

From Mothering Without a Net to Mothering on the Net

The Impact of an Online Social Networking Site on Experiences of Postpartum Depression

This research speaks to the desire expressed by women, health care professionals, and researchers alike, for an alternative, non-pharmacological or therapy-related intervention for postpartum depression (PPD). Interviews with twenty-two mothers and members of Momstown.ca—a social networking site focused on connecting mothers online and face-to-face—demonstrated new mothers are increasingly isolated and without community. However, mothers reported becoming members of Momstown allowed them to build a social network providing them company, camaraderie, and community, resulting in improved mental health. We conclude services like Momstown could be viable, alternative interventions for women with PPD, enabling mothers to survive and thrive postpartum.

The culture of motherhood is rapidly changing (Warner). Today's mothers are likely to transition into motherhood more socially isolated than in previous generations (Nelson). Women's increased participation in the paid workforce (Gaudet, Cooke, and Jacob), geographical distance between family members (Posmontier and Horowitz), and increased rates of single parenthood (Gallagher, Hobfall, Ritter, and Lavin) have resulted in many women mothering without a safety net and consequently at risk for developing postpartum depression (PPD). Within this cultural shift, Abrams, Dornig, and Curran argue that, "more exploratory research needs to be conducted to develop testable interventions for PPD that capitalize on mothers' natural help-seeking strategies and self-care inclinations" (548).

This paper responds to the call for exploratory research on PPD through a research project with Momstown.ca (MT)—a Canadian social networking site that connects mothers both online and face-to-face. We will discuss the impact

of MT on experiences of postpartum depression and postpartum depression symptoms, arguing that, through the provision of company, camaraderie, and community, MT improved maternal mental health for women who describe motherhood as overwhelming and isolating. Our research demonstrates that women are moving from mothering without a safety net, to mothering on the Net. The findings demonstrate that women's use of MT is an act of self-care, one that decreased their symptoms of PPD and increased their self-reported levels of mental health. We begin with an exploration of existing literature on postpartum depression before turning to the data gathering decisions and findings of the study.

Background

Postpartum Depression

Postpartum depression occurs widely across a variety of diverse cultures and social identities (Posmontier and Horowitz) and is the most frequent form of maternal morbidity following delivery (Dennis "Peer Support"). Postpartum mood disorders range from the "normal" adjustment period known as "the baby blues"—characterized by mood swings, tearfulness, irritability, and anxiety, which usually dissipate within two weeks postpartum—to the more severe and less frequently occurring postpartum psychosis—characterized by symptoms of delusions, paranoia, and hallucinations (Abrams and Curran "Middle-Class"). If feelings of depression and anxiety persist past the baby blues and are combined with symptoms such as helplessness, hopelessness, or concerns about hurting oneself or the baby, the disorder is termed postpartum depression (PPD) (Kennedy, Beck, and Driscoll).

PPD has been documented in approximately 13 percent of women postpartum, but it must be noted that the illness is under-reported (Ugarriza, Brown, and Chang-Martinez) and rates are much higher for populations that are already structurally vulnerable—for instance, women of colour, women with pre-existing mental health issues, single mothers, immigrant women, rural women and so forth (Abrams and Curran "Maternal Identity"). The cause of PPD is unknown, or at the very least, multi-faceted. Hormonal changes as a result of childbirth are the most commonly cited possible cause of PPD, but most research demonstrates that biological explanations alone cannot explain the illness (Knudson-Martin and Silverstein). Psychosocial and cultural factors have been explored (Beck) and the conclusion is that PPD is an umbrella term for a wide variety of postpartum mental health concerns that are likely multi-factorial in etiology (Dennis "Preventing Postpartum Depression"). However, we do know that PPD is a major maternal and public health issue (Wisner, Logsdon, and Shanahan) with significant consequences

for mother, child, and family (Field; Dennis “Peer Support”).

