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Elizabeth M. du Toit  
It Takes a Village: A Survey  
of Women's Experiences of  
Emotional Support During  
Prenatal Care Visits

### **ABSTRACT**

Research has shown that post-partum depression often begins during pregnancy. This study seeks to examine the extent to which prenatal care providers (PNCP's) are sufficiently attending to the emotional concerns of their patients. This study consisted of 117 women. Participants were asked a series of rating questions to determine their overall satisfaction with their PNCP's ability to attend to their emotional concerns. In addition to the rating questions, respondents were asked two open ended questions to better illustrate their experience with their PNCP, as well as to discuss which resources they felt would be helpful to women during pregnancy. While many of the women reported having a positive PNCP experience, discussion of emotional health during prenatal appointments were infrequent. The overall response to this survey was that having a greater focus on women's emotional health would be beneficial to both mother and child. This study emphasizes the need for collaboration between social workers and PNCP's as a way to provide more holistic and patient-centered care for pregnant women.

**IT TAKES A VILLAGE: A SURVEY OF WOMEN'S EXPERIENCES OF EMOTIONAL  
SUPPORT DURING PRENATAL CARE VISITS**

A project based upon an independent investigation,  
submitted in partial fulfillment of the requirements  
for the degree of Master of Social Work.

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2015

## ACKNOWLEDGEMENTS

There were many people without whom this thesis would not have been possible, and I am extremely grateful to all of them.

First, I would like to thank the women who participated in this survey and shared their pregnancy experiences with me. I am also grateful to those individuals who helped me collect participants by sharing my survey with the women in their lives.

I would also like to thank Laurence Cadorette, my thesis advisor, who has been reliable, consistent and has always encouraged me to think a little deeper and pushed me toward writing the best thesis I could.

Ali and Lisa – we did it!! Long summer days, nights in the library, lunch breaks and walks to the corner store have been some of my favorite times over the past couple of years thanks to both of you. I am so grateful for the love and support you have both given me. I've learned a lot from you and am excited to see what is next for us!

Ali, Dylan, Frances & Sophie – Thank you for being amazing friends and for taking such good care of my baby, and in doing so, allowing me to pursue my dreams. Without you, this degree would not have been a possibility.

Anna & Orion – Thanks for being best friends with Lucy and I! We love you, and our weekend play dates kept me laughing. You've provided me with so much support and encouragement and I'm so appreciative!

Mummy, Deirdre & Renee – I love you all so much. I am so grateful for your constant encouragement, support, and love. I couldn't have done this without you.

Lucien & Lucy - The love and light of my life! You are the reason for everything I do. Thank you for believing in me always.

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## **CHAPTER I**

### **INTRODUCTION**

The purpose of this study is to determine the extent to which traditional prenatal care providers (PNCP) are able to provide emotional support to women during pregnancy. This researcher hopes to examine women's attitudes about their prenatal care experience, and to what degree they felt their PNCP addressed emotional concerns that arose throughout pregnancy. This study included a survey that asked a non-clinical population of women to identify the extent to which their PNCP spent time addressing their emotional needs.

In recognizing pregnancy as a period of major transition in a woman's life (Poleshuck & Woods, 2014), it is important to ensure accessible mental health services during this time. Recent research finds that traditional prenatal care providers are falling short in identifying and treating mental health issues in their patients (Massey, Rising, & Ickovics, 2014). Additionally, there is research that finds disparities in access to mental health in impoverished communities (Belle, 1990). Poverty is associated with heightened stress, mental illness as well as increased instances of substance use and domestic violence (McCormick et al., 1990). Each of the above listed circumstances are associated with adverse birth outcomes (Poleshuck & Woods, 2014). Recently, there has been a push in the medical field to move toward "patient-centered care", which involves providing patients with care that is custom to their individual needs. Incorporating social workers and other mental health professionals into medical practices is one possible way to provide more individualized care. This is seen as a step toward providing higher quality and



more comprehensive treatment for patients (Massey, Rising, & Ickovics, 2014). This research seeks to examine women's experience with prenatal care and the potential lack of accessible mental health care. Gaining greater insight to the limitations of traditional prenatal care is an important step in looking at ways to bridge the gap between physical and mental health care in pregnant women.

## **CHAPTER II**

### **LITERATURE REVIEW**

The literature review is divided into ten sections. The first section reviews literature that recognizes pregnancy as a time of heightened emotional stress in a woman's life. The second section reports on rates of poverty and associated hardships that can occur during pregnancy. The third section provides a brief history of maternal mental illness, including treatment and the social stigma that accompanies it. The following five sections will take a closer look at several common stressors that arise during pregnancy. These sections include a review of literature discussing: depression during pregnancy, unintended pregnancies, pregnancy complications, intimate partner violence during pregnancy, and substance use during pregnancy. Each of these sections will identify the stressor and discuss the ways that a mental health practitioner may be able to intervene and provide treatment. Before summarizing the reviewed literature, the writer will also include a section that discusses several alternative prenatal care practices that emphasize the importance of a woman's emotional wellbeing. In the summary section of this literature review, the author will discuss the ability of traditional prenatal care doctors to detect and treat mental health issues during pregnancy and an explanation of why it is important that maternity care offices provide support and mental health care during pregnancy. Finally, the summary will include the intention of the study to evaluate women's experiences with their maternity care providers, and assess the level of emotional support they felt they received

throughout their prenatal care. Through gaining information about women's experiences with prenatal care, we can shed light on areas that require improvement.

### **A Brief History of Maternal Mental Illness**

Mental illness during and after pregnancy is an area that has been gaining greater attention in recent history, however, it is by no means a new phenomenon. The first known reference to postpartum depression came in the 4<sup>th</sup> century when Hippocrates proposed that blood flowing from the uterus to the brain caused "...agitation, delirium, and attacks of mania." (Rysavy, 2013) Later, in the 13<sup>th</sup> century, a female physician named Trotula of Salerno wrote about excess moisture in the body following pregnancy, causing tearfulness in new mothers (Rysavy, 2013). Society has long held the belief that pregnant women and new mothers should be perpetually happy. In the middle ages, women who appeared depressed during or after pregnancy were "...thought to be witches or victims of witchcraft." (Rysavy, 2013)

During the 19<sup>th</sup> century, there were some major advances in the research of maternal mental health. Jean Etienne Esquirol was one of the first physicians who documented that postpartum depression was likely a much more common occurrence than was previously believed. In this same time period, an American psychiatrist, John MacDonald, also began to conduct research about maternal mental illness. MacDonald identified a list of symptoms associated with maternal mental illness, these symptoms included: "...decreased strength and spirit, restlessness, sleeplessness, and irritability." (Rysavy, 2013) MacDonald stated that treatment should include "...tepid baths – specifically given between 94 and 98 degrees Fahrenheit – as well as a large amount of opium to calm the mind." (Rysavy, 2013)

In 1858, the article *Treatise on Insanity in Pregnant, Postpartum, And Lactating Women*, by Louis Victor Marcé was published. This paper stated that 9% of women developed depression

during pregnancy, 58% in puerperal period (within six weeks of childbirth), and 33% in the lactational period (lasting longer than the initial six weeks following childbirth) (Rysavy, 2013). Marcé proposed that "...postpartum cases of depression had many features that distinguished them from other mental illnesses and proposed that this should indeed be classified as a separate diagnosis." (Rysavy, 2013) Contrary to Marcé's findings, in 1926, researchers Edward Strecker and Franklin Ebaugh stated that "...depression following childbirth had no actual relationship to the pregnancy, delivery, or postpartum changes and was indistinct from other psychiatric illness." (Rysavy, 2013) Due, in large part, to Strecker and Ebaugh's research, the American Psychiatric Association and American Medical Association removed "postpartum psychosis" from their diagnostic manuals (Rysavy, 2013). To this day, there continues to be tension around the diagnosis of postpartum depression as a separate diagnosis from Major Depression. There is a great deal of contention around at what point following birth, is depression no longer considered to be related to the pregnancy and hormonal shifts in the postnatal period. The DSM-V classifies "postpartum depression" as a depression that occurs within the four weeks following delivery. Many individuals feel that this time frame should be extended to four to six months following delivery.

An additional theory about the root of postpartum and pregnancy related depression came about in the late 1920's and 1930's. This theory suggested that women experiencing mental health issues following the birth of their child had "...suppressed homosexuality, unresolved oedipal longings, or anal-regressive resultant-father identification." (Rysavy, 2013)

Due to the lack of understanding and the general stigmatization of the mentally ill, treatment of women experiencing maternal mental illness has a dark history. During the 19<sup>th</sup> century, treatment for postpartum depression included restraints and separation from the

woman's infant, which, not surprisingly, often worsened the individual's mental state (Rysavy, 2013). Due to the fear of being hospitalized and separated from their families, women often did not disclose their depression. In an effort to combat this, in the late 1940's Britain and Australia began creating "mother – and- baby units where mothers suffering from postpartum depression could receive care, while remaining close to their infants." (Rysavy, 2013)

Thankfully, there is growing understanding and acceptance around maternal mental illness. It is considered a very common and treatable illness, and there is a growing awareness of the role that a woman's environment plays in her mental health. It is routine that doctors will screen for depression at the postpartum visits, and there are many support groups that can offer resources to all new mothers, including those suffering depression. There is also growing evidence that postpartum depression often begins during pregnancy (Belluck, 2014). By incorporating social workers into prenatal care offices, providers will be better able to screen and treat women who are experiencing depression, before it becomes postpartum.

### **Pregnancy & Emotional Wellbeing**

In the Poleshuck and Woods article, *Psychologists partnering with obstetricians and gynecologists: Meeting the need for patient-centered models of women's health care delivery* (2014), the authors discuss pregnancy as a time of transition in a woman's life. Even in cases where a pregnancy is desired, uncomplicated and the woman has adequate familial and community support, having a child requires change and adaptation (Poleshuck & Woods, 2014). Over the course of her pregnancy, women will often use this time to "...address unresolved issues from their own childhoods or their current relationship or to learn new skills for the sake of their unborn child." (Poleshuck & Woods, 2014) Providing support through this transitional time would be a benefit to the woman and her growing family. Clinical social workers could

facilitate this adjustment period by providing "...family therapy or psychoeducational counseling on health in pregnancy, parenting skills, nurturing an intimate relationship while caring for an infant, preparing older children for the birth of a sibling, self-care skills as a new parent, and navigating intergenerational relationships as a new parent." (Poleshuck & Woods, 2014)

### **Poverty & Pregnancy**

In a study that "...describes income levels and the prevalence of major hardships among women during or just before pregnancy" (Braverman et al., 2010) it was found that nearly half of all pregnant women are either in poverty or near poverty during the course of their pregnancy (Braverman et al., 2010). With "hardships" being defined as "...divorce/separation, domestic violence, homelessness, financial difficulties, spouse/partner's or respondent's involuntary job loss or incarceration, and...food insecurity and no social support." (Braverman et al., 2010) It was found that nearly 60% of low-income pregnant women experienced at least one of the above listed hardships (Braverman et al., 2010).

