Empowering Mothers: A Conceptual Model for Promoting Perinatal Mental Wellness Among Women in the United States

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EMPOWERING MOTHERS:
A CONCEPTUAL MODEL FOR PROMOTING PERINATAL MENTAL WELLNESS
AMONG WOMEN IN THE UNITED STATES

A Dissertation
Submitted to the School of Education

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In partial fulfillment of the requirement for
the degree of Doctor of Philosophy

By
Kayla G. Acklin

May 2021
ABSTRACT

EMPOWERING MOTHERS:
A CONCEPTUAL MODEL FOR PROMOTING PERINATAL MENTAL WELLNESS AMONG WOMEN IN THE UNITED STATES

By
Kayla G. Acklin

May 2021

Dissertation Supervised by Dr. Waganesh Zeleke

Globally, there are certain expectations surrounding becoming a mother related to pregnancy and the birth. For many women, the birth of a child represents a natural event filled with joy. Societally, the expectation is that pregnancy, birth, and the transition into motherhood are normal, positive experiences for all women (Davis-Floyd & Cheyney, 2019). However, research shows that some women develop impairments in physical and mental health functioning and wellbeing as a result of the major physical and psychosocial changes that take place during the transition into motherhood (Austin et al., 2010; Ayers & Pickering, 2001; O’Hara et al., 2014).

This study is designed to provide a starting point for understanding the concept of perinatal mental wellness in the context of the culture of the United States and strategies that support mental wellness during the perinatal period. The focus of this study is to meaningfully define
perinatal mental wellness, explore how wellness is supported during the perinatal period, and explore strategies that could provide increased support for perinatal mental wellness.

The data analysis indicated four categories including perinatal mental wellness; factors supporting perinatal mental wellness; factors not supporting perinatal mental wellness; and systemic change. Additionally, the data analysis clarified the meaning of perinatal mental wellness. Perinatal mental wellness in the context of this study means mental readiness for birth and the changes to come via mental healthcare provided alongside physical healthcare throughout the perinatal period. The final model that emerged from the data suggests that the systemic change themes could be used as strategies implemented within the existing perinatal care model in order to promote perinatal mental wellness among mothers in the United States. These findings align with other research findings from countries throughout Europe and findings from Australia.

**Keywords:** Perinatal Mental Wellness; Pregnancy; Birth; Maternal Mental Health
DEDICATION

To the participants who bravely shared their stories, through laughter and tears, in order to contribute to this research. I am so grateful to you and proud to complete this work. Hearing and telling your stories is a privilege. To the participants and all mothers, may others see the beauty as well as the sacrifice, determination, and grit it takes to become a mother.
ACKNOWLEDGEMENT

I would like to thank God for providing me the opportunity to grow in my knowledge and make a meaningful contribution to the field of counseling. Serving others is a privilege and I am grateful for the abilities I have been blessed with. Additionally, I would like to acknowledge all of the people who helped me realize my potential and mentored me throughout this process. Thank you to my committee members who dedicated time and effort to supporting me and providing valuable feedback for my work. I appreciate your understanding and encouragement throughout this process. Dr. Zeleke, your style of giving feedback to me was powerful yet gentle and helped me grow as a professional.

To my husband, Josh, I am forever grateful to you for all your love, encouragement, and support throughout this journey. Thank you for always pushing me to do my best and to never give up on my dreams. Without your unwavering support, I would not have completed this process. To my beautiful daughters, Everly and Amelia, thank you for your love and understanding. Balancing a career, education, and motherhood has not been easy but you girls have been a complete joy and light in my life. I hope to be a positive example for you both of what women are capable of in this world.

I would like to acknowledge the strong, intelligent women at Auburn University who inspired me to realize my potential and chase my dreams. Without your mentorship and encouragement, I would not have undertaken a doctoral program of study. Thank you to Dr. Harriet Giles, Dr. Kate Thornton, and Dr. Amanda Evans for seeing my potential and helping me realize it was there all along. Your lived examples of intelligent, capable academic women helped me push through the difficult moments in my journey and continue to move forward.
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CHAPTER I: INTRODUCTION

Background of the Study

Globally, there are certain expectations surrounding becoming a mother related to pregnancy and the birth. For many women, the birth of a child represents a natural event filled with joy. Societally, the expectation is that pregnancy, birth, and the transition into motherhood are normal, positive experiences for all women (Davis-Floyd & Cheyney, 2019). The transition into motherhood is a process that encompasses two key physical events: the pregnancy and the childbirth. These events can have either positive or negative implications for the woman’s transition into motherhood. Positive implications may include feelings of empowerment and competence as a parent. Negative implications may include a myriad of complications including physical or mental health problems (Prinds et al., 2012). The purpose of this research is to focus on the mental health and wellbeing aspect of this pivotal transition in women’s lives.

Motherhood, as a concept, has been described by many women as a highly pleasurable and fulfilling experience that is incomparable to anything else. (Hanley, 2009; Gamble, & Creedy, 2004). However, research shows that some women develop impairments in physical and mental health functioning and wellbeing as a result of the major physical and psychosocial changes that take place during the transition into motherhood (Austin et al., 2010; Ayers & Pickering, 2001; O’Hara et al., 2014).

The prevalence rates for both minor and major depression are around 20% during pregnancy and the first three months postpartum (O’Hara et al., 2014). A study by Austin et al. (2010) focused on the prevalence of depressive and anxiety disorders in the postpartum period along with a focus on improving detection. This study found that 20.4% of the women in their sample (n=235) had an anxiety disorder with two-thirds of these women also having comorbid
depression. Further, 37.7% of this sample were found to have major depression with comorbid anxiety disorder. These diagnoses were ascertained by using the Edinburgh Postnatal Depression Scale with additional interview questions regarding the severity of their symptoms over the last two months (Austin et al., 2010). Additionally, Ayers & Pickering (2001) found that at least 1.5% of women develop chronic post-traumatic stress disorder as a result of childbirth. For women experiencing mental health issues during pregnancy and in the postpartum period, the sharp contrast between societal expectations and personal experiences often lead to feelings of failure and exclusion from the mainstream of society (Edozien & O’Brien, 2017; Hanley, 2009). In other words, when women experience the transition into motherhood and even motherhood itself as negative, they may feel alienated by their experiences because, societally, motherhood is expected to be a positive event (Davis-Floyd & Cheyney, 2019; Edozien & O’Brien, 2017; Hanley, 2009).

Mental health issues related to the perinatal period are complex and not well understood by mainstream society. Mothers themselves may not understand these issues, which could also be a factor that may impact their ability to recognize that they are experiencing a perinatal mental illness (Edozien & O’Brien, 2017). Perinatal mental health problems and illnesses include those which complicate pregnancy and the year following the birth. In the perinatal time period, women are more vulnerable to mental health problems (Hanzak, 2016). Some would argue that pregnancy and birth are the most complex events in the human experience due to the myriad changes taking place including the onset or intensification of symptoms of psychiatric disorders (Brockington, et al., 2017; Edozien & O’Brien, 2017). Due to the complexity of the event, pervasive stigma related to perinatal mental illness, and the positive outcome, the child, women may minimize their negative experiences and have difficulty addressing perinatal mental health

Many factors affect the identification of perinatal mental health concerns including: societal norms and attitudes; stigma surrounding perinatal mental illness; and cultural differences related to notions of wellness and illness (Buist & Bilszta, 2011; Cantwell & Smith, 2009). Due to these factors and disconnection in communication between professionals involved in the care of perinatal women, perinatal mental health concerns can be overlooked (Buist & Bilszta, 2011; Cantwell & Smith, 2009; Laios, et al., 2013). Research shows that the practice of managing pregnancy and birth as a complex medical event does not leave enough room to allow mothers to discuss their distress while professionals may not fully understand the distress mothers are feeling is related to perinatal mental health (Brockington, et al., 2017; Davis-Floyd & Cheyney, 2019; Laios, et al., 2013). In one study, mothers identified internal conflicts regarding ambivalence related to seeking support and hope for healing (Muzik et al., 2017). In another study, the researcher found that mothers often experience difficulty in acknowledging their distress due to stigma, lack of understanding by healthcare professionals, poor recognition of the difference between depression and normal adjustment, and difficulty accepting help (Buist, 2011). When mothers do not feel able to discuss these issues with their health care providers or professional counselors then they continue to experience the negative effects of perinatal mental illness (Buist, 2011; Laios, et al., 2013; Muzik et al., 2017). Additionally, health care providers may not have the knowledge and skills necessary to facilitate the conversation related to perinatal mental health (MPhil, 2014; Noonan et al., 2018). In a study by MPhil (2014) midwives expressed difficulty caring for distressed women in the postpartum period due to having a limited understanding of trauma and its relationship to the care women received. Having conversations about poor perinatal mental health was difficult for these professionals. In addition, Noonan et al.
(2018) found that the participants in their study, general practitioners, felt unprepared to address perinatal mental health with their patients due to limited continuing education opportunities. Furthermore, the participants identified pharmacology related to perinatal mental health as more of a niche, and that they had limited education in this area (Noonan et al., 2018). Therefore, it is important for counselors and the profession of counseling to continue working to de-stigmatize mental health concerns especially related to perinatal mental health so that women will feel comfortable discussing concerns they have with their healthcare providers. Additionally, counselors and the profession of counseling can support health professionals to have the skills necessary to facilitate these conversations by providing relevant continuing education opportunities.

Statement of the Problem and Research Questions

Statement of the Problem

The United States spends more than any other nation in the world on perinatal healthcare; however, it currently and consistently ranks near the bottom on most standard measures of perinatal health to include mental health and wellness (Creanga et al., 2014; Lu, 2010; MacDorman et al., 2016). Some argue that in the culture of the United States, women are viewed and treated as “wrappers” for babies and are not useful once the baby has been born (Verbiest et al., 2016, p. S5). Following this argument, perinatal care in the United States can be characterized as infant-centered care rather than woman-centered (Creanga et al., 2014; Davis-Floyd & Cheyney, 2019). In contrast, a system based on woman-centered care, postpartum services would include coordinated care that includes maternal health and healing along with family wellness and function (Verbiest et al., 2016, p. S5). Researchers have noted that women receiving mainstream care have reported feelings of dissatisfaction with the emotional aspects of
care (Gamble & Creedy, 2007). The issue of lack of support and emotional care during the perinatal period has been identified by others as a problem to be solved (Shah, 2012).

The current system of perinatal health care in the United States is characterized by greater access, higher utilization, and less fragmentation which creates opportunities to identify mental health problems sooner and respond appropriately (Leight, et al., 2010; Verbiest et al., 2016). This is a strength; however, limitations continue to exist in this system. Specifically, in the later stages of pregnancy, women attend visits with their healthcare provider weekly to ensure the health and wellbeing of the mother and infant. Despite more frequent contact and opportunities to identify mental health problems, women with psychiatric disorders in the perinatal period are less likely to receive mental health treatment (Leight, et al., 2010; Verbiest, et al., 2016). This gap in services could be related to the sharp decrease in care and attention provided to women in the postpartum period. Once the baby is born, women typically do not see their healthcare provider until six weeks have passed (Creanga et al., 2014; Davis-Floyd & Cheyney, 2019; Leight, et al., 2010; Verbiest et al., 2016). During this large gap in services, mental health problems can escalate quickly before health care providers have an opportunity to assess women and connect them with appropriate services. During this time period, infants attend several appointments depending on the individual needs of the child and family (Creanga et al., 2014; Davis-Floyd & Cheyney, 2019; Leight, et al., 2010; Verbiest et al., 2016). For example, the infant will visit with their pediatrician and may also visit a lactation consultant if the mother has chosen to breastfeed. With the focus on the infant, the mother may develop a mental health problem that goes unnoticed and untreated leading to negative consequences for the mother, the infant, and the family (Creanga et al., 2014; Davis-Floyd & Cheyney, 2019; Leight, et al., 2010; Verbiest et al., 2016). Mothers often experience difficulty in acknowledging their distress due to
stigma, lack of understanding by healthcare professionals, poor recognition of the difference between depression and normal adjustment, and difficulty accepting help (Buist, 2011).

Perinatal mental illness may result in the children experiencing increased behavioral and neurocognitive delays and disorders throughout childhood and into adulthood (Buist, 2011). Additionally, traumatic birth experiences can cause disruption in mother-infant bonding leading to impaired child development due to resulting attachment issues (Simpson & Catling, 2016). Untreated perinatal mental illnesses have been shown to result in suffering for mothers; strained familial relationships; negative effects on children’s emotional social, and cognitive development; and maternal suicide (Buist, 2011; Hanzak, 2016; Simpson & Catling, 2016). In sum, perinatal mental illness and complications have a global affect on women, children, and families. Additionally, the stigma related to perinatal mental illness has an effect on professionals which may lead to hesitation related to conversations around perinatal mental health (MPhil, 2014; Noonan et al., 2018). These two factors collide in a way that women suffering with perinatal mental illness are not able to express their distress and professionals are not comfortable facilitating conversations around perinatal mental health which then leads to increased complications for women and their families because they are going undiagnosed and untreated.

Currently, the literature is replete with studies concerned with perinatal mental illness and treatments for them while there are fewer studies concerned with perinatal mental wellness (Ayers., et al., 2007; Bonacquisti, et al., 2017; Cantwell & Smith, 2009; Gamble, & Creedy, 2004; Gamble & Creedy, 2009). Furthermore, the focus of research efforts thus far has been on secondary and tertiary prevention efforts. The current literature delves deeper into perinatal mental illnesses, how to conduct screening and assessments; how to treat perinatal mental
illnesses; and some information regarding the effectiveness of the treatments available at this time (Ayers, et al., 2007; Bonacquisti, et al., 2017; Cantwell & Smith, 2009; Gamble, & Creedy, 2004; Gamble & Creedy, 2009). Researchers have suggested ways to improve perinatal mental health in the context of studies related to identification and treatment of perinatal mental illness; however, these suggestions have not been met with increased research on the effectiveness of the strategies for improving perinatal mental wellness (Edozien & O’Brien, 2017; Rafferty, 2013; Simpson & Catling, 2016). This suggests that less is known about primary prevention of perinatal mental illness and the promotion of wellness during the perinatal period. Furthermore, researchers have noted that primary prevention should be at the forefront of new research so that new models of care can be developed that ensure the psychological wellbeing of women and reduce the stigma of mental health complications (Boorman et al., 2014; Fenwick et al., 2013; Johnson-Agbakwu et al., 2014).

**Purpose of the Study**

The culture around pregnancy, birth, wellness, and illness varies globally. Many westernized countries, like the United States, treat birth as a medical event that needs to be managed by specialists, namely obstetricians (Davis-Floyd & Cheyney, 2019). Consequently, women typically give birth in the hospital and receive several medical interventions such as epidurals for pain relief, intravenous fluids and medications, continual monitoring, and more in order to mitigate perceived risks (Davis-Floyd & Cheyney, 2019). In other countries, birth is treated as a natural event where women give birth at home or in a birthing center in the community and are attended by midwives, doulas, or other female healers. In these cultures, women do not receive as many medical interventions, and are not viewed as needing to be managed like a person with an illness (Davis-Floyd & Cheyney, 2019). Due to these cultural
differences, the concept of perinatal mental illness varies like other aspects of pregnancy and birth. Therefore, the identification of perinatal mental illness can be affected even more so by cultural factors (Davis-Floyd & Cheyney, 2019). This study is designed to provide a starting point for understanding the concept of perinatal mental wellness in the context of the culture of the United States and strategies that support mental wellness during the perinatal period. The focus of this study is to meaningfully define perinatal mental wellness, explore how wellness is supported during the perinatal period, and explore strategies that could provide increased support for perinatal mental wellness.

**Research Questions**

Consistent with the statement of the problem and the purpose of the study, the following research questions were designed to guide this study:

1. What does perinatal mental wellness mean to mothers?
2. What aspects of maternity care help to support mental wellness for mothers in the perinatal period?
3. What aspects of maternity care do mothers want to change in order to better meet their mental health needs in the perinatal period?

**Significance of the Study**

Perinatal mental illness is a pervasive and costly issue that has profuse negative effects on women, their children, and families (Ayers, et al., 2006; Brockington, et al., 2017; Creanga et al., 2014). In the United States, in particular, an increasing number of women are being affected by perinatal mental illnesses but may not be connected to appropriate services before these negative effects take hold and have long term implications for the mother, her infant, and the family (Creanga et al., 2014). As previously noted, the existing literature is aimed toward increased
understanding of secondary and tertiary prevention (Ayers., et al., 2007; Bonacquisti, Cohen,, & Schiller, 2017; Cantwell & Smith, 2009; Gamble, & Creedy, 2004; Gamble & Creedy, 2009).
Secondary prevention aims to detect illness early and prevent the illness from escalating while the purpose of tertiary prevention is to treat the symptoms of illness and improve quality of life with the illness (Cantwell & Smith, 2009; Tandon et al., 2011). In the context of the literature regarding perinatal mental illness, researchers have focused on screening, assessment, and treatment. In contrast, this research aims to uncover pathways toward primary prevention by focusing on the promotion of mental wellness during the perinatal period. The purpose of primary prevention is to prevent the onset of an illness. In the context of perinatal mental health, primary prevention efforts are significant because women and their families could avoid the development of illness and the associated complications such as decreased relationship satisfaction among partners; mother-infant bonding and attachment problems; feelings of grief and loss; and more (O’Hara et al., 2014; Simpson & Catling, 2016). Instead, by focusing on perinatal mental wellness, mothers and families can be supported throughout this transformative experience in a way that may instead lead toward increasingly positive outcomes for mothers and their families.

**Theoretical Framework of the Study**

This study is designed to meaningfully define perinatal mental wellness and better understand how mental wellness is sustained throughout the perinatal period along with strategies that are used to promote perinatal mental wellness. Following grounded theory methodology, interviews with women will be conducted for data collection. Data analysis will consist of coding the transcribed interviews following the constant comparative approach associated with grounded theory methodology (Strauss & Corbin, 1997). These codes will serve
to ground the developing theory in the data and become the theory itself through a series of iterations and abstractions. An audit trail will be created in order to support trustworthiness of the study.

Because this inquiry may result in a vast amount of information related to various aspects of the perinatal period and the development of motherhood, I need a way to meaningfully organize this data. One way to organize and examine the data is through the lens of the Indivisible Self Model of Wellness (Myers & Sweeney, 2004). This framework is a wellness, strengths-based approach intended for use in counseling; therefore, this framework fits nicely with the research proposed due to the focus on promoting wellness among women in the perinatal period. Using this holistic approach as an organizing framework, I will be able to examine several dimensions of wellness which will provide a more detailed, clear picture of wellness in the perinatal period along with situating any interventions or strategies within a dimension of wellness.

**Indivisible Self Model of Wellness.**

The Indivisible Self Model of Wellness evolved from the Wheel of Wellness model first presented by Sweeney and Witmer (1991) and Witmer and Sweeney (1992). The Wheel of Wellness model was based on Individual Psychology and Adlerian major life tasks including work, friendship, love, self, and spirit. The model was meant to be used in counseling to promote the development of wellness through the construction of wellness plans (Myers, et al., 2000). In the process of evaluating the Wheel of Wellness, the researchers found that the interrelationships among the components and the structure of the model were not well supported by the factor analysis; however, the results did provide a base for re-examining the structure of wellness (Myers & Sweeney, 2004). The Indivisible Self Model of Wellness was born out of the re-evaluation of the Wheel of Wellness Model, and is still based in Adlerian theory. The five factors
of the model were identified by using exploratory and confirmatory factor analysis using the original 17 scales of the Wheel of Wellness. The resulting factors are as follows: Essential Self, Social Self, Creative Self, Physical Self, and Coping Self (Myers & Sweeney, 2004).

The Essential Self encompasses four components: spirituality, self-care, gender identity, and cultural identity. This dimension of wellness is concerned with one’s existential sense of meaning, purpose, and hopefulness toward life. Gender and cultural identity are viewed as filters through which experiences are seen; therefore, affecting the meaning making processes. The Creative Self includes five components: thinking, emotions, control, positive humor, and work. This dimension of wellness is concerned with how individuals make a unique place for themselves among others related to social interactions. This dimension highlights the interrelatedness of emotions and cognitions. The Coping Self is made up of four components: realistic beliefs, stress-management, self-worth, and leisure. This dimension of wellness is concerned with how one regulates responses to life events and how to overcome adversity. The Social Self encompasses two components: friendship and love. This dimension is concerned with relationships, and how positive relationships enhance the quality and length of life. The Physical Self is made up of two components: exercise and nutrition. This dimension of wellness is concerned with how one takes care of the physical body (Myers & Sweeney, 2004; Myers, et al., 2004).

**Definition of Key Terms**

**Perinatal**- Around childbirth; The period of time between twenty two weeks gestation and seven days after the birth of the infant. *World Health Organization (WHO)*, 2019.

**Prenatal Period**- The developmental period between conception and birth consisting of the following three stages: Germinal Stage (first two weeks), Embryonic Stage (the following six
Postpartum Period - The period consisting of approximately 6 weeks following the delivery of the infant in which the mother’s reproductive system returns to its pre-pregnant state. *APA Dictionary of Psychology, 2018.*

Perinatal Mental Health - Mental health of women around childbirth usually between twenty-two weeks gestation and four weeks postpartum. (Buck, 2009)

Perinatal Mental Illness - Mental health disorders occurring right before or right after childbirth usually between twenty-two weeks gestation and four weeks postpartum or after the birth. Perinatal mental illness can include depression, anxiety, psychosis, bipolar disorder, post-traumatic stress disorder (PTSD), and more (O’Hara & Wisner, 2014).