Prevention and Treatment

Preventing PPD has been complicated due to inconsistent screening techniques, insufficient knowledge about PPD among both the general population and the medical community, and a lack of responsiveness by health professionals (Abrams and Curran “Middle-Class”). These barriers to prevention are compounded by the fact that women tend not come forward with possible symptoms of postpartum depression. Research has demonstrated that while PPD affects a significant number of mothers each year, approximately half of these cases go unreported and undetected (McGarry, Kim, Sheng, Egger, and Baksh). Mothers often recognize they have symptoms of PPD but tend not to report their symptoms for multiple reasons including fear of social stigma related to mental illness (Abrams and Curran “Maternal Identity”), intervention by Child Protective Services (Chew-Graham, Sharp, Chamberlain, Folkes, and Turner), and shame (Sword, Busser, Ganann, McMullan, Swinton). Women who do seek help for PPD have reported negative experiences with health care professionals who reject, minimize, or ignore their symptoms or offer impractical, unhelpful advice (Abrams and Curran “Maternal Identity”). Chew-Graham et al. found that physicians and health care professionals also describe the current system as hindering women’s ability to come forward with PPD symptoms.

Those mothers who do report symptoms are typically offered two main forms of treatment: counseling (Bledsoe and Grote) and/or pharmaceuticals (Wisner et al.). However, research has demonstrated that many women are dissatisfied with counselling (Abrams Dornig, and Curran) and report a strong desire to treat their illness using non-pharmacological methods (Dennis and Chung-Lee; Goodman). Research suggests that facilitating social support is a particularly viable strategy for both preventing and treating postpartum depression (Ugarriza et al.). Indeed, Dennis (“Peer Support”) found that peer support creates a protective effect on women. Yet new mothers in Canada are discharged from hospitals too early into support systems that are too small (Zelkowitz), often separated geographically from family and left to adjust to the life-changing arrival of a new baby on their own (Nelson). Health care providers understand social support to be a major factor in the prevention and treatment of PPD, but they do not know how to facilitate that support for the women in their care (Leahy-Warren et al.; Sword et al.).

Taken together, this literature demonstrates there is a need, expressed by women, health care professionals, and researchers, for postpartum strategies that offer an alternative to pharmacological and therapy related treatments while fostering social support. Our study of Momstown.ca suggests that

online social networking creates one such alternative intervention.

The Purpose of the Study

The initial objective of this project was to investigate the roles of online social networking in the development of social capital for mothers. In doing so, we explored experiences of social isolation among mothers who were members of MT, a social networking community aimed at connecting mothers online and face-to-face. We did not set out to study postpartum depression. In fact, our interview guide contained only one question that spoke specifically to women's mood postpartum. We asked, "Have you had low moments as a mother? If so, has MT done anything to make those moments more bearable?" Despite the lack of attention directly paid to PPD in our interview guide, just over thirteen percent of the women interviewed disclosed formal diagnoses of PPD, while many others discussed self-diagnosis and negative emotions that persisted throughout their early experiences of motherhood. Thus, while we did not intend to study the impact of MT on women's experiences with PPD, this unintentional finding is a major contribution of our project.

Methods

MT is an online social networking site created in 2007 by three Southern Ontarian mothers for "for moms who believe in community." The site aims to facilitate connections between mothers in the same geographical location. For a membership fee of \$45 per year, mothers and their families access an online calendar that schedules roughly 20 events each month in the local community. Their 24-hour message board ("perfect for those sleepless nights") allows women to meet online, connect, chat, ask advice, and if necessary, vent. In exchange, the site includes ads targeted towards moms, mom-related product reviews, sponsored "e-blast" email messages and blogs. Though the connection is formed in cyberspace, the goal of MT is to connect mothers face-to-face so that they can "get off the computer and out of the house."

Recruitment and Data Collection

Purposive sampling was used to recruit participants based on "their relevance to the research question, analytical framework, and explanation or account being developed in the research" (Schwandt 232). Recruitment techniques included an email advertisement mailed to each member of one Southern Ontarian MT franchise through an "e-blast", an invitational "post" on the MT message board, and a brief talk given at an organized MT event. We also used snowball sampling to recruit participants (Patton); at the end of each interview, participants were asked to suggest another member of MT

who might be willing to participate in this study. Through these methods we recruited twenty-two members of MT.

We conducted “active interviews” (Dupuis) lasting approximately one hour. These interviews took place wherever the participant felt was most comfortable and convenient, which in all cases resulted in the interviews taking place in the participant’s home. Participants were offered reimbursement for childcare costs accrued as a result of the interview, though no participants took us up on this offer. Children were at home during every interview conducted; often this meant participants were tending to children while being interviewed, but just as often children were napping, playing quietly, or being watched elsewhere in the home by a spouse or childcare provider. All interviews were digitally recorded and professionally transcribed with each participant assigned a pseudonym. The quality of data was monitored through periodic checking of interview files with the accompanying transcriptions.