Braverman et al., (2010) states hypothesized pathways between low income and health include inadequate nutrition, housing, or other health-related material conditions, as well as exposure to stressful conditions with fewer resources to cope. This study found startling rates of both homelessness and food insecurity among pregnant women in the United States.

Approximately 150,000 women experience homelessness during pregnancy, and close to 800,000 U.S. women experience food insecurity throughout their pregnancy (Braverman et al., 2010). "Prenatal nutrition can affect the health of women and infants, shaping subsequent child and adult health and, nutritional deprivation during childhood can have lasting consequences." (Braverman et al., 2010) In a country that is considered to be one of the most affluent nations in the world, the rates of poverty, homelessness, and food insecurity among pregnant women is

unacceptable and “...suggests a need for economic and psychosocial support services to be routinely available to all pregnant women.” (Braverman et al., 2010) Access to comprehensive prenatal care that includes a focus on woman’s emotional health would be a step forward in improving care for low-income pregnant women.

### **Depression during Pregnancy**

Post-partum depression is an illness that society has begun to gain awareness of, and in recent years there has been a multitude of research that shows depression can often begin during pregnancy (Belluck, 2014). Depression during pregnancy is an issue that is not well recognized in society, and has not been studied to the same extent as post-partum depression (Herzig et al., 2006). In a study of depressed mood during pregnancy and after childbirth, researchers found that 14% of women experience clinically significant depression during pregnancy (Evans, Heron, Francomb, Oke, & Golding, 2001), and for women who are low-income, this rate is almost twice as high (Bornstein, 2014). Additionally, there are multiple studies that find detection and treatment of depression during pregnancy very low within obstetrician offices (Poleshuck & Woods, 2014). Poleshuck and Woods state that detection of depression rates in obstetrician offices is less than 25%, meaning the majority of women who are experiencing depression are not having their mental health needs addressed. Amongst women who are identified as being depressed by their obstetrician, few of them go on to receive and sustain treatment (Poleshuck & Woods, 2014). Studies show that providing access to mental health counseling in the same office as the prenatal care provider greatly improves the likelihood that a woman will receive and sustain treatment. One study found that “...women’s health patients are nearly four times more likely to follow up with behavioral health treatment when services are offered at the same site.” (Poleshuck, & Woods, 2014)

Depression can have many negative impacts on a woman as well as her family. These impacts include both social and physical effects. Women who are experiencing depression during pregnancy can experience feelings of isolation and shame (Lee, 1997). Social expectations that pregnant women should be overjoyed can contribute to feelings of guilt that perpetuate depression (Lee, 1997). These expectations may also make it difficult for a woman to disclose feelings of depression, and thus less likely to receive treatment (Lee, 1997). Women who are severely clinically depressed experience "...feeling listless, anxious, guilty, lonely and frequently suicidal." (Bornstein, 2014)

In addition to impacting the way a woman experiences her social world and pregnancy in general, depression can have many serious physical effects on the woman and her fetus. Untreated depression during pregnancy is associated with "...poor birth outcomes, such as smoking, substance abuse, hypertension, preeclampsia, and gestational diabetes..." (Poleshuck & Woods, 2014) As a consequence of these increased health problems, depression during pregnancy is associated with low birth weight, and an increase of preterm births (Poleshuck & Woods, 2014). Women who are experiencing depression are also often hesitant to take antidepressants for fear that the medication will have a negative impact on the fetus (Poleshuck & Woods, 2014). In addition to the direct risks associated with depression during pregnancy, it is also often associated with other risk behaviors that can have a negative impact on the fetus and the mother (Herzig et al., 2006). "Depression is a risk factor for domestic violence and is associated with alcohol, illicit drugs, and postpartum depression. Asking about depression may be easier for some providers than asking about risk behaviors, and so may be a means for opening a dialogue about other psychosocial stresses or factors in the patient's life." (Herzig et al., 2006)



Clinical social workers are trained to address mental health needs including depression. By providing in-office access to a mental health professional, women will be able to receive psychotherapy treatment for their depression, and will also have the opportunity to discuss their concerns around anti-depressants as it relates to their pregnancy. Therapies such as Cognitive Behavioral Therapy and Interpersonal Therapy have been found to have significant success in treating depression. One study found that "...about a third of women who get treated for chronic or recurrent depression achieve remission, and more than half see an improvement in their symptoms." (Bornstein, 2014) With information and access to therapy, women can make decisions about what will be best for them and their families moving forward in their pregnancy (Poleshuck & Woods, 2014).

### **Unintended Pregnancy & Mental Health**

Research shows that close to half of all pregnancies in the United States are unintended (Fifner & Zolna, 2011). When a pregnancy is unexpected and unplanned it can create a great deal of stress on a woman and her family (Poleshuck & Woods, 2014). This stress is multiplied when the woman has other potential stressors such as; being young, lack of social and familial support, lack of financial stability, interpersonal conflict, when she has been impregnated by force, or does not want a child (Poleshuck & Woods, 2014.) In a maternity care practice that includes a mental health clinician, a referral can be made if a woman disclosed that her pregnancy was unplanned.

Meeting with a social worker may be an effective way to provide support and aid in the decision making process for a woman and her family. Statistics show that about half of couples who become pregnant unintentionally choose to continue their pregnancy (Fifner & Zolna, 2011). In cases of unplanned pregnancy where the woman has chosen to keep the child, social

workers can provide support and “...help women and couples explore their feelings, reframe their expectations, elicit resources and ...prepare for the anticipated changes.” (Poleshuck & Woods, 2014)

For the women who choose not keep their baby, social workers can provide information about their options, as well as assist them throughout the process. About 1% of American women who experience an unplanned pregnancy will choose to put their child up for adoption (Child Welfare Information Gateway, 2011). About 22% of unplanned pregnancies in the US end in abortion (Jones & Kooistra, 2011). For the women who choose not to have or keep their child, access to mental health services may be an effective way for managing any feelings that may come up related to their decision. For some women, deciding whether or not to have a child is a difficult decision that requires a great deal of self-reflection, and having access to a clinical social worker will allow the space for this process in a way that maternity care providers are unable to.

### **Pregnancy Complications & Mental Health**

In the United States, medical technology has become advanced enough that we are often able to detect pregnancy complications early. Finding out about a complication, however serious, can create a great amount of stress for a woman and her family (Poleshuck & Woods, 2014). In some of the most devastating of pregnancy complications, a woman may miscarry, or choose to terminate the pregnancy (Poleshuck & Woods, 2014). Having a pregnancy end in such a way can be a traumatic loss for a woman and her family. “First trimester losses are associated with increased risk for the onset of depression and anxiety up to three years later (Blackmore et al., 2011). The death of a late gestation baby, stillborn, or a neonatal death is usually intensely painful for the parents; these losses are emotionally complex and can cause acute stress reactions

as well as long-lasting symptoms of grief.” (Poleshuck & Woods, 2014) Processing the grief of losing a child due to a pregnancy complication is a complex and timely endeavor. Providing adequate support for a woman and her family during this time goes beyond the scope of what a maternity care practitioner can provide (Poleshuck & Woods, 2014). Clinical social workers are trained to assist individuals experiencing grief, as well as “...encourage the parents to elicit support from family and friends, find ways to talk with others about their loss, and develop rituals that fit the family’s personal circumstances.” (Poleshuck & Woods, 2014) Pregnancy complications can be devastating, not only for the families but also for the maternity care providers who are working with the family. Clinical social workers can provide support for the doctors and care providers who are experiencing emotional challenges related to their work (Poleshuck & Woods, 2014).

### **Interpersonal Violence during Pregnancy**

Intimate partner violence is the leading cause of death among pregnant women (Charles & Perreira, 2007). This startling statistic highlights the need for adequate intervention provided by a woman’s prenatal care provider. Violence can be categorized into different forms. The National Institute of Justice states that violence can be split into five different categories including: physical violence (hitting, slapping, pushing, etc.), sexual violence, threat of physical or sexual violence, stalking, and psychological or emotional abuse (verbal abuse, coercive or controlling behaviors, etc.) (Charles & Perreira, 2007). While there is some research that finds pregnancy as a time where intimate partner violence declines, researchers Burch & Gallup (2004), found that pregnancy was actually a stimulus for violence (Charles & Perreira, 2007).

Prenatal care is crucial to improving birth outcomes for all women (Charles & Perreira, 2007). Women who are experiencing interpersonal violence are at a heightened risk for adverse

birth outcomes (Poleshuck & Woods, 2014), yet research also indicates that they are 30% more likely to receive inadequate prenatal care than women who do not report interpersonal violence (Charles & Perreira, 2007). Intimate partner violence during pregnancy is associated with “...inadequate prenatal care, labor complications, and psychological problems such as, emotional distress, depression, anxiety, and low self-efficacy...” (Charles & Perreira, 2007) In relation to these maternal issues, interpersonal violence (IPV) during pregnancy can harm the physical health of the fetus, and the socio-emotional development of the infant (Charles & Perreira, 2007). In addition to the negative impacts IPV has on pregnancy outcomes, there is also research that finds that violence before or during pregnancy is a strong predictor of future violence, thus putting the unborn child at an increased risk of witnessing and/or being the victim of abuse. Charles & Perreira (2007) found that of women who reported experiencing IPV before or during their pregnancy, 70-80% of them went on to experience IPV post-partum.

Despite the heightened risks for both mother and fetus that are associated with IPV, research finds that PNCP’s are falling short in their ability to screen for physical and sexual abuse (Poleshuck & Woods, 2014). A study conducted in 2005 found that only 11 – 39% of physicians conducted at least one screening for IPV amongst their pregnant patients. Follow up screening for IPV during pregnancy dropped off to only about 3-4.5% of physicians (Stayton & Duncan, 2005). Researchers found that the primary reason for this inadequate screening was related to a lack of training (Stayton & Duncan, 2005). Social workers and other mental health providers are specifically trained in family dynamics and may be better equipped to screen for IPV and also to intervene in cases where they determine a woman is at risk for abuse.

## **Substance Use during Pregnancy**

Pregnancy is often a time where women see an opportunity to end behaviors such as substance use and make a positive change in their lives. Despite this intention, it can be extremely challenging to change these behaviors, particularly if there is a lack of social support. One study found that "...most providers believe that pregnancy is the most opportune time for a woman to change risky behaviors" (Herzig et al., 2006) One provider in this study made the statement that pregnancy may be the only time in some women's lives that they seek medical care, and so it is important that health care providers seize this time to assess and intervene (Herzig et al., 2006). Substance use such as "...cigarette smoking, and use of alcohol and illicit drugs is associated with low birth weight, preterm delivery, and specific physical, cognitive, and behavioral problems with children." (Herzig et al., 2006) Research on the prevalence of substance use during pregnancy found that 11-23% of pregnant women report cigarette smoking, 4-9% of pregnant women report alcohol use, and 7-11% of women report illicit drug use during pregnancy (Herzig et al., 2006).

