myself… I went through it, but I really worked on like so many parts of myself to get out of fight-or-flight mode."*

In addition to prioritizing themselves, women also *prioritized their relationships* with their spouses, children, and friends in an effort to spend more quality time with them. Adina, a manager at an educational not-for-profit, talked about balancing time between work and family:

> *"I've just been very transparent. Normally I'm just like 'yes, yes, yes. I can take this on. I can do this…'. I've just been able to set more boundaries this time and not really say yes to everything, because I've realized that I need to kind of prioritize my time between my family and work, [and put] family over work."*

Prioritizing relationships with their child(ren) was particularly relevant to the women we studied, as PPD had often been initiated by feeling disconnected. Sophia, a dentist, explained:

> *"The high point [from having PPD] is that I feel connected to my kids, and I feel more present with them and feel like they are connected, like we're connected with each other. It was really hard to connect with the second one when all that other stuff [tied to having PPD] was going on. It took a long time, but that's probably the high point is that I do feel very connected to them and feel like we have a good relationship."*

Finally, as noted in some of the quotes above, prioritizing oneself and one's relationships often meant work needed reprioritization. For some, this meant leaning into their job and the sense of purpose it gave; for others, it meant scaling back or finding more meaningful work (as

noted above) and/or a workplace that was more flexible or supportive. Several women discussed job changes that led to a better work environment or a career that better fit their new career goals and aspirations. Indeed, women were prompted to change jobs or fields, move companies, or shift their work hours. For example, Serena changed positions to facilitate reprioritization of work and allow for more flexibility, which the job she had at the time of her diagnosis lacked:

> *"I changed professions to be able to accommodate being more with my family. And I have put my foot down in ways that I never would have before. Meaning no, I can't be at that meeting. No, I won't answer those emails after 5:00. No, I won't work on the weekends, like in a way that I never would have if I hadn't gone through that experience, because like I said before, like I just understand now that I have to prioritize my well-being because I cannot parent if I'm not well, and I can't be a good working professional if I'm not well."*

For others, reprioritizing meant an increased commitment to work or a simple shift in their thinking about their work relative to their other identities. Kara described some of the processing she went through in trying to sort out what her career goals would be after having PPD:

> *"When you deal with something like postpartum depression or any mental illness or any physical illness, it has to put some things into perspective. [Having PPD] allowed me to think about what like a successful career would be for me. And what it's like to be a successful parent or mother. And I realized that I look now at the things that I love about academics, about what I've studied. I love research. I really, really love teaching. Could I do that on a lecture track or academic track? Absolutely. But are there other ways in which I could do that? Yeah. I could be in a museum world that could [involve] doing policy work… it's allowed me to be more flexible and gentler with myself to [say], 'There are various versions of what success will look like and what a good career will look like, just like there are different versions of what a good parent looks like or a good mother.'"*

Karoline, who held a director role in an admissions office for a university, described how she was able to think more clearly and creatively about her work since having and coping with PPD:

> *"I really appreciate much more of my work, and I am much more excited, and I'm much more creative, and I really want to go for the big prize. I really am very engaged in what I'm doing. And I really have these new perspectives of how much I can do and what I really want to do. I'm feeling that society's trying to stop me, and I say, 'no, I'm going to.' That's how I reacted to [having kids and PPD]. It's helping me."*

The Importance of Compassionate Responding to Oneself and Others

We also found several instances where women emphasized the importance of responding to themselves and others with greater compassion. This stemmed from the imposing nature of their PPD identity, in that the women identified strongly with being compassionate individuals moving forward. Starting with the women themselves, crafting new personal work-family narratives involved stories regarding greater self-compassion, which meant the women reported instances of cutting themselves some slack and giving themselves grace. Melinda, who worked part-time as a cashier and customer service representative for a major U.S. retailer, explained:

> *"I kind of just thought I used to be messed up in the head and heart. But [having PPD] is real, and it's chemical, and it's not my fault, and there are ways to get help and to help myself. I'm just trying to learn those ways. And I think that it's really healthy to learn healthy, positive habits. And I am thankful for that because otherwise… I would still be spiraling downward. But that's helpful to know and helpful to talk about it."*

Melinda then directly began commenting on how self-compassion turned into compassion for others—in this case, for friends who may also have mental health struggles associated with PPD:

> *"I'm happy to talk to other people about [having PPD]. I have friends who probably really, really, really need help… I'm not afraid to tell them about my experiences and hope that they work to get help for themselves."*

Angelica, who held an hourly office job at a concrete company, also described how she was able to give herself more grace and how this spilled into her compassionate responding to others:

> *"I felt better equipped, and I didn't feel as down on myself after coming to terms with [having PPD] when I would feel like I was a failure as a mother. I had an easier time redirecting my mind…And we talked through some of the girls at work, and they had all dealt with it when their kids were young. [We] kind of normalized it."*

Continuing with compassion at work, women described exhibiting compassion toward their coworkers' personal challenges and struggles. More specifically, they expressed greater empathy and gave grace to others—and not just about mental health challenges. Valeria gave us the following example of how she was able to be more compassionate toward others at work:

> *"I think I'm much more compassionate. I don't think it's just that I'm a mom. I think it's*

that I was a mom who struggled with becoming a mom [because of PPD]. It makes me a lot more compassionate to other parents, both not only when they give birth or right after birth, and they have newborns, but just overall. I'm aware that I always thought that I would be the person who bounced back, that, unless you knew me at work, you would never know that I was a parent because I was working as hard. I was doing all the hours. I was staying late, coming early, and [now I'm] realizing that that's just completely bullshit and unfair, that we as women shouldn't have to tough it out."