Wellness - A state of physical, mental, and social well-being which results from four key factors over which individuals have some control. The four key factors are as follows: biology (referring to body condition), environment, lifestyle, and health care management. *APA Dictionary of Psychology, 2018.*

Organization of the Dissertation

The proposed study is organized into five chapters. Chapter I explores the background of the study that provides an overview about the nature of perinatal mental illness and factors related to the recognition of perinatal mental health concerns based on the existing research and my personal as well as professional experience. Examples of difficulties mothers and professionals face related to perinatal mental health concerns are presented and discussed. Next, this chapter provides a statement of the problem to be examined along with the goal to demonstrate the gap in research on the awareness and intervention of perinatal mental health and wellness. The
research questions are listed along with an overview of how the study will be conducted. Definitions of the terms used throughout the study are listed. Chapter II examines the relevant literature, including a review of the existing work on perinatal mental illness, and expands on the theoretical framework of the study.

Chapter III includes an overview of the dissertation’s research design, methods, and sampling procedures along with the rationale for choosing the methodology. In this chapter, I present my qualifications, population and sample, method of gathering data, method of data analysis, triangulation, limitations of the study, and a chapter summary. Chapter V includes the findings of the study generated from semi-structured interviews as well as the themes generated from the constant comparative analysis. The themes are explained and the final model is presented. Chapter V explores the major findings and connections to the existing literature. The implications of the findings are presented and how these could practically apply in the context of perinatal care in the United States. The chapter concludes with an explanation of the limitations of the study, implications for further researchers, recommendations for professionals, and the contribution of this study to the literature.
CHAPTER II: LITERATURE REVIEW

Understanding perinatal mental wellness requires familiarity with the relevant literature. Several articles were reviewed that addressed prevention related to perinatal mental illness along with how to promote perinatal health. Perinatal mental wellness was not directly addressed; however, mental health is considered among the perinatal health research articles. Further, a vast amount of literature exists related to perinatal mental illness, risk factors for perinatal mental illness, treatment models, and suggestions to support and improve perinatal health care including mental health. Therefore, this body of work will be reviewed in order to understand the inverse of the topic at hand. Understanding perinatal mental illness and the pathways to these illnesses will reveal pertinent information regarding how to then approach perinatal mental wellness. In sum, understanding the development of perinatal mental illness will provide knowledge regarding what to avoid when working to promote perinatal mental wellness.

Perinatal mental illness can be defined as mental health disorders occurring right before or right after childbirth usually between twenty weeks gestation and four weeks post-partum or after the birth. Perinatal mental illness can include depression, anxiety, psychosis, bipolar disorder, post-traumatic stress disorder (PTSD), and more. Perinatal mental illnesses result in impaired functioning of the mother along with suboptimal infant development (O’Hara & Wisner, 2014).

Perinatal mental wellness, as defined by this researcher, is a state of being healthy in mind during the perinatal period between twenty weeks gestation and four weeks postpartum. This definition is left imprecise as each woman is unique; therefore, perinatal mental wellness may look different for each woman. Further, one of the aims of this study is to delineate this concept further based on the data collected. Therefore, this definition may change once data has
been collected and analyzed.

**Perinatal Mental Wellness**

Perinatal mental wellness refers to being healthy in mind during the perinatal period. This term is not yet well defined; however, more precisely defining the term is one aim of this research. Understanding perinatal mental wellness could be beneficial to the counseling profession due to the interventions that could be developed to promote wellness during this transformative season in life. Counseling is a profession based on a wellness model; therefore, discovering innovative, dynamic processes to promote wellness fits well within the scope of practice of the profession. Helping women to sustain mental wellness during the perinatal period has potential for preventing the development of perinatal mental illness along with decreasing the stress related to adjusting to new family roles. This could have a trickle-down effect, and further promote wellness among the family unit which has positive implications for all family members.

**Barriers to Perinatal Mental Wellness.**

Several researchers have investigated barriers and facilitators of mental health care during the perinatal period. In a study by Nakku et al. (2016), several themes arose that created a clearer picture of the barriers to perinatal mental health care experienced by women in Uganda. The uptake and delivery of perinatal mental health care was affected by household, health-system, and community level factors. Participants in this study reported inadequate provision of maternal mental health care, lack of knowledge related to perinatal mental health among both women and care providers, poverty, low support, and stigma as barriers to maternal mental health treatment.

A study by Watson et al. (2019) explored the experiences of ethnic minority women
related to perinatal mental health in Europe. This study identified cultural expectations, lack of awareness, stigma, and culturally insensitive services as barriers to accessing appropriate treatment wherein women were left suffering in isolation. The women in this study revealed that they had to overcome cultural expectations of not discussing personal issues outside of the family home in order to seek support. The women identified that it was culturally unacceptable to talk about problems to anyone outside the family home, and that if they did discuss their problems then it would result in stigma. Women in the study reported feeling fearful of accessing support for perinatal mental illness because they felt that identification of their symptoms would result in being judged as a bad mother and having their children taken away from them. In short, lack of awareness of perinatal mental illness, cultural expectations, stigma, culturally insensitive services, and interactions with culturally insensitive providers negatively affect ethnic minority women’s access to appropriate perinatal mental health services and support in Europe (Watson et al., 2019).

Noonan et al., (2018) explored the perceptions of general practitioners in Ireland related to perinatal mental health and found that the health care professionals were aware of barriers related to assessing perinatal mental health along with the persistent stigma related to perinatal mental illness. The participants in this study identified time, language barriers, and fear related to uncomfortable interactions with women as barriers to assessment. Further, the participants reported that lack of insight and stigma related to perinatal mental illness were key factors related to women’s reluctance to disclose symptoms. The participants noted that accessing care related to perinatal mental health was a barrier for their patients because of the disjoint in services. They reported that women with severe perinatal mental illness received needed care while in maternity services; however, when they were discharged to the community mental
health services, all contact with maternity services ceased. In other words, collaboration between services related to perinatal mental health was lacking. The general practitioners further noted that being approachable was an important characteristic related to having conversations with women regarding perinatal mental health. This qualitative study produced another important theme related to continuing education or the lack thereof. The participants in this study reported that continuing education opportunities related to perinatal mental health were limited, and as a result, the medical professionals felt unprepared to address perinatal mental health with their patients. Furthermore, the participants identified pharmacology related to perinatal mental health was more of a niche, and that they had limited education in this area.

**Preventative Interventions and Treatments.**

Several researchers have explored prevention related to perinatal mental health from the perspective of women and providers. Throughout the process of reviewing the literature, three important topics arose related to the prevention of perinatal mental illness including education, practical tools for health care providers, and preventative interventions for women. These topics will be discussed in turn along with the suggestions made by the researchers for engaging in prevention efforts effectively.

**Education.**

Education regarding perinatal mental health and perinatal mental illness is an important aspect of prevention according to Dossett, et al. (2018) and Nakku et al. (2016). According to Dossett et al. (2018), educational programs addressing perinatal mental illness should be tailored to families, partners, and first time mothers. Furthermore, these programs should be accessible for the audience they are intended for by offering various modes of communication such as written, verbal, web applications, and public service announcements. The researchers also note
that it is important to offer these educational tools in multiple languages including indigenous languages so they are accessible to more people (Dossett et al., 2018). The participants in this study highlighted the importance of educating families in order to decrease stigma and dismissive behaviors regarding perinatal mental illness. In addition, the participants noted that it would be helpful to teach families about how to treat perinatal women with compassion and empathy in order to increase support. Finally, the researchers found that health care providers could benefit from further education regarding how to appropriately screen, assess, and treat perinatal mental illness along with how these may present in different cultures (Dossett et al., 2018). Similarly, Nakku et al., (2016) asserts that mental health literacy among mothers in the perinatal time period should be addressed through education in order to increase help seeking behaviors. This researcher also highlights the role of the male partner, and asserts that the involvement of the partner in the education program is paramount in order to harness their support. Educating the community regarding perinatal mental health and illness is also beneficial because this can help to decrease stigma which affects the help seeking behavior of women in a positive manner (Nakku et al., 2016).

**Practical tools for health care providers.**

For women experiencing perinatal mental illness, opening up about their symptoms may be difficult. Therefore, Noonan et al. (2018) highlights the importance of building a relationship between the health care provider and the woman. Having a positive relationship as characterized by strong rapport and mutual trust facilitates women to disclose their symptoms therefore making assessment, diagnosis, and treatment more likely. Nakku et al. (2016), notes the importance of keeping screening tools brief so that health care providers are able to address perinatal mental health needs effectively even when they are experiencing a large caseload or a
busy schedule. Furthermore, the researchers also note that supports for the healthcare providers are necessary in order for effective decisions to be made in regard to perinatal mental health. Supports for healthcare providers include having access to a referral network, collaborating with perinatal mental health specialists for advice regarding level of care, interpreter services, information regarding free accessible services in the community, and alternative pathways for mothers who do not wish to use medication (Noonan et al., 2018).

**Preventative interventions for women.**

Several researchers have investigated preventative interventions for women related to perinatal mental health ranging from prenatal yoga to multilevel counseling interventions. Beginning with prenatal yoga, these interventions will be discussed in further detail. Uebelacker et al., (2016) investigated perinatal depression and changes in depression with two groups of participants. One group participated in the yoga intervention while the other group participated in the Mom Baby Wellness Workshop intervention which consisted of a series of wellness education workshops. In the yoga group, the instructors adhered to a manual and no injuries were reported throughout the intervention. Changes in the severity of depression were in the expected direction and suggest that prenatal yoga could be a helpful intervention for women with mild levels of depression. These researchers assert that pregnant women need more treatment options beyond traditional forms of services. Furthermore, prenatal yoga is a promising alternative because it is widely accessible, acceptable to pregnant women, and has a positive impact on both physical and mental health (Uebelacker et al., 2016). Another researched intervention is support groups (Watson et al., 2019; Nakku et al., 2016). According to Watson et al., (2019), support groups are helpful because they are a safe space for women to share their feelings, be listened to, and feel connected to others. Women valued the support from others with similar experiences of
poor perinatal mental health whether the group was in person or in a virtual space. The work of Nakku et al., (2016) corroborate these findings and assert that group counseling is a viable treatment modality because it is culturally relevant as women already sit together and discuss issues that affect them. The findings of these studies suggest that support groups for women in the perinatal period have a positive effect on women’s mental health, and these types of groups are accepted by women (Watson et al., 2019; Nakku et al., 2016).

Tandon et al. (2011) explored a preventative cognitive behavioral therapy (CBT) intervention among women that was connected to a home visiting program. The study highlights the feasibility of the CBT preventative intervention as evidenced by strong buy-in, collaboration, high participant attendance, and high retention rates among participants. This CBT intervention aimed to prevent the onset and worsening of depressive symptoms among women, and the intervention was conducted over a period of six weeks. The findings of the study were positive and indicated that clients at risk for developing major depressive disorder who participated in the intervention exhibited decreased depressive symptoms from baseline to 1 week post-intervention and even further decrease in symptoms at 3 months post-intervention. In sum, this study suggests that preventative CBT interventions for perinatal depression can be implemented by home visiting programs and that CBT models can reduce symptoms of depression among women (Tandon et al., 2011). Another study, by Judd et al. (2011), aimed to prevent the development of mental health problems in the perinatal period and provided assessment and treatment for women who did develop mental health problems in the perinatal period. This service was more broad than the intervention related to the Tandon et al. (2011) study. This intervention addressed the following areas: increasing awareness of perinatal mental illness; providing information and advice; providing treatment and support; and providing education, training, and capacity
building. Increasing awareness of perinatal mental illness was accomplished by providing community education activities such as workshops regarding perinatal mental health along with the established childbirth and parenting classes. Providing information and advice was accomplished by giving information to women and families via a range of health care providers such as midwives, lactation consultants, and mental health professionals. With many providers being knowledgeable regarding perinatal mental health, women could have a conversation regarding mental health with several professionals during their perinatal care. Providing treatment and support was accomplished by providing treatment for women by mental health professionals including counselors and psychiatrists either in an office setting or in the woman’s home; further, the treatment could be provided for up to twelve months postpartum. Education, training, and capacity building was accomplished by educating midwives, lactation consultants, general practitioners, parenting support agencies, and mental health professionals on perinatal mental health and illness. Supervision was provided to these professionals so that they could review their cases with a perinatal mental health specialist. Further, some clinicians developed a support group for women in the community to address early intervention for mothers experiencing mild symptoms; further, these clinicians educated other professionals to provide the group in various settings. Participants in the study indicated that the program was valuable due to several factors including broad coverage of perinatal mental illness; inclusion of early intervention and prevention; outreach capacity; partnership and support for capacity building with several different professionals; accessibility of location; non-stigmatizing attitudes; and a staff consisting of highly skilled clinicians. This study suggests that a broad range of services targeting perinatal mental health can be successfully implemented in a community with various healthcare professionals, and successfully provide services to women at-risk for perinatal mental
illness or women experiencing mild symptoms (Judd et al., 2011).

**Holistic Approach**

According to a statement by Mental Health America (2014), perinatal mental illness negatively affects babies, mothers, fathers, and the entire family unit. To address this issue, Mental Health America (2014) states that support for parenting along with mental health treatment are both important aspects of addressing perinatal mental illness. The Australian government took a further step and created funding in their budget for perinatal mental health initiatives with the goal of providing routine screening for all women in the perinatal period along with support and care for women at-risk of developing perinatal mental illness and training healthcare professionals in perinatal mental health screening (Ferguson-Hill, 2010). A common aspect with both of these government statements and action is that of including more than treatment alone provided by mental health professionals. These positions suggest that the family as a whole should be involved along with providing parenting support; routine screening and assessment; and training more healthcare professionals on perinatal mental health and recognizing symptoms. Furthermore, these positions highlight the need for a holistic approach to perinatal mental health by including more than women and mental health professionals when addressing the issue of perinatal mental health.

The study by Ferguson-Hill (2010) focused on the Aboriginal and Torres Strait Islander populations and perinatal mental health. This researcher highlighted the role of spirituality, familial relationships, and culture related to perinatal mental health and found that these were vital for the wellbeing of these populations. Furthermore, programs such as ‘Strong Women, Strong Babies, Strong Culture’ that incorporate traditional cultural approaches to parenting and lifestyle alongside support provided to women in the perinatal period was helpful for promoting
mental wellness (Ferguson-Hill, 2010, p. 233). In a study by Watson et al. (2019), these findings were corroborated via the study participants and their responses related to coping. The women reported that they responded to their perinatal mental health difficulties with the following coping skills: minimizing & self-silencing; drawing on their inner strength; problem-solving; seeking spiritual treatment from a religious leader; and other sources of spiritual support such as personal faith, private prayer, and accepting prayer from others (Watson et al., 2019). These two studies highlight that the spiritual aspect of a woman’s health is important to promoting mental wellness in the perinatal period.

Two other studies also point toward approaching perinatal mental health with a holistic approach. A study by Chen et al. (2011) focuses on early intervention for Singaporean women experiencing depression in the perinatal period, and the interventions used in this study consisted of screening and assessment, psychoeducation, individual counseling, medication, and a support group. These interventions were nested within a case management model with a multidisciplinary team which provided integrated, individualized, and continuous care. The participants in this study who underwent the intervention had significant improvements in their Edinburgh Postnatal Depression Scale (EPDS) scores indicating that their symptoms had decreased (Chen et al., 2011). This multifaceted approach further indicates that a holistic approach is helpful when addressing perinatal mental health. The participants in the study by Nakku et al. (2016) corroborate this idea via their feedback to the researchers. The participants in this study were from Africa and they recommended the following associated with perinatal mental health care: ensuring mental health medications are available at maternity units; providing food to women when they are admitted to the hospital; educate midwives regarding perinatal mental health; train midwives how to screen for perinatal mental illness; ensure
resources are provided to enable mental health services to be provided alongside maternal health care; and provide training in the communities to decrease stigma and boost support of women at the community level. The participants in these studies represent a variety of populations around the world; therefore, indicating that a holistic approach to perinatal mental health care is acceptable to many different cultures and is an important aspect of interventions aimed at promoting perinatal mental health and treating perinatal mental illness.

**Collaborative Approach.**

Researchers have highlighted the need for a collaborative approach when addressing perinatal mental health. In particular, a study by Lomonaco-Haycraft et al. (2018) explores the development of an integrated behavioral health model related to perinatal mental health. The program developed by these researchers integrates behavioral health into perinatal settings and focuses on improving perinatal mental health along with expanding this type of integrated care. The major strengths of the program are the interdisciplinary collaboration and the consistency of the program throughout the perinatal clinics. The program implemented universal screening for perinatal mental illness which was then followed up by the integrated behavioral health intervention including consultation with behavioral health professionals, in-depth assessment with a behavioral health professional, treatment planning, and treatment. This program was nested within the existing perinatal health settings such as doctor’s offices and midwives’ offices where women attended appointments regularly, and wherein the behavioral health team and the medical team could collaborate. The qualitative data from this study was promising, and showed a decrease in depressive symptoms in mothers who participated in the program. Furthermore, the data showed a decrease in toxic stress in the home which had a trickledown effect of improving the wellness of the family unit.
Another study by Dossett et al. (2017) supports the idea of collaboration and integration that Lomonaco-Haycraft et al. (2018) presented. In this qualitative study, the participants reported difficulty with disclosing mental health issues to health care providers due to hardship with developing trusting relationships. The participants disclosed that trusting relationships were hard to develop with providers as the provider was different at each appointment and that the providers dismissed their concerns regarding mental health. The participants in a study by Watson et al. (2019) echoed the same sentiments reporting that the model of care they received negatively affected their ability to access support for perinatal mental health problems. These women suggested that a continuous care model would be beneficial for establishing a trusting relationship with health care providers in which they could feel comfortable disclosing mental health difficulties (Watson et al., 2019). These studies together highlight the need for a continuous, collaborative model of care in order to more effectively meet the mental health care needs of women during the perinatal period.

Women are not the only population suggesting a collaborative model of care to address perinatal mental health. The participants in the study by Noonan et al. (2018) consisted of general practitioners who also reported that collaboration was critical for meeting the needs of women experiencing perinatal mental illness. These healthcare professionals cited the need for support from specialist perinatal mental health professionals along with a collaborative relationship in order to make appropriate referrals for psychological therapies along with the medical care they provide. Furthermore, Ferguson-Hill (2010) suggests that collaboration in the community is important when addressing perinatal mental health with the Aboriginal and Torres Strait Islander populations. Culturally specific healers in the local community centers provide programs for women and families focusing on strengthening wellness. When perinatal mental
illness is diagnosed outside of these culturally specific health centers, collaboration with the healers in the community promotes recovery among these women as the healers are experts in community-relevant knowledge. When collaboration is occurring, cultural information exchange and increased understanding of culturally specific issues by the health care team serve to promote wellness among the women in this population (Ferguson-Hill, 2010). The study by Dossett et al. (2018) supports this notion and suggests that partnerships between community based organizations and medical centers are beneficial because the needs of women and their families are met in spaces that are accessible to them. In sum, collaboration among women, their healthcare team, and community resources benefits the mental health of women during the perinatal period.

**Systemic Change**

Along with the above considerations related to perinatal mental wellness, researchers have begun to explore the implications for systemic change within the current maternity care model. Mental Health America (2014) states that a comprehensive system of prevention, outreach, and response is needed in order to respond effectively to perinatal mental illness and the consequences for the family unit. This position implies that the current model of maternity care is not as effective as necessary in addressing perinatal mental illness and that systemic changes would improve care for women and families.

A study by Dossett et al. (2018) highlights policy level issues related to perinatal mental healthcare through a qualitative, community-based participatory research. Four main themes emerged from their work including: importance of education; information delivery related to perinatal mental illness; the role of culture in treating perinatal mental illness; provider and patient relationship; and accessibility of maternal mental healthcare. Following these themes,
solutions to the issues were developed through the research to include policy level, systemic changes. First, an important solution in addressing perinatal mental health that was highlighted in the data was to promote and implement home visiting programs so that women could receive effective services in a place where they were comfortable; further, easily accessible community support groups were found to be vital for promoting a culture of health among women who experience perinatal mental illness. Next, a critical solution emerged that focused on educating the community about perinatal mental illness especially child care centers, schools, churches, and community centers. A policy suggestion related to this focused on child protective service agencies. The participants in this study revealed that mothers fear disclosing their mental health issues because they worry that their children will be removed from their care and lose custody. Therefore, child protective service agencies need to be educated regarding perinatal mental illness and how to support mothers in healing by connecting them to appropriate care rather than removing their children. Another government policy suggestion is that of funding for appropriate services. This study highlighted that perinatal mental health specialist services is limited, and that a policy solution would be for federal, state, and local agencies to allocate more funding and resources to address this shortage in services. Finally, a solution addressing the training of professionals emerged from this data. These researchers suggest that education regarding perinatal mental illness should be incorporated into the curriculum of physicians in medical school along with education regarding how to establish a positive provider-patient relationship as participants in the study noted that it is vital for providers to be sensitive and culturally competent. Further, the researchers assert that training for all health professionals regarding screening and treatment pathways for perinatal mental illness should be mandated. The researchers also suggest that toolkits for prenatal care clinics should be created in order to
support professionals in addressing perinatal mental health. They suggest that the toolkit include a checklist of potential stressors to review with women along with some preventative measures that women can be connected to (Dossett et al., 2018). The study by Noonan et al. (2018) corroborates these findings in their study which asserts that physicians require access to culturally sensitive, community based perinatal mental health services along with evidenced based interventions in order to successfully address perinatal mental illness with their patients. Additionally, physician participants in this study highlighted the need for a standardized curriculum on perinatal mental health for physicians in medical school along with clinical placements in community mental health settings (Noonan et al., 2018).