Data Analysis

To analyse the data, we used the constant comparative method (Glaser and Strauss) in which open coding within and axial coding within and between interviews resulted in identification of recurrent conceptual themes. Each interview transcript was first analyzed using open categories to develop initial descriptive categories (e.g. “someone who understands” and “friendship”). Focused or selective coding was then used to compare categories both within and between interviews, and to look for emerging conceptual themes, (e.g. “Camaraderie”). Subsequently, patterns of relationships among themes were also examined (such as the relationship between “Camaraderie” and “Community”). These patterns of relationships were developed into the major themes for this article (for instance “You are not alone”). Consistent with this method, the data analyses and coding processes proceeded simultaneously with the data collection process. In this sense, the process was iterative so that emergent ideas from the analysis of the early interviews were used to provide direction for later interviews so that interesting ideas were followed up on (Rubin and Rubin). Although individual transcripts were analyzed through the development of themes, the group of transcripts were also analyzed as a whole to compare and contrast developing patterns of relationships among the participants’ comments and experiences. Thus, the themes were inclusive of data across the interviews.

Profile of the Participants

Twenty-two women participated in the study. Of those twenty-two women, three reported formal diagnoses of postpartum depression (PPD-FD), two reported self-diagnoses of postpartum depression (PPD-SD), and eleven women reported experiences we described as postpartum depression symptoms (PPD-

SYM). These eleven women did not describe their experiences specifically as PPD; however, their descriptions of their postpartum experience included a significant number of PPD symptoms such as anxiety, shame, grief, numbness, lack of attachment to their child, inability to cope, and sadness that lasted more than two weeks postpartum (Beck). It should be noted that twenty-one women interviewed for this study described the transition to motherhood as isolating and overwhelming. However, these women were not defined as symptomatic of PPD unless those feelings were in combination with several other reported symptoms, persisted past the “baby blues”, and were described as significantly impacting upon their experience of motherhood. Thus, sixteen interviews were analyzed as data for this paper. The participants ranged in age from twenty-six to forty years old. All but one of the participants were married, one was separated. None of the participants self-identified as either gay or lesbian. Five of the women were on parental leaves, while five worked full time, another five worked part time, and one was a stay-at-home mother. All participants had between one and three children with ages ranging from seven months to six years. The majority of respondents identified as White Canadians; however, two participants were immigrants to Canada, two identified as Hispanic, and one as Southeast Asian. All participants had at least some college education, with the majority holding university degrees and one holding a Master’s degree. The household incomes of participants ranged from \$20,000 to over \$100 000 a year.

Findings

Data analysis of the interviews with MT members revealed three main themes (each with accompanying subthemes) that described the participants’ struggles as new mothers, their experiences with MT, and the ways those experiences with MT addressed their struggles with motherhood: (1) “I’m so alone” (isolation), (2) “You’re not alone” (company, camaraderie, community) and (3) “We’re gonna get through this” (improved mental health).

“I’m So Alone”

Isolation. All participants interviewed described new motherhood as “isolating”, a struggle in which they felt overwhelmed and alone without a strong community. Andrea (PPD-SYM) remarked, “Everyone warns ... being a mother is challenging and it can be isolating, but you can know and be told these things but until you’re actually going through them you don’t understand how bad it can get, how isolated you can be, how overwhelmed.” Participants suggested their isolation was exacerbated by factors such as the cold Canadian winters, moving to a new location, living geographically distant from family, leaving

the paid work force, and having little social support. As Margaret (PPD-FD) described: “I quit my job, moved here, desperately lonely, desperately lonely ... so stuck ... you’re standing around going oh my god there’s nobody here, no one, there’s no peer support, and it’s just hard.” Participants described a lack of connection with community, including communities of other mothers, as a contributing factor to the isolation they felt as new parents. Maureen (PPD-SYM) reported a loss of community upon becoming a mother: “It’s just so isolating in that sense that you lost all of your community.” And Helene (PPD-SYM) argued: “We were never meant to be in a room alone with a child as an adult. We’re not meant to be that way. You have these ... communities that should be together. And you weren’t meant to be a mom alone with a child or two children. No wonder people go crazy.” Without a support system to help ease the transition that comes with the arrival of a new baby, and without a strong community of friends and family to help guard against isolation, these women were facing new motherhood alone. Being left alone with a new baby and at times older children as well was reported to be at the very least a contributing factor to the exacerbation of pre-existing postpartum depression symptoms. At the most, women in this study reported that this isolation and lack of community left them directly susceptible to PPD.