Importantly, the compassionate displays were not just toward coworkers but toward clients as well. Maryam, who worked as a compliance consultant, described the following experience:

"I had postpartum depression, and everyone commented on my weight loss or breastfeeding and all that. And it's just made me more aware of boundaries in the workplace, not just about women, but men too. Part of my job is social in the sense that I'm consulting with clients, and to consult with clients and be seen as a trusted advisor, you have to create relationships. I've become more aware of how to create relationships with clients without being intrusive because now I'm aware that sometimes people are going through things, and they don't want to talk about it."

Like Angelica and Valeria above, many women also talked about a desire to help support other women who were struggling with motherhood or PPD as they transitioned back to work. Kay, who transitioned to a healthcare startup partly motivated by her own experiences with PPD and mental health, described becoming a resource for new moms in her company, whereas Haley actually detailed an instance of supporting someone she previously had a conflict with:

"There's a few new moms here that just joined us, and so it's super exciting. So many babies. But, having those open dialogues with them [about PPD], and just being a friend to them… We basically don't have HR, so there's no one to go talk to if you don't have support in the workplace. Not to put myself in more work, but… it impacts me because I feel so connected to it. I have to be the one to do it if no one else is going to."

"I had somebody at work who I butted heads with a lot before I had a baby—like, a lot. I really didn't like her very much, and she got on my nerves a lot. She told me when I was a few weeks postpartum that she was pregnant… She had some abnormal findings… and so her son… he was born with like a lot of delays… and had a really complicated medical history. I was like a lot more open to talking to her and being more personal with her and letting our work stuff [stay] off to the side and trying to understand her as a person."

Finally, in responding compassionately to themselves and to others, working mothers with PPD also spoke of the importance of supporting mothers in the workplace broadly (versus

the direct one-to-one support that Haley, for example, provided to her coworker as detailed above). Adina noted that while she did not feel comfortable disclosing her PPD diagnosis at work, she did feel comfortable vocalizing the support she (and other working mothers) needed:

> *"…I even, you know, try to normalize a lot of things… for example, like I'm a pumping mom… I need to pump two to three times a day while I'm in the office. And I need this space and just, you know, over-communicating about things that are considered like normal to moms. But like a lot of people in workspaces, they're not really aware of like these different needs of a parent. I'm being really intentional, so [when] the next mom that works in our office that comes along, it won't be as weird for them, to look for something as simple as a space to pump or even trying to find time to pump. [I'm] trying to, I guess, lay the groundwork for future moms."*

How Nonwork and Workplace Supports Shape PPD Sensemaking and Overall Experiences

Women's experiences with PPD unfolded as a function of the broader social context they were a part of. Much has been written about the ability of social supports to buffer the impact of psychological stress on various outcomes at work (Adams et al., 1996; Colbert et al., 2016; Jones et al., 2022), and evidence of their influence was found here as well. The women we spoke to perceived instrumental and emotional social supports at home (e.g., partners, parents, other family members, friends, online support networks) and work (e.g., coworkers, supervisors, HR). Instrumental supports involved tangible help, information, and assistance (Barerra, 1986), while emotional supports involved receiving empathy and acts signaling caring (Wills & Shinar, 2000).

Notably, women spoke of supports they received (e.g., "I have a super supportive partner, super supportive family") and lack of supports (e.g., "I didn't have much in the way of support"). But they also spoke of more insidious behaviors that went beyond the absence of helping and instead actively harmed the women. We label these *antisupports*—ranging from lacking empathy to hostile/aggressive language in response to a women's PPD diagnosis or treatment, ultimately discrediting women's struggles. As we detail below, antisupports took slightly different forms in nonwork and work domains; outside of work, they primarily delegitimized the diagnosis or

impeded the treatment directly, while at work they involved career-related undermining.

Perceptions of Nonwork Supports

Instrumental nonwork supports were practical and included helping with nonwork roles such as caring for children or taking care of housework. These supports had the goal of helping women to focus on themselves and their mental health, encouraging the sensemaking process that was unfolding as women navigated PPD and motherhood. As an example, Adina said:

> *"[My family members] were really helpful, just being able to take my daughter from me sometimes and give me time to reconnect to the person that I was before I had a child."*

Sometimes these instrumental supports were more specific to PPD. For example, many women told stories of family members or friends who had insight or experience with mental health issues and were able to help encourage women in our study to find the care they needed. As Haley noted, she was grateful that her husband was knowledgeable about mental health:

> *"With my husband being a psychologist, I was lucky that he knew somebody who knew somebody that was a PPD psychologist, basically, who only sees people with postpartum mood disorders."*