**Perinatal Mental Illness**

Perinatal mental illness refers to a broad group of illnesses that occur in mothers just before or just after childbirth (Hanley, 2009). Perinatal mental illnesses can vary in severity from adjustment disorders to postpartum psychosis. Perinatal mental illnesses include postpartum depression, postpartum anxiety, post-traumatic stress disorder, eating disorders, tokophobia, bipolar disorder, schizophrenia, and postpartum depression with psychotic features (Edozien & O’Brien, 2017). Perinatal mental illnesses (PMI) have long-term implications for mothers, children, and the family; further, PMI’s are the most common complication of pregnancy (Lomanaco-Haycraft et al., 2018). The following sections will review the most researched PMIs.

**Diagnosis**

Postpartum depression (PPD) is the most common perinatal mental illness identified among women with studies identifying that 3% of women will suffer severe depression and 7% will experience a less severe episode (Hanley, 2009). Other researchers have found that 12% of women suffer from severe depression during pregnancy and 19% of women suffer from severe
depression in the postpartum period (Edozien & O’Brien, 2017). Although the statistics vary, depression in the perinatal period has become increasingly understood over the past thirty years. PPD, like PMI, can vary in severity from major acute psychotic postpartum depression to minor chronic postpartum depression. Major PPD involves a marked lowering of the mood with an alteration in clear thinking, slowing down of psychomotor functions, and the symptoms of typical major depression (Hanley, 2009). Studies have identified that one third of women to develop PPD may present with symptoms within the first four weeks after the birth and two thirds between ten and fourteen weeks after the birth. Often, women who present with symptoms early have more profound illness while those to present with symptoms later tend to be misdiagnosed or not diagnosed at all. PPD can dissipate over time, and can recur with future pregnancies (Brockington, et al., 2017; Hanley, 2009). In a study by Austin et al. (2010), researchers found that 37.7% of women in their study presented with comorbid PPD and postpartum anxiety (PPA). In severe cases, PPD may include self-harm behaviors or suicidal behaviors (Hanley, 2009).

Postpartum psychosis includes illnesses such as postpartum mania and PPD with psychotic features, and is a severe mental illness. Postpartum psychosis typically begins abruptly within a few days of the birth and escalates quickly; therefore, postpartum psychosis should be treated as an emergency requiring urgent assessment and treatment. Postpartum psychosis occurs more often among women who have a family history of mental illness, a diagnosis of bipolar disorder, and first time mothers. In fact, in women with a history of bipolar disorder the risk for developing postpartum psychosis increases to at least one in three (Cantwell & Smith, 2008). Studies have found that in about one quarter of mothers who suffer postpartum psychosis, it will recur in future pregnancies (Edozien & O’Brien, 2017; Hanley, 2009). Women suffering with
postpartum psychosis typically experience auditory and visual hallucinations that are frightening and complicated (Hanley, 2009).

Some women develop post-traumatic stress disorder (PTSD) as a result of pregnancy and childbirth. In a study by O’Donovan et al. (2014), 45.5% of women reported that their childbirth experience was traumatic (n=4394), and 7.9% of these women went on to develop PTSD between four and six weeks postpartum. The current literature on the topic suggests that the nature of childbirth may reactivate previous trauma such as physical or sexual abuse; further, becoming pregnant and ultimately a parent may result in complex feelings that contribute to resultant PTSD (Brockington, et al., 2017; Hanzak, 2016). The rate of occurrence identified by research varies with some studies finding that up to 5% of women develop PTSD as a result of childbirth while others have found that 1.5% of women develop the illness (Ayers & Pickering, 2001; Brockington, et al., 2017). Two prospective studies indicated that the incidence of PTSD as a result of childbirth is above zero and that there are contributing factors which are identifiable (Ayers & Pickering, 2001; O’Donovan et al., 2014). Ayers & Pickering (2001) found that 2.8% of women met PTSD criteria at 6 weeks postpartum while 1.5% of women met PTSD criteria at 6 months postpartum. O’Donovan et al. (2014) identified that it is possible to identify psychosocial, psychiatric, antenatal, and perinatal factors predictive of women who go on to develop PTSD in the postpartum period. As with PTSD resulting from other causes, mothers experiencing PTSD as a result of childbirth may experience intrusive flashbacks, nightmares, and avoidance of reminders including their infants (Brockington, et al., 2017). In a study by Maggioni, et al.(2006), 32.1% of mothers in their sample experienced one or two positive sub scales of PTSD symptoms. Of these mothers, 15.5% had positive intrusion sub scales, 25% had a positive arousal subscale, and 3.6% had a positive avoidance subscale. In this study, 2.4% of
mothers in their sample were identified as having complete PTSD. The researchers concluded that depression prior to pregnancy shows comorbidity with PTSD and that psychosomatic vulnerability increases the incidence of PTSD development. Currently, women are not screened or assessed for PTSD in the obstetrical postpartum survey; therefore, detection is poor. Further, the suffering of the mother may have implications for the development of the infant and the familial relationships (Maggioni, et al., 2006).

Edozien & O’Brien (2017) suggest that birth is a strong trigger for bipolar recurrence; further, as many as one in two women will suffer a recurrence with one in five women experiencing a severe episode. With bipolar disorder, moods may shift dramatically and women may experience episodes of extreme mania with high energy levels or debilitating depression with feelings of despair with relatively normal moods occurring between the shifts. Some evidence suggests that women with bipolar disorder are at an increased risk of developing postpartum psychosis with episodes occurring following 25-50% of deliveries (Hanley, 2009).

Tokophobia is an extreme fear of childbirth in which women will avoid pregnancy in order to avoid the birthing process. There is not agreement in the field regarding the measurement of tokophobia as the fear of birth presents as a spectrum ranging from mild fear to a pathological level of anxiety. Tokophobia may affect nulliparous women which is called primary tokophobia or result from a previous negative birth experience which is known as secondary tokophobia (Edozien & O’Brien, 2017).

Consequences

Perinatal mental illness can have a variety of significant short and long term effects on the mother and her family which impacts day to day functioning and quality of life (Edozien & O’Brien, 2017; Hanley, 2009). Qualitative studies have revealed that women have reported
feelings of inadequacy which impacts their mental wellbeing negatively (Butler-O’Halloran & Guilfoyle, 2015). In particular, atypical depression and bipolar disorder have been related to poor maternal functioning. In a study by Barkin et al. (2016), maternal functioning was negatively correlated with the mother’s age, depression, and atypical depression. Women experiencing PTSD as a result of birth may experience high anxiety and avoid reminders of their birth which can result in avoidance of health professionals and health care settings. Further, women who experience PTSD as a result of birth may also experience feeling a loss of trust in health care professionals and be increasingly sensitive to feeling judged, not listened to, or not taken seriously by those professionals (Ayers, et al., 2007). Beck (2004) found that women who experienced PTSD resulting from a traumatic birth, in particular, had an intense need to know the details of their births and ask questions of their health care providers. These women reported a strong need to understand what happened and why it happened. Due to the experience of perinatal mental illness, PTSD in particular, women have reported feeling cut off from motherhood, and that they miss out on bonding appropriately with their infant, making friends who are mothers, and hopes for additional children (Beck, 2004). Mothers have identified internal conflicts regarding ambivalence related to seeking support and hope for healing (Muzik et al., 2017). Mothers often experience difficulty in acknowledging their distress due to stigma, lack of understanding by healthcare professionals, poor recognition of the difference between depression and normal adjustment, and difficulty accepting help (Buist, 2011).

Perinatal mental illness may result in the children experiencing increased behavioral and neurocognitive delays and disorders throughout childhood and into adulthood (Buist, 2011). Traumatic birth experiences can cause disruption in mother-infant bonding therefore leading to impaired child development due to resulting attachment issues (Simpson & Catling, 2016).
Untreated perinatal mental illness has been shown to result in suffering for mothers; strained familial relationships; negative effects on children’s emotional social, and cognitive development; and maternal suicide (Hanzak, 2016).

Fenech & Thomson (2014) found that traumatic birth in particular leads to perinatal mental illness including depression, anxiety, PTSD, anger, suicidal thoughts, and intense feelings of loss and grief. The psychological impact of a traumatic birth for mothers can be intense and lead to mothers feeling negatively toward themselves and their infants. Women have even reported suicidal thoughts as well as homicidal thoughts toward their infants. Women have reported feeling trapped in dark thoughts and dysfunctional coping strategies to the point of women feeling ‘tormented by ghosts of their past’ with the ghosts being violence, despair, and loss. Women may grieve for the relationship they could have had with their infants and the loss of the ideal family due to fear of future pregnancies- tokophobia. Women have reported problems with being intimate with their partners including inability to provide affection and support along with the inability to engage with their partners sexually. These problems result in strained relationships that sometimes result in separation. With traumatic birth and resulting mental illness, the ideals of motherhood are shattered and women experience difficulty communicating this new reality with their loved ones due to stigma which then strains the relationship further isolating mothers (Fenech & Thomson, 2014).

Ayers, et al. (2006) found that childbirth related PTSD had myriad effects on women and their relationships. The effects on women themselves included changes in physical wellbeing, mood, behavior, social interaction, and fear of childbirth. These women further reported difficulties with their partner including sexual dysfunction, disagreements, and blaming behaviors related to the birth. Finally, the women reported effects related to mother and infant
bonding. Nearly all women in the study reported feelings of rejection toward their infants; however, this changed over time with most women feeling accepting of their infant after several weeks. These initial feelings of rejection did affect attachment between mother and infant resulting in avoidant or anxious attachments.

According to a study by Felder et al. (2016), current depression and anxiety symptoms are associated with increased self-judgement and isolation and decreased self-kindness in perinatal women. One highlight from the study is that women with histories of depression or anxiety showed deficits in self-compassion when controlling for current symptom level. Finally, one study reviewed for the purposes of this research found some positive outcomes related to traumatic birth including women feeling stronger as a person, increased empathy, personal growth, and increased understanding between partners (Beck & Watson, 2016).

In sum, perinatal mental illness can affect women in a variety of ways that have both short term and long term consequences. Women may experience myriad feelings and thoughts related to her birthing experience which can then result in symptoms of mental illnesses such as depression, anxiety, and even PTSD. Women may have difficulty bonding with their infant resulting in anxious or avoidant attachments which then have implications for the child’s wellbeing well into the future. Further, women and their partners may experience strained relationships due to symptoms of mental illness and disagreements regarding how the birthing event unfolded. Overall, perinatal mental illness has negative implications for families as a whole as each member is affected in a different manner.

**Screening & Assessment**

Currently, there are many tools available for the screening and assessment of perinatal mental illness. Most women and health care professionals are accepting of screening and
assessment of perinatal mental illness; however, some women have reported feeling embarrassed or other negative emotions related to it (Edozien & O’Brien, 2017; Kingston et al., 2015). At this time, the recommendations for screening for postpartum depression are at the first postnatal obstetrical visit which is typically 4 to 6 weeks after delivery (Leight et al., 2010). Other screening tools such as those for anxiety, bipolar disorder, PTSD, and psychotic disorders are given based on the provider. In other words, PPD is typically the focus and other disorders may not be screened for; however, this varies among health care providers. As previously noted, the consequences of perinatal mental illness are significant and far-reaching; therefore, health care providers need to take a proactive stance in regard to perinatal mental health care. Researchers have suggested that one way for health care providers to be proactive is to screen all women and monitor their score fluctuations so that issues can be identified and addressed in a timely manner (Butler-O’Halloran & Guilfoyle, 2015). Researchers have noted that screening is especially important for women who have a history of trauma as they are increasingly vulnerable to the effects of poor care during labor and birth. Screening for trauma prior to the birth would help to ensure that women receive care that fits their needs (Ford & Ayers, 2011). When at-risk parents and infants are identified early in the perinatal period, opportunities for primary and secondary prevention is increased and adverse consequences of perinatal mental illness are decreased (Brockington, et al., 2017).

Available tools for assessing perinatal mental health problems include the Whooley Questions, Edinburgh postpartum depression scale (EPDS), the postpartum depression screening scale (PDSS), the Beck Depression Inventory, Zung Self-Rating Depression Scale, the General Health Questionnaire (GHQ-12), and a modified GHQ-12 (Wellbeing). Tools available for prenatal screening include the Antenatal Risk Questionnaire (ANRQ), Antenatal Psychosocial

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Health Assessment (ALPHA), Australian Routine Psychosocial Assessment (ARPA), Camberwell Assessment of Needs- Mothers (CAN-M), and Contextual Assessment of Maternity Experience (CAME). However, these screening tools still require research to ensure appropriate psychometric properties are met prior to introducing them into widespread practice (Edozien & O’Brien, 2017). A study by Austin et al. (2010) highlights how combined screening methods improve the detection of depression and anxiety cases in the perinatal period. These researchers used the Composite International Diagnostic Interview (CIDI) combined with the EPDS and an interval question which consisted of asking women if they experienced any depression symptoms between EPDS administrations. The researchers found that using the EPDS only identifies the CIDI diagnosis in the following proportions: 59.7% of all major depression cases, 40.3% of all minor depression cases, and 68.4% of all anxiety disorder cases. With the interval question, the researchers obtained 88.3% CIDI-positive for major depression, 83.9% positive for minor depression, and 94.7% for anxiety disorder. Thus, using combined screening methods produced improved diagnostic measures across diagnostic categories (Austin et al., 2010). Other researchers have furthered these findings by including assessments for resilience and child maltreatment history prior to pregnancy in order to provide more criteria for risk assessment (Sexton et al., 2015). Research regarding screen and refer models have revealed that these do not consistently improve entry into treatment. In a study by Phillips et al. (2004), out of 63.3% of women who accepted referrals for post-partum depression, only 30.5% received in-person counseling. Further, most universal screening programs do not screen for severe mental illness such as schizophrenia; although, women who experience more severe symptoms such as those present during a psychotic episode have the highest rates of morbidity and mortality (Laios, et al., 2013).
Prenatal appointments are a prime opportunity for screening and identifying women who may be at an increased risk for developing perinatal mental illness. Therefore, health care providers who routinely interact with women regarding their health throughout the pregnancy are in a prime position to engage in screening and discussing mental health. These providers may be midwives, nurse practitioners, or obstetricians. These screenings and conversations could take place at each appointment from the first interaction until the birth which would then provide critical information regarding the mother’s mental health and wellbeing (Haynes, 2018). Then, in the postpartum period, health care providers can make intentional observations of the mother, and would be able to interact with her appropriately along with providing referrals when needed. The literature suggests that those responsible for screening also have a reliable referral network for those mothers who require further intervention (Brockington, et al., 2017).

A quantitative study by Kingston et al. (2015) provides data regarding the benefit and harm related to perinatal mental health screening. In this study, a majority of women, 78%, identified screening as beneficial and reported that it made them feel that their health care professional cared about them, and 69% of women reported that they felt glad about being asked. Less than 7% of women identified feeling negatively about the screening.

Another study by Miller et al. (2012) demonstrated that with increased provider training and support, case coordination, and multidisciplinary collaboration, routine diagnostic assessment for depression in perinatal care for women is feasible, and that doing so increases treatment entry for women with major depression. This study confirms findings of prior studies that screen and refer models for depression during perinatal visits led to low rates of entry into mental health treatment. However, when diagnostic assessment and engagement strategies were added, entry into treatment was improved. In fact, approximately 80% of women who screened
positive in this study were able to begin treatment due to the on-site engagement strategies used.

**Risk Factors**

Multiple studies have pointed to quality of care as a major factor in the development of perinatal mental illness. According to Fenwick et al. (2013), “Postnatal care that is characterized by rushed, routine, and ‘tick box’ midwife-to-woman interactions is potentially harmful to women’s emotional wellbeing and family functioning. Edozien & O’Brien (2017) echo this sentiment by stating that health care providers may aggravate maternal stress by their approach to care. Further, Ford & Ayers (2011) assert that low support during birth from health-practitioners is directly predictive of symptoms of post-traumatic stress disorder in women with prior trauma which supports Fenwick et al. (2013) and Edozien & O’Brien (2017) in that supportive care during labor and birth is necessary for positive psychological outcomes in the perinatal period.

In a qualitative study by Butler-O’Halloran, & Guilfoyle (2015), participants described feeling deserted by health care providers upon discharge from the hospital. This study found that women were unprepared for the difficulties of new motherhood, and experienced isolation and lack of support. The women in this study discussed the need for greater emotional support from health care providers in order to create a working relationship in which the discussion of mental health was more approachable. At a systemic level, lack of time, suitable care settings, and referral and treatment infrastructure are issues that contribute to perinatal mental illness and require attention (Edozien & O’Brien, 2017). A lack of consistency in care and fragmented care from multiple different healthcare providers can act as a disconnect between women, their families, and the healthcare team which can lead to women feeling more vulnerable (Hanzak, 2016).
Some women perceive and describe their birthing experience as traumatic. Some researchers have explored this further, and found that there are several risk factors for this experience. Boorman et al. (2014) identified psychiatric morbidity, being a first time mother, and experiencing a caesarean section as risk factors for perceiving the birth as traumatic. These researchers assert that these risk factors should act as cues for healthcare providers to provide additional screening and support related to mental health. Ayers (2007) also explored experience of birth and the development of perinatal mental illness symptoms and found that women may be more likely to develop symptoms if their birth experience included increased panic, anger, thoughts of death, mental defeat, and dissociation. Harris & Ayers (2012) echo these ideas in their study which found that interpersonal difficulties and obstetric complications are associated with increased risk of developing PTSD.

Buist (2011) identified several risk factors associated with the development of perinatal mental illness in general which include: family history of mood disorder; previous history of mood disorder; lack of social support especially from mother and partner; low socioeconomic status; domestic violence; childhood abuse; young or teenage first time mothers; personality factors such as neuroticism, perfectionism, and high interpersonal sensitivity; negative attitudes toward pregnancy; poor sleep; and birth trauma. Hanzak (2016) echoes these findings by stating that stress, sleep disturbance, pain, psychological trauma, previous psychiatric diagnosis, and history of abuse are key factors in the development of perinatal mental illness.

Postpartum depression has been the most studied perinatal mental illness; therefore, there are several studies that identify and discuss the risk factors for the development of this issue. Gaudet, et al. (2013) found associations between problematic perinatal pain and postpartum depression (PPD) symptoms especially for participants who had a caesarean delivery, were first
time mothers, had increased perceived stress, had more previous stressful life events, lacked social support, had a history of depression, and had a history of abuse. A study by Ripley et al. (2018) found that dyadic adjustment (AOR = .12, [.03, .47] and trait forgiveness (AOR = .87, [.78, .98]) predicted lower odds of postnatal depression.

Another serious perinatal mental illness with substantial research is posttraumatic stress disorder (PTSD) resulting from childbirth. Several researchers have explored this topic and identified risk factors for the development of this issue. It has been identified by existing literature that women are at an increased risk for developing PTSD after birth if they have increased medical intervention such as a caesarean delivery, forceps delivery, or episiotomy; history of psychiatric diagnosis; negative relationships between mothers and health care providers; feelings of loss of control and bodily integrity; lack of partner support; and neonatal complications and death (Ford & Ayers, 2011; Hanzak, 2016; O’Donovan et al., 2014; Olde et al., 2006; Simpson & Catling; 2016). Some cases of perinatal mental illness become so severe that mothers experience suicidal thoughts and actions with some mothers completing suicide following birth. Some risk factors for maternal suicidality include recent significant change in mental state; emergence of new symptoms; new thoughts or acts of violent self-harm; feeling estranged from the infant; and new or recurrent feelings of incompetence as a mother (Edozien & O’Brien, 2017).

**Multicultural Considerations**

Concepts of health, illness, and wellbeing vary among cultures and individuals; therefore, these concepts are not easily defined. However, these concepts are important to the dialogue around birth and associated mental illness. Culture and ethnicity can influence how women define and identify wellness versus illness, and these attributes must be considered when health
care professionals identify and diagnose mental health issues. Poor perinatal mental health appears across cultures; although, the social construction of the concept varies even though the symptoms are similar. In western culture, pregnancy, birth, and perinatal mental health is considered within the medical framework, for the most part, and influences how perinatal mental illness is treated. Within this model, pregnancy and birth are highly medicalized and women encounter myriad medical interventions. However, not every woman will subscribe to the westernized concept of perinatal mental illness or the typical medicalized treatment of pregnancy and birth. Other women view pregnancy and birth as a natural process; therefore, medical intervention is viewed as harmful. Consequently, services and providers need to be culturally competent so that they are able to appropriately provide treatment for women of diverse backgrounds. Cultural competence can be defined as the ability to provide care and deliver services to effectively meet the needs of a culturally, socially, and linguistically diverse population. Further, health care providers have their own internal beliefs regarding pregnancy and childbirth which drives their approach to care. Therefore, being aware of these biases and how they affect the ways in which professionals treat women and families is important so that the professional is able to meet the needs of each woman and family in an appropriate manner. Finally, services that interact with diverse women and families should review their client’s feedback and ensure they are truly meeting their needs and enacting changes when necessary (Edozien & O’Brien, 2017; Hanley, 2009).