“You’re Not Alone”

The women in this study described motherhood as lonely and isolating; however, these women repeatedly reported that becoming a member of MT made them feel they were not alone after all. MT allowed these women the opportunity to make connections with other mothers, providing them with company, camaraderie, and community, all vital connections they were previously mothering without.

Company. The mothers interviewed for this study credited MT with supplying company. Participants described the mere presence of adult company outside the home as vital for alleviating isolation and providing peer support. Anna (PPD-SD) maintains: “I think the psychological benefits are just getting up in the morning and knowing that you have somewhere to go and you have people to get together with and, and that’s a huge psychological benefit.” Kristen (PPD-FD) suggested her PPD would have been greatly improved had she engaged in the company of other mothers earlier: “I had postpartum depression after I had Abby, so I was just like, no, I need to keep to myself. I don’t need to meet anybody right now... and I really wish I had just overstepped myself and joined MT when I had postpartum depression because I think I would have been able to deal with things a lot better and differently.” Many mothers stressed the importance of being able to access the company of other women both online and face-to-face, for, as Meredith (PPD-SYM) explains: “Sometimes you can’t

leave your house, sometimes we can, and it's nice because it had both sides, it has in-person activities and then also has online for when you are stuck at home and can't leave, 'cause there's a snowstorm or the child's sick." Mothers reported requiring these connections with other mothers for the simple yet significant reason that they needed to get out of the house and be in the company of other adults, which alleviated feelings of isolation and loneliness.

Camaraderie. However, participants expressed that it is not simply the company of any other adult that they desire; MT enabled them to meet "comrades". This sense of camaraderie facilitated by MT was significant in terms of connecting women to *peers* who were *non-judgmental*. As Morgan (PPD-SD) explained: "I want to hear somebody that's gone through it, I want somebody to be here with me that's gone through it and can tell me this is fine. And that's hard to find when you're in the middle of it. And I go on the message boards and I get a fast reply ... and then that makes me feel like, well, okay, I'm not alone." Women with diagnoses of PPD found the sense of camaraderie and community of mothers they gained through MT was therapeutic, whether their peers had PPD or not. Jo (PPD-FD) describes: "I needed other people in my circumstance. Not necessarily with postpartum but other new moms. Just the social and emotional aspect of getting out of your house and talking to someone else and interacting and knowing that someone else knows what you're going through, they understand and you know it just, it's reassuring knowing that you're not the only one going through this. So, sanity. I get sanity out of it." Participants also maintained that MT members are uniquely *non-judgmental*, which strengthens that sense of camaraderie. Andrea (PPD-SYM) recalled: "Everyone's so supportive there. Like, I never breastfed and sometimes you tell some people that and you're in big trouble. And I've met other moms there that are like, "oh I wish I didn't breastfeed," you know what I mean, instead of a typical, "you didn't???" Women reported a strong sense of camaraderie from their membership in MT due to their perception that other members were truly peers—and also due to the uniquely non-judgmental environment—a sharp contrast to many of their experiences with overcritical fellow mothers.

Community. Having reported a lack of community before joining MT, many women emphasized the importance of gaining membership to an entire network of other mothers. Many mothers described their neighbourhoods as unfriendly, suggesting that these changing neighbourhoods are the result of a more transient culture, and that MT helps build community in the wake of those changes. Meredith (PPD-SYM) explained: "Instead of being with family or the community that I grew up with, it's with this new group of moms ... I'm a part of that community.... The way that our society's changing so much, you don't even know your neighbours nowadays. . . you wouldn't go to your neighbours and ask for a cup of sugar now. But I could totally call up one of my moms