Emotional nonwork supports were empathetic and helped women process and cope with their PPD more effectively, as they were able to find others who had "been in their shoes." In most cases, these supports hastened the sensemaking process, benefiting women. As is the case with Dana, many felt their families' support stemmed from having similar experiences associated with mental health, while some, like Clarissa, were grateful for friends who normalized PPD:

> *"[My mom] manages her depression. My grandma managed hers. My mom made a joke that like all of the teachers were on anxiety meds and depression meds to get through [it]… they've always been supportive."*

> *"I talked to a lot of friends who were very affirming. They're like, 'yes, this is normal [struggling with motherhood and PPD]. You're going to be great.' Like a lot of affirmations and supports."*

Women spoke of lack of supports as well, sometimes in a way that reflected their reality

(i.e., not having friends with kids). In these cases, the women did not disclose to family or friends because they anticipated a lack of supports. For example, Serena said:

> *"We had friends, but none of them were married or had kids or anything. They just really didn't understand. It was just like a very like young, singles, go-to-the-bar-and-drink sort of group of people."*

Importantly, lack of nonwork supports seemed to impede women's PPD sensemaking, reducing the speed at which experiencing PPD symptoms led to their diagnosis or treatment. However, antisupports were more damaging—and shockingly common. In their nonwork lives, these included minimizing the symptoms and diagnoses and suggesting that the women should carry on as normal. These acts often stemmed from family members questioning the legitimacy of their symptoms, "not liking medications," and not "believ[ing] in mental health." Antisupports made it more difficult for women to manage their intrusive thoughts and get help. An example of antisupports comes from Tess, who worked in social work and hospice care:

> *"Some family members were way more supportive than others. Some were supportive initially, but then, oh, you know, after a month [would have a] 'Why the hell aren't you getting better?' kind of attitude. You know you have to, you have to deal with this [form of antisupports]. And it was disempowering."*

Another example comes from Serena, whose sister stopped talking to her after she disclosed her PPD diagnosis because her sister she thought she made it up. Serena explains that this antisupportive behavior marked an important turning point in their relationship:

> *"Just realizing that she was capable of thinking that I would intentionally hurt her, rather than that I was sick, even though so many people told her I was sick and that I couldn't function. That was very damaging. And I mean, this is probably the biggest relationship that's changed, but also with my mother-in-law. Her lack of understanding in all of it was also really challenging and put a huge strain on our relationship to the point that I literally haven't talked to her in a year."*

While antisupports impeded initial PPD sensemaking, they also hastened and—in some ways—positively shaped the reprioritization process, as these behaviors often motivated women

to prioritize their personal goals and relationships. Chloe's experience led her to change careers:

> *"I felt like there was all of this boiling stuff inside me that wasn't being expressed and was stagnant in my job. And it was sort of like a dead end, but I wasn't really supported, and I wasn't, like, growing… I felt like I wanted to still have an impact and purpose… I really, like, I was in sort of like a counseling role, but that was how it led me into life coaching. And I felt like with my experiences that I feel like are so relevant to what working women face on all sorts of spectrum. I mean, full-time working women, whether they say it or not, it's a very difficult road with young kids just with all the parts of your life. So I felt like I wanted a way to help women through that. I feel more aligned with like what I'm doing because it has an impact now."*

Perceptions of Workplace Supports

At work, instrumental supports came in formal policies, including the availability of paid maternity leave, flexibility (e.g., reduced work hours, flextime), support groups, or other work-family benefits. Instrumental supports could also be company-wide policies aimed at helping pregnant women, new mothers, or employees with mental health challenges—something crucial for women with PPD. For example, Julia's employer (a major restaurant chain in the U.S.—her role was in social programs for the company) focused on mental health and flexibility. She described how her company could expand this to further support working mothers (something we explore in more detail in our practical implications below):

> *"My company has mental health benefits. They also give people a maternity leave packet. And I think that they need to in that packet include the mental health benefits or benefit services. And then a transition plan, like a formal one, because not everyone's as fortunate as I am to have a boss who just asked me when I'm coming back and what days I'm going to be there… I appreciated [that flexibility from my boss] very much because if she went and took a job somewhere else, that's not guaranteed."*

Instrumental work supports could also be practices directed by one's supervisor, as was the case with Haley, whose immediate boss was also a working mother:

> *"So my employer is extremely flexible. My boss is a mom. My boss's boss is a mom, so they're understanding. They, you know, they care a lot about what's going on with me. And they're very much in support of, you know, if I need to go do something during the day and I want to work at night. Sometimes if my work is done and I don't feel like I need to put [in] seven and a half hours and I've got something else to do, then, they're pretty*

good about recognizing that and being flexible with it, which is wonderful."