**Treatment for Perinatal Mental Illness**

The literature explores many treatment approaches related to perinatal mental illness and the effectiveness of the treatments. In order for these treatments to be effective, women need to be able to access them. According to Price et al. (2010) elevated symptoms and symptoms
severity are significant factors related to help-seeking behaviors. Further, relational comfort or discomfort can greatly affect help-seeking behaviors and symptom disclosure. When the relationship between women and their healthcare provider is uncomfortable, and the provider does not facilitate conversation related to mental health then women are more likely not to disclose their symptoms. Alternatively, when the relationship between women and their health care provider is comfortable, and the provider facilitates conversation related to mental health then women are more likely to disclose their symptoms. Therefore, creating a relationship of trust and eliminating stigmatizing behaviors on the part of the health care provider are powerful first steps to early detection of perinatal mental illness, and providing recommendations for entry into treatment (Kingston et al., 2015). Olde et al. (2006) suggests that a psychosocial approach to identification and treatment is beneficial for women. First, crisis management should be provided to women who are acutely upset following their birth. Next, provide all women with an opportunity to speak with a mental health professional following birth to assess risk for perinatal mental illness. Finally, refer women who meet criteria for perinatal mental illness to an appropriate treatment provider.

Buist (2011) suggests that planning and collaboration are necessary components of early identification and risk management. Further, this researcher asserts that the 5 E’s of risk be implemented as follows: early identification, estimate risk, engage, educate, and enable the mother to keep her baby’s physical and emotional needs in mind. Early identification of perinatal mental illness is vital in regard to the timeliness of treatment and reducing long-term negative outcomes, and can be accomplished via continual observation, open communication, and the use of screening tools. Estimation of risk can be accomplished by understanding the biopsychosocial risk factors for perinatal mental illness, family history of mental illness, and available supports.
To gain this understanding, providers need to have open lines of communication and encourage conversations related to mental health in the perinatal period. Engage refers to helping the woman to understand that taking care of her mental health is vital for the health and wellbeing of herself and her infant. Again, open lines of communication and conversations related to mental health are important for meeting this component. Educate refers to helping women and their families understand what perinatal mental illness looks like and how it can develop. Finally, enable the mother to keep her baby’s physical and emotional needs in mind refers to helping the mother understand the importance of early identification and early intervention related to perinatal mental illness. All of these components require providers to establish a trusting relationship with women and their families along with facilitating conversations related to mental health often (Buist, 2011).

Treatment of perinatal mental illness can include individual psychotherapy, group therapy, guided self-help, and medication therapy. The level of functional impairment is an important factor to consider when making decisions related to treatment approach. For example, a woman experiencing severe perinatal mental illness such as a psychotic episode would be an inappropriate candidate for guided self-help groups. Further, a combination of treatments may be required for some women such as using both psychotherapy and medication therapy. Talking therapies and counseling constitute an important part of the treatment of perinatal mental illness, and cognitive behavioral therapy (CBT) has been shown to be an effective approach. Further, various types of groups have been explored by researchers and show promising results (Edozien & O’Brien, 2017; Hanzak, 2016).

Guided self-help or peer support groups can be helpful for women who want to establish connections with others who share similar experiences, and can be beneficial for women with
subclinical symptoms. These types of groups help women to build resilience, and feel supported. In particular, women who experience loss such as miscarriage benefit from these types of groups. These groups are deliverable in a variety of community settings making them accessible for women. It is important that health care providers be familiar with groups available in their community so that they can refer women who could benefit from them (Edozien & O’Brien, 2017; Price, 2010). Butler-O’Halloran & Guilfoyle (2015) explored these groups more closely and found that women benefitted from these groups due to the validation and support experienced along with the feeling of safety in disclosing difficulties. The researchers discovered that between discharge from the hospital and joining a group was an isolating time for mothers because they did not feel as though they could speak about their struggles with anyone due to a fear of being perceived as a bad parent. Women in these groups reported that they were able to speak openly about their difficulties which then lead to the discovery that they were not the only ones struggling with motherhood which helped to increase their confidence and to feel reassured that they were good parents. It was suggested that bringing mental health professionals to the groups as guest speakers would be beneficial so that if women felt that they needed an increased level care, they would be familiar with some of the providers in the community.

Townshend et al. (2018) explored the effects of a mindfulness based program, Caring for Body and Mind in Pregnancy (CBMP), on depression, anxiety, general stress, and mindfulness. The researchers found that the program did improve participants’ scores via Wilcoxon Signed Rank Test analysis with pre and post group measures. In particular, CBMP reduced depression, anxiety, and general stress scores while increasing mindfulness and self-compassion scores. Perinatal depression scores prior to program participation were significantly influenced by post
program self-compassion $t(73) = -2.90, p<.01, R^2=.10, a1= -.03, SE=.01, CI= -.05, -.02$. In sum, CBMP significantly reduced perinatal depression and anxiety in this sample of women. Self-compassion was a stronger mediator than mindfulness in reducing perinatal depression.

Tandon et al. (2018) explored the effects of the Mothers and Babies 1-on-1 (MB 1-on-1) intervention with prenatal clients. This program is based on a CBT curriculum and delivered in the client’s home. Women who received MB 1-on-1 exhibited decreases in depressive symptoms between baseline and three months postpartum with continued symptom decline exhibited at six months postpartum. Women receiving a higher doses of the intervention appeared to exhibit greater symptoms relief, $n=20$, between baseline ($M= 11.0, SD= 8.1$) and six months postpartum ($M=6.6, SD= 5.9$). Further, at the six month postpartum assessment, only 6% of women in the intervention condition met criteria for postpartum depression while 18% of women receiving care as usual met criteria for postpartum depression.

Further studies have sought to investigate cognitive behavioral therapy (CBT) and effectiveness related to treating perinatal mental illness. Ayers, et al. (2007) used a case study method to analyze the effectiveness of CBT in treating post-traumatic stress disorder (PTSD) caused by birth. These researchers found that CBT was an effective treatment leading to symptom relief, and that a combination of reliving, exposure, and cognitive reappraisal techniques is vital for treatment success. Another study by Harvey et al. (2018) found that a nurse-led community model of service provided effective assessment and brief intervention services. This study focused on the value of mental health nurses and what they can provide insofar as mental health services. These researchers suggest that mental health nurses are skilled in establishing a therapeutic relationship and providing care that includes health promotion, assessment, psychosocial interventions, and collaborate well with other service providers.
Further, the researchers argue that this model of care fills gaps in service that are not met by the biomedical model and that nurses are more approachable which increases engagement. In this study, nurses were trained in the delivery of CBT, and provided brief intervention for women with symptoms of perinatal mental illness. These new CBT skills along with their knowledge of psychotropic medications was beneficial for women related to making informed decisions regarding their care and facilitating the continuation of treatment. This innovative model was also more economically viable when compared with services provided by psychiatrists. The rate of attendance in the study was excellent with a fail to attend rate at less than 10 percent once women attended one appointment. This can be explained by the easy accessibility of the physical locations of the program along with the welcoming culture established there (Harvey, 2018).

Other researchers have experimented with training midwives to deliver mental health interventions in the perinatal period. These studies have produced mixed results. In a study by MPhil (2014), findings indicated that some midwives may lack the confidence and ability to provide effective care for women experiencing birth as traumatic. All of the midwife participants in this qualitative study noted that learning the counseling skills and delivering the intervention were challenging due to being unfamiliar with counseling techniques and learning to change their approach with women who experienced birth as traumatic. Prior to participating in the study, midwives expressed difficulty caring for distressed women in the postpartum period due to having a limited understanding of trauma and its relationship to the care women received. During the training process, many of the participants expressed that they struggled to adapt and found that the new way of working with women was uncomfortable. Even upon completion of the training, some of the midwives felt that they were not able to gain the knowledge and skills necessary to deliver the intervention. However, some of the midwives were able to gain
confidence and skills in implementing the program which helped them to be able to feel more
comfortable listening to women’s narratives even if the narrative was distressing. Of the
midwives who were able to learn and use the skills, many of them felt as though these new skills
gave them confidence in their practice regarding having mental health conversations with women
and when discussing distressing births with colleagues (MPhil, 2014).

Gamble et al. (2005) further studied midwife-led intervention. In this study, the
intervention highlighted the role of midwives in providing postpartum emotional care including
increased time to talk with women about their birth in a meaningful way, providing information
about the birth, and assisting with the integration of this transformative life event. The
researchers note that prior literature asserts that single debriefing sessions within the first few
days of birth is likely to be ineffective in reducing symptoms of perinatal mental illness and that
these could contribute to an increase in symptoms (Gamble & Creedy, 2004; Gamble et al.,
2005). Therefore, it is important for the midwife to talk with the mother more than one time. The
participants in this study identified that there is a need for emotional support following a
distressing birth experience, and the intervention responded to this need by providing women
with a face-to-face session with their midwife and a follow-up phone call. The intervention
focused on linking emotional responses with perceived causes of distress to decrease self-blame
and increase resilience. The participants in this randomized control trial reported reduced trauma
symptoms along with increased confidence regarding future pregnancies. Further, the
participants reported that the intervention was helpful. However, there was no significant
difference in the number of women diagnosed with post-traumatic stress disorder at three months
postpartum when examining outcome measures. The researchers found no indication of harm
when examining outcome measures; therefore, discussing the birth on more than one occasion
will not create problems or contribute to distress.

A review of the literature regarding counseling interventions following a distressing birth experience by Gamble & Creedy (2004) highlights that providing women the opportunity to discuss their birth draws upon Rogerian principles in which active listening and a deep sense of empathy conveyed to the woman serves to affect therapeutic change. Inviting women to tell their birth story and helping them to develop a birth narrative in the context of a humanistic working relationship can help to decrease symptoms. Further, social support from partners can moderate the development of post-traumatic stress disorder (PTSD) symptoms.

A qualitative study by Fenwick et al. (2013) echoed these assertions and findings. In this study, participants were provided with psychoeducation within six weeks of giving birth along with consultation with a midwife to review their experiences. Women in the study, again, reported a need for emotional support following their birth. The participants reported that knowing that a midwife would contact them to follow-up and provide space to share their experience and ask questions lead to feeling cared for which had a positive effect on the participants’ wellbeing. Telling the birth story, clarifying any misunderstandings regarding how the birth unfolded, and having the opportunity to ask questions helped the participants to make connections between the events, intense emotions, and subsequent responses. These participants were then able to explore solutions with a midwife with whom they had an established therapeutic alliance. These women reported feeling cared for and that the intervention improved their wellbeing.

Several researchers have proposed and explored integrated behavioral health models related to the perinatal period (Cantwell & Smith, 2008; Laios, et al., 2013; Leight, et al., 2010; Lomonaco-Haycraft et al., 2018). The model developed by Lomanaco-Haycraft et al. (2018)
proposes the implementation of a universal screening process along with integrated behavioral health during the perinatal time period within the existing healthcare system. These researchers propose that the universal screening program will serve to identify perinatal mental illness early in pregnancy and monitor the wellbeing of women throughout the perinatal period. Further, any women identified as at risk for the development of perinatal mental illness or those who are affected by it can then be connected with appropriate behavioral health care in the same setting in which they receive healthcare services related to pregnancy. With this model, the behavioral health team and the healthcare team are able to collaborate effectively in order to best meet the needs of the woman. Comprehensive mental health assessment and management, like the above described model, integrated with maternity care has been shown in qualitative studies to be an effective approach to the detection and management of perinatal mental illness; however, further quantitative studies are needed to assess how effective these programs are (Laios, et al., 2013). Cantwell & Smith (2008) assert that there are some key components necessary for these models to work effectively. First, multidisciplinary care plans are needed to ensure that appropriate care is delivered across sectors. Next, all health care and behavioral health care providers must collaborate and communicate effectively regarding the woman’s current state of wellness along with the interventions being provided and how well these interventions are working. Further, Leight et al. (2010) proposes that for assessment to be effective the healthcare team must have a thorough understanding of several factors related to the development of perinatal mental illness including genetic factors, social factors, and behavioral factors. Therefore, taken as a whole, these models assert that integrated behavioral health must include a thorough understanding of factors related to the development of perinatal mental illness; universal screening and assessment; multidisciplinary care plans; and collaboration and communication across healthcare
Suggestions to Improve Perinatal Mental Health

Several researchers have addressed and explored ways to better support women in the perinatal period along with strategies to improve perinatal mental health. First, literature has established risk factors for the development of perinatal mental illness; therefore, researchers have called for increased identification of these early in pregnancy by using screening tools over and beyond those for depression and using them frequently to continually assess perinatal mental health along with any changes that may occur (Edozien & O’Brien, 2017; Rafferty, 2013; Simpson & Catling, 2016). Women should be asked about current and previous mental health conditions including severe mental illness such as schizophrenia, bipolar disorder, psychosis, and severe depression; further, providers should gather information regarding current and past treatment of mental health conditions (Rafferty, 2013). Having an in-depth understanding of women’s mental health can help providers in creating a plan to ensure the woman’s mental wellbeing is addressed appropriately. In qualitative studies, women have reported that being asked psychosocial questions and provided with screens opens the conversation regarding mental health and helps them to start making plans earlier in the pregnancy to address their needs. Once women have been identified as at risk or diagnosed with a perinatal mental illness, a range of services should be made available promptly to address their needs. All women are unique; therefore, a service that is helpful to one woman may not fit the needs of another which is why it is crucial to have several different services available (Edozien & O’Brien, 2017; Phillips et al., 2004).

One risk factor for the development of perinatal mental illness is low support and low quality interactions with health care providers. Researchers suggest that health care providers
should be educated regarding how paramount their relationship with women is, and how detrimental a low quality relationship and low support is for women’s mental health (Ayers, 2007; Butler-O’Halloran, & Guilfoyle, 2015; Simpson & Catling, 2016). Feeling safe has been linked to feelings of being in control, being listened to, and being taken seriously. A major factor in creating a safe birthing environment for mothers is being provided with evidence-based, understandable information throughout their care. Information provided to women is powerful and can help decrease anxiety while enabling women to make decisions appropriate for their current needs (Hanzak, 2016). Further, studies suggest that staff across disciplines such as nurses, physicians, midwives, psychologists, and social workers should be educated regarding perinatal mental illness to provide a safety net for mothers. With staff being trained across disciplines, there are more professionals who should be able to recognize and note mothers who may be struggling with perinatal mental illness and connect them to appropriate professionals (Brockington, et al., 2017; Verbiest et al., 2016). Ayers (2007) further adds that any sign of excessive fear, panic, mental defeat, fear, anger, or dissociation noted by the health care provider should be addressed and steps taken to reduce these negative emotions. Sensitive management of the events occurring during the birth can make a large difference in women’s experience and appraisal of these events (Ayers, et al., 2007). Again, strong, empathetic relationships and clear communication between healthcare providers and women are critical for supporting perinatal mental wellness. Another area for continued education is that of the mother herself and her family. Having health care and mental health professionals as guest speakers in prenatal classes could serve to reduce fear and stigma around mental illness by providing the family information regarding triggers of perinatal mental illness; clarifying facts around mental illness therefore removing the shroud of mystery related to symptoms of mental illness versus typical adjustment;
and helping the family to better understand how to support the mother. Another benefit of this education is that family and partners can better understand perinatal mental illness versus typical adjustment and provide much needed support along with potentially connect the mother to services before a healthcare professional has the opportunity to do so. Existing literature has found that partner support is a protective factor against perinatal mental illness (Pilkington, et al., 2016; Verbiest et al., 2016). Consequently, educating partners about the importance of their role in supporting the mother can help to increase the level of support the mother receives while providing a layer of prevention related to the development of perinatal mental illness.

Additionally, providing a doula to support mothers has several positive effects such as improved physical outcomes for both mother and baby including shorter labor hours, less analgesia, decreased operative deliveries, and increased maternal satisfaction with the birth experience (Edozien & O’Brien, 2017). Hanley (2009) further supports the notion that appropriate support leads to improved outcomes for mothers, and also suggests that any form of social support can improve the experience of mothers. Support can be provided by partners, doulas, nurses, or counselors all with positive effect (Hanley, 2009). Further, women could be provided with a better understanding of the type of care required in the first few weeks postpartum (Butler-O’Halloran & Guilfoyle, 2015). This education, understanding, and support can help mothers and their families address incongruence between expectations and the realities of parenting a newborn infant which can help families to be more flexible and accepting of challenges that may arise which can be protective against the development of perinatal mental illness (Pilkington, et al., 2016).

Some researchers have suggested that more frequent visits with providers would be beneficial for women’s mental wellbeing and decrease feelings of vulnerability. Currently,
women do not meet with a provider until 6 weeks postpartum. In this lengthy timeframe, mental illness can manifest and escalate quickly before health care providers have an opportunity to intervene. Therefore, visiting a healthcare provider prior to six weeks postpartum is important especially for women with existing psychosocial problems (Butler-O’Halloran & Guilfoyle, 2015; Edozien & O’Brien, 2017). Mothers have reported that continuity of care, for example, seeing the same providers throughout pregnancy, and good communication among the treatment team, was vital to supporting their mental health in the perinatal period (Shah, 2012). Further, mothers reported that having a multidisciplinary birth plan was paramount in ensuring their mental wellbeing. These plans should include contingencies for when the birth goes awry, the mother’s mental health history and how mental illness manifests for her uniquely, and a support plan including partner and family support. When health care providers get to know the mother intimately over the course of the pregnancy due to continuity of care and have a detailed birth plan, they are able to recognize the signs and symptoms of perinatal mental illness in the context of the woman’s life and birth leading to improved outcomes (Shah, 2012). A crucial part of developing a relationship between healthcare providers and mothers is empathy. Empathy can be defined as the ability to perceive the internal frame of reference of another with accuracy including the emotional components and meanings as if one were the person. Empathetic communication has been associated with increased adherence to treatment and fewer malpractice complaints. Empathy in the relationship between healthcare providers and mothers creates a positive feedback loop resulting in enhanced relationships and increased satisfaction (Edozien & O’Brien, 2017).

Services for mothers experiencing birth as traumatic should be tailored to address the trauma in a holistic manner. First, the relationship between the mother and healthcare team
should be one where caring and providing clear, effective communication is prioritized (Beck, 2004). The services for trauma-exposed mothers should help to promote hope by including a family-centered model of care, social support, and peer interaction. The name of the program should reflect healing and optimism rather than focusing on the trauma. In qualitative studies, women affected by trauma have reported that a safe atmosphere and strong social support with peers who have also been affected by birth trauma are essential for healing. Further, the women reported that having high quality child care parallel to support groups gives them the opportunity to be fully present for the group with the confidence that their child is being well cared for and provided with a nurturing environment (Muzik et al., 2017). Ford & Ayers (2011) corroborate the finding that support is a vital factor especially for trauma-affected women. Their study found that support from health care providers served as a protective factor against the development of posttraumatic stress disorder symptoms in women with trauma history. A study by Sexton et al. (2015) found that resilience moderated the development of perinatal mental illness among mothers with trauma history; therefore, interventions aimed at building resilience may serve to benefit perinatal mental wellness and reduce the risk of the development of perinatal mental illness. In sum, providing reassurance, support, and identifying and dealing with interpersonal difficulties may serve to prevent a birth being experienced as traumatic and buffer the development of PTSD (Harris & Ayers, 2012).

Finally, Laios, et al. (2013) have suggested that all of these improvements are no good unless the culture around perinatal care is improved. These researchers suggest that the culture of perinatal care must include mental health as an integral component rather than something that is dealt with by providing a screen and moving on. Leight et al. (2010) supports this notion and suggests that screening must be tied to a system of care that addresses common barriers to
treatment such as stigma, lack of child care, insurance limitations, and accessibility. The gap between the screening and assessment of perinatal mental illness and entry into treatment is one that needs to be addressed (Leight et al., 2010). Olde et al. (2006) suggests that primary and secondary prevention need to be at the forefront of further research regarding perinatal mental illness. The researchers suggest that primary prevention may include educating all women about childbirth in a realistic way addressing labor, birth, the risks and benefits of obstetric interventions, and the symptoms of perinatal mental illness. Lu (2010) echoes the suggestion that primary prevention be at the forefront of new research. This author suggests that new research prioritize primary prevention strategies that enhance understanding of the biological mechanisms of pre-disease pathways along with early and long-term biological, behavioral, psychological, and social precursors to disease. In sum, improving perinatal mental health in the United States will require a cultural shift which includes increasing access to continuous, comprehensive, and coordinated women’s healthcare over the life-course (Lu, 2010).