Research has found that screening and counseling are the most effective means of reducing risky behaviors, such as substance use, during pregnancy (Herzig et al., 2006). Despite this knowledge, PNCP's frequently "...either fail to take advantage of prenatal visits to address behavioral risks, fail to conduct follow up assessments, provide further counseling, or make referrals." (Herzig et al., 2006) Barriers to providing adequate screening and intervention include: "...underestimating risk prevalence, pessimism about changing behaviors, and time constraints." (Herzig et al., 2006)

A PNCP who participated in the above study made the following statement regarding pregnancy as a time for positive change:

Pregnancy is a very powerful thing for many women. People on the streets who are homeless, drug addicts, or sex workers, a lot of them are looking for hope, for a new beginning, and, in a way, the pregnancy can be viewed as that. Some of them will make it. Many will not, but we need to have faith in them and try to help them in every way we can. [OB/GYN resident, university, male]. (Herzig et al., 2006).

One way to provide the best possible care for patients who are struggling with substance use is to incorporate social workers into prenatal care provider offices. In addition to providing in-office assessments and counseling for addiction and substance use during pregnancy, social workers could also facilitate groups that are specific to women who are struggling with substance use. Research shows that providers believe "...social isolation generates shame, exacerbates, and perpetuates substance abuse." (Herzig et al., 2006) Bringing together groups of pregnant women to discuss their shared difficulties, is a way to foster social support. Social support is viewed as one of the most important protective factors when it comes to depression and domestic violence, both of which contribute to substance abuse during pregnancy (Herzig et al., 2006).

## **Alternative Prenatal Care Options**

### **The DAWN Program**

The Depression Action for Women Now (DAWN) Program, is an organization that integrates mental health care into OB/GYN offices (Bornstein, 2014). The creation of this program came as a response to the limited accessibility of mental health care. Studies have shown that "about a third of women in the country see their ob-gyn physicians for their primary care..." (Bornstein, 2014) and "...when depression screening and treatment are handled in the same place as primary care, it's more likely that women will get effective help." (Bornstein, 2014)

The DAWN program insures that trained “care managers” are in place, so that when a woman is identified as having signs or symptoms of depression, there is an individual who can provide an in-office intervention. Primary interventions may include “...educating the woman about depression, exploring real or perceived barriers in her life, and motivate her to pursue treatment.” (Bornstein, 2014) The DAWN program strives to meet the varying needs of all their patients. The offices offer different treatment approaches (anti-depressants vs. talk therapy), as well as offering in person as well as phone therapy for those patients who may have limited transportation (Bornstein, 2014). The care managers who are assigned to an individual will continue to follow up with the woman over the course of a year, and “...if their symptoms persist, they adjust or increase the intensity of treatment.” (Bornstein, 2014) In 2014, two studies that reviewed the effectiveness of the DAWN program found that those who participated in the program had “...significant improvements in depressive symptoms” and “...women were more satisfied with the care they got...” (Bornstein, 2014) The DAWN program is an excellent example of the benefits of in-office collaboration between mental health practitioners and PNCP’s.

### **Group Prenatal Care**

In an effort to address the mental health needs and promote community support for their patients, some maternity care offices have incorporated “group prenatal care”, into their practices (Massey, Rising, & Ickovics, 2006). Centering Pregnancy is a group prenatal care program that utilizes a relationship-centered approach to provide both physical and mental support to women throughout pregnancy. In an article that reviews the experiences of women participating in Centering Pregnancy, the author describes the benefits of group prenatal care and discusses some of the limitations of traditional prenatal care. Massey, Rising, and Ickovics (2006) explain that

individual care provides limited contact with providers, typically does not provide support services, and is often too fragmented to respond to the complex needs of pregnant women. The use of group prenatal care is meant to efficiently increase the amount of contact time between a woman and her maternity care provider. A study found that women participating in Centering Pregnancy received more than 20 hours of contact time with her care provider, "...compared to typical 1.5 hours delivered in interrupted 15-minute blocks in individual appointments." (Massey, Rising, & Ickovics, 2006) Time limitations are one of the major challenges to providing adequate mental health screening and care in traditional prenatal care settings (Massey, Rising, & Ickovics, 2006). Clinics that utilize group prenatal care allow room for the development of a relationship between a patient and her provider, increasing the likelihood that a woman would seek treatment if necessary, and also the likelihood that a practitioner would detect an issue with the patient (Massey, Rising, & Ickovics, 2006). In addition to strengthening the relationship between a woman and her maternity care provider, the woman would find additional support from her pregnant peers (Massey, Rising, & Ickovics, 2006).

In an evaluation of the Centering Pregnancy program, researchers found that women who participated in group prenatal care experienced, "...lengthened gestation, which in turn resulted in higher birth weight...Group prenatal care also appeared to protect against early preterm delivery, low and very low birth weight, and neonatal mortality." (Massey, Rising, & Ickovics, 2006) In terms of women's satisfaction with prenatal care and attendance, this study found that "women randomly assigned to group care had greater overall satisfaction with prenatal care than those who received individual care. Attendance at prenatal care was extremely high (76%, compared to clinic norms of 50% - 60%)." (Massey, Rising, & Ickovics, 2006)



This writer believes that group prenatal care in conjunction with individual appointments would be an excellent measure in addressing the mental health concerns of pregnant women. Women could maintain their traditional individual appointments with their maternity care provider, and then also attend groups with other women who have close due dates. Groups could be co-lead by a clinical social worker and a medical professional so that the mental health needs and physical needs are being attended to. Many stressors can arise throughout pregnancy and providing support during this time is critical to both the health of the woman and her family.

### **Summary**

For each of the above listed psychosocial issues that can arise throughout pregnancy, research finds that PNCP's are not adequately screening or providing interventions for their pregnant patients (Poleshuck & Woods, 2014). The above listed stressors can have serious impacts on the health and wellbeing of both the mother and her child. In an effort to provide the best possible care, and in conjunction with a patient centered approach, PNCP's should incorporate social workers or other licensed mental health practitioners into their offices.

Research finds various reasons that PNCP's are falling short in their ability to address their patient's emotional concerns (Herzig et al., 2006). A few of these identified barriers include time constraints, lack of training and attitudes regarding patient's ability to change (Herzig et al., 2006). Having mental health practitioners in place whose specific job is to provide assessments and interventions for emotional concerns will relieve some of this work from physicians.

This researcher is conducting a study on women's attitudes about the quality of their prenatal care and their PNCP's ability to attend to their emotional wellbeing during pregnancy. The outcome of this study hopes to identify limitations within traditional prenatal care practices and to establish the benefit of partnering with mental health providers. It is this researcher's

hypothesis that women who have experienced traditional prenatal care will feel that their PNCP was unable to adequately attend to their emotional concerns during pregnancy.

## **CHAPTER III**

### **METHODOLOGY**

This study is an exploratory investigation into women's experiences with prenatal care. Specifically, this study is asking women to assess their PNCP's ability to address emotional concerns that may have arisen throughout the course of their pregnancy. This is a mixed methods exploratory study aimed to answer the following questions: 1) for this sample, what are the rates of reported mental health concerns?, 2) Is there a relationship between overall satisfaction with PNCP ability to attend to emotional concerns (OS) and practice modality (midwife vs. OB/GYN)?, 3) Is there a relationship between OS and reported income?, 4) For this sample, what is the rate of OS?, and 5) how do women think PNCP's can improve their ability to attend to emotional concerns that arise during pregnancy? It is the researcher's hope that this survey will allow for greater insight to limitations of traditional prenatal care, and shed light on the ways in which a collaborative practice between OB/GYN's and social workers can lead to greater accessibility to mental health services for women.

#### **Sample**

The purpose of the study is to examine women's experience of prenatal care, therefore all participants were required to be females who have been pregnant and received prenatal care. Due to their status as federally defined vulnerable populations, women under the age of 18, as well as women who were currently pregnant or have an active mental health diagnosis for which they were under current treatment, were not included in this sample. In an effort to screen out

ineligible participants, individuals were asked a series of questions at the beginning of the survey to ensure that they met the inclusion criteria.

Due to the limited time and resources available, this researcher utilized nonprobability convenience, and snowball sampling to collect participants. Non-probability sampling method means that participants were chosen by convenience rather than in a random manner in which all members of the population had an equal chance of participating (Engel & Schutt, 2013). Participants were recruited through the researcher's personal network of connections to parents in the Pioneer Valley. The researcher posted information about the survey, as well as a link to the survey, on her personal Facebook page and on the page of multiple parenting groups including: "Pioneer Valley Parents – Fall and Winter 2013, Northampton Area Baby/Kids Marketplace, Western Mass Gentle Parenting, BB Parents – Spring and Summer 2014, Spring + Summer 2013 Valley Parents, Western MA Moms Connect, and Mommies Unite." Since participants were chosen from the researchers own circle of connections, the sample was homogenous and reflective of the researcher's social characteristics. Due to the lack of diversity in the sample, the findings of this survey will not be generalizable to the greater population.

In addition to convenience sampling, this study also used snowball sampling methods. Snowball sampling is the method in which existing participants are asked to recruit future participants from their own network of connections (Engel & Schutt, 2013). The researcher requested that individuals "share" the link to the survey with other potential participants who are in their network. Included in the link to the survey was an explanation as to the nature of the study, the eligibility criteria, and the researcher's contact information for any questions that individuals may have had. Before accessing the survey, participants were required to read and electronically sign an informed consent.

## **Ethics and Safeguards**

When conducting research that involves human subjects, it is imperative that efforts are taken to protect those who choose to participate. This study was submitted, reviewed and approved by the Smith College Human Subject Review Board (HSRB) prior to collecting participants. The purpose of the HSRB is to ensure that adequate efforts are being made to minimize risks to participants and to preserve confidentiality.

All data was collected through the use of Survey Monkey ([www.surveymonkey.com](http://www.surveymonkey.com)), an online survey tool. Participation in this study was anonymous, as Survey Monkey does not collect identifying information on participants. All of the electronically stored data was password protected and accessible only to the researcher. In compliance with federal regulations, once data analysis had been completed the researcher downloaded the data onto a portable USB drive that was stored in a secure location for three years and then destroyed. In the event that identifiable information was mistakenly disclosed in the open response sections of the survey, all answers that correspond with that participant have been deleted.

In accordance with ethical guidelines, there were no relationships between the researcher and participants that might lead to the appearance of coercion. The researcher did not directly request any participants, and instead posted a general request for participation that allowed individuals to anonymously choose whether or not they would like to participate. Outside of posting the announcement to Facebook, the researcher had no further interaction with participants. In the event that a participant contacted the researcher with a question, the researcher answered the question and that was the extent of the interaction.