The women in our study also spoke of emotional work supports. Like emotional nonwork supports, these included behaviors which conveyed love and affection, of which the women were sorely in need. These supports helped to make them feel as if their organization cared about them and the struggles they were experiencing. As Sophia described to us in her interview:

> *"It was really helpful to be able to go back to work to relieve the postpartum symptoms that I was having and to also feel that love and support from my coworkers and my friends… it just made life a little bit more normal. I don't know how women who are stay-at-home moms go through this. I don't know how they survive it because I don't know that I would have if that was me… I had my little team of supports and love and normalcy and it, it really made a huge difference."*

Kelsey also talked about how her coworkers responded to the challenges she was experiencing with PPD with compassion and prayer:

> *"They'll pray for me. They'll ask me how I'm doing... There's a group of women that send each other confidential prayers. They pray for the group and provide meals… it was good, a lot of support… they'll ask you if you want more people to know or not. But I felt supported, and I know that in my previous corporate job, it probably would have been a million times different, but here [it] was nice."*

Instrumental and emotional work supports were well received and greatly helped women, and, like nonwork supports, they were influential in the sensemaking process. When organizations were open and understanding, women were better able to prioritize what was important to them. Kelsey, for instance, felt instrumental support (i.e., flexibility) and emotional support (i.e., love), which allowed her to better identify with and appreciate her job:

> *"I think I became more grateful for my job. You know, if I needed a day to just take time, I don't have to come in… If I just, I can't function… it's nice to know that you have people here that support you and love you and want the best for you."*

In their work lives, we also saw evidence of denigrating and harmful antisupports. These were perceived as hostile and aggressive acts, but compared to nonwork supports, these acts actively impeded women's career progress. Valeria recounted her struggle to regain the

legitimacy she had before her pregnancy and PPD diagnosis due to her boss's overt behavior, with Clarissa similarly describing her supervisor as "openly hostile" and exclusionary to her:

> *"My boss and my board director were not [supportive]. I had been working with him for six years, I had been promoted three times by him. He knew that I was capable. [But] I had to prove myself all over again… this is where I get angry. I still have the same capabilities, the same knowledge… there was no reason for him to assume that I somehow was incapable or had forgotten everything prior."*

> *"It wasn't until a little later that I realized that my boss had kind of just written me off and was no longer inviting me to meetings and no longer including me in decision making processes that I suspected that something else was up. And this woman is definitely someone who gets legal advice because she waited until one year to the date that I returned from maternity leave to fire me because she knew that I might have action against her if she had fired me sooner. So I'm pretty sure she fired me because I had a baby, [though I] can't prove it legally."*

Interestingly, some women found the lack of support they received to be a catalyst to help others in their organizations and/or be an advocate for others. For example, six months post-diagnosis, Siena—who ran a biochemistry lab and had traditionally kept her distance from addressing personal issues at work—felt compelled to meet with students in the lab and share her story, offering support to those who may be suffering in silence as she once had.

In sum, the support (or lack thereof) that the women received across domains was pivotal to their sensemaking—either in facilitating or slowing down their diagnosis, or in helping to shape the ways coping ultimately gave way to new work-family narratives. Thus, experiences of PPD can be helped or hindered by the broader social environment, with antisupports emerging as a particularly powerful social signal to which women with this imposing identity are attuned.

Discussion

Using a grounded theory approach involving interviews with women diagnosed with PPD and key informants with expertise on PPD, we uncovered how working women make sense of PPD—a difficult diagnosis overlaying the already challenging experiences associated with being a working mother. Our analysis revealed an interrelated process of PPD sensemaking explicating

how these women worked through intrusive thoughts, diagnosis, and treatment of PPD, emerging from this with a renewed narrative about what it means to be a working mother. While most individuals (and prior theory) would suggest that an imposing identity like PPD would derail women's work and nonwork lives, the women we studied found a way to cope with this work-life shock event that was facilitated by their diagnosis and treatment. Thus, although PPD was certainly a negative experience, our findings suggest that the imposing identity from PPD helped women to develop resilience, leading to the reprioritization of themselves, their relationships, and their work, and further allowing them to treat themselves and others with greater compassion. The notion of an imposing identity challenges what we currently know about the intersection of work and family identities by uncovering a hidden identity. Although a PPD identity is temporary, the timing and experiences that come along with it pose an additive effect that may alter the course of how work and family narratives are challenged and strengthened. We elaborate on these implications below and identify areas for further research.

Theoretical Implications

We first contribute to the identity literature by introducing the notion of an imposing identity—an identity that is unexpected and unwanted and has a lasting impact on existing identities. PPD as an imposing identity inhibits or facilitates the recrafting of personal work-family narratives and existing identities. Like a liminal identity, an imposing identity offers space for identity reconstruction and cross-domain growth (Ibarra & Obodaru, 2016; Ladge et al., 2012). Importantly, however, the imposing nature of a PPD identity is more complicated than a liminal identity in that it often needs to be prioritized over other identities. As can be seen in the examples of the rock-bottom catalyzing events, PPD as an imposing identity includes symptoms and experiences that urgently need to be addressed. Treatment of and coping with

PPD are therefore driving forces influencing the clarity of new and existing identities and helping to recraft work-family narratives. And even as the symptoms associated with PPD wane over time (often within months of diagnosis; O'Hara & McCabe, 2013), the identity remains.