**Chapter Summary**

This chapter presented a broad review of the literature related to perinatal mental health. A clear understanding of barriers to perinatal mental wellness; ways to promote wellness and improve perinatal mental health care; and the development, course, and treatment of perinatal mental illness was provided. This chapter also include information about the promotion and support of perinatal mental wellness. These studies highlighted several barriers to perinatal mental wellness including poverty, lack of transportation to health facilities, lack of partner support, stigma related to mental illness, insensitive health care staff, and inadequate health care staff. Additionally, these studies highlighted prevention efforts and interventions such as providing education to women and families regarding perinatal mental health; rapport building
between women and health care providers; using appropriate screening tools; yoga; support groups; and cognitive behavioral therapy (CBT) interventions. Holistic, collaborative approaches to perinatal mental health were also discussed as a way to improve perinatal mental health by taking the whole person into account and drawing on the expertise of several different health care providers. This topic lead to the exploration of systemic change in the approach to perinatal health care wherein a comprehensive system of prevention, outreach, and response along with embedding mental health care into existing health care systems would provide for an improved system of care for women. Furthermore, this chapter reviewed the literature related to perinatal mental illness (PMI) including common diagnosis; consequences of PMI; screening and assessment; risk factors; multicultural considerations; treatments for PMI; and suggestions to improve perinatal mental health. These studies provided for an understanding of the development, course, and treatment of perinatal mental illness among women worldwide. Together, the literature reviewed for this study illuminated salient issues related to the current systems of perinatal mental health care.
CHAPTER III: METHODS

This study is designed to meaningfully define perinatal mental wellness and better understand how perinatal mental wellness is sustained throughout the perinatal period along with strategies that are used to promote perinatal mental wellness. The study aims to delineate a meaningful definition of perinatal mental wellness in order to facilitate deeper understanding of the phenomenon in question.

The purpose of this chapter is to introduce and discuss the research process related to this study. This study is designed to answer the following research questions:

1. What does perinatal mental wellness mean to mothers?
2. What aspects of maternity care help to support mental wellness for mothers in the perinatal period?
3. What aspects of maternity care do mothers want to change in order to better meet their mental health needs in the perinatal period?

This study is guided by a qualitative research approach and grounded theory methodology in order to address the gap in the current knowledge related to perinatal mental wellness. While there are several approaches to the grounded theory framework, this study is based on evolved grounded theory by Strauss and Corbin (1997). This approach to grounded theory research is based on symbolic interactionism which is a sociological perspective that addresses the subjective meaning people place on objects, behaviors, or events based on what they believe is true (Tie, et al., 2019; Bluff, 2005). In other words, symbolic interactionism relies on the meanings people ascribe to in the processes of social interaction (Tie, et al., 2019; Bluff, 2005). Grounded theory methodology is associated with the qualitative approach to research which is appropriate to apply in this study because the goal in qualitative research is to examine context...
and phenomena in an in-depth manner that is culturally sensitive (Marshall & Rossman, 2016). Thus, this approach is appropriate for developing a meaningful definition of perinatal mental wellness along with better understanding how this state of being is sustained and is supported because the perinatal period is experienced uniquely by individual women in the context of their culture and family.

This chapter outlines the sample, sampling procedures, data collection, and data analysis. The sample size, sample selection, and recruitment procedures are provided in detail in order to illuminate where the data is derived from. Next, the data collection procedures are provided including the interviewing procedures. Finally, the data analysis procedures are illustrated including the coding process following the constant comparative method. All of the processes and procedures discussed follow Grounded Theory (GT) methodology which aims to create functional theory which aligns with the research questions addressing the definition of perinatal wellness, how this state of being emerges, and how this state of being is supported or promoted.

Research Approach and Design

Approach

Grounded theory methodology as defined by Strauss and Corbin (1997) is based on symbolic interactionism. As discussed previously, symbolic interactionism addresses the behavior of individuals within their context. More specifically, the roles that individuals adopt influence their behavior, and roles and behaviors are determined by how individuals interpret and give meaning to symbols such as language, dress, and actions. The meaning of symbols is shared by individuals within a particular culture and are learned through the processes of socialization. Therefore, behaviors are influenced by the context in which they take place. Furthermore, behaviors of others can be fairly predictable due to the shared meaning of symbols within a
context and culture. Following this line of reasoning, behavior and roles that individuals fulfill are negotiated and renegotiated through the process of interaction and change over time rather than remain static (Bluff, 2005; Annells, 1996). This approach is appropriate for this study due to the social aspects of the perinatal period. During this transformative experience, women may interact with several entities in order to prepare for the birth. Typically, women attend appointments with their physicians or midwives at the very least. Other services women may elect to attend include childbirth classes; lactation and breastfeeding classes; newborn care classes; and support groups for women in the perinatal period including pregnancy and postpartum groups. Women experiencing mental health issues in the perinatal period may also attend appointments with counselors, psychologists, or psychiatrists in order to meet their mental health needs. Finally, women interact with their family, friends, communities, and cultures day to day during the perinatal period. All of these opportunities for interacting with others can affect how women assign meaning to their experiences during the perinatal period for better or for worse. Therefore, this approach facilitates understanding of how women assign meaning to their experience and how these experiences affect their mental wellbeing during the perinatal period.

**Design**

This study follows a qualitative design with the intention to focus on depth, context, and the relationships around perinatal mental wellness. In order to interpret and understand the data collected, grounded theory method developed by Barney Glaser and Anselm Strauss in 1960 and modified by Strauss and Corbin in 1997 is used. Grounded Theory (GT) provides insight into phenomena under study via the iterative and recursive process of collecting and analyzing data. The purpose of GT is to create or modify theory when there is a lack of knowledge regarding a specific phenomenon (Annells, 1996; Bluff, 2005; Tie, et al., 2019). In this case, the use of
grounded theory is appropriate because there is a lack of theory and knowledge related to perinatal mental wellness. Therefore, this research is aimed toward developing practical, functional theory related to perinatal mental wellness including a meaningful definition along with initial ideas regarding how to promote and support perinatal mental wellness. GT methodology is a creative process that illuminates the social processes of interaction around the phenomenon in question - perinatal mental wellness. GT studies follow specific guidelines in order to produce a trustworthy theory. This study will follow evolved GT methods outlined by Strauss and Corbin (1997). The data was collected via interviews with mothers. Next, each interview transcript was coded using the open coding procedure which fragmented the data into many concepts. Then, axial coding was performed in order to transform these early concepts into more abstract concepts so that the theory can begin to emerge. Finally, selective coding was performed to interrelate concepts, detail the relationships between categories, and identify the core category. The theory itself emerged from this step in the coding process. Two important aspects of GT research are theoretical sampling and data saturation. Theoretical sampling is a procedure that identifies additional cases to include in the study in order to gather additional insight, expand concepts, and refine concepts. This type of sampling is beneficial to ensure each category is conceptually dense. Data saturation occurs when each category is conceptually dense, variations in each category have been identified and explained, and no further data related to the categories emerges during data collection. Therefore, theoretical sampling and data saturation work together. The GT researcher should continue to use theoretical sampling as needed until data saturation as been reached. In order to assess data saturation, a thematic saturation analysis was conducted. The thematic saturation analysis process involves comparing themes across interviews to assess how well the themes explain the data. Once data saturation has been
reached, no new information is coming from the data and the final sample size is identified (Bluff, 2005; Kolb, 2012; Tie, et al., 2019).

**Sampling and Participants**

**Sampling**

Initially, I used purposive sampling in order to ensure I gathered relevant data regarding the construct being studied- perinatal mental wellness. Purposive sampling is beneficial as the participants identified have knowledge and experience related to the perinatal period (Bluff, 2005; Tie, et al., 2019). Additionally, I used snowball sampling which consists of one participant referring an additional participant for the study which will be beneficial due to the phenomenon under study being a lesser-known topic (Bluff, 2005). Finally, theoretical sampling was conducted as the theory began to emerge. Theoretical sampling means that analysis of the data informs the sample selection and the addition of cases for the purpose of gathering new insights, expanding concepts, and refining concepts. Theoretical sampling is an important aspect of GT research as it directs ongoing data generation (Bluff, 2005; Kolb, 2012; Tie, et al., 2019). Once data saturation in each category was reached as confirmed by the thematic saturation analysis, theoretical sampling came to a close and the final sample size was known (Bluff, 2005). Data saturation occurs when no further data related to the categories emerges during data collection. Additionally, as saturation is reached, each category will be conceptually dense and variations explained.

**Participants**

Participants of this study included mothers who have experienced at least one pregnancy and birth. Interviewing women is appropriate for answering the research questions because this is the population that is affected by the construct- perinatal mental wellness. Women were able to
provide first-hand information regarding perinatal mental wellness versus perinatal mental illness in the context of their personal experiences during pregnancy and birth. These insights provided rich data that served not only to answer the questions, but to also explore what women prefer in the context of perinatal care which informed and enriched the strategies to promote perinatal mental wellness.

I was able to reach out to potential participants via social networking groups. One example of a social networking group is a mother’s support group hosted on Facebook. There are many of these support groups on social media platforms that include women from across the United States. With these types of groups, I was able to collect a sample of women to interview who are diverse in their ethnicity, socioeconomic status, age, sexual orientation, family composition, and culture. Having diverse participants served to gather in-depth information regarding perinatal mental wellness and the nuanced cultural differences that exist in the context of pregnancy and birth that influence the development of wellness versus illness. Furthermore, snowball sampling was used and some of the participants connected me to others interested in participating.

**Data Collection**

Qualitative researchers are the principal instruments of data collection and analysis (Charmaz, 1996; Strauss & Corbin, 1997). This means that data collected are processed through the person collecting them. Scholars in qualitative research have suggested some principles in collecting qualitative data that ensures that the data collection process remains rigorous and decreases bias. These principles include being aware of our biases and considering that data is a two-way street where the participants tell their stories and in turn, the researcher tells them his or her understanding of their stories. Hence a process of checks and balances occurs. Qualitative data collectors should be nonjudgmental, active listeners, and culturally sensitive (Charmaz,
1996; Strauss & Corbin, 1997). Furthermore, researchers are recognized as instruments because of their qualifications and level of understanding about the phenomena under study. My credentials, clinical experiences, and personal experience with the phenomena under study served as tools to help establish rapport and process the questions throughout the interview procedures. My credentials include a master’s degree in Clinical Mental Health Counseling from a CACREP accredited institution; a National Certified Counselor (NCC) credential; and I am a Licensed Professional Counselor (LPC) in the state of Alabama. I have several years of post-master’s clinical experience working with a variety of populations including children, adolescents, adults, and families. Further, the clients I have had the privilege of helping presented with many different mental health concerns including depression, anxiety, post-traumatic stress disorder, and addiction. Finally, I have experienced the phenomenon under study myself; therefore, I am able to empathize with participants from both a professional and personal standpoint. Due to my professional clinical experience, I hold the skills necessary to bracket and hold my own story separate from participants in the study so that their voices can be heard. Having these as the core concepts, I used a semi-structured, in-depth interview to guide the data collection.

My interest in studying perinatal mental wellness developed from my own journey to becoming a mother. When speaking with other women regarding pregnancy and birth, my own story stood in sharp contrast to many of the stories I was being told by others. Several of the stories that I had the privilege of hearing included negative feelings associated with pregnancy and birth. My story, however, is blessedly positive, and when I shared it with other women the reactions I received were those of shock and even guilt. Women tended to respond by saying they did not know birth could be empowering or that they felt guilty that they did not have a
birthing experience similar to mine. Further, women expressed regrets regarding their birth and how it transpired. Women have also highlighted that they were not prepared for these negative feelings and that they felt like bad mothers or that something was wrong with them. With all of this negativity surrounding pregnancy and birth, it is no wonder that women develop perinatal mental illnesses. However, this does not have to continue to be the norm. My own story, and others like it, are a testament to that and that birth can be beautiful, empowering, and build resilience rather than resulting in mental health complications. Therefore, my hopes are that this research will provide the tools necessary for women to be empowered to advocate for their own mental wellness throughout the perinatal period.

**Procedures**

The data for this study is comprised of information gathered from interviewing women who have experienced at least one pregnancy and birth. Participants were interviewed via an online format, specifically zoom meetings. I audio recorded the interviews with full permissions from participants and then transcribed the audio recordings for data analysis.

**The Interview Guide**

The interview guide is designed in a way that elicits in-depth information on the experience of the informants. Interviewing is a commonly used method of data collection in qualitative studies (Bryant & Charmaz, 2007; Charmaz, 1996; Kolb, 2012). Semi-structured interviews were beneficial for data collection in this case because these interviews allowed me to ask questions specifically aimed toward answering the research questions while also leaving space for participants to provide other information which further enriched and further explained as well as provided context for the research questions. A semi-structured interview protocol facilitates collection of data relevant to answering the research questions along with the
development of the theory. A limited number of questions were asked related to the research questions so that the process of discovery and the experiences of participants were illuminated (Bluff, 2005; Bryant & Charmaz, 2007). Women were asked to discuss their experiences with mental health care during the perinatal period along with their conceptualization of perinatal mental wellness. This perspective helped to illuminate different aspects of perinatal mental wellness along with more clearly defining this phenomenon. The interview protocol is detailed in Appendix A.

Data Analysis

The data in this study was analyzed using the constant-comparative method. Using constant comparative analysis involves constant comparison between the data verbatim including words, sentences, and paragraphs and the codes and categories that emerge. This is a key feature of a grounded theory study (Bluff, 2005; Bryant & Charmaz, 2007). The purpose of the process is to identify similarities and discrepancies in the data leading to the development of categories and finally the theory itself. Practically, the constant comparative process involves transcribing and open coding each interview as it is collected. In subsequent interviews, the researcher will repeat the process while comparing newly collected data with the previously collected data. The constant comparative analysis process continued until the final report was written. Figure 1 provides a diagrammatic depiction of the constant comparative process.
An important aspect of this type of analysis to note is that of data saturation. Data saturation needs to be reached because this means that no new information is being generated that could affect the final theory. If information is left out, then the theory could have looked very different than what was reported and omit important information. Data saturation was assessed via thematic saturation analysis. Saturation occurs when each category is conceptually dense, variations in the category have been identified and explained, and no further pertinent data emerges from the data collection (Annells, 1996; Bluff, 2005; Charmaz, 1996; Strauss & Corbin, 1997). The thematic saturation analysis table is provided in table 1.
To begin data analysis, I engaged in open coding to begin to give meaning to the data. In this phase, comparisons are made among the data and the researcher continually asks questions about what is and what is not understood. Each line of the data was coded to facilitate an analytic stance toward the work and begin building the theory. The questions that were generated can be used in later interviews to gather relevant information for the study or clarify concepts (Bluff, 2005; Charmaz; 1996; Kolb, 2012; Strauss & Corbin, 1997).

Next, I engaged in axial coding to make connections between categories and sub-categories which allowed a conceptual framework to emerge. In this stage, the codes were linked to form categories and become more conceptual allowing relationships and patterns to emerge. The relationships between concepts in this stage was verified by constant comparison and enabled the theory to be developed. In practice, the categories in each interview transcript were compared with each of the other interview transcripts in order to ground the analysis in the data and assess for variations. Memos were used to ground the analysis in the data and define patterns in relationship to the data (Bluff, 2005; Charmaz; 1996; Kolb, 2012; Strauss & Corbin, 1997).
The final step in coding the data was selective coding wherein the core category is identified and systematically connected to other categories. The core category is the central category that links and accounts for variations in the data. This process integrated and refined the major categories with the core category so that the grounded theory can emerge. In this step, it is important that data saturation was reached to ensure that adequate information was gathered to accurately reflect the perspectives of the study participants and that the theory did not omit any crucial information. I assessed data saturation by conducting a thematic saturation analysis. The process of thematic saturation analysis involves identifying the themes and categories in each interview and comparing them to assess the degree to which the themes and categories explain the data. Additionally, this comparison identified whether more explanation is necessary to account for variations in the data. Once data saturation was reached, no further data collection was necessary and the sample size was finalized (Bluff, 2005; Charmaz; 1996; Kolb, 2012; Strauss & Corbin, 1997).

Considerations to Enhance the Quality of the Research

In research, investigators aim to satisfy concerns related to validity, reliability, objectivity, and generalizability. These terms fit nicely into a quantitative design. However, with qualitative work, studies aim for depth, context, and relationships. Therefore, the criteria above do not easily apply because there are no quantitative results to analyze statistically (Marshall & Rossman, 2016). When discussing qualitative research, it is more helpful to consider the constructs proposed by Lincoln and Guba (1985) which are credibility, dependability, confirmability, and transferability.

Credibility can be compared to internal validity in that the researcher is aiming to address how congruent the findings are with reality. Rather than using statistical analysis, the qualitative
researcher can utilize other methods to ensure that the findings are reflective of the participants’ reality. In this study, I used member checking to address credibility. Member checking calls for the researcher to review the interpretations of the data along with codes and categories generated with the participants and make changes as needed. This process helps to decrease researcher bias, clarify participant responses, and increase researcher reflexivity (Bowen, 2009; Kolb, 2012).

Dependability can be compared to reliability in that the researcher is concerned with the stability and consistency of the findings. In order to establish dependability in this study, I aimed to be transparent in all processes of the study so that future researchers could repeat the work if they choose and so that readers can assess for themselves the rigor of the work. The planning of the study and the execution of the study is described and discussed in detail so that others can assess my work. Furthermore, my data collection methods and field work are described and discussed in detail so that others may assess to what degree the theory is grounded in the data (Creswell & Miller, 2000; Marshall & Rossman, 2016; Shenton, 2004).

Confirmability is comparable to objectivity wherein the researcher is concerned with how well the findings reflect the ideas, experiences, and voices of the participants. I have provided an audit trail which consists of documentation to support the decisions made throughout the research project. Details of the analytical decisions made throughout the project are made explicit so that others could retrace the steps and arrive at the same conclusion or theory (Bowen, 2009). I have provided a diagrammatic audit trail for this study using a data-oriented approach. A data-oriented approach to the audit trail details how the data was collected and processed, how the codes were formed, how the categories were formed, and how the three-step coding process lead to the formation of the theory (Shenton, 2004).

Transferability can be compared to external validity because the concern is whether or not
the research is applicable to other populations. In qualitative studies, the reader decides whether or not the study and findings are applicable to a population they are concerned with. In order to make this decision, the reader needs to be provided with sufficient detailed contextual information. In order to accomplish this, I explained the boundaries of the study including the number of participants, detailed descriptions of the populations contributing to the study, the number and length of the interviews, and the time period of the data collection (Creswell & Miller, 2000; Shenton, 2004).

In my research process, I aimed to satisfy the four constructs set forth by Lincoln & Guba (1985) to ensure that this study is rigorous and of satisfactory quality. Further, satisfying these constructs helps to ensure that researcher bias is accounted for and decreased along with ensuring that the resulting theory is grounded in the data. To address credibility, dependability, confirmability, and transferability, I engaged in several techniques including member checking and providing an audit trail with descriptive and visual components. Using these techniques improved the trustworthiness of the study by making the research process clear.

**Ethical Considerations**

For professional counselors, ethical considerations are informed by the American Counseling Association code of ethics. This research involves interaction with human subjects; therefore, the study is guided by the Duquesne University IRB which adheres to the Belmont Report on human subject ethical guidelines. The Belmont report guidelines include the following: beneficence, respect for human dignity, and justice. Beneficence means that the researcher takes reasonable measures to ensure that the participants are not harmed during participation in the study. Respect for human dignity means that the researcher respects the participants and their rights to privacy, anonymity, and rights to participate or not with full
consent. Justice refers to the consideration of who benefits and who does not benefit from the study keeping in mind historical societal injustices (Marshall & Rossman, 2016). Ethical considerations related to this study include confidentiality, data storage, and advocacy.

Confidentiality

Confidentiality for participants was guided and informed by the American Counselor Association (ACA) code of ethics. The participants were informed of the conditions under which confidentiality may be broken including risks of suicide or homicide, child abuse, or elder abuse. In this study, the use of individual interviews provided for privacy and confidentiality. The participants were provided with an opportunity to choose a pseudonym prior to audio recording to protect their anonymity. The Institutional Review Board of Duquesne University was informed and provided approval for this study prior to the signing of informed consent by any participant. Participants provided verbal and written informed consent prior to any interview questions being asked. Prior to conducting the interviews, I explained the purpose of the research, right and procedure to withdraw, and confidentiality to each participant.

Data Storage

The participants in this study were informed of the strategy for data storage. Audio recorded interviews were saved electronically in a password-protected file on a personal computer. The participants were made aware that only the researcher has access to the original audio recording files. For transcription, all identifying information was removed. These transcriptions and audio files will be retained for up to five years.

Advocacy and Intervention

Throughout the field work and data collection process, I anticipated some issues around advocacy and intervention to arise due to the nature of the research topic. Some women reported
negative experiences in the process of receiving perinatal care. My impulse as a counselor was to intervene; however, as a researcher, that is not my place. I supported participants in the interview by ensuring they knew which pathways they could take to address any negative issues they brought up. Therefore, I provided participants with information regarding perinatal mental health support.
CHAPTER IV: FINDINGS

This chapter presents the major findings and themes that emerged from this study. The first section highlights the demographic information and other important attributes of the participants in order to aid in the understanding of the context that underlies their experience of the perinatal period. The second section reviews the analysis procedures and the saturation analysis in order to provide an audit trail. In total, 33 codes were generated from the participants’ experiences with the perinatal period in the open coding process. Axial coding indicated 15 themes emerged, and selective coding indicated four categories including perinatal mental wellness; factors supporting perinatal mental wellness; factors undermining perinatal mental wellness; and systemic change. The final section of the chapter presents each category with its related themes as well as the final model for promoting perinatal mental wellness for mothers in the United States.