There were no significant (financial, social, legal, etc.) risks associated with participation in this survey. It is possible that participants may have felt stressed or saddened when recalling

times of difficulty during their pregnancy. The majority of questions appeared to be relatively benign, however, individuals were asked questions related to their emotional health, which could have potentially been upsetting. In order to provide for this potentiality, participants were informed that they may exit the survey at any point, for any reason. After completing the survey, each participant was directed to a referral list of mental health centers in Northampton.

Benefits to participating in this survey included being given the space to reflect and offer information on their pregnancy experience. Participants may also have appreciated knowing that their voices may be contributing to a movement toward improving access to mental health for pregnant women. No compensation was provided for participating in this survey.

### **Data Collection**

This survey was developed by the researcher, using Survey Monkey, an online data collection program. The completed survey was then reviewed and approved by the HSRB and the author's thesis advisor. The survey was composed of 49 multiple-choice questions and concluded with two open-ended questions. The open-ended questions were included to provide a richer narrative of individual experiences, answer the research questions regarding women's overall satisfaction with their PNCP experience, and hear participant's perspectives on ways to improve PNCP's ability to attend to emotional concerns. By including the space for an open response, participants have the opportunity to offer information and insight beyond what was offered in the multiple-choice component of the questionnaire.

Individuals who chose to participate in this study were first directed to a webpage that asked them to read and electronically sign an informed consent page. Individuals who signed the informed consent were then directed to the questionnaire. The survey included a demographics section that was comprised of multiple choice questions that asked participants to identify: race,

age range, socioeconomic status, geographic location, type of prenatal care (OB/GYN, midwifery center, etc.), employment information, when they last gave birth, and the number of times they had been pregnant. After completing the demographics section, participants were then asked a series of rating questions.

Each rating question was posed as a statement (i.e. “I always saw the same prenatal care provider throughout my pregnancy”), and participants were asked to rate on a scale of 1 to 5 how much they agree with each statement, with 1 equaling “strongly disagree” and 5 equaling “strongly agree.” Following the rating questions, the survey included two open-ended questions that were analyzed using qualitative methods. The first open-ended question asked participants to describe in their own words how sensitive and effective their PNCP was to their emotional needs during the course of their pregnancy. The second question asked participants to include any other thoughts or information they would like to share about how prenatal care providers may be able to better attend to women’s mental health needs. These questions allowed the participants’ the space to provide more personalized information about their PNCP experience, and their perspective on what resources may be helpful to women during pregnancy.

### **Data Analysis**

This is a mixed methods study; the questionnaire includes a combination of multiple choice, likert-scale and open-ended questions. Data, thus, was analyzed using a combination of quantitative and qualitative methods. With the assistance of Marjorie Postal, Smith College’s data analyst, all data was examined using a combination of descriptive statistics, inferential statistics and qualitative methods for the open-ended responses. Descriptive statistics were used to analyze the multiple-choice questions, and inferential statistics were used to analyze the “...relationship between demographic characteristics and likert responses.” (Fenzel, 2010) This

researcher then used thematic analysis for the open-ended questions. “Responses to each open-ended question of the survey [were] manually entered by the researcher into separate text tables. The researcher... read through the responses noting possible themes/categories. The resulting tables for each open-ended question [were then] grouped according to these themes/categories.” (Fenzel, 2010)

## **Discussion**

One major limitation of this study is the lack of diversity in the sample. This researcher used non-probability convenience sampling methods, meaning that participants were selected by convenience from the researcher’s acquaintances. Due to this sampling method, the participants in this study were largely reflective of researchers characteristics, in that 98% of participants were White, middle-class women. The participants in this study are not representative of the larger population, and therefore the results cannot be generalized. The researcher selected this sampling method due to the limited time frame and resources available to conduct this study. Future research should include a sample that is larger and more diverse in order to provide more accurate information about the general population. In order to conduct a study that would be accurately reflective of the community in which the study was taking place, a researcher would need to utilize random sampling, so that all members of the population have an equal chance of participating in the study. In order to avoid the limitation of non-generalizability, the researcher would use different sampling methods in order to access other members of the population. For example, the researcher would provide alternate forms of the survey (email, paper, etc.), and would attempt to recruit participants through posting information about the survey in public spaces and additional online forums.



## **CHAPTER IV**

### **FINDINGS**

The purpose of this study was to assess the overall ability of traditional PNCP's to attend to the emotional concerns of a non-clinical population of women. In an effort to gain insight to this question, participants were asked to complete a survey regarding their attitudes about their PNCP experience. The survey included a series of rating questions, as well as two open-ended questions. The first open-ended question asked participants to put into their own words how satisfied they felt with their PNCP's ability to attend to emotional concerns. The second open-ended question asked women to describe the ways in which they felt PNCP's could have been able to better attend to the emotional concerns of their patients. One major finding of this study was the relationship between type of provider (OB/GYN vs. midwife), and overall satisfaction with their PNCP's ability to attend to emotional concerns. The second major finding was the number of women who indicated the need for more personalized treatment, or increased access to mental health services within PNCP offices. The third major finding of this study was the relationship between income and reported rates of depression and ambivalence regarding their pregnancy.

This chapter will include three different sections reporting the major findings of this study. The first section will review the demographics of the sample, the demographics section includes the following sub-sections: location, age, race, income and employment demographics, and pregnancy and birth demographics. Next, the quantitative results of the survey will be

reviewed. The quantitative portion of the survey was divided into three subcategories; general mental health questions, attitudes about pregnancy, and questions about the respondents' relationship with their PNCP. Included in the quantitative section of this chapter, this researcher will list first the descriptive statistics and then the inferential statistics, which will examine the relationship between variables. Finally, this chapter will include a report of the qualitative findings of this study. This section will review the results of the open-ended questions and include several participant responses that best illustrate the findings of this study.

## **Demographics**

### **Location Demographics**

The survey was available online from November 12, 2014 to January 6<sup>th</sup>, 2015. In that time, a total of 117 individuals participated in this study. One participant's responses were eliminated due to her report that she was currently pregnant. Of the 116 responses that were remaining, an additional 12 participants did not complete the survey. A total of 104 participants were included for analysis, the majority (54.3%) of participants currently reside in Massachusetts. There were also a number of participants from other areas of the United States [CA (12.1%), CO (6.9%), CT (.9%), FL (2.6%), IN (.9%), KS (.9%), MO (.9%), NH (.9%), NY (2.6%), NC (.9%), OK (.9%), PA (.9%), SC (1.7%), TX (.9%), WA (3.4%)].

### **Age Demographics**

Table 1 presents the distribution of ages for women in this sample. As can be seen, the vast majority (79.2%) of women who participated in this study were between the ages of 25 and 44 years old. Less than 10% of the participants were from each of the other age categories. Due to their status as a federally defined vulnerable population, women under the age of 18 were not included in this survey.

Table 1

*Age Demographics*

Age Range	Frequency	Percent
18-24	8	7.5
25-34	49	46.2
35-44	35	33.0
45-54	9	8.5
55-64	5	4.8

**Race Demographics**

A major limitation to this study was the lack of diversity, 87.1% (n= 101) of participants identified as White when asked to report their race. 2.6% (n=3) reported that they were Asian, .9% (n=1) stated Latina, and .9% (n=1) identified as Black or African American.

**Income and Employment Demographics**

Below, Table 2 details the income data that was reported by this sample. Most (67.2%) participants reported that their average household income was \$50,000 or above. 7.8% of participants reported making between 0 and \$24,999, 16.4% reported their household income was between \$25,000 and \$49,999. 21.6% of respondents stated an income between \$50,000 and \$74,999. 19.0% of women reported their income was between \$75,000 and \$99,999. 11.2% reported incomes between \$100,000 and \$124,999, 4.3% identified their incomes as between \$125,000 and \$149,000, 4.3% of participants reported making between \$150,000 and \$174,999. Two women (1.7%) reported that their household income was between \$175,000 and \$199,999.

At the highest end of the spectrum, 5.2% of women reported that their average household income was \$200,000 or more.

Table 2

*Income Demographics*

Income Range	Frequency	Percent
\$0 – 24,999	9	8.5
\$25,000-49,999	19	17.9
\$50,000-74,999	25	23.6
\$75,000-99,999	22	20.7
\$100,000-124,999	13	12.3
\$125,000-149,000	5	4.7
\$150,000-174,999	5	4.7
\$175,000-199,999	2	1.9
\$200,000 and up	6	5.7

A majority (56.1%) of all participants indicated that they had full-time employment. The remaining responses included: 19.6% part-time employment, 5.6% stated that they were students, and 6.5% reported that they were currently unemployed. 12.1% of participants selected the “other” option when asked about employment. Write-in answers to this question included: “contract/varies”, “contract/freelance”, “full-time work and student”, “full-time stay at home mother/part-time postpartum doula”, and “graduate student and also working part-time”, and seven reported stay-at-home parent as their employment status.

## **Pregnancy and Birth Demographics**

A majority (55.2%) of the women who participated in this study reported having given birth just once. 21.9% of respondents gave birth twice, 19% three times, and 2.9% four times. One participant (1.0%) reported having given birth more than five times.

The number of reported pregnancies was slightly higher than the reported number of times having given birth. 10.4% of women reported having been pregnant more than five times, 9.4% reported four pregnancies, 23.6% reported three pregnancies, 23.6% reported two pregnancies, and 33.0% of respondents stated they had been pregnant only once.

30.5% of participants reported having given birth in the last year, 23.8% in the last two years, 11.4% in the last three years, 7.6% in the last four years, and 26.7% reported that it had been five or more years since their most recent birth.

A majority of (64.5%) of participants reported that they received prenatal care through an OB/GYN office, 23.4% of participants reported the use of midwifery services, and 12.1% of participants stated “other.” Write-in responses to “other” included: home-birth midwives, or a combination of both OB/GYN and midwifery services.

## **Quantitative Findings**

### **General Mental Health Questions**

The first series of Likert-type questions asked respondent’s to identify experiences related to their general mental health within the course of their pregnancy. These issues included: depression, anxiety, pregnancy complications, interpersonal violence, whether they had sought mental health counseling, and if their PNCP had asked if they wanted to speak with a counselor. The results to each question can be seen in the subsequent tables:

Table 3

*I experienced depression over the course of my pregnancy.*

---

Level of Agreement	Frequency	Percent
Strongly Disagree	44	42.3
Disagree	26	25.0
Neither agree nor disagree	8	7.7
Agree	21	20.2
Strongly Agree	5	4.8

---

As seen in the above chart, a vast majority (67.3%) of participants clearly felt that they had not experienced depression during the course of their pregnancy.

Table 4

*I experienced anxiety over the course of my pregnancy.*

---

Level of Agreement	Frequency	Percent
Strongly Disagree	15	14.4
Disagree	22	21.2
Neither agree nor disagree	9	8.7
Agree	38	36.5
Strongly Agree	20	19.2

---

A majority (55.7%) of participants felt that they had experienced anxiety over the course of their pregnancy.