Indeed, PPD as an imposing identity led to identity work, likely due to the intensive sensemaking processes that they would likely not have had if they had not been diagnosed and experienced it as a "shock" (Crawford et al., 2019). Of note, whereas many working mothers manage the intersection of multiple identities with little acknowledgment of the challenges tied to managing it all simultaneously, having PPD enabled women to get the support they needed to cope with their PPD identity *and* integrate their work and family identities. Further, while prior research has revealed how work and family identities co-evolve over time (Ladge et al., 2012; Ramarajan & Reid, 2013), particularly through identity work (Vough et al., 2020), the focal point has been on the intersection of primary identities (i.e., work and family), taking for granted that imposing identities can affect multiple identities (which may also be in flux) at the same time. Moreover, when studying new mothers, the work-family literature has tended to focus on the intersection of maternal and work identities as opposing forces due to competing resources (Ladge & Greenberg, 2015; Little & Masterson, 2021); other work has taken an external view focusing on image management (Little et al., 2015). We find that imposing identities *facilitate* clarity about goals and desires in *other* identity domains via PPD sensemaking.

Additionally, imposing identities may serve as a vehicle for identity play, defined as an "iterative engagement in provisional trials of possible future selves" (Ibarra & Obodaru, 2016, p. 56). Individuals often engage in identity play when they are between identities, such as being between roles or changing occupations (Ibarra, 1995; Ibarra & Petriglieri, 2010). Our study suggests that imposing identities and related sensemaking instigate a dynamic form of identity

play that can serve as a critical resource for women struggling to understand and prioritize multiple identities. While we focused on PPD, there are likely other imposing identities which may arise from work or family in the wake of work-life shock events (Crawford et al., 2019), such as job loss (Shepherd & Williams, 2018), denied promotions (Vough & Caza, 2017), managing temporary or chronic illness that has the potential to yield long-term health implications (Charmaz, 2000, 2002), mental illness (Charmaz, 1994; Flowers et al., 2006), or pregnancy loss (Hazen, 2003), that might be explored in future work. This would also shed light on construed image work per Williams and Murphy (2022, p. 1560), who noted that people may be "tinkering with a construed image"; here, PPD sensemaking likely contributes to internal identity work, which manifests into personal work-family narratives.

Our work also continues a much-needed discussion of mental illness at work. Wilkinson (2022) noted that conditions like PPD have a two-directional relationship with work. On the one hand, engagement in work can allow women to better cope with their symptoms, depending on the nature of the work itself (i.e., stressful work is unlikely to be fruitful for this endeavor). On the other hand, mental illness can impede work progress and women's ability to meet job-related requirements (e.g., Kensbock et al., 2022). We bring a perspective that diagnoses tied to mental illness, due to their imposing nature, can foster positive changes for individuals and in their interactions with others through the crafting of more adaptive personal work-family narratives.

These findings and contributions also align with research on post-traumatic growth, some of which originated as an opportunity to shift the discussions associated with negative effects of women's health (O'Leary & Ickovics, 1995; see also: Hefferon et al., 2009). Organizational research associated with post-traumatic growth has focused on *lost* identities—those from job loss (Shepherd & Williams, 2018) or a career-ending injury (Conroy & O'Leary-Kelly, 2014). In

those cases, post-traumatic growth occurs in light of an identity being taken away. With PPD, post-traumatic growth stems from being given a new and sudden imposing identity that shapes work and family narratives. Through experiencing an imposing identity, women were able to shift into a restoration orientation. In this way, our work suggests that with diagnosis, treatment, and support, women with PPD can reframe their ill-being tied to PPD into states of health.

Further, part of channeling ill-being into health also comes from women being able to take their mental health experiences and *improve* the mental health experiences of others. Work on compassion in organizations describes how some employees can become experts in “toxin handling” (i.e., become toxin handlers) and “serve as peacemakers, listeners, and healers” in the face of suffering at work (Worline & Dutton, 2017, p. 85). The current study we have conducted would suggest that, as a function of their developing loss and restoration coping orientations, women were able to become toxin handlers by becoming not only mental health advocates, but also speaking directly to those who were struggling with their own mental health challenges. Thus, born from women’s suffering was a novel ability for them to speak boldly in organizations in ways that helped, rather than hindered, others’ suffering from other mental health diagnoses, perhaps helping reduce the suffering in silence that can occur from mental health challenges (e.g., Follmer & Jones, 2018; Kelloway et al., 2023). In this way, compassionate acts triggered by women with an imposing identity from PPD operates as a means through which individuals can tackle taboo topics in the workplace (Grandey et al., 2020) to create a common language for such challenges. This also suggests that elements of the PPD identity, even after the experience, can be “activated” under certain circumstances, such as when others need compassion at work.

Practical Implications

Supporting women’s reentry and mental health offers a clear way for organizations to

support and retain women in the workforce. It also represents a reality that organizations likely need to reckon with, as "of the two out of every three new mothers who return to work, each new mother has a 25% chance of developing postpartum depression symptoms" (Ledesma Ortega & Reio, 2016, p. 132; c.f., O'Hara & Swain, 1996). The women we studied offered many ideas for organizations. For example, they highlighted the importance of organizations having not only flexible work arrangements but also flexible parental leave (for women and men). When we asked Chelsea what the leadership at her elementary school could have done for her, she noted:

> *"I think what would have been helpful to me would have been the option to return to like a half-day when I first started back, and I realize in all industries and jobs that's not possible. But it would have been very helpful to me to have more of an easing into the workday and trying to find that new normal. It's a huge adjustment on top of already having the baby. You just jumped straight back in."*