and they'd drive over with a cup of sugar for me." This sense of community was often referred to as a major factor in sustaining women's mental health. As Lucy (PPD-SYM) suggested: "The meeting people, the community, it's really what it fills I think. Because if I had to deal with that (*referring to kids in background*) all day long by myself I might go crazy ... I think that helps that you're miserable together." Though the ability to create friendships online was appreciated by many women, participants also stressed the importance of meeting face-to-face for building community. Lucy (PPD-SYM) maintained: "I had joined other forums in the past but it's not the same. You can sit in front of a computer all day long, but you don't feel like you really know these people a lot of the times, you know? So when you're getting out meeting them face-to-face you feel like you're forming actual friendships as opposed say just to you know talking at somebody online." In the wake of changing neighborhoods and more transient populations, MT helps build a community of non-judgmental peers bound together by a sense of camaraderie that keep each other company resulting in this simple yet significant message: "you are not alone." This message, a defense against the experiences of isolation, loneliness, and lack of community that plague new mothers, enables women to imagine that they might just get through this, whether "this" refers to negative emotions surrounding motherhood or full-blown PPD.

"We're Gonna Get Through This"

Connecting with a community of other mothers enabled women to believe that they could get through the struggles they were experiencing as new mothers. Women reported that membership with MT left them experiencing improved mental health.

Improved mental health. Mothers suggested that the support provided through Momstown benefitted their mental health and enabled them to feel better equipped to cope with their depression, anxiety, and other low moments of motherhood. As (Helene, PPD-SYM) describes: "Oh you just feel like a different person. You feel like you, you're not just a mom anymore. Even though you are one. You feel like a human being again." Participants noted they felt more confident as mothers after joining MT. Meredith (PPD-SYM) stated: "It makes me feel better about myself. I'm less self-conscious and I'm more confident." Several women reported they would not have survived their depression without this community of other mothers. Jo (PPD-FD) explains: "It means just somewhere I can go to feel good about myself. I suffer from postpartum depression and I honestly I wouldn't have survived the first year without a group of women that I could talk to and depend on and who could get me out of the house and keep me busy and you know, keep my mind off of all the bad stuff that was going through my head." And women also suggested

that MT could be a powerful tool in the prevention and treatment of PPD. Margaret (PPD-FD) argued: “The whole focus is connecting neighbourhood moms and finding someone in your neighbourhood and finding someone in the same life space that you are.... And it doesn’t matter if it’s your first baby or your third baby. It still happens ... the number one way to prevent [PPD] is peer to peer support and you could have a fabulous husband and a fabulous mother and lots of friends, but if there isn’t, you have a two month old, you need to find someone else with a two month old to connect. And that’s the number one way to avoid postpartum depression.” Participants argued today’s mothers need a service like MT. Kristen (PPD-FD) describes:

What MT has done, and like I would be the first, I’m not a public speaker, but I’d be the first person up there to say, you need to put funding into this so moms don’t have to pay for it ... I’m wholeheartedly on board for something to be done because they say one in five have postpartum. I think they’re a little off on that. I think there’s more than that ... ‘Cause people don’t report it all the time I think the government should get involved because what [the creator] has done is just incredible.... I think every community needs to have a MT. Every woman should join a group like MT. Because who knows how, if I even would have had postpartum depression if I was involved with something like this with Abby ... maybe the severity of it wouldn’t have been as bad.

At the very least, these mothers suggest that MT might lessen the intensity of postpartum depression, and that is a significant step toward treating and preventing the illness.

Discussion

Our study of MT members contributes to the literature an alternative PPD intervention. Research has demonstrated women want alternatives to medication and traditional forms of therapy, and physicians and other health professionals want to help their clients find these interventions, but ultimately have “no services to which to refer women for further treatment” (Chew-Graham 1). The use of social media such as MT to strengthen women’s social support networks, could be employed in conjunction with other forms of PPD treatment to create more integrative care for women experiencing the illness. This would address the call for PPD treatments that focus on interdisciplinary collaborations between health professionals, clients, and community (Kennedy; Posmontier and Waite). Our research suggests that, though it is far from a “quick fix,” MT does offer women an alternative postpartum intervention that has been

reported to combat symptoms of postpartum depression and defend against the development of the illness.