Table 5

*I experienced pregnancy complications that caused me emotional distress.*

---

Level of Agreement	Frequency	Percent
Strongly Disagree	33	31.7
Disagree	25	24.0
Neither agree nor disagree	6	5.8
Agree	28	26.9
Strongly Agree	12	11.5

---

About a third (38.4%) of participants reported having experienced pregnancy complications that caused emotional distress.



Table 6

*I experienced interpersonal violence during my pregnancy.*

Level of Agreement	Frequency	Percent
Strongly Disagree	89	85.6
Disagree	6	5.8
Neither agree nor disagree	2	1.9
Agree	5	4.8
Strongly Agree	2	1.9

Only 6.7% of participants agreed that they had experienced interpersonal violence during their pregnancy. This is consistent with the CDC's report of rates of domestic violence during pregnancy.

Table 7

*I sought mental health counseling outside of my PNCP during my pregnancy.*

---

Level of Agreement	Frequency	Percent
Strongly Disagree	70	67.3
Disagree	18	17.3
Neither agree nor disagree	1	1.0
Agree	10	9.6
Strongly Agree	5	4.8

---

About 14% of participants agreed that they sought mental health counseling during their pregnancy.

Table 8

*My PNCP asked me if I wanted to talk to a counselor.*

Level of Agreement	Frequency	Percent
Strongly Disagree	64	61.5
Disagree	17	16.3
Neither agree nor disagree	9	8.7
Agree	6	5.8
Strongly Agree	8	7.7

A majority of participants (55.2%) reported that their PNCP had not asked if they would like to speak with a counselor during the course of their pregnancy.

### **Attitudes about Pregnancy**

The second set of rating questions addressed participants' attitudes about their most recent pregnancy. These questions asked women to consider what their feelings were about becoming pregnant; had they been trying to get pregnant or was the pregnancy a surprise? Were they happy to find out they were pregnant or did they have uncertainty about continuing the pregnancy? Did they choose to end the pregnancy? Additionally, this segment of the survey asked participants to evaluate how prepared they felt for the task of parenthood, both emotionally and financially. Finally, this section asked women whether they felt they had enough social supports to become a parent. The aim of this line of questions was to gain insight as to how women were feeling about becoming pregnant and to evaluate how those feelings may have

influenced their overall mental health during pregnancy (i.e., was there a relationship between women who did not feel financially prepared for parenthood and reporting of anxiety?). The following tables illustrate to what extent women agreed or disagreed with each of the statements.

Table 9

*I was surprised to find out I was pregnant.*

---

Level of Agreement	Frequency	Percent
Strongly Disagree	40	38.8
Disagree	16	15.5
Neither agree nor disagree	12	11.7
Agree	18	17.5
Strongly Agree	17	16.5

---

Over half (54.3%) of participants disagreed that they were surprised to find out that they were pregnant.

Table 10

*I felt unsure of whether I wanted to continue my pregnancy.*

---

Level of Agreement	Frequency	Percent
Strongly Disagree	73	70.9
Disagree	14	13.6
Neither agree nor disagree	3	2.9
Agree	10	9.7
Strongly Agree	3	2.9

---

Just 12.6% of participants reported feeling unsure of whether or not they wanted to continue their pregnancy.

Table 11

*I chose to terminate my pregnancy.*

---

Level of Agreement	Frequency	Percent
Strongly Disagree	89	87.3
Disagree	10	9.8
Neither agree nor disagree	1	1.0
Agree	0	0
Strongly Agree	2	2.0

---

Just two participants reported choosing to terminate their pregnancy. This is in contrast to previous research that finds that 22% of all pregnancies end in abortion.

Table 12

*I was happy to find out I was pregnant.*

---

Level of Agreement	Frequency	Percent
Strongly Disagree	1	1.0
Disagree	4	3.9
Neither agree nor disagree	15	14.6
Agree	23	22.3
Strongly Agree	60	58.3

---

A vast majority (80.6%) of participants agreed that they were happy to find out they were pregnant.

Table 13

*I had been trying to get pregnant.*

---

Level of Agreement	Frequency	Percent
Strongly Disagree	16	15.5
Disagree	12	11.7
Neither agree nor disagree	6	5.8
Agree	9	8.7
Strongly Agree	60	58.3

---

Over half (67%) of participants reported that they had been actively trying to become pregnant.



Table 14

*I felt like I was emotionally prepared to become a parent.*

---

Level of Agreement	Frequency	Percent
Strongly Disagree	1	1.0
Disagree	5	4.9
Neither agree nor disagree	15	14.7
Agree	29	28.4
Strongly Agree	52	51.0

---

A majority (79.4%) of participants reported feeling emotionally prepared for parenthood at the time of their pregnancy.

Table 15

*I felt like I was financially prepared to become a parent.*

---

	Frequency	Percent
Strongly Disagree	5	4.9
Disagree	15	14.6
Neither agree nor disagree	19	18.4
Agree	30	29.1
Strongly Agree	34	33.0

---

Just 19.5% of participants reported feeling financially unprepared for parenthood.

Table 16

*I felt that I had enough social supports to become a parent.*

Level of Agreement	Frequency	Percent
Strongly Disagree	1	1.0
Disagree	5	4.9
Neither agree nor disagree	8	7.8
Agree	33	32.4
Strongly Agree	55	53.9

More than three quarters (86.3%) of participants reported feeling that they adequate social supports to become a parent.

### **Quality of Relationship with PNCP**

The final portion of multiple-choice questions aimed to evaluate the quality of the relationship between the participant and their PNCP, specifically with regard to the PNCP's ability to attend to emotional concerns. In order to obtain information about the quality of the relationship between the patient and the PNCP, the survey asked women how emotionally supported they felt by their PNCP, whether they felt comfortable discussing emotional concerns with their PNCP, did they feel there was enough time during appointments to adequately address emotional concerns, and what role did the PNCP play in the patients decisions related to the pregnancy? The following tables represent the degree to which participants agreed or disagreed to the statement included in this section.

Table 17

*I felt emotionally supported by my PNCP.*

---

Level of Agreement	Frequency	Percent
Strongly Disagree	6	6.2
Disagree	9	9.3
Neither agree nor disagree	14	14.4
Agree	40	41.2
Strongly Agree	28	28.9

---

Most (70.1%) of the participants reported that they had felt emotionally supported by their PNCP during the course of their pregnancy.

Table 18

*I felt that my PNCP was attuned to my moods.*

---

Level of Agreement	Frequency	Percent
Strongly Disagree	8	8.2
Disagree	17	17.3
Neither agree nor disagree	22	22.4
Agree	32	32.7
Strongly Agree	19	19.4

---

It is noted that 25.5% of the participants reported that they disagreed with the statement “I felt that my PNCP was attuned to my moods.”

Table 19

*My PNCP was usually able to see when I was feeling sad/stressed/anxious, etc.*

---

Level of Agreement	Frequency	Percent
Strongly Disagree	8	8.2
Disagree	16	16.3
Neither agree nor disagree	34	34.7
Agree	22	22.4
Strongly Agree	18	18.4

---

40.8% of participants agreed that their PNCP was able to see when they were feeling sad/stressed/anxious, etc.

Table 20

*I felt comfortable discussing my emotional health with my PNCP.*

---

Level of Agreement	Frequency	Percent
Strongly Disagree	6	6.2
Disagree	25	25.8
Neither agree nor disagree	11	11.3
Agree	29	29.9
Strongly Agree	26	26.8

---

Over a third (32.0%) of participants reported that they did not feel comfortable discussing their emotional health with their PNCP.

Table 21

*My PNCP always asked me how I was feeling.*

---

Level of Agreement	Frequency	Percent
Strongly Disagree	3	3.1
Disagree	13	13.4
Neither agree nor disagree	10	10.3
Agree	43	44.3
Strongly Agree	28	28.9

---

A majority (73.2%) of participants reported that their PNCP's "always" asked them how they were feeling during the course of their pregnancy.



Table 22

*I felt like I had time to build a solid relationship with my PNCP.*

---

Level of Agreement	Frequency	Percent
Strongly Disagree	12	12.2
Disagree	14	14.3
Neither agree nor disagree	15	15.3
Agree	33	33.7
Strongly Agree	24	24.5

---

Over a quarter of participants (26.5%) reported that they did not feel they had enough time to build a solid relationship with their PNCP.

Table 23

*I felt like I had time in my appointments to talk about how I was feeling with my PNCP.*

---

Level of Agreement	Frequency	Percent
Strongly Disagree	9	9.2
Disagree	18	27.6
Neither agree nor disagree	13	13.3
Agree	34	34.7
Strongly Agree	24	24.5

---

More than half (59.2%) of all participants reported that they had sufficient time in appointments to discuss their feelings with their PNCP.

Table 24

*My PNCP was friendly and easy to talk to.*

---

Level of Agreement	Frequency	Percent
Strongly Disagree	4	4.1
Disagree	5	5.1
Neither agree nor disagree	8	8.2
Agree	45	45.9
Strongly Agree	36	36.7

---

Very few participants (9.2%) disagreed with the statement “My PNCP was friendly and easy to talk to.”

Table 25

*My PNCP asked me if I had any concerns about being able to provide for a child.*

---

Level of Agreement	Frequency	Percent
Strongly Disagree	25	25.5
Disagree	35	35.7
Neither agree nor disagree	14	14.3
Agree	12	12.2
Strongly Agree	12	12.2

---

A majority (61.2%) of women reported that their PNCP did not ask if they had any concerns about being able to provide for a child.

Table 26

*My PNCP asked me if I was experiencing any fears about becoming a parent.*

---

Level of Agreement	Frequency	Percent
Strongly Disagree	23	23.5
Disagree	37	37.8
Neither agree nor disagree	15	15.3
Agree	13	13.3
Strongly Agree	10	10.2

---

Just 23.5% of women agreed that their PNCP had asked them if they had any fears about becoming a parent.

Table 27

*My PNCP asked me how I was feeling about becoming a parent.*

---

Level of Agreement	Frequency	Percent
Strongly Disagree	19	19.4
Disagree	35	35.7
Neither agree nor disagree	14	14.3
Agree	18	18.4
Strongly Agree	12	12.2

---

Just 30.6% of respondents reported that their PNCP had asked them how they were feeling about becoming a parent.

Table 28

*My PNCP asked me if I had any fears about giving birth.*

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Level of Agreement	Frequency	Percent
Strongly Disagree	20	20.6
Disagree	26	26.8
Neither agree nor disagree	14	14.4
Agree	28	28.9
Strongly Agree	9	9.3

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Just 38.2% of participants stated that their PNCP had asked them if they had any fears about giving birth.

Table 29

*My PNCP asked me about my birthing preferences (ex. Do you want an epidural/water birth/ C-section, etc.)*

Level of Agreement	Frequency	Percent
Strongly Disagree	10	10.2
Disagree	13	13.3
Neither agree nor disagree	6	6.1
Agree	42	42.9
Strongly Agree	27	27.6

A majority (70.5%) of women reported that their PNCP asked them about their birthing preferences.