In the U.S., rather than focusing on 12 consecutive weeks of unpaid leave as specified by the Family and Medical Leave Act (U.S. Department of Labor, 2021), a novel solution would be to create structures for women to take leave as needed throughout the first year when they are experiencing fluctuations in symptoms. The Family and Medical Leave Act specifies offering "[t]welve workweeks of leave in a 12-month period for the birth of a child and to care for the newborn child within one year of birth"; the consecutive nature is the default that most take, but some women suggested that this was not as advantageous. Of course, longer leave—and *paid* leave—is an improvement that organizations can also undertake to help women. Some women noted that they could not afford unpaid leave, which added to their symptoms. As Irene, a lawyer who had just started at her company at the time of her pregnancy and PPD diagnosis, stated:

> *"I can't really afford to take 12 weeks of unpaid [leave], so they [the organization] offer no support in that regard… […] But I feel like… I had some comfort in knowing that my employer supported me a little bit more, even if it is financially, because that's also another stressor that adds on to the anxiety and depression."*

We recognize that suggesting that organizations offer additional leave and/or create

flexible work structures can be costly and take time. Thus, actionable *and* cost-effective solutions are a must. One recommendation was to encourage "touchpoints" with women on leave to signal that their health and well-being matter and that the organization recognizes the major life transition they have gone through. Jocelyn commented how she was always able to receive help when she asked for it but wished her organization would have proactively checked on her:

> *"So they were really… willing to kind of do whatever I wanted, but it was all kind of on me... If nobody had reached out to me and say, 'How can I help you with this?' Or, 'What can I do with this?' Or, [just] followed up with me to check on me. Anything I asked for, I got. But if I didn't ask, I wasn't getting it. I don't know. Maybe it would have been nice. We have a ton of people devoted to like the social, emotional health of our students. It would have been nice if one of those people had like followed up with me and checked on me, even if I didn't end up needing it."*

Such an idea could be an extension of agency interventions proposed by Hideg et al. (2018), who recommended that organizations keep in touch with women during parental leave to keep their work agency high. Although this could be perceived as benevolent sexism to the extent that women do not want help (e.g., Jones et al., 2020), we see this as a social signal for organizations to show they recognize and prioritize the mental health and well-being of their working mothers.

Although organizational parental leave policies (or flex-time policies) can be fruitful, there are likely other ways that organizations can support women with PPD and their return to work—particularly when it comes to supervisors and coworkers. The recent conclusions from Jones et al. (2022) dovetail with our findings surrounding supports for working mothers, in that social support from supervisors and coworkers can reduce PPD symptoms. Although Jones et al. (2022) focused on support during pregnancy affecting PPD symptoms, we suspect that similar findings are likely to transcend to women's reentry after having PPD given the benefits from perceived organizational support (e.g., Little & Masterson, 2021) and compassion (e.g., Gabriel et al., 2020) during this time. Additionally, our results suggest that it is crucial that supervisors

and coworkers are informed about the challenges linked to motherhood *and* mental illness to break down the dual stigma working mothers with PPD face. For example, a recent randomized trial by Gast et al. (2022) found that managers who were assigned to a one-day workshop focused on mental illnesses (versus a control group) reported reduced stigma surrounding mental health. Further, we suspect that greater awareness around mental health can broaden more positive workplaces that are supportive of mental health conditions and employee well-being.

As a final note, our recommendations have focused on what organizations can do to promote thriving for mothers with PPD. This was intentional; we do not feel it is actionable or sustainable to have women experiencing PPD be the primary people responsible for their well-being. As the women in our study are making efforts to facilitate their own coping, growth, and resilience, we feel that organizations can meet women where they are in order to help them. Further, we hope our findings highlight that the women were serious about maintaining high levels of performance in their work roles; they simply needed time for treatment to develop resilience and allow them to thrive moving forward in their personal and professional lives.

Limitations and Future Directions

Although we made efforts to ensure a rich, initial exploration of the intersection of PPD and work, there are limitations. At a basic level, the representation of participants in research on women's health needs to improve. Though we sought to recruit racially diverse women, our sample was predominantly White, and our participants' experiences indicated that more work is needed on cultural differences. Irene, who self-identified as Hispanic/Mexican, described her experience with her diagnosis and disclosure to her family in the following way:

> *"My mom grew up with Mexican traditions, and so have I. She didn't know what postpartum depression was. There's five of us [in our family]. And, she didn't know until recently that she—when I talked to her about how I felt about [my baby]—she's like, 'Oh, I felt like that, too.' And I was like, 'Well, Mom, you probably had depression.' And she*

> *didn't [get diagnosed]. None of my sisters suffered from depression before pregnancy or even during, so it's hard talking about it because I'm the only one in the family that is."*

Such cultural differences in the discussion and disclosure of PPD could shape the ways that women allow this diagnosis and imposing identity to blend into workplaces or not, suggesting possible boundary conditions to our model. Future work should continue to explore such themes and also delve into the experiences of non-birthing parents, including fathers, who may experience PPD in distinct ways to birthing mothers (Stewart & Vigod, 2019).