Participants

Ten female participants who fulfilled the criteria of the study were recruited to participate in the study. Participants residences include four different states: Pennsylvania, Alabama, Ohio, and Maryland. To maintain the anonymity of the participants, the researcher used only the first initial of the participants. Participant 1, “C”, is a 31-year-old female from Pennsylvania. She reported one pregnancy with one birth and received care with a midwife in the hospital setting. Participant 2, “J”, is a 34-year-old female from Alabama. She reported two pregnancies with one birth and one miscarriage. J received care with an obstetrician in the hospital setting. Participant 3, “J”, is a 31-year-old female from Pennsylvania. She reported three pregnancies with two births and one miscarriage. J received care with an obstetrician in the hospital setting. Participant 4, “A”, is a 32-year-old female from Pennsylvania. She reported one pregnancy with one birth and...
received care with an obstetrician in the hospital setting. Participant 5, “S”, is a 31-year-old female from Pennsylvania who reported one pregnancy with one birth. She received care with an obstetrician in the hospital setting. Participant 6, “J”, is a 34-year-old female from Alabama who reported three pregnancies and three births. She received care with an obstetrician in the hospital setting. Participant 7, “A”, is a 37-year-old female from Ohio who reported four pregnancies with four births. A received care with her first pregnancy with a midwife in her home and received care with a midwife in the hospital setting for her last three pregnancies. Participant 8, “P”, is a 43-year-old female from Ohio who reported six pregnancies with six births. She received care with a midwife for all of her pregnancies and birthed two babies in a hospital setting and birthed four babies at home. Participant 9, “H”, is a 41-year-old female from Alabama. She reported two pregnancies with one ectopic pregnancy and one birth. She received care with an obstetrician in the hospital setting. Participant 10, “J”, is a 31-year-old female from Maryland who reported one pregnancy and one birth. She received care with a midwife in the hospital setting. A concise table of participant demographics can be found below in table 2.

Table 2. Participant Demographic Characteristics

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Location</th>
<th>Number of Pregnancies</th>
<th>Number of Births</th>
<th>Pregnancy Loss(es)</th>
<th>Model of Care</th>
<th>Setting of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. C</td>
<td>31</td>
<td>Pennsylvania</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>Midwife</td>
<td>Hospital</td>
</tr>
<tr>
<td>2. J</td>
<td>34</td>
<td>Alabama</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>Obstetrician</td>
<td>Hospital</td>
</tr>
<tr>
<td>3. J</td>
<td>31</td>
<td>Pennsylvania</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>Obstetrician</td>
<td>Hospital</td>
</tr>
<tr>
<td>4. A</td>
<td>32</td>
<td>Pennsylvania</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>Obstetrician</td>
<td>Hospital</td>
</tr>
<tr>
<td>5. S</td>
<td>31</td>
<td>Pennsylvania</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>Obstetrician</td>
<td>Hospital</td>
</tr>
<tr>
<td>6. J</td>
<td>34</td>
<td>Alabama</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>Obstetrician</td>
<td>Hospital</td>
</tr>
<tr>
<td>7. A</td>
<td>37</td>
<td>Ohio</td>
<td>4</td>
<td>4</td>
<td>0</td>
<td>Midwife</td>
<td>1 – Home 3 - Hospital</td>
</tr>
<tr>
<td>8. P</td>
<td>43</td>
<td>Ohio</td>
<td>6</td>
<td>6</td>
<td>0</td>
<td>Midwife</td>
<td>2 – Hospital 4 – Home</td>
</tr>
<tr>
<td>9. H</td>
<td>41</td>
<td>Alabama</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>Obstetrician</td>
<td>Hospital</td>
</tr>
<tr>
<td>10. J</td>
<td>31</td>
<td>Maryland</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>Midwife</td>
<td>Hospital</td>
</tr>
</tbody>
</table>
Analysis Procedures and Audit Trail

The data in this study were analyzed using the constant-comparative method. Using constant comparative analysis involves constant comparison between the data verbatim including words, sentences, and paragraphs and the codes and categories that emerge. Constant comparative analysis is an iterative and recursive process that occurs throughout the data collection process and with each interview. The constant comparative method is a key feature of a grounded theory study (Bluff, 2005; Bryant & Charmaz, 2007). First, open coding of the data was conducted resulting in thirty-three codes. In this phase, comparisons were made among the data and the researcher continually asked questions about what was and what was not understood. Memos were recorded by the researcher to facilitate the comparison and questioning process and ground the process in the data. Next, axial coding was conducted resulting in fifteen themes. The codes were linked to form categories allowing conceptual patterns to emerge. The relationships between concepts at this stage were verified by constant comparison to the raw data. Memos were used to facilitate the constant comparison process. Finally, selective coding was conducted and four categories emerged. This process integrated and refined the major categories from the data (Bluff, 2005; Charmaz; 1996; Kolb, 2012; Strauss & Corbin, 1997).

Throughout the axial and selective coding processes, theoretical sampling took place. Theoretical sampling began after interview six because more data regarding the midwifery care model would further clarify and explain some of the emerging themes. Up until interview six, one participant received care with a midwife. Therefore, some of the emerging themes were unclear due to lack of data related to the midwifery model of care. Additionally, up until interview seven, all healthcare was provided in hospital settings. Therefore, more data regarding alternative care settings such as the mother’s home would help to further clarify and explain the
emerging themes related to the midwifery model of care (Bluff, 2005; Kolb, 2012; Tie et al., 2019). Memos were used throughout the analysis process to ground the analysis in the data. A thematic saturation analysis was conducted as the themes and categories emerged from the data. Data saturation was reached after ten interviews as no new, unexplained concepts or themes were emerging. A cross-case analysis of themes is presented in table format in appendix B.

Although other wellness-based theories are available, the data from this study was unique to mothers and did not fit well into general wellness theory. In particular, the data was compared to the Indivisible Self Model of Wellness and the data was not well explained within this model (Myers & Sweeney, 2004). The data within the Indivisible Self Model of Wellness was fitting insofar as explaining how mothers might be able to identify some coping strategies in the perinatal period; however, the model did not fully explain the connections among the themes and the importance of the context or quality of care. A diagrammatic explanation of the analysis procedures is provided in figure 2.

Figure 2. Analysis Procedures
Perinatal Mental Wellness

A primary goal of this study was to better define perinatal mental wellness as indicated by research question 1 - what does perinatal mental wellness mean to mothers? The participants in this study highlighted the need for mental readiness for birth as well as mental readiness for the changes to come in the immediate postpartum period; preparation; and the lack of perinatal mental health care. Participant “A” in interview 4 described perinatal mental wellness and exemplified the different aspects of the process:

There's the pregnancy mental aspect of it which is I'm carrying this child. I'm going to have a baby. All of the thoughts and, you know, things that go on mentally that kind of causes some of those mental challenges that we have at that time. And then there's the after birth, where this crazy thing has happened to you and you don't really know how to reconcile that. So the action of having the baby, dealing with caring for a child, and the hormonal changes is kind of a perfect storm opening you up to challenges and how you cope with that. – A, Interview 4.

The data indicated that part of perinatal mental wellness is talking about mental wellbeing throughout the experience from pregnancy to postpartum with a trusted provider in order to track changes, provide support, and prepare for the event of becoming a mother. Participant “J” in interview 6 noted the following in regard to perinatal mental wellness: paying attention to what is the baseline for that particular woman and her unique needs and then just kind of keep track of it and keep asking. While this was expressed as needed, several participants noted that these conversations and follow-up were lacking in their care experiences.

When I went back for my six weeks appointment, she asked me how I was doing and if I was exhibiting any symptoms like other than that, there was none, no talk about it. –J, Interview 2.
There wasn't really a lot of discussion about the mental health side of it at all. – P, Interview 7

Wellness would have been having someone focus on my mental health. – S., Interview 5

The absence of perinatal mental health care was made clear by participants when discussing perinatal mental wellness as evidenced by the following:

I think it’s non-existent and the reason I say that is because during my whole pregnancy, not once was I really talked to about mental health. -J, Interview 2

For me they had the questions at the pediatrician, like the follow-up visits, but even answering those honestly, I was only ever borderline. I tried their screenings, but I felt like I couldn't function. - S, Interview 5

I think postpartum baby blues or depression, I never was treated for anything, but it got worse with each pregnancy. So, with my first, I just kind of had postpartum anxiety, worrying a lot, and then by my fourth, I was feeling really sad and lonely. -A, Interview 7

The data indicated that absence of mental health care and no specific preparation for the transitions in the perinatal period was a barrier to perinatal mental wellness for these participants. The participants would have preferred to have mental health discussions included as standard protocol in their perinatal care as well as some guidance regarding preparing for the challenging mental aspects of the perinatal period and the transitions therein. Considering the data presented, perinatal mental wellness in the context of this study means mental readiness for birth and the changes to come via mental healthcare provided alongside physical healthcare throughout the perinatal period.
Factors Supporting Perinatal Mental Wellness

This category includes the following themes: multi-dimensional support; attentive healthcare provider; attending counseling or support group; and attending informational classes. Additionally, this category corresponds with research question 2 - What aspects of maternity care help to support mental wellness for mothers in the perinatal period? The themes presented in this category serve to answer this question. Specifically, having multidimensional support; engaging with an attentive healthcare provider; attending counseling or a support group; and attending informational classes are all factors that supported perinatal mental wellness for the participants in this study.

Multidimensional Support. Multidimensional support in the context of this study means that women received support from various sources such as partners; family; friends; colleagues; and healthcare providers throughout the perinatal period. The participants in this study highlighted that this support was an important aspect of maintaining wellness as well as helping better understand any changes in their mental wellbeing. Having multidimensional support lead to participants feeling cared for and understood. Seven of the ten participants highlighted the importance of multidimensional support and the following quotes provide some insight into these conversations.

So during pregnancy. I think I had a good personal support system. friends that were very willing to talk about everything that's involved. A partner that's very supportive and understanding. He was great throughout. I went through a midwife care center and I really liked the midwife approach to pregnancy. – C. Interview 1
Having someone just to be on the lookout for any kind of, you know, depression or anxieties or shifts and kind of my mental well-being was big. Because I think when you're in it, you can't always see if things have changed, or if you are different.- A., Interview 4.

**Attentive Healthcare Provider.** This theme highlights the importance of having the healthcare provider be attentive to the needs of the mother by taking the time to listen to her concerns and respond to those in a thoughtful manner. Some attributes of attentive healthcare providers include active listening; spending more time talking to mothers; building positive rapport; respecting mothers’ choices for their birthing plans; following the birthing plan; and encouraging mothers to engage in self-care. Nine out of the ten participants specifically mentioned this factor as an important aspect of their care experiences. The participants in this study provided several examples of instances in which the attentiveness of their healthcare provider was beneficial for their mental wellness.

*I will say, so when I first got pregnant, my doctor, she was very to the point with first pregnancy. She was like, so you got pregnant, make sure you're taking it easy, taking care of yourself and that kind of stuff. But then after had a miscarriage and then I got pregnant again, she would spend more time with me in the office and let me ask a million questions and not rush me.* – J, Interview 2

*The delivery went exactly as I'd hoped. I was basically able to follow my birth plan. And so, that felt very empowering and I didn't have a lot of kind of mental anxiety around that just because of how well it went.* - A, Interview 4

*My obstetrician was really great when I followed up about... it's like I had told her, you know, I'm very afraid of this happening with the next pregnancy. So she took quite a while to talk me through the risks and the benefits.* – S, Interview 5
I felt much more supported when I was with midwives model of care rather than going to an obstetrician. But with the first appointment there, they took an entire hour to just sit down and talk and talk about family life. And it was a lot more empowering and you could ask you all the questions and they would give you information. I felt like I was respected, and it was about just as much about my emotional health and my mental health as it well as my physical health. – Interview 8.

**Attending Counseling or Support Group.** Several participants in the study reported that attending counseling or a support group helped to support their mental wellness. The counseling and support groups were aimed toward maternal mental health wherein the professionals facilitating the counseling or group were trained specifically to work with perinatal mental health concerns. Additional attributes of the counseling or support groups included positive rapport; encouragement of positive self-care; normalization of negative emotions or experiences; and a non-judgmental environment. Attending counseling or a support group helped women to feel supported from a mental and emotional standpoint; helped to increase their insight into their mental wellbeing; and helped to normalize their experiences.

*I checked into my therapist two weeks after the baby was born, so I already had a relationship established.* – J, Interview 3

*New Mom’s Coffee. That was a big thing, that was a big thing for me to feel supported. Even though my family was supportive, and my husband was supportive, that's still... it made me feel like people got it. And that was one of the groups that made me realize I wasn't okay.* — S, Interview 5

*Having that community support and other people in the group and realizing that, okay, everybody else is as clueless as I am. So it's okay.* – H, Interview 9
**Attending Informational Classes.** Participants reported that attending informational classes helped them to feel more prepared for the transition into caring for a newborn and ready for the changes to come postpartum. Informational classes were lead by perinatal health professionals such as lactation consultants and nurses. These classes covered a variety of topics including basic infant care; infant first aid; breastfeeding and formula feeding; and methods for managing labor and birth. Attending the informational classes links with the definition of perinatal mental wellness outlined above directly by supporting mental readiness.

_H, Interview 9_

**Our pediatrician’s office, they had classes, and that was really helpful. I think it was with the lactation consultant, but she talked about all kinds of stuff with newborns and just kind of parent training kind of stuff. I mean, even though she was the lactation consultant, she covered a ton of different stuff. Because we were in the classes together several times, you met other new parents. You met people who were kind of in the same stage or going through some of the same experiences as you. So you could have people to have conversations with.

And then, you know, it kind of helped you feel more comfortable with all of the stuff that was coming._

**Factors Undermining Perinatal Mental Wellness**

This category corresponds with research question 2 - What aspects of maternity care help to support mental wellness for mothers in the perinatal period?; however, this category corresponds inversely to the question. This category includes the following themes: lack of follow up; poor communication; lack of information; and work related stressors. The themes presented in this category highlight factors that undermined perinatal mental wellness, and were perceived by the participants as stressors.
**Lack of follow up.** Participants highlighted that the lack of follow up from their providers was distressing especially as related to mental health. The participants noted that the length of time, typically six weeks, between their birthing experience and check-up felt like too long. Several participants expressed that they would have found it beneficial to have some type of check-in with their provider much sooner. The participants also noted that there was a lack of follow up related to mental health screenings. Specifically, postpartum depression screenings were provided, but following through with recommendations based on those screenings was limited. Additionally, participants noted that postpartum depression was the only screening tool provided and their postpartum anxiety was not addressed.

_A thing that always made me mad was the lack of follow up, but I don't know what the better solution is. So your follow up appointment with your OB is after 6 weeks. They give you like this 10-question mental health questionnaire which I think is good and important. The problem is, I could pass all of those. Thankfully, I wasn't feeling like so down that like I needed to be flagged for depression but I answered honestly. Answering honestly, I still pass those and like wasn't flagged for anything, but there was so much that it didn't cover that I probably wouldn't have passed because of anxiety._ – J, Interview 3

_Once I left the hospital, I felt very kind of out of control. I think it would have been nice to have maybe my ob/gyn or someone just to have some kind of relationship with. Some kind of check in, just to say what's going on; how are you feeling; what can I answer for you instead of having to Google everything right in this in the first few days. I don't even remember my ob/gyn talking about it (mental health)._ – A, Interview 4

_They may have brought it up (PPD), but they didn't really want to do anything with it. It was like, they're just kind of like checking the box to say, yeah, we asked. I'd have to fill out a_
survey about what I was feeling when I would take my daughter in (pediatrician), you know, within like the first month probably. But they wouldn't do anything with it – J, Interview 10

**Poor Communication.** Participants reported instances of poor communication with their providers that negatively impacted their sense of wellbeing and were distressing. This ranged from poor communication in the processes of labor to providers not listening to the needs that women were presenting. Two participants highlighted what poor communication looked like for them while in labor and how it affected them emotionally.

*The plan was for me for my pain management was to use nitrous oxide. It was recently made available at our hospital, if you were with the midwives. And it was just never provided so I was not told prior that not everyone’s trained in it. It's only if there’s trained staff available like I wasn't told about all these caveats. So here I am in labor and I'm like, okay, the pains too much. Now let's go my pain plan and just nobody ever came. It was too long after that & I was just, I couldn't handle it. So, we went with the epidural. And it was placed wrong. And so, they had to place it a second time right there, like right away. So that was pretty good for a little while and then the pump broke. It became disconnected. And so, we had to call again and it took a long time for them to come down again, and then they weren't listening to us that the pump broke. And so we had to kind of fight and advocate for me to get the pump fixed so it had to be placed the third time. – C, Interview 1

*My second one, I felt like nobody was really communicating with me. I know this is an educational hospital, but I don't feel safe. But I felt like, you know, we were just kind of rushing to get it done. And I don't know, I just remember a lot of people being in the room and I didn't like that. – J., Interview 6
One participant noted being laughed at by a provider for her choices related to labor and birth.

*I started off going to an OB with I think they had like six different doctors in the practice and it was at a recommendation of a coworker and it was very get-in, do all the blood work and the urine sample, the nurse came in and did the blood pressure and there wasn’t much conversation. And I remember saying that I wanted to have a natural birth and she laughed at me.* – P, Interview 8

A few participants noted that there was poor communication related to mental health specifically in which they were not able to get the care they needed in a timely manner. Participants endorsed suffering with symptoms causing increased stress for months without appropriate care.

*I feel like there was a big need there for me. And at the time, I don't know that I really advocated for myself the way that I think I would now. Because it was just, everything was so fresh and so raw and so new. And I feel like there was a big opportunity there for somebody to be like, hey, you just went through an ectopic pregnancy, you just had surgery. Are you okay? But I feel like there was a need at that point for somebody to have followed through and asked, hey, emotionally, how are you doing? You know, are you depressed? Are you handling this okay? Where's your head at? And nobody did. And so I feel like that was kind of a negative for me was that there was a place there for that to happen and it just didn’t happen.* – H, Interview 9

*I started researching a little bit, but then when I would bring it up to the doctors, I would still get a lot of pushback. I think I first brought it up to the pediatrician, because that was the first professional that I would be in contact with. And it was actually a male at that*
appointment instead of our regular female that we would meet. And I said something to him like, hey, I think I'm having a lot of anxiety issues. At the time, I'm still nursing and so I was asking him to ask if there were safe things to do while nursing. I remember he scooted close to me, like taps my knee and says everything's going to be fine. You're doing a good job. And I was like, okay, well, screw you. I know my daughter is doing well but I'm not doing well. And he literally handed me a piece of paper of psychiatrists. And was like, here, you can make some phone calls. And I thought well, that was terrible. – J, Interview 10

**Lack of Information.** Participants reported that lack of information related to physical changes, breastfeeding, and mental health directly related to the pregnancy left them feeling distressed as well as not sure how to cope with these issues. In regard to mental health, this lack of information was connected to gaps in services for participants.

_I didn't really know how to deal with this body that had just produced this baby. I didn't know how to breastfeed. I didn't know how to take care of a baby. I've always been kind of an overachiever and then all sudden, I was in this place where I just had no idea what I was doing and I was very much like I am at a loss. I am struggling. This suck. I had no idea about the physical changes that I would see after being pregnant just immediately after you know all the bleeding and all the pain and the pads and ice packs, you know all of this kind of extreme stuff that you go through. I don't think that anyone really talked to me about the difficulties that can come along with breastfeeding._ – A, Interview 4

_I had no idea what was happening. And I didn't know what was normal. Nobody really communicates what to expect. They don't say you might feel disconnected from the fetus or you might be stressed out. Nobody really tells you the emotional roller coaster that you're about to endure. And I feel like doctors don't, you know, they're there for medical not mental._
They tell you that you're going to grow or you're going to get sore or that kind of thing. They're not telling you that your hormones affect your day to day emotions and mood and your interactions with other people. – J, Interview 6

So I think that my symptoms were more like a postpartum anxiety than it was depression, but that's not talked about at all. So I didn't really recognize that that was a problem until like six months out. – J, Interview 10

**Work Related Stressors.** Participants reported that work related stressors had a negative impact on their sense of wellbeing due to issues with time off and expectations from their employers to work even when they felt that they needed rest. The participants highlighted that having to choose when to work even though they were not feeling well lead to feelings of fear and increased stress.

*It was very stressful that I had to pick and choose when I had to go to work sick, and I had to work through sickness and I was stressed and scared about what that might look like after the baby came. A couple weeks before my birth. I lost my job.* – C, Interview 1

*I was still working 10-hour days up until probably eight months pregnant. And then I cut out like an hour a day. And then I worked up until three days before she was born. But it was like, that was like expected. Like when I stopped working, they were like, oh, really? Like you want to stop?* – J.S. Interview 10

**Systemic Change**

The category of systemic change corresponds with research question 3 - What aspects of maternity care do mothers want to change in order to better meet their mental health needs in the perinatal period? This category includes the following themes: increased education regarding pregnancy, birth, and postpartum; including mental health counseling in the standard of care;
increased communication regarding mental health; and including mental health check-ins and screening in the standard of care. Specifically, these themes can be used as systemic change strategies within perinatal care to support and promote perinatal mental wellness among mothers.