Table 30

*I felt that my PNCP was respectful of the choices I made throughout my pregnancy.*

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Level of Agreement	Frequency	Percent
Strongly Disagree	4	3.4
Disagree	3	2.6
Neither agree nor disagree	14	12.1
Agree	43	37.1
Strongly Agree	34	29.3

---

Most women (66.4%) reported that their PNCP was respectful of the choices they made throughout their pregnancy.

Table 31

*I felt that my PNCP was supportive of the choices I made throughout my pregnancy.*

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Level of Agreement	Frequency	Percent
Strongly Disagree	3	3.1
Disagree	6	6.1
Neither agree nor disagree	12	12.2
Agree	44	44.9
Strongly Agree	33	33.7

---

Most women (78.6%) agreed that their PNCP was supportive of the choices they made throughout their pregnancy.

Table 32

*My PNCP helped me make decisions throughout my pregnancy.*

Level of Agreement	Frequency	Percent
Strongly Disagree	6	6.1
Disagree	9	9.2
Neither agree nor disagree	14	14.3
Agree	42	42.9
Strongly Agree	27	27.6

A majority (70.5%) of the women in this sample agreed that their PNCP helped them make decisions throughout their pregnancy.

### **Descriptive Statistics**

#### **Midwives vs. OB/GYN: Overall Satisfaction**

In addition to the descriptive statistics that were obtained in this survey, the researcher was also interested in the relationships that existed among variables. This researcher hypothesized that there would be a relationship between provider type (OB/GYN vs. Midwife) and overall satisfaction with PNCP's ability to attend to emotional concerns. This study shows that women who were seen by midwives reported higher rates of overall satisfaction with their PNCP's ability to attend to emotional concerns, with  $p = .055$ . The difference did not reach significance at the .05 level, the usual minimum standard for scientific significance.

“Overall satisfaction” was based on level of agreement to the following set of

statements: I felt emotionally supported by my PNCP, I felt that my PNCP was attuned to my moods, my PNCP was usually able to see when I was feeling sad/stressed/anxious etc., I felt comfortable discussing my emotional health with my PNCP, PNCP always asked me how I was feeling, I felt like I had time to build a solid relationship with my PNCP, I felt like I had time in appointments to talk about how I was feeling with my PNCP, My PNCP was friendly and easy to talk to, my PNCP asked me about my birthing preferences, and lastly, I felt that my PNCP was respectful of the choices I made throughout my pregnancy. This researcher focused on this set of questions to determine “overall satisfaction” with their PNCP experience, because the purpose of these questions was to determine the quality of the relationship and the ability of the PNCP to manage emotional concerns that arose during the course of the pregnancy. This set of questions was used to compute an overall satisfaction composite so as to assess whether statistical differences existed between groups. Smith’s data analyst, Marjorie Postal, ran a Cronbach’s alpha for the ten above listed questions in order to determine internal reliability. These ten questions had strong internal reliability (alpha=.941, N=95, N of items=10).

For the purpose of determining overall satisfaction, the researcher divided answers into either “agree” or “disagree”, meaning there was no differentiation between someone who stated “strongly agree” and someone who said “agree”, both answers were considered to simply indicate that the participant agreed with the statement, likewise for “strongly disagree” and “disagree.” Those who responded with “neither agree nor disagree” were not included in this summary of the data. The following table illustrates the differences that exist between participants who reported seeing a midwife vs. and OB/GYN and overall satisfaction with their PNCP’s ability to attend to their emotional concerns:

Table 33

*Overall Satisfaction Rates for Midwives vs. OB/GYN*

Statement	OB/GYN (N=69)	MIDWIFE (N=25)
I felt emotionally supported by my PNCP.	Agree: 60.7% Disagree: 21.3%	Agree: 87% Disagree: 4.35%
My PNCP was attuned to my moods.	Agree: 45.2% Disagree: 30.7%	Agree: 65.2% Disagree: 13.05%
My PNCP was usually able to see when I was feeling sad/stressed/anxious, etc.	Agree: 32.3% Disagree: 27.4%	Agree: 56.5% Disagree: 13.05%
I felt comfortable discussing my emotional health with my PNCP.	Agree: 52.5% Disagree: 32.8%	Agree: 65.2% Disagree: 30.4%
My PNCP always asked me how I was feeling.	Agree: 68.9% Disagree: 21.3%	Agree: 78.3% Disagree: 4.4%
I felt like I had time to build a solid relationship with my PNCP.	Agree: 56.5% Disagree: 30.7%	Agree: 60.9% Disagree: 17.4%
I felt like I had time in my appointments to talk about how I was feeling with my PNCP.	Agree: 51.6% Disagree: 33.4%	Agree: 78.3% Disagree: 8.7%
My PNCP was friendly and easy to talk to.	Agree: 80.6% Disagree: 9.7%	Agree: 91.3% Disagree: 4.4%
My PNCP asked me about my birthing preferences.	Agree: 61.3% Disagree: 30.6%	Agree: 91.3% Disagree: 8.7%

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Table 33 Continued

Statement	OB/GYN (N=69)	MIDWIFE (N=25)
I felt that my PNCP was respectful of the choices I made throughout my pregnancy.	Agree: 75.8%	Agree: 91.3%
	Disagree: 11.3%	Disagree: 0.0%

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For each question that was used to determine overall satisfaction, women who saw midwives rated higher levels of agreement.

### **Relationship between Income and Overall Satisfaction with PNCP**

The next relationship the researcher wished to examine was the correlation between income and overall satisfaction with PNCP. The researcher hypothesized that those who reported lower socioeconomic status (SES) would have decreased overall satisfaction with their PNCP as compared to those who reported higher SES. In addition to overall satisfaction this researcher was interested in reported rates of anxiety and depression amongst those who reported low SES and those who reported high SES.

This study indicates that there is a correlation between lower SES and increased reported anxiety and depression during pregnancy. 44.4% of participants who reported low SES endorsed feeling depressed during pregnancy, while none of the individuals who were of high SES reported depression. There were no major differences in reported anxiety based on income; 44.4% of those of low SES agreed that they had experienced significant anxiety during their pregnancy, compared to 42.9% of those who were of high SES. In response to the statement “ I felt unsure of whether or not I wanted to continue my pregnancy”, 66.7% of the low SES participants stated they disagreed with this statement versus 100% of the high SES participants who disagreed with this statement. Finally, one major difference between those who reported

low SES and those who reported high SES was whether or not they felt financially prepared to become a parent; just 11.1% of low SES respondents stated that they agreed with the statement “I felt financially prepared to become a parent”, versus 85.7% of the high SES respondents.

For the purpose of determining whether there is a correlation between income and overall satisfaction with their PNCP, the researcher compared results between those who indicated that their approximate average household income was between zero and \$24,999, and those who reported that their household income was above \$175,000. The researcher chose to compare this set of variables as they had close to the same number of people who reported incomes in each of these categories, and they represent women on both the low and high end of the spectrum. Nine of the participants reported an income of \$24,999 or under, and seven respondents reported an income of \$175,000 and over. One of the participants that identified being of high SES, did not answer the questions related to overall satisfaction with their PNCP, and so the percentages related to satisfaction were based on the six individuals who answered the questions.

Table 34

*Relationship between Income and Overall Satisfaction*

Statement	Annual Household Income: 0-\$24,999 (N=9)	Annual Household Income: \$175,000 and up (N=7)
I felt emotionally supported by my PNCP.	Agree: 77.8%	Agree: 50.0%
	Neither agree/disagree: 0.0%	Neither agree/disagree:33.3%
	Disagree: 22.2%	Disagree: 16.7%
My PNCP was attuned to my moods.	Agree: 55.5%	Agree: 16.7%
	Neither agree/disagree:11.1%	Neither agree/disagree:50.0%
	Disagree: 33.3%	Disagree: 33.3%

Table 34 Continued

Statement	Annual Household Income:	Annual Household Income:
	0-\$24,999 (N=9)	\$175,000 and up (N=7)
My PNCP was usually able to see when I was feeling sad/stressed/anxious, etc.	Agree: 22.2%	Agree: 16.7%
	Neither agree/disagree:44.4%	Neither agree/disagree:50.0%
	Disagree: 33.3%	Disagree: 33.3%
I felt comfortable discussing my emotional health with my PNCP.	Agree: 55.5%	Agree: 33.3%
	Neither agree/disagree:11.1%	Neither agree/disagree:33.3%
	Disagree: 33.3%	Disagree: 33.3%
My PNCP always asked me how I was feeling.	Agree: 66.7%	Agree: 66.7%
	Neither agree/disagree: 0.0%	Neither agree/disagree:16.7%
	Disagree: 33.3%	Disagree: 16.7%
I felt like I had time to build a solid relationship with my PNCP.	Agree: 44.4%	Agree: 50.0%
	Neither agree/disagree:11.1%	Neither agree/disagree:33.3%
	Disagree: 44.4%	Disagree: 16.7%
I felt like I had time in my appointments to talk about how I was feeling with my PNCP.	Agree: 55.5%	Agree: 33.3%
	Neither agree/disagree: 0.0%	Neither agree/disagree:16.7%
	Disagree: 44.4%	Disagree: 50.0%
My PNCP was friendly and easy to talk to.	Agree: 77.8%	Agree: 66.7%
	Neither agree/disagree:11.1%	Neither agree/disagree:16.7%
	Disagree: 11.1%	Disagree: 16.7%
My PNCP asked me about my birthing preferences.	Agree: 55.5%	Agree: 50.0%
	Neither agree/disagree: 0.0%	Neither agree/disagree:16.7%
	Disagree: 44.4%	Disagree: 33.3%



Table 34 Continued

Statement	Annual Household Income: 0-\$24,999 (N=9)	Annual Household Income: \$175,000 and up (N=7)
I felt that my PNCP was respectful of the choices I made throughout my pregnancy.	Agree: 22.2%	Agree: 83.3%
	Neither agree/disagree:55.5%	Neither agree/disagree:16.7%
	Disagree: 22.2%	Disagree: 0.0%

Reported rates of overall satisfaction with their PNCP’s ability to attend to emotional concerns were actually slightly higher for participants who reported low SES compared to those that reported high SES. However, this difference was not statistically significant. This finding is contradictory to previous research, and may be related to the small sample size.

**Relationship between Race and Overall Satisfaction with PNCP**

This researcher was interested in whether there would be a difference in overall satisfaction with PNCP based on participants’ race. Unfortunately, this sample was overwhelmingly white (N=101) compared to participants who identified as non-white (N=5). Due to this disparity, and the lack of diversity in the sample, this researcher was unable to obtain meaningful results from the data.