Further, we recruited women who reported being diagnosed. Yet PPD commonly goes undiagnosed and untreated (Stewart & Vigod, 2019), and so limiting our exploration to those with a formal diagnosis may not reveal the whole story. Women who struggle with symptoms of PPD that go undiagnosed, or just below diagnosable levels, may struggle with the same issues along with an additional layer of complexity, given their suffering has not been recognized by a formal diagnosis. Indeed, women in our study found a sense of relief at having professionals validate their PPD identity; women who are not diagnosed may continue to suffer without support. Thus, future work should closely examine the interplay between PPD diagnosis and identity formation to understand the experiences of women coping with this condition—both those diagnosed and those suffering just shy of the diagnostic cutoff. Additionally, the women in our study almost exclusively discussed their own sensemaking process related to their PPD and its implications for their work and family domains. Future research should continue to explore how women experiencing PPD manage their image (e.g., Roberts, 2005) at work and at home.

Although PPD typically resolves within a few months after giving birth, we recruited women who had reported experiencing PPD in the last five years to ensure that different amounts of time had elapsed to support the generalizability of our themes, as well as to determine if mothers of multiples had recurrent experiences with PPD. Because of this, however, we cannot

rule out self-reflection bias, particularly for the women who thrived in the face of this trauma. On the other hand, this decision allowed us to feel confident that the themes we identified as related to experiencing an imposing PPD identity were consistent through time. Future research should track women from pregnancy through the first year to track not just the prevalence of PPD, but also how it evolves over the first year (which tends to be when PPD dissipates). Related to this, an additional limitation is that our model may be interpreted rather linearly. However, it is possible that there are feedback loops. Coping could "revive" symptoms and reinitiate the sensemaking process. Additionally, women who have multiple children may have multiple PPD diagnoses, suggesting that this process can restart. Taking a longitudinal perspective on disorders like PPD could be fruitful to better map out the "life course" of sensemaking that unfolds.

Finally, our research focuses on how women with an imposing PPD identity can find ways to still thrive. Yet we tragically recognize that not all women diagnosed with PPD reach such a point, as at the extreme (and if left untreated), women with PPD can engage in harmful behaviors, including substance abuse, self-harm, and suicide (Stewart & Vigod, 2019). We say this to recognize that although growth may come from having PPD, there is still the possibility, both with PPD and with other imposing identities, of significant trauma and loss. Thus, our findings—which, in our view, help pave the path forward for how organizations can support such growth—should be interpreted with caution and awareness of the struggles linked with PPD.

Conclusion

To support working mothers, it is crucial to study all elements of motherhood that can impose challenges for women's work and nonwork lives. In this investigation, we uncovered that PPD serves as a critical imposing identity, allowing women to build resilience and recraft their work and nonwork roles in significant ways. As alluded to in our title, the insights gleaned

highlight the potential power of women's PPD to facilitate strength-finding in the storm.

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Table 1

Pseudonyms and Demographic Information for Participants

Name	***Age***	***Race***	***Work Status***	***Job Title or Description***	***Marital Status***	***Number of Children***
Melinda	28	White	PT	Cashier	Married	2*
Kara	41	White	FT	Postdoctoral Fellow	Divorced	2
Haley	34	White	FT	Assistant Director of Academic Services	Married	2
Valeria	39	White	FT	Grant Program Officer	Married	2
Jessica	31	White	FT	First-Grade Teacher	Married	1
Myra	33	Asian American	FT	Assistant Professor of Nursing	Married	1
Serena	30	White	PT	PhD Student of Public Health	Married	2
Kay	32	White	FT	Operational Effectiveness Director	Married	1
Mona	26	White	FT	Ultrasound Technician	Married	2*
Tara	36	White	FT	Service Sales Coordinator	Divorced	2
Chelsea	43	White	FT	High School Teacher	Married	3
Adina	29	Black	FT	Non-Profit Manager	Married	2
Daphne	42	White	PT	Early Childhood Teacher	Married	2
Kelsey	34	White	FT	Director of Communications	Married	2^
Kendall	28	White	FT	Medical Assistant	Engaged	3
Sophia	36	White	FT	Dentist	Married	2
Tess	38	White	FT	Social Worker in Hospice Care	Married	2*
Siena	40	White	FT	Research Scientist	Married	3
Shannon	30	White	FT	Research Coordinator and Childhood Counselor	Married	1
Kinsley	38	White	FT	Director of Student Engagement	Married	2
Julia	30	White	FT	Public Relations for Social Programs	Married	3
Felice	37	Hispanic	FT	Mechanical Engineer	Married	3
Faye	36	Hispanic	FT	Social Worker in Criminal Justice	Married	3
Jocelyn	33	White	FT	Teacher	Married	2
Angelica	27	White	PT	Gas Station Employee	Married	2^
Katrina	28	Hispanic	FT	Researcher in Proteomics	Married	1
Karoline	40	White	FT	Director of Admissions	Married	1^
Audrey	45	White	FT	Associate Director of Library	Co-Parenting	1
Clarissa	37	White	FT	Assistant Dean	Married	1
Maryam	35	Muslim	FT	Compliance Consultant	Married	2
Rosalind	40	White	PT	Teaching Resource	Married	3
Celeste	33	Hispanic	FT	Postdoctoral Fellow	Married	1
Jane	37	White	FT	Associate Professor of Biomedical Engineering	Married	2