**Increased Education Regarding Pregnancy, Birth, and Postpartum.** Increased educational information regarding pregnancy, birth, and postpartum includes providing mothers with knowledge regarding the realities of pregnancy, birth, and postpartum as well as what to expect. Information regarding the physical changes in pregnancy and postpartum as well as the mental and emotional changes need to be provided to mothers in a manner that helps to prepare them for what they will be experiencing even though some of this information can be intense. Participants reported that realistic information about the difficulties of the perinatal period including physical and mental aspects would be helpful for increasing mental readiness for birth and the changes that occur postpartum via preparation. This links to the definition of perinatal mental wellness presented in this study directly by providing a pathway to supporting mental readiness across the perinatal period from pregnancy to postpartum by providing education to mothers in order to prepare for the changes that occur throughout the perinatal period and the difficulties that accompany the changes.

*I think there's still so much like sugarcoating pregnancy and birth that it's just not the reality for so many of us. I think that should be more available like the information about how difficult it can be throughout pregnancy. I think just being a little bit more prepared about what the realities are of pregnancy and birth and postpartum would be helpful in mentally preparing and setting expectations.* – C., Interview 1
People need to be talking about here's what to expect within yourself. If you notice that this is happening while you're pregnant or even after you have your baby. Here are some resources. – J., Interview 2

I definitely feel like there should be some sort of class you can or should be required even to like take beforehand about—I mean, not like about labor delivery, birthing, things like that, but more about the mental aspects of being prepared, you know, things like self-care for mom and, you know, the importance of, you know, making time for yourself and still trying to find things that are for yourself. And then like warning signs of things that could happen. – J, Interview 10

**Including Mental Health Counseling in the Standard of Care.** Including mental health counseling in the standard of care refers to having a mental health professional available within the context of perinatal care so that mothers can access this resource throughout their perinatal experience. This looks like having mental health professionals employed and working alongside physicians and midwives in the healthcare setting. Having a mental health professional available within the context of the healthcare setting increases access to mental health services as well as reduces stigma related to seeking mental health services. Participants expressed that having a specific professional to talk with in the context of perinatal care would be beneficial for closing gaps in care, decreasing the stigma related to perinatal mental health issues, and providing a specific place that is safe for mothers to voice their concerns.

*I think it would be great to see a counselor for one or two appointments postpartum just as protocol because it is a significant number of women that it (PPD & PPA) happens to. It would be helpful to make every new mom talk to somebody.* – S, Interview 5
I really feel like women should have counseling instead of just seeing a doctor to check up on the medical part. I think also being able or being required would help women find it necessary and find it normal if we could just offer them counseling. – J, Interview 6

When you're going back for that two-week follow up or six-week follow up and all that, like I really think that it would help to have either a social worker or a counselor of some sort meet with new parents. So many women go through, you know, postpartum depression and all of that. Making it a priority to ask and realizing that some people are not okay and that they're not going to advocate for themselves or say that out loud unless you specifically bring it up. That may mean having a counselor at a certain number of appointments, you know, during pregnancy and a certain number of appointments post pregnancy. – H, Interview 9

**Increased Communication Regarding Mental Health.** Increased communication regarding mental health includes more frequent and more thorough conversations regarding mental health taking place throughout the perinatal experience with a professional. Increasing the frequency and depth of communication regarding perinatal mental health would serve to identify any issues that arise quickly and decrease gaps in care due to earlier identification of perinatal mental health concerns. Participants highlighted the need for increased communication with providers in regard to mental health. They noted that this could help with closing gaps in diagnosis and seeking mental health care. Participants reported that the gap in between birth and the six-week appointment seemed like a long time to wait for a follow-up appointment.

*The provider needs to be checking in throughout the entire pregnancy about the mental health stuff.* – J, Interview 2

*I remember postpartum thinking it was super weird that they don’t want to talk to you until you’re like six weeks postpartum. I really feel like they should like at least call you at like two*
weeks and be like, how's it going? You know, even if it's just like a nurse or, you know, you
know, how is everything going? And then they should see you at four weeks and then another
phone call follow up at like six or eight weeks or even further. – J, Interview 10

I had my six-week follow-up and like I said, my scores were like borderline and no one ever
really followed up with that. So I don't know. I feel like if you have a borderline or an iffy
score that maybe they should check on you a couple months later or at some point down the
line. But it was like, oh well, you don't test positive for it. You're okay. See you in a year. I
mean, after being pregnant, not seeing your doctor for a year just seems like you're being
abandoned even though it's normal. - S., Interview 5

Including Mental Health Check-Ins and Screening in the Standard of Care. Including
mental health check-ins and screening in the standard of care means including more thorough
screening and following up borderline and positive screenings with a mental health check-in with
a professional in order to connect mothers with appropriate treatment as part of the standard
postpartum healthcare appointment. Part of this effort includes screening mothers for multiple
perinatal mental health concerns rather than screening for depression only. Additionally, this
includes providing a mental health check-in with a professional alongside the screening tool so
that borderline scores and positive scores can be explored further as well as making appropriate
referrals. Participants expressed that the provision of mental health check-ins and screenings as
part of their regular healthcare would help to make mental health care more accessible for those
who need it; provide a more thorough examination so that diagnosis is correct; and catch issues
that arise sooner so that there are minimal gaps in service with decreased suffering. The
participants noted that while the screening tool for postpartum depression is helpful, anxiety
tends to be left unaddressed. Additionally, they noted that borderline scores tend to lack follow-
up and appropriate recommendations. Therefore, there are gaps in services in which mothers are suffering with mental health issues without appropriate care.

*I think if there would be some way that you could that every mom like could check in with a mental health professional. I understand that not everybody needs it. Or it might not get past like one or two visits for everybody, but I feel like that'd be another way for people who need it to make that more available. I would so definitely add questionnaires that include the questions that cover anxiety, not just depression.* - J, Interview 3

*I don't think that the, you know, little questionnaire screening tool is really enough to find out who needs help and who doesn't.* – A, Interview 7

*Perinatal anxiety and depression are such a big deal. I think it would have been beneficial for me to have also started being examined on a mental well-being level during some of those physical checkups.* – A, Interview 4

*I think it'd be nice to have some aspect of, you know, every postpartum mom gets a mental health check in, a professional to talk it through as opposed to just having a questionnaire.* – S, Interview 5

**Cross-Case Analysis of Themes**

In this section, I provide a cross-case analysis of themes, similarity, and difference in the table below. Some of the findings emphasize the contexts related to the experience of perinatal mental wellness including the definition of perinatal mental wellness and systemic change. Some of the findings emphasize barriers that exist in the environment of perinatal care that undermined perinatal mental wellness. Some of the findings emphasize protective factors that appear supportive to perinatal mental wellness.
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<td>Perinatal wellness</td>
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<td></td>
<td>• no specific preparation</td>
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Chapter Summary

This chapter aimed to present the findings and highlighted the categories and themes that emerged from the data in the present study. The participants’ demographic information and pertinent characteristics were outlined. A brief outline of the analysis procedures as well as a diagrammatic audit trail are provided. Then, the findings were presented as grouped by the major categories that emerged from the data as well as the final model.

The first category that emerged from the data is perinatal mental wellness. This category focused on defining the concept as well as illustrated barriers that participants faced as related to sustaining mental wellness in the perinatal period. From the data in this study, perinatal mental wellness is defined as *mental readiness for birth and the changes to come via mental healthcare provided alongside physical healthcare throughout the perinatal period*. The second category is factors supporting perinatal mental wellness and includes the following themes: multi-dimensional support; attentive healthcare provider; attending counseling or support group; and attending informational classes. The third category is factors undermining perinatal mental wellness and includes the following themes: lack of follow up; poor communication; lack of information; and work-related stressors. The fourth category is systemic change and includes the following factors: increased education regarding pregnancy, birth, and postpartum; mental health counseling included in standard of care; increased communication regarding mental health; and mental health check-ins with screening. In the next chapter, the implications of these results and conclusions are provided as well as the conceptual model.
Chapter V: Discussion

In this chapter, selected themes that have implications for professionals, interventions, and research recommendations are discussed and the final model is presented. Although this researcher hypothesized existing wellness models may fit well with the data generated in this study, that was not the case as determined by the data analysis. An attempt was made to fit this data into the Indivisible Self Model of Wellness; however, this model did not sufficiently explain the unique attributes of the systemic factors related to the perinatal period. Therefore, the development of a new model was necessary in order to clearly explain the data generated in this study accounting for both the wellness-based perspective as well as incorporating the strengths-based systemic change strategies.

Motherhood, as a concept, has been described by many women as a highly pleasurable and fulfilling experience that is incomparable to anything else. (Hanley, 2009; Gamble, & Creedy, 2004). However, research shows that some women develop impairments in physical and mental health functioning and wellbeing due to the major physical and psychosocial changes that occur during the transition into motherhood (Austin et al., 2010; Ayers & Pickering, 2001; O’Hara et al., 2014). The transition into motherhood is a process that encompasses two key physical events: the pregnancy and the childbirth. These events can have either positive (e.g., feeling empowered; parental competency) or negative (e.g. physical and mental health problems) implications for the women transitioning into motherhood (Prinds et al., 2012). The purpose of this research is to focus on the mental health and wellbeing aspect of this pivotal transition in women’s lives specifically for women in the United States.

The United States spends more than any other nation in the world on perinatal healthcare; however, it currently and consistently ranks near the bottom on most standard measures of
perinatal health to include mental health and wellness (Creanga et al., 2014; Lu, 2010; MacDorman et al., 2016). Researchers have noted that women receiving mainstream care have reported dissatisfaction with the emotional aspects of care (Gamble & Creedy, 2007). Others have identified the issues of lack of support and emotional care during the perinatal period as a problem to be solved (Shah, 2012). The current system of perinatal health care in the United States is characterized by greater access, higher utilization, and less fragmentation, creating opportunities to identify mental health problems sooner and respond appropriately (Leight, et al., 2010; Verbiest et al., 2016). Even with this strength, limitations continue to exist in this system due to gaps in care and physically-focused healthcare. This gap in services is related to the sharp decrease in women’s care and attention provided in the postpartum period. Once the baby is born, women typically do not see their healthcare provider until six weeks have passed (Creanga et al., 2014; Davis-Floyd & Cheyney, 2019; Leight, et al., 2010; Verbiest et al., 2016). During this significant time in the service provision process, mental health problems can escalate quickly before health care providers have an opportunity to assess women and connect them with appropriate services. Additionally, Mothers often experience difficulty acknowledging their distress due to stigma, lack of understanding by healthcare professionals, poor recognition of the difference between depression and normal adjustment, and difficulty accepting help (Buist, 2011). Untreated perinatal mental illnesses have been shown to result in suffering for mothers; strained familial relationships; negative effects on children’s emotional social, and cognitive development; and maternal suicide (Buist, 2011; Hanzak, 2016; Simpson & Catling, 2016).

In sum, perinatal mental illness and complications have a global effect on women, children, and families. Stigma related to perinatal mental illness and gaps in services collide in a way that women suffering from perinatal mental illness cannot express their distress which then
leads to increased complications for women and their families because they are going undiagnosed and untreated.

**Research questions**

This study is designed to provide a starting point for understanding the concept of perinatal mental wellness in the context of the United States’ culture and strategies that support mental wellness during the perinatal period. The focus of this study is to meaningfully define perinatal mental wellness and explore strategies that could promote perinatal mental wellness. The following research questions were designed to guide this study:

1. What does perinatal mental wellness mean to mothers?
2. What aspects of maternity care help to support mental wellness for mothers in the perinatal period?
3. What aspects of maternity care do mothers want to change in order to better meet their mental health needs in the perinatal period?

**Participant Profile**

The participants in this study include mothers who have experienced at least one pregnancy and birth. All participants reside in the United States as well as received their perinatal care in the United States. All of the women who participated in the study are over the age of eighteen. The participants presented a variety of experiences related to mental wellness during perinatal period. Specifically, four of the participants shared their experiences within a midwifery model of care and six participants shared their experiences with perinatal care provided by a physician. Although these participants received healthcare from different types of providers, they reported similar experiences regarding the mental wellness aspect of their care.
Perinatal mental wellness

By comparing the findings of this study with existing studies, it was found that mental wellness is identified in a variety of perinatal care contexts. As related to perinatal mental wellness, participants highlighted the importance of mental readiness for the birth and transition into motherhood as well as continued conversation with their healthcare provider related to mental wellbeing in order to track changes. Several participants reported that the need for mental preparation and conversations about their mental health went unmet. This finding is corroborated by researchers across the globe including Dossett et al. (2018), Nakku et al. (2016), and Watson et al. (2019). These researchers also found that their participants reported a lack of mental health conversations with health care providers. The lack of information about mental wellness in perinatal care poses a barrier for treatment entry. Lack of information and lack of ongoing conversations regarding perinatal mental health can affect the wellbeing of mothers because they ultimately suffer more than necessary due to not being treated.

Supportive factors for perinatal mental wellness and implications for systemic change

Several factors supporting perinatal mental wellness were identified in the context of this research study including: multidimensional support; attentive healthcare provider; attending counseling or support group; and attending informational classes. These factors are supported by existing literature and will be discussed in turn.

Multidimensional support

Multidimensional support refers to women receiving support from various sources such as partners, family, friends, colleagues, and healthcare providers throughout the perinatal period. Multidimensional support provides women with support in multiple domains of their lives and opportunities to explore their mental wellness or lack thereof in a non-judgmental manner.
Having multidimensional support led to feelings of being cared for and understood for participants in this study. Multidimensional support also provides women with multiple perspectives to consider when identifying areas of their mental wellness that may need attention.

Several researchers have noted the importance of support for women in the perinatal period. Edozien & O’Brien (2017); Ford & Ayers (2011); and Fenwick et al. (2013) all assert that support from healthcare providers throughout pregnancy, birth, and the immediate postpartum is necessary for positive psychological outcomes in the perinatal period. Edozien & O’Brien (2017) argue that health care providers may aggravate maternal stress by their approach to perinatal care including not attending to mental wellbeing. In a qualitative study by Butler-O’Halloran, & Guilfoyle (2015), participants described feeling deserted by health care providers upon discharge from the hospital. This study found that women were unprepared for new motherhood difficulties, and experienced isolation and lack of support. The women in this study discussed the need for greater emotional support from health care providers in order to create a working relationship in which mental health discussions were more approachable. Participants in the current study echoed these sentiments and expressed the need to be more supported by healthcare providers as related to mental and emotional health via more frequent and thorough discussions about perinatal mental health.

Existing literature asserts that partner support is a protective factor against perinatal mental illness (Pilkington, et al., 2016; Nakku et al., 2016; Verbiest et al., 2016). Partner support encourages mothers and help seeking behaviors (Dossett et al., 2018; Nakku et al., 2016). Participants in the current study highlighted the importance of partner support and shared that their partners often noticed if their mental wellbeing was suboptimal before they noticed it for themselves. According to participants’ reports, having a supportive partner lead to increased...
conversations regarding mental health and encouraged help-seeking behaviors. Other types of support were also highlighted by participants in this study including family and friends. Support from family and friends benefitted participants via increased understanding and practical help with household tasks other than caring for the baby. Participants noted that help with pets, laundry, dishes, making meals, and other household tasks felt supportive and allowed them more dedicated time to bond with their infants. Other researchers corroborate these notions and assert that support in any form is beneficial. Hanley (2009) asserts that appropriate support leads to improved outcomes for mothers, and also suggests that any form of social support can improve mothers’ experience. Support can be provided by partners, doulas, nurses, or counselors, all with positive effects (Hanley, 2009). In sum, the importance of multidimensional support cannot be understated and is a critical component for promoting perinatal mental wellness.

**Attentive healthcare provider**

Participants in this study highlighted how having their healthcare provider be attentive to their needs supported their mental wellbeing. The participants noted instances when their provider took time to sit down and talk with them rather than rushing through appointments and how this led to them feeling more understood and cared for. Existing research supports this finding and notes how providers’ attentiveness impacts the mental wellbeing of mothers. Some researchers have found that low support and low-quality interactions with healthcare providers is a risk factor developing perinatal mental illness (Ayers, 2007; Butler-O’Halloran, & Guilfoyle, 2015; Simpson & Catling, 2016). When the relationship between women and their healthcare provider is uncomfortable and the provider does not facilitate conversation about mental health, women are more likely not to disclose their symptoms. Alternatively, when the relationship between women and their health care provider is comfortable, and the provider facilitates
conversation related to mental health, women are more likely to disclose their symptoms. Therefore, creating a relationship of trust and eliminating stigmatizing behaviors on the part of the health care provider are powerful first steps to early detection of perinatal mental illness, and providing recommendations for entry into treatment (Kingston et al., 2015). In addition, Noonan et al. (2018) highlight the importance of building a relationship between the health care provider and the woman. Having a positive relationship characterized by strong rapport and mutual trust facilitates women to disclose their symptoms making assessment, diagnosis, and treatment more likely. Data from the current study and previous literature clearly demonstrates the importance of the mother and healthcare provider’s relationship. An attentive healthcare provider is an essential factor in supporting and promoting perinatal mental wellness.

**Attending counseling or support group**

Attending counseling or a support group was reported as an essential factor in supporting mental well-being among the participants in this study. In particular, the participants noted that counseling or support groups provided support from a mental and emotional standpoint; helped to increase their insight into their mental well-being; and helped to normalize their experiences. Literature supports this finding and asserts that women accept group in particular as a helpful support format. According to Watson et al., (2019), support groups are helpful because they are a safe space for women to share their feelings, be listened to, and feel connected to others. Women valued support from others with similar experiences of poor perinatal mental health, whether the group was in person or in a virtual space. The work of Nakku et al., (2016) corroborates these findings. It asserts that group counseling is a viable treatment modality because it is culturally relevant as women already sit together and discuss issues that affect them. The findings of these
studies and the current research suggest that support groups for women in the perinatal period positively impact women’s mental health.

**Attending informational classes**

Participants in this study reported that attending informational classes helped them to feel more prepared to transition into caring for a newborn and ready for the changes to come postpartum. This mental readiness was supportive of their wellbeing by helping them to set more realistic expectations for the perinatal period. Existing literature corroborates this finding and asserts that education leads to more positive outcomes regarding perinatal mental wellness. Nakku et al., (2016) asserts that mental health literacy should be addressed among mothers in the perinatal period through education in order to increase help-seeking behaviors. In a study by Doessett et al., 2018, the participants highlighted the importance of educating families in order to decrease stigma and dismissive behaviors regarding perinatal mental illness. Educating the community regarding perinatal mental health and illness is also beneficial because it can help decrease stigma, which affects women’s help-seeking behavior positively (Nakku et al., 2016). The findings of the current study and previous studies completed demonstrate that providing information and education for mothers and their families has a positive effect on mental well-being.

**Systemic change**

Several systemic change strategies developed from the data collected in the current study include the following: increased education regarding pregnancy, birth, and postpartum; including mental health counseling in the standard of care; increased communication regarding mental health; and including mental health check-ins and screening in the standard of care. These strategies are supported by existing literature that has been conducted across the globe.
Although several participants in this study reported that they attended informational classes during their perinatal experience, they also reported that these did not adequately address how drastically their bodies, mental well-being, and lives would change due to birthing their first baby. The informational classes that the participants attended focused heavily on infant care topics such as first aid and feeding as well as topics related to the management of labor and delivery. The findings of this study suggest that increased information regarding the postpartum period would be beneficial for mothers so that they are able to mentally prepare for the unique challenges therein. Realistic information about the difficulties of the perinatal period including physical and mental aspects unique to the postpartum period would help to increase mental readiness via preparation. This links to the definition of perinatal mental wellness presented in this study directly by providing a pathway to supporting mental readiness across the perinatal period.

Lomonaco-Haycraft et al. (2018) conducted a qualitative study to examine an integrated program for perinatal mental healthcare. The program developed by these researchers integrates behavioral health into perinatal settings and focuses on improving perinatal mental health and expanding this type of integrated care. The program implemented universal screening for perinatal mental illness followed up by the integrated behavioral health intervention including consultation with behavioral health professionals, in-depth assessment with a behavioral health professional, treatment planning, and treatment. This qualitative study’s data was promising, and showed a decrease in depressive symptoms in mothers who participated in the program. Furthermore, the data showed a reduction in toxic stress in the home which had a trickledown effect of improving family unit’s wellness (Lomonaco-Haycraft et al., 2018). This study’s findings support the change strategy of including mental health counseling in the standard of
Participants in the current study noted that having a specific professional to talk to within the context of perinatal healthcare would be beneficial for closing gaps in care, decreasing the stigma related to perinatal mental health issues, and providing a specific place that is safe for mothers to voice their concerns. Integrating mental health counseling into existing physical healthcare decreases stigma and make these services increasingly accessible to women.

Several participants in the current study highlighted that their healthcare provider was attentive; however, this did not address the care gap following the birth. Participants reported that the gap between birth and the six-week appointment seemed like a long time to wait for a follow-up appointment and that more communication regarding mental health during this time period would be beneficial. This idea is supported by existing research, and some researchers have suggested that more frequent visits with providers would be beneficial for women’s mental wellbeing and decrease feelings of vulnerability. Currently, women do not meet with a provider until six weeks postpartum. In this lengthy timeframe, mental illness can manifest and escalate quickly before health care providers have an opportunity to intervene. Therefore, visiting a healthcare provider before six weeks postpartum is important especially for women with existing psychosocial problems (Butler-O’Halloran & Guilfoyle, 2015; Edozien & O’Brien). Closing this gap in services and increasing communication regarding mental wellbeing during this time would be beneficial for promoting perinatal mental wellness among mothers.