**Qualitative Findings**

The final section of the survey consists of two open-ended questions to be analyzed using qualitative methods. The researcher chose to include the open-ended questions in order to give participants the opportunity to give a more personal account of their prenatal care experience and to explore what could have been done differently to make the experience more positive for other pregnant women. Upon review, the researcher observed that certain themes emerged in the open-ended responses. For the purpose of this study, and in an effort to answer the question of whether

or not PNCP's were able to sufficiently attend to the emotional concerns of women, the open-ended questions were analyzed by grouping responses into different categories (i.e., positive and negative PNCP experiences).

The first question asked respondents to: **“Describe in your own words how sensitive and effective your PNCP was to your emotional concerns during pregnancy.”** There was a wide variation of responses to this question, but for the purpose of analyzing the data, the researcher identified four main themes into which each response could be categorized. The first category consisted of participants who indicated that their PNCP experience had been positive overall and that they had felt their PNCP was well attuned to their emotional concerns. 42.3% of the women who responded to this question felt that their PNCP had been adequately attentive to their emotional concerns throughout pregnancy.

### **Positive PNCP Experience**

One participant highlighted the time her PNCP took to attend to her emotional concerns: “My midwife left lots of room for processing emotions. Our appointments were over an hour long and most of this time was spent talking about how I was feeling physically and emotionally, and my worries about becoming a parent.”

Another woman indicated that having a variation of disciplines within the same practice helped make her experience more positive. This participant described her PNCP as “very sensitive and kind. The OB/GYN office had one MD, two midwives, and an MSW on staff who met with all patients regularly.”

### **Negative PNCP Experience**

25.3% of women indicated that their PNCP experience had been negative, and described their providers as being impersonal. One common complaint among participants was feeling like

“just another number”, and an overall lack of personalized care.

One participant stated: “I didn’t feel comfortable talking about these things there [emotional concerns]. It was just business...measuring and testing and scheduling the next appointment. I am going to use a midwife next time.”

In a particularly poignant description of her PNCP experience, one woman detailed her traumatic pregnancy and the lack of sensitivity of her providers:

My last pregnancy was a surprise. We found out at our first trimester screening that the baby had chromosomal defects and a condition that gave less than a 10% chance of live birth after a very stressful pregnancy. We were sent to a specialist and after many agonizing days, made the choice to terminate the pregnancy. We already had two daughters (age 2 and 7 months) and we couldn’t figure out how to explain that I was going to have a baby but that the baby would most likely go to heaven. My stress level made me a bad mom to everyone. I spoke to my OB about the choice and she immediately changed her tune and became distant. We were sent to another clinic to terminate, began the process and were to return the next day. I woke up in labor and delivered our stillborn son on the way down the stairs to leave for the hospital. I was rushed to the ER, where I was treated abominably by the treating doctor. This loss resulted in three infections before I was able to demand a D&C to remove left over tissue. It was horrible. My doctor hasn’t been the same since and actually told me that I shouldn’t try to get pregnant again after my last experience. It was hideous. I would love another doctor but we don’t have any others in the area. My last pregnancy left me broken, scarred, and disgusted with my OB.

## **Neutral and Mixed PNCP Experience**

The other categories were labeled as either neutral (10%), or those who reported a mixed experience (15.6%). As an example of a response that was categorized as neutral, one participant stated: “My PNCP in the first two trimesters of my pregnancy was kind like a friend, but not helpful like a mental health provider.” The responses that were categorized as “mixed experience”, were those who reported both positive and negative aspects of their care, or those who saw multiple providers, some more sensitive than others; “I saw both doctors and midwives. It was much easier and much more comfortable to talk to midwives about emotions, but I don’t recall doctors asking any of these questions.”

The second open ended question asked women to “**include any other thoughts or information that you would like to share related to how PNCP’s may be able to better attend to women’s emotional concerns.**” Once again, responses were categorized into various themes. The four different categories were those who believed that treatment needed to be more personalized to the individual’s needs, those who believed that having more time with their PNCP would increase the providers ability to attend to emotional concerns, the third category was those who felt having a trained mental health professional in office would be helpful, and lastly, those who believed additional information and resources regarding perinatal and postnatal mental health should be offered by PNCP’s.

## **More Personalized Care**

61.9% of participants felt that having more personalized care would have been beneficial to them during pregnancy. More personalized meaning; asking more specific questions, listening to individuals preferences and adjusting treatment to better suit those preferences, and also just generally being more sensitive and accommodating of women’s needs. Participants stated that

PNCP should remember that "...having a baby is never a routine event for the parents..." and to "...stop treating birthing mothers like an assembly line."

### **More Time**

11.9% of women responded that having longer appointments, and thus more time to get to know your PNCP and vice versa, would have increased the likelihood of patients disclosing that they were experiencing emotional issues. Participants also stated that having more time set aside during appointments to specifically discuss emotional concerns would have been helpful during pregnancy. One individual summarized this sentiment by stating: "I think if all appointments were allowed to be 30 minutes, instead of the often scheduled quick 15 minute intervals, maybe a wider range of questions and ideas could be discussed. And a comfortable space could be established to talk about feelings, fears, etc. with a longer visit."

### **In-Office Access to Mental Health Provider**

Of the 42 valid responses to the question of how PNCP's may be able to better attend to women's emotional concerns, five women (11.9%) explicitly stated that having in-office access to a mental health provider would have been beneficial to them during pregnancy. In response to this question, one participant responded:

I don't even know where to start! Your body and mind undergo immense changes during and after pregnancy. They barely have time to address your body, never mind your mind, maybe having a counselor on staff that is mandatory on the rotation to check in and see how women are doing. I was on my fourth pregnancy and because of unforeseen complications and health issues, I needed someone who wasn't there.

### **Additional Information Related to Perinatal and Postnatal Mental Health**

14.3% of participants indicated that having additional information and resources related

to mental health during and after pregnancy would have been helpful. Many of the individuals whose responses fell under this category explained feeling unaware of many of the emotional issues that can arise throughout pregnancy, and that having information about mental health issues as well as recommendations on how to treat these concerns, would have been helpful to them during pregnancy.

One woman explained that she:

...definitely experienced increased anxiety with all three pregnancies and it would have been helpful to have a professional talk to me about that. It did not occur to me to bring it up with my PNCP. The anxiety I experienced after birth was also a trip and never went away completely. I had heard so much about postpartum depression but not about the possibility of increased anxiety, which would have been very helpful to be on the lookout for and to know it was normal.

## **CHAPTER V**

### **DISCUSSION**

The purpose of this study was to examine women's experiences with their prenatal care providers (PNCP), specifically with regard to PNCP's ability to attend to emotional concerns that arose during pregnancy. In an effort to better understand the limitations that exist in PNCP's attendance to emotional concerns, this researcher sought to answer the following questions: For this sample, what are the rates of reported mental health concerns? Is there a relationship between overall satisfaction with PNCP ability to attend to emotional concerns (OS) and practice modality (midwife vs. OB/GYN)? Is there a relationship between OS and reported income? For this sample, what is the rate of OS? How do women think PNCP's can improve their ability to attend to emotional concerns that arise during pregnancy?

Research finds that although women tend to report high satisfaction with their prenatal care, there are major limitations in PNCP's ability to attend to emotional concerns (Roter, Geller, Bernhardt, Larson & Doksum, 1999). The results of this study are consistent with this finding. Generally, participants reported that they were satisfied with PNCP's ability to attend to emotional concerns, yet when asked whether they had been asked broader questions specific to emotional well-being (i.e., Do you have any fears about becoming a parent?), the majority of women stated they had never been asked these types of questions. Results of this study support the idea that asking more questions specific to women's emotional well-being will improve patient's satisfaction with care. The final question of this survey asked women to report the ways

in which they felt PNCP's could improve their ability to attend to the emotional concerns of their patients. 61.9% of participants stated that having more personalized care, with specific questions related to women's emotional wellbeing would improve their satisfaction with their PNCP's attendance to emotional concerns.

This chapter will compare and contrast the major findings of this study with the results found in previous literature, and discuss the possible reasons and implications of the results. This writer will first detail the quantitative findings (general mental health ratings, influence of practice modality on OS, and the relationship between OS and income) and how they compare with previous research. Next, the writer will outline the qualitative findings (overall satisfaction with PNCP ability to attend to emotional concerns, and ways to improve PNCP's ability to attend to emotional concerns) and how the results compare with the researchers hypothesis and previous literature on the subject. After the comparison between the findings of this study and previous literature, this chapter will discuss the implications of this study to the field of social work. Additionally, this chapter will review the limitations of this study and provide recommendations for future research. Finally, this thesis will end with the writer's reflection on the research process.

## **Quantitative Findings**

### **Reports of Mental Health Concerns among Pregnant Women**

Pregnancy is considered a time of major transition and heightened emotional stress for women and their families (Poleshuck & Woods, 2014). Previous research finds that PNCP's are not adequately addressing emotional concerns during pregnancy, and that the majority of individuals with behavioral health needs are undertreated (Poleshuck & Woods, 2014). The rates



of reported emotional concerns during pregnancy in this sample were fairly high, and in some instances higher than the rates that are reported in previous studies.

### **Depression & Anxiety during Pregnancy**

Previous research reports rates of clinically significant depression in pregnant women to be approximately 14% (Poleshuck & Woods, 2014). In this sample, 25% of women reported experiencing depression during their pregnancy, and more than half of participants (55.7%) reported experiencing increased anxiety over the course their pregnancy. It is important to highlight the difference between clinically diagnosed depression and self-reported depression, which may or may not meet the clinical criteria for a diagnosis of depression. Though 25% of the women in this sample reported experiencing depression during their pregnancy, it is possible that not everyone who reported feeling depressed, had an actual clinical diagnosis. This particular sample reported few social stressors (i.e., low rates of reported IPV and financial stressors, high ratings for social support) and so, it is reasonable to assume that if this study were to be replicated amongst a high-risk population with increased socio-emotional stressors, rates of depression and anxiety would be even higher.

### **Interpersonal Violence during Pregnancy**

Rates of reported interpersonal violence (IPV) during pregnancy were consistent with previous research. The Center for Disease Control (CDC) reports that in the United States (US) each year, roughly 324,000 women (4-8%) experience IPV during their pregnancy. 6% of participants in this study reported experiencing IPV during their pregnancy. Research finds that instances of domestic violence tend to increase amongst impoverished populations (Tolman & Rosen, 2001). It is interesting to note that this sample was largely middle-class, and so not

representative of the probable rates of IPV that exist among populations that are of lower socioeconomic status.

### **Rates of Unintended Pregnancy**

The vast majority (59.5%) of women who participated in this study reported that they had planned their pregnancy. This is in stark contrast to previous research that finds “nearly half of all pregnancies in the US are unintended.” (Poleshuck & Woods, 2014) Just 24.1% of participants in this study reported that their pregnancy was unintended. Previous studies report that 22% of all pregnancies that occur in the US are terminated (Poleshuck & Woods, 2014); in this sample, just two participants (1.7%) reported that they chose to abort their pregnancy. The inconsistency of this data is likely due to the fact that this sample was largely comprised of individuals who were of higher socioeconomic status. This study was not representative of the larger population, thus the data does not accurately reflect the number of unintended pregnancies that occur in the US.