Astrid	39	White	FT	Marketing/PR	Married	2
Dana	30	Asian American	FT	Active-Duty U.S. Military	Married	2
Irene	35	Hispanic	FT	Lawyer	Married	1
Kira	31	White	FT	Dealer/Tech Support for Lawnmower Company	Married	2
Leisha	34	Black	FT	IT Support	Married	2
Nora	36	White	FT	Genetic Counselor	Married	1
Georgette	30	Black	FT	IT Auditor in Cybersecurity	Married	1
Chloe	38	White	FT	Personal Coach	Married	3

Note. Each participant was assigned a pseudonym, and no pseudonym matched the name of a participant in our sample to preserve anonymity. All demographics were self-disclosed from participants during the opt-in survey and/or interview process. PT = part-time work at the time of the diagnosis; FT = full-time work at the time of the diagnosis. Marital status is reported as the status at the time of diagnosis, as at least one woman in our sample was divorced after the diagnosis occurred. Work status was also from the time of diagnosis, though as our model illustrates, some women used their sensemaking processes to change their work status (e.g., shifting from full-time to part-time work). * recognizes women who have children who are also stepchildren. ^ recognizes (and sends support) to women who disclosed that they lost a child in addition to the children they currently had.

Figure 1

Visual Depiction of Data Collection and Analytic Procedure

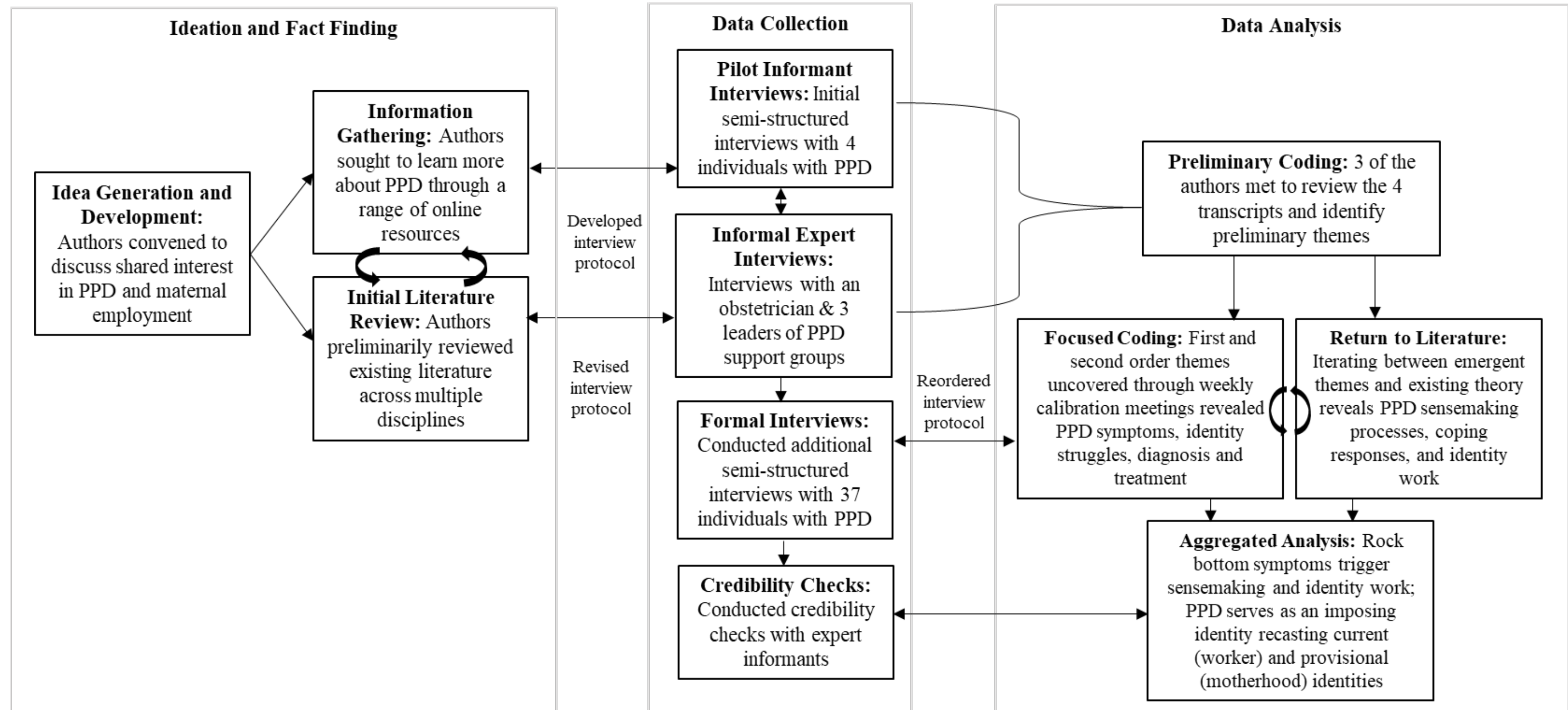

Figure 2

Theoretical Model of Postpartum Depression (PPD) as an Imposing Identity for Working Mothers