Our research also speaks to the need for postpartum interventions that address community and social support as a major risk factor in the development of PPD (Sword et al.). The literature demonstrates repeatedly that a lack of social support is a major predictor of PPD (O'Hara), that we cannot rely solely on spouses and immediate family to support women with PPD (Davey et al.), and that we need to put new social structures in place that will support all new mothers and protect them during the postpartum period (Zelkowitz). Support groups have been shown to be beneficial for new mothers, but are often based around breastfeeding (such as the Le Leche League (<http://www.lllc.ca/>), which has the potential to exclude many new mothers, including those whose PPD symptoms coincided with trouble breastfeeding (Scrandis). Support groups based around PPD are also helpful, but are often poorly attended due to the social stigma attached to the illness (Abrams et al.). Furthermore, women with PPD report finding formal therapeutic environments too "intimidating" (Abrams et al.) and that they would rather talk to a "a friend than a counsellor" (Chew-Graham et al.). Studies have advised that building up a new mother's social network should be a "high priority" for health care providers, yet the literature is not clear on how exactly health care providers are to do this (Leahy-Warren et al.). MT addresses these concerns raised in the literature by offering a new social structure for women in the postpartum period that builds community where community was lacking, provides social support beyond spouses and extended family, and guards against social isolation. This service is not based around breastfeeding or any specific parenting ideology, nor is it based specifically around mental health, and women reported MT to be uniquely non-judgmental; these attributes might help ease stigma and allow women to feel more comfortable reporting symptoms of PPD. Health care professionals left feeling helpless in their responsibility to grow women's social support networks could easily refer women in their care to this service or facilitate a meeting with a MT member or leader. Such interventions could make a significant change in the lives of women who resoundingly describe motherhood as overwhelming and isolating.

Finally, our research speaks to the need for a uniquely structured peer support network for women with PPD that addresses concerns raised by existing studies of PPD peer support systems. Peer support has been touted in the literature as a "significant element in the delivery of quality care" in a health care system that is overburdened and often unresponsive to the needs of women with PPD (Dennis "Peer Support" 322). Dennis' study ("Preventing Postpartum Depression") of a mother-to-mother telephone support network for women with PPD is a sterling example of a successful peer support intervention; however, women

involved in the study complained of inadequate “matches” with peer volunteers, and they identified several changes they would like to see including face-to-face interaction and online access to peer support. Our study reveals that the unique structure of MT addresses these concerns raised by existing PPD peer support literature. Through MT, mothers reported making their own “matches”, both online and face-to-face, and finding women they felt truly comfortable with as peers. Mothers described feeling a sense of camaraderie with fellow MT members, compounded by the feeling that MT was a safe, non-judgmental space to share experiences and advice about mothering.

Our study, however, is not without its limitations. Although the response from this study was largely positive, mothers’ groups can also impact negatively on women’s experiences of motherhood (Dennis and Chung-Lee; Mauthner; Mulcahy, Parry and Glover). Our group of participants is also relatively small; further studies of PPD and social networking sites like MT are needed to ascertain their effectiveness. And although our participants comprised women who were relatively diverse in terms of social identity, we were unable to perform an analysis that spoke specifically to experiences of women marginalized due to race, class, sexuality, age, disability, marital status, and so forth. Furthermore, future research on the use of social networking sites for women with PPD should explore barriers to accessing these services such as income barriers (especially relevant in reference to the \$45.00 membership fee associated with MT), language barriers, transportation barriers, or a lack of access to the internet. Investigating mothers’ internet access is particularly important given the existence of a ‘digital divide’ (Blackburn, Read and Hughes) between socio-economically advantaged and disadvantaged groups, which often corresponds to race and ethnicity (Brodie, Flournoy, Altman, Blendon, Benson, and Rosenbaum; Fox and Livingston).

Conclusion

In sum, our research with MT members found this social networking site, due to its unique structure and provision of peer support, improved mental health for women with PPD and PPD symptoms. Women in this study reported struggling through motherhood alone, isolated, and without community; MT enabled these mothers to feel they were not alone, and that they were, through company, camaraderie, and community, going get through it together. We identified several limitations of this study and suggested further research that if conducted will create a more complex understanding of PPD and the possibilities of online peer support. As Knudson-Martin and Silverstein maintain, “Interventions that focus on developing supportive relationships that can sustain the emotional vicissitudes of childbearing have potential to empower

rather than silence women ... such interventions could significantly impact the devastating effect of PPD" (157). Perhaps, then, if used in conjunction with other forms of PPD prevention and treatment, services like MT might take us one step further to providing women a truly multi-faceted intervention to an unquestionably multi-faceted illness.

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