The six-week postpartum check-up was the standard in the United States for many years; although, the reasoning for this practice is not fully clear. According to the American College of Obstetricians and Gynecologists (ACOG), some policies related to insurance reimbursement for services contributed to this standard, and a cultural standard of forty days convalescence for women and infants also contributed to the standard. As of 2018, ACOG revised this standard and
recommended that the postpartum check-up should be an ongoing process rather than a single encounter. The new recommendation states that women should meet with a provider after three weeks for mental health assessment, and the physical aspect of the postpartum check-up should be individualized to each woman based on their medical history and birthing experience. Although the recommendation has changed, the standard of practice has been slow to follow as evidenced by the data in this study as well as other studies reviewed for this research. The reasoning for this is unclear; however, it may be that third-party payers have not adjusted to this standard of care so providers may not get reimbursement for services provided prior to the long-established standard of six weeks (Optimizing postpartum care, 2018).

Participants in the current study highlighted that the current standard postpartum depression screening is not adequate for assessing mothers’ mental well-being in the perinatal period. Several participants passed the PPD screenings; however, later received a postpartum anxiety (PPA) diagnosis. The participants also noted that borderline scores on the PPD screening tend to lack follow-up and appropriate recommendations. Therefore, there are gaps in services in which mothers are suffering from mental health issues without the appropriate care. Other researchers have corroborated this finding and have highlighted the benefits of more comprehensive screening tools. Literature has established risk factors for the development of perinatal mental illness; therefore, researchers have called for increased identification of these early in pregnancy by using screening tools over and beyond those for depression and using them frequently to continually assess perinatal mental health along with any changes that may occur (Edozien & O’Brien, 2017; Rafferty, 2013; Simpson & Catling, 2016). Including mental health check-ins and screening as part of the standard of care would serve to make mental health care more accessible
for those who need it; provide a more thorough examination so that diagnosis is correct; and
catch issues that arise sooner so that there are minimal gaps in service with decreased suffering.

The systemic change strategies developed from the data in the current study can promote
perinatal mental wellness among mothers in the United States. For systemic changes to be
effective, the current manner of providing perinatal healthcare will need to be adjusted so that
providers can develop a relationship with women through intentional interactions, and providers
will need to increase collaboration such that appropriate, timely referrals can be made. Other
researchers have called for similar system-level changes and note that the current system needs
improvement. According to Fenwick et al. (2013), postnatal care that is characterized by rushed,
routine, and ‘tick box’ midwife-to-woman interactions is potentially harmful to women’s
emotional well-being and family functioning. The participants in another study reported
difficulty disclosing mental health issues to health care providers due to hardship with
developing trusting relationships. The participants disclosed that trusting relationships were hard
to develop with providers as the provider was different at each appointment and that the
providers dismissed their concerns regarding mental health (Dossett et al., 2017). The
participants in a study by Watson et al. (2019) echoed the same sentiments reporting the care
they received negatively affected their ability to access support for perinatal mental health
problems. Laios, et al., (2013) summarize these ideas well and have suggested that all of these
improvements are no good unless the culture around perinatal care is improved. These
researchers suggest that perinatal care culture must include mental health as an integral
component rather than something that is dealt with by providing a screen and moving on. The
current study aligns with this idea and provides practical systemic change strategies to address
the issues mentioned earlier.
Participants’ experiences of factors undermining perinatal mental wellness

Participants in the current study brought forward some factors that undermined their mental wellness in the perinatal period, and several of these factors can be addressed via the systemic change strategies presented in this study. The factors undermining perinatal mental wellness include: lack of follow-up, poor communication, lack of information, and work-related stressors. Regarding lack of follow-up, participants specifically noted the gap in services and not getting appropriate referrals for mental healthcare. Participants in this study reported suffering with mental health symptoms for up to six months or even one year before being connected to appropriate care. This finding reinforces that integrated health systems are critical for ensuring that mothers are receiving appropriate care in a timely manner. Collaboration between physical and mental healthcare providers is essential in creating an integrated health system.

Poor communication issues included women feeling unable to advocate for themselves and providers not listening to the needs women were presenting. Participants reported that lack of information related to physical changes, breastfeeding, and mental health left them feeling distressed and not sure how to cope with these issues. Regarding mental health, this lack of information was connected to gaps in services for participants. Finally, participants reported that work-related stressors negatively impacted their sense of wellbeing due to issues with time off and expectations from their employers to work even when they felt that they needed rest. The participants highlighted that having to choose when to work even though they were not feeling well led to feelings of fear and increased stress.

These factors resulted in increased stress for women in the perinatal period and gaps in service such that women suffered longer than necessary without appropriate treatment. Throughout perinatal care provision, women need to feel heard, understood, and respected to
support their mental and emotional well-being. Avoiding these undermining factors in providing perinatal care would be a good first step toward the support and promotion of perinatal mental wellness.

**Conceptual Model**

Below is the conceptual model the researcher of the current study designed to capture the findings of the factors that promote perinatal mental wellness. The model emerged from the data and suggests that there are practical strategies that can be implemented into the existing perinatal care system that would promote perinatal mental wellness among mothers in the United States.

There are existing factors that support perinatal mental wellness; however, the data highlighted that there are other factors that undermine perinatal mental wellness that also impact on the mental wellbeing of mothers. In this study, participants endorsed both supportive and undermining factors in their experiences which impacted on their mental wellbeing in both positive and negative ways. Therefore, including the practical systemic change strategies that emerged from this study could promote perinatal mental wellness among mothers in the United States by mitigating and addressing some of the undermining factors that were brought forth in this study. The conceptual model in this study serves to connect well-researched constructs related to perinatal mental wellness in a new way. This model captures these constructs and connects them in a strategic, strengths-based manner with practical application potential.

The participants resoundingly noted that more open, frequent, and thorough dialogue about mental health with their care providers in the perinatal period would be a positive first step in promoting perinatal mental wellness. The systemic change strategies that emerged from the data would help to better support and promote perinatal mental wellness even further due to the opportunity to open more dialogue between providers and women; making mental health
services more accessible; and minimizing the stigma related to perinatal mental health concerns.

The conceptual model is presented in diagrammatic format in figure 3.

Figure 3. Conceptual Model for Promoting Perinatal Mental Wellness

The conceptual model highlights the existing factors that are supportive of perinatal mental wellness and connects these to the proposed systemic change strategies in order to illustrate how these strategies further promote perinatal mental wellness among women in the United States. The factors supportive of perinatal mental wellness as well as the systemic change strategies are derived directly from the data and reflect aspects of care that women need. Building on existing strengths is a positive way to affect meaningful change such that women are able to receive the care they need in the existing healthcare system.

**Conclusion**

The constant comparative data analysis indicated four categories including perinatal mental wellness; factors supporting perinatal mental wellness; factors undermining perinatal mental wellness; and systemic change. These categories and the themes associated with the categories are well established in the existing literature; however, this research is unique in that these
categories are now connected in a unique manner. Through this qualitative study, well-established constructs related to perinatal mental health were connected in a way that provides practical strategies to improve the existing perinatal healthcare system from a wellness and strengths-based perspective. This new model highlights the importance of an integrative healthcare system in which physical healthcare providers and mental healthcare providers work alongside one another so that mothers are able to receive the care they need in a timely, efficient manner. Additionally, the analysis clarified the meaning of perinatal mental wellness. Perinatal mental wellness in the context of this study means mental readiness for birth and the changes to come via mental healthcare provided alongside physical healthcare throughout the perinatal period.

The conceptual model that emerged from the data suggests that the systemic change themes could be used as strategies implemented within the existing perinatal healthcare model in order to promote perinatal mental wellness among mothers in the United States. These systemic change strategies would help to better support and promote perinatal mental wellness due to the opportunity to open more dialogue between providers and women; making mental health services more accessible; and minimizing the stigma related to perinatal mental health concerns. The conceptual model presented builds on identified strengths that exist in the perinatal care system and provides practical strategies to promote perinatal mental wellness.

**Implications for further research**

The present study’s findings have implications for potential increased understanding of perinatal mental wellness at the individual level, the professional level, and the community level. The results of this study indicated that we could define perinatal mental wellness, and some strategies can be used by professionals and lay support people to promote perinatal mental
wellness among women in the United States. As this study was grounded theory in nature, further studies could explore if this model applies to other populations and engage in quantitative work to clarify generalizability, reliability, and validity of the model further. Additional parallel work could also be explored with professionals working in perinatal health and mental health care in order to explore the concept of perinatal mental wellness from another perspective. Other research could focus on how to build increasingly integrated health systems within the context and culture of the United States. Further inquiry may also include why has the United States been slow to engage in the uptake of integrated healthcare systems especially given the benefits of such systems. Particular research questions for future inquiries may include: Does this model apply to a wider population of women?; If this model does apply to a wider population of women, how valid and reliable is it?; Is the concept of perinatal mental wellness defined similarly among professionals in the field of perinatal health care?; How acceptable is this model to professionals in the field of perinatal health care?; If this model is reliable, valid, and acceptable among women and professionals, how can this model be implemented into practice?

Implications and recommendations for professionals

As wellness-based professionals, counselors are in a prime position to help to facilitate several of the strategies especially multidimensional support; counseling and support groups; and facilitating psychoeducation and information-based workshops for perinatal women. Additionally, counselors are positioned to help advocate for the systemic change strategies and provide education to other professionals about creating positive therapeutic alliances; screening procedures and follow up recommendations; and building a network for appropriate referrals. Health care providers could be further educated regarding how paramount their relationship with women is, and how detrimental low support is for women’s mental health. It is vital to
develop a positive relationship with mothers to feel safe to disclose their distress. It is helpful to provide mental and emotional support for mothers in the perinatal period by directly asking about their mental well-being and keeping the conversation open throughout the process of care. Counselors are well trained in establishing a therapeutic alliance and facilitating rapport throughout the provision of care. Therefore, counselors are well positioned to support healthcare providers with these skills. Health care providers could also be supported by the counseling profession with information about how to screen and then use the results to inform recommendations to follow up with mental health providers. This requires collaboration between healthcare providers and mental health providers so that women are connected to appropriate care in a timely manner. As previously mentioned, the whole family unit is affected by perinatal mental illness, including the child. Therefore, more urgent attention needs to be given to mental health concerns in the perinatal period. Support and collaboration are both paramount in ensuring women receive appropriate care and that the family is not negatively impacted by untreated perinatal mental illness.

**Implications for Interventions and Policy**

Counselors are well equipped to support and promote perinatal mental wellness among clients. Counselors should be supportive of women throughout the perinatal period and encourage them to identify additional support networks in order to build multidimensional support. According to the findings of this study, multidimensional support is a critical component for supporting and promoting perinatal mental wellness. Counselors can also use additional screening tools beyond those for postpartum depression to track women’s mental well-being so that any changes are identified early. Identifying changes early means that interventions can be provided before symptoms escalate to an unmanageable level. Counselors can provide women
with psychoeducation in session so that they can prepare for changes that occur throughout the perinatal period. Finally, counselors can collaborate with the community and with healthcare providers to advocate for the needs of women in order to promote perinatal mental wellness.

Policies related to perinatal healthcare at local, state, and national levels need to incorporate an integrated healthcare model. The findings of this study and existing studies clearly demonstrate that integrated healthcare systems meet the needs of women more effectively and efficiently by closing gaps in services and increasing accessibility to services. Integrating physical and mental healthcare is an important step forward for ensuring the promotion of perinatal mental wellness.

**Contribution to the professional literature**

The findings of this study provide an early definition of perinatal mental wellness as well as practical strategies for promoting perinatal mental wellness among women. This study explored the inverse of perinatal mental illness and provided perinatal mental wellness pathways and primary prevention pathways. These findings highlight the necessity of integrated healthcare systems wherein both physical and mental healthcare are accessible in a timely manner. Mothers should not have to suffer with mental health symptoms for months without appropriate care due to a disjointed system in which accessibility is compromised.

These findings could be used to advocate for women in the perinatal period which is vital because perinatal mental illnesses have detrimental implications for women, children, and the family unit. Finally, the systemic change strategies presented are practical tools that professionals can use to work toward promoting perinatal mental wellness in their practices. These strategies are wellness based and strengths-based strategies that fit within the existing perinatal care system.
and encourage increased accessibility to necessary mental healthcare services in the most transformational time in women’s’ lives.

**Limitations of the study**

In the present qualitative study, ten informants who had experienced at least one pregnancy and birth were interviewed to gain in-depth understanding of their lived experiences related to perinatal mental health and wellness. The major findings included defining perinatal mental wellness and providing a model for promoting perinatal mental wellness among women in the United States. The findings included factors supporting perinatal mental wellness and factors that did not support perinatal mental wellness. Due to the nature of this study, some limitations exist.

The purpose of the study was to further define perinatal mental wellness and identify some strategies for promoting perinatal mental wellness among women in the United States. Therefore, transferability to other countries and cultures may be limited. Transferability is ultimately decided by the reader and other researchers; therefore, the findings have potential for transferability. However, transferability will be somewhat limited due to contextual factors directly related to the culture of healthcare in the United States. This study has value for future research regarding increasing understanding of perinatal mental wellness and expanding on these early findings.

The process of this study was affected by the COVID-19 pandemic. Originally, this researcher intended to engage in recruitment in the community by placing flyers in locations where women frequent such as doctor’s offices, midwifery centers, daycares, and community support group spaces. However, recruitment in this manner was impossible due to COVID-19 restrictions. Therefore, all recruitment was conducted online. Additionally, this researcher intended to conduct interviews in person with women in spaces comfortable to them. Again, this method of
data collection was not possible due to the COVID-19 restrictions. The topic of perinatal mental wellness brought forward difficult to discuss issues such as distressing memories related to the perinatal period and perinatal mental illness; therefore, connecting with participants in-person rather than via Zoom could have produced a greater depth of data because of the opportunity to create a stronger alliance between researcher and participants. The healing nature of counseling lies in the therapeutic alliance created between clinician and client. While research is not meant to be counseling, fostering that connection could have created more opportunities to explore participants’ stories in more depth.

Questions Generated by This Study

Generating questions for further research is expected in qualitative studies. The questions that were generated in this study are as follows:

- What barriers exist that prevent providers from spending more time addressing perinatal mental health?
- What barriers exist between providing a screening tool and entry to treatment?; what barriers exist that cause women to suffer for extended periods of time prior to treatment entry?
- What barriers exist that make it difficult for women to access perinatal mental healthcare?
- How can women access the care they need more efficiently?
- How can providers of both physical and mental perinatal healthcare collaborate to better meet the needs of women?
Chapter Summary

Chapter five discussed the present research findings and linked them to previous studies related to perinatal mental health. Major contributions included the development of a definition of perinatal mental wellness and providing practical strategies to promote perinatal mental wellness. Additionally, factors that undermined perinatal mental wellness are presented and further clarify how to support perinatal women. This chapter highlighted the significance of multidimensional support and that incorporating mental healthcare into existing perinatal healthcare systems can promote perinatal mental wellness among women. The study’s limitations are explained. Finally, this chapter provided implications for professionals and recommendations for further research.
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APPENDIX A

RECRUITMENT MATERIALS

Social Media Post

Please consider participating in this research study focusing on perinatal mental wellness.

_Empowering Mothers: A Conceptual Model for Promoting Perinatal Mental Wellness Among Women in the United States_

Kayla Acklin, M.Ed., LPC, NCC
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**Purpose of the Study:** This study is designed to provide a starting point for understanding the concept of perinatal mental wellness in the context of the culture of the United States and strategies that sustain mental wellness during the perinatal period. The focus of this study is to meaningfully define perinatal mental wellness, explore how wellness is sustained during the perinatal period, and what strategies are used to promote perinatal mental wellness.

Data will be collected via interview so let’s talk about your mental health experiences during pregnancy and post-partum. Your insight is valuable for understanding how to support the mental health needs of mothers. Contact me to participate.
Please consider participating in this research study focusing on perinatal mental wellness.

*Empowering Mothers: A Conceptual Model for Promoting Perinatal Mental Wellness Among Women in the United States*

Kayla Acklin, M.Ed., LPC, NCC
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School of Education
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**Purpose of the Study:** This study is designed to provide a starting point for understanding the concept of perinatal mental wellness in the context of the culture of the United States and strategies that sustain mental wellness during the perinatal period. The focus of this study is to meaningfully define perinatal mental wellness, explore how wellness is sustained during the perinatal period, and what strategies are used to promote perinatal mental wellness.

Data will be collected via interview so let’s talk about your mental health experiences during pregnancy and post-partum. Your insight is valuable for understanding how to support the mental health needs of mothers. Contact me to participate.
Perinatal mental illness is a pervasive and costly issue that has profuse negative effects on women, their children, and families (Ayers, Eagle, & Waring, 2006; Brockington, Butterworth, & Glangeaud-Freudenthal, 2017; Creanga et al., 2014). In the United States, in particular, an increasing number of women are being affected by perinatal mental illnesses but may not be connected to appropriate services before these negative effects take hold and have long term implications for the mother, her infant, and the family (Creanga et al., 2014). Helping women to sustain mental wellness during the perinatal period has potential for preventing the development of perinatal mental illness along with decreasing the stress related to adjusting to new family roles. This could have a trickle-down effect, and further promote wellness among the family unit which has positive implications for all family members.

There are minimal risks associated with participating in this study, but no greater than those encountered in everyday life. The benefits of participation include providing insight into an important topic affecting women and their adjustment to motherhood. Due to the nature of the study, the exact number of participants is unknown at the outset; however, my best estimate based on current research is approximately ten participants.

PURPOSE:

You are being asked to participate in a research project that is investigating perinatal mental wellness. This study is designed to provide a starting point for understanding the concept of perinatal mental wellness in the context of the culture of the United States and strategies that sustain mental wellness during the perinatal period. The focus of this study is to meaningfully define perinatal mental wellness, explore how wellness is sustained during the perinatal period, and what strategies are used to promote perinatal mental wellness.

In order to qualify for participation, you must:

- be at least 18 years of age
- have experienced at least one pregnancy and birth

PARTICIPANT PROCEDURES:

If you provide your consent to participate, you will be asked to participate in an interview with me. The interview will be semi-structured and I will ask a few specific questions about your pregnancy and birthing experience related to mental health and wellness. The interview will be audio recorded and transcribed. You will be asked to provide a pseudonym prior to the start of the recording to protect your privacy. The interview can be completed in-person or via Zoom meeting. If a Zoom meeting better fits your needs, I will schedule the interview with you and provide the link to join as well as the phone number for call- in participation. The length of the interview will depend on how in-depth we are able to go with your experiences; therefore, this is unique for each participant and their level of comfortability. However, the interview can be expected to last between 45 minutes to 1.5 hours. Once the interview is complete, the audio recording will be transcribed and analyzed. I will then ask for your review to ensure I have
understood your answers thoroughly. Due to the exploratory nature of the study, the exact number of participants needed at the outset is unknown. My best estimate based on current research is approximately ten participants will be needed to complete the study.

RISKS AND BENEFITS:

There are minimal risks associated with participating in this study, but no greater than those encountered in everyday life.

COMPENSATION:

There is no compensation for this study.

There is no cost for you to participate in this research project.

CONFIDENTIALITY:

Your participation in this study, and any identifiable personal information you provide, will be kept confidential to every extent possible, and will be destroyed three years after the data collection is completed. Your name will never appear on any research instruments. All written and electronic forms and study materials will be kept secure via password protected computer. Audio files will be kept on a password protected computer and will be destroyed after 3 years. You will provide a pseudonym prior to the start of the recording; therefore, your name will not be included on the transcription of the interview. The transcribed interviews will be stored on a password protected computer and destroyed after three years. In addition, any publications or presentations about this research will only use data that is combined together with all subjects; therefore, no one will be able to determine how you responded.

RIGHT TO WITHDRAW:

You are under no obligation to start or continue this study. You can withdraw at any time without penalty or consequence by contacting the researcher and requesting to be removed from the study. Once you request to be removed, the researcher will remove all contributions from the study.

SUMMARY OF RESULTS:

A summary of the results of this study will be provided to at no cost. You may request this summary by contacting the researchers and requesting it. The information provided to you will not be your individual responses, but rather a summary of what was discovered during the research project as a whole.
FUTURE USE OF DATA:

Any information collected that can identify you will not be used for future research studies, nor will it be provided to other researchers.

VOLUNTARY CONSENT:

I have read this informed consent form and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw at any time, for any reason without any consequences. Based on this, I certify I am willing to participate in this research project.

I understand that if I have any questions about my participation in this study, I may contact Kayla Acklin, M.Ed., LPC, NCC at [redacted] or acklink@duq.edu or her advisor Wagnesh Zeleke, Ed.D at [redacted] or zelekew@duq.edu. If I have any questions regarding my rights and protections as a subject in this study, I can contact Dr. David Delmonico, Chair of the Duquesne University Institutional Review Board for the Protection of Human Subjects at 412.396.1886 or at irb@duq.edu.

Participant’s Signature ___________________________ Date ____________

Researcher’s Signature ___________________________ Date ____________
APPENDIX C

Instruments

Semi-structured interview protocol for women

Please choose a pseudonym to further protect your privacy.

1. Demographic information:
   Age:
   Location:
   Number of pregnancies:

2. What does perinatal mental wellness mean for you?

3. Can you discuss aspects of your maternity care that supported your mental wellness?

4. Can you discuss aspects of your maternity care that you felt did not support your mental wellness?

5. What would you change about maternity care to better support mental wellness?
   - Why?