### **Influence of Practice Modality on Overall Satisfaction**

Women who reported seeing a midwife rather than an OB/GYN for their PNCP had higher rates of reported OS. This finding is consistent with previous research. In an article that evaluates patient’s satisfaction with their PNCP, researchers found that “...women experiencing low-risk pregnancies were more satisfied with care by midwives than with care provided by doctors.” (Harvey, Rach, Stainton, Jarrell & Brant, 2002) Harvey et al., (2002) suggest that the difference in satisfaction may be due to different expectations of midwives versus doctors. Midwives tend to provide a more personalized pregnancy and birth experience, while doctors tend to adhere more to the medical model.

For each question that was asked to determine OS, women who were seen by midwives rated higher agreement than those who were seen by physicians. Given that most women in this survey reported a desire for more personalized treatment, it makes sense that those who were seen by midwives reported higher rates of satisfaction.

Women in this sample, who were dissatisfied with their PNCP's ability to attend to emotional concerns, often referenced feeling like "just another patient." This research, as well as previous studies show that women who receive prenatal care from midwives tend to report having a more personalized experience than those who see physicians (De Koninck, Blais, Joubert & Gagnon, 2001). In order to get more information about why women tend to have higher OS when seen by a midwife, this researcher would want to ask more questions specific to what elements of the relationship contributed to the feeling of greater personalization. Previous studies indicate that midwife appointments tend to be more frequent, and also longer in duration (De Konink et al., 2001). It is possible that the greater amount of time that is spent between patient and PNCP allows for the development of a more personal relationship, allowing the patient to feel more comfortable to disclose information regarding their emotional health. For the statement, "I felt like I had enough time in appointments to talk about how I was feeling with my PNCP," 78.3% of women who saw midwives reported agreeing with this statement versus, 51.6% of women who saw an OB/GYN. In order to better assess differences, this researcher would specify whether "how I was feeling," referencing patient's physical or emotional health was.

Aside from length of visit, this researcher would also be interested in assessing differences in how midwives and physicians interact with their patients. For the statement "my PNCP was friendly and easy to talk to," 91.3% of midwife patients agreed compared to 80.6% of

OB/GYN patients. In order to better understand this difference, an open-ended question asking participants to describe their PNCP's demeanor may have been helpful. In prior research that evaluates differences in demeanor between midwives and physicians, women described their midwives as "warm" "respectful", and "supportive." In comparison, women described their doctors as "humanly austere", "hurried", and feeling like "just a number." (De Koninck et al., 2001)

### **Relationship between Income and Overall Satisfaction**

This researcher hypothesized that there would be a positive correlation with lower SES subjects reporting lower overall levels of satisfaction. This researcher did not find any significant differences in OS based on income, however, participants who reported low SES actually had slightly higher OS ratings than those who were of high SES.

Previous research found major disparities in quality of care between individuals who were low SES, compared to those who were higher SES (Sheppard, Zambrana & O'Malley, 2004). In an article that discusses levels of trust between low-income patients and their providers, the authors make the point that "...accessibility includes more than the mere existence and availability of services, it also includes quality patient-provider relationships." (Sheppard, Zambrana & O'Malley, 2004) This study found that rates of satisfaction with prenatal care among low-income patients were lower than among clients who were non low-income. The researchers went on to explain that "...patient trust is a central component in the delivery of quality medical care" and that good communication is one of the key factors to creating trust between client and provider (Sheppard, Zambrana & O'Malley, 2004).

The findings of this study were contrary to previous research in that reported rates of overall satisfaction with their PNCP's ability to attend to emotional concerns, were actually

slightly higher for participants who reported low SES compared to those who reported high SES. This sample did not specifically look at low SES communities, and so it is difficult to speculate about why the OS rates were slightly higher for low SES participants. One possible reason is that low SES participants may have been living in resource rich communities, where there is greater access to quality prenatal care. The findings of this study support this idea because though rates of depression and anxiety were higher in low SES participants, rates of satisfaction with their PNCP were about the same as high SES participants.

Individuals who reported low SES had heightened rates of depression and ambivalence around continuing their pregnancy. 44.4% of participants who reported low SES endorsed feeling depressed during pregnancy, while none of the individuals who were of high SES reported depression. In response to the statement “I felt unsure of whether or not I wanted to continue my pregnancy,” 66.7% of the low SES participants stated they disagreed with the statement versus 100% of the high SES participants who disagreed with this statement. Finally, one major difference between those who reported low SES and those who reported high SES was whether or not they felt financially prepared to become a parent; just 11.1% of low SES respondents stated that they agreed with the statement “I felt financially prepared to become a parent,” versus 85.7% of the high SES respondents. In low SES communities where providers may have much larger caseloads and service a larger number of “at-risk” clients, it is reasonable to assume that levels of satisfaction with PNCP’s attendance to emotional concerns may be lower. The findings of this study also show that even in high SES communities, where providers may be servicing far fewer “at-risk” clients, PNCP’s ability to attend to emotional concerns are still quite limited.

Most of the women in this study (87.0%) reported having between one and three children,

and 67.3% reported incomes of \$50,000 or higher. The federal poverty line for a family of five in the US is \$27,910 ([www.obamacarefacts.com](http://www.obamacarefacts.com), 2015). Based on this guideline, the majority of women in this study would not be considered to be of low socioeconomic status. 24.2% of women who participated in this study report incomes below \$50,000, and just 17.9% of participants stated that they did not feel financially prepared to become parents. In order to gain more accurate insights to the differences in service based on SES, one would need to conduct research that looks specifically at low resource communities.

## **Qualitative Findings**

### **Overall Satisfaction with PNCP Ability to Attend to Emotional Concerns**

The findings of this research are consistent with previous literature on the topic of patient satisfaction with provider's attendance to emotional concerns. In a study that examines the relationship between obstetrician gender and reported patient satisfaction, researchers found that 55% of women reported being highly satisfied with PNCP's emotional responsiveness, yet it was also found that "...categories of talk with explicit emotional content were infrequent with the exception of reassurance." (Roter et al., 1999) This study supported previous data, in that 42.3% of women reported feeling that their PNCP had been adequately attentive to emotional concerns throughout pregnancy, however, broader questions specific to women's emotional health appeared to be infrequent.

Examples of questions that would allow for a broader discussion of women's emotional wellbeing include: do you have any concerns about being able to provide for a child? Just 24.4% of women agreed they had been asked this question. Another question that could elicit discussion around women's emotional concerns would be: do you have any fears about becoming a parent? Again, less than a quarter (23.5%) of participants reported being asked about any apprehension

they were experiencing regarding becoming a parent. Only a slightly higher percentage of women agreed that they had been asked simply how they were feeling about becoming a parent (30.6%), or any fears they had specifically about giving birth (38.2%). These findings are consistent with previous research, which found that "...the first obstetrics visit presents an opportunity to establish therapeutic rapport and explore medical, social and emotional adjustments to a pregnancy. However, we found that the focus of those visits was largely biomedical." (Roter et al., 1999) It is not this researcher's implication that doctors and midwives should take on the task of counseling their patients, however, access to individuals who are trained to screen, treat and provide resources specific to mental health issues should be a part of routine prenatal care. Pregnancy is a time of major transition and, as one participant eloquently stated, is "never routine" for the woman. Research shows that emotional and physical health are directly linked to one another, (Poleshuck & Woods, 2014) and so the opportunity to discuss feelings and challenges associated with their pregnancy is an important piece to offering holistic prenatal care.

### **Women's Perspectives on How to Improve PNCP's Ability to Attend to Emotional Concerns**

In the final question of this survey, women were asked to offer suggestions on ways to improve PNCP's ability to attend to the emotional concerns of their patients. The overwhelming response (61.9%) was that PNCP's should take the time and effort to provide more personalized care. A common complaint among participants was feeling like "just a number", or that doctors treated pregnant women like an "assembly line." Just 11.9% of women stated specifically that having in-office access to a social worker or other mental health professional would improve their PNCP experience. 11.9% of women stated that having more time in appointments would

allow for a stronger relationship to form between patient and provider, and 14.3% of individuals stated that greater access to resources and information about perinatal and postnatal health would be beneficial. For midwives, and perhaps more so for doctors, the focus of their job is primarily on the physical health of both mother and child. Collaboration between social workers and PNCP's would serve as a step toward filling in the gaps that exist between providing quality physical and emotional care to pregnant women.

### **Implications for the Field of Social Work**

The findings of this study support the researcher's belief, and prior research, that indicates collaboration between health care professionals and social workers would increase patient satisfaction with care (Poleshuck & Woods, 2014). Pregnancy is often viewed as a "window of opportunity," particularly for at-risk women, who otherwise may not seek health care treatment (Herzig et al., 2006). In the article written by Herzig et al. (2006) *seizing the 9-month moment: Addressing behavioral risks in prenatal patients*, researchers found that most PNCP's believed that pregnancy was the most opportune time for a woman to change risky behaviors. During pregnancy, providers noted that women have more motivation to change behavior and greater continuity of care. For women who are living in poverty and are suffering with addiction or domestic violence, breaking the cycle of abuse is a daunting task, and accessing quality physical or mental health care can be difficult. A woman who may otherwise find it difficult to attend to her own health needs, may begin reaching out for routine care when she becomes pregnant. As social workers, it is our responsibility to seize this moment and provide adequate resources that may serve as an intervention for at-risk women and their children. By not including routine access to mental health care during prenatal visits, we are failing to grasp the opportunity for change that this "9-month moment" presents.



Although this study did not focus specifically on an at-risk population of women, the results support the researcher's hypothesis that there is a gap in care when it comes to women's emotional health. Social workers are the answer to filling this gap. PNCP's often cite lack of time and training as barriers to being able to provide adequate screening and treatment for women's mental health needs during pregnancy (Herzig et al., 2006). The qualitative results of this research support the latter finding. Participants, particularly those who had seen OB/GYN often cited lack of time and lack of discussion around mental health issues as reason for not being satisfied with PNCP's attendance to emotional concerns. Having in-office social workers whose specific job it is to attend to these needs will alleviate this duty from the PNCP's and allow for more comprehensive prenatal care. Though PNCP's should still work to provide sensitive and individual care to each of their patients, collaboration with social workers will allow more time for PNCP's to focus on patient's physical well-being and answer questions related to the pregnancy.

In the article *Psychologists Partnering with Obstetricians and Gynecologists*, by Ellen Poleshuck and James Woods (2014), the ways in which mental health clinicians can collaborate with OB/GYN's to provide more patient centered care are discussed. This article offers a model by which practices could incorporate mental health practitioners. Social workers can take on a number of roles within OB/GYN or midwifery practices including "...offer[ing] screening, engagement, assessment, consultation, treatment, and health promotion to women's health patients and consultation and support to OB/GYN providers." (Poleshuck & Woods, 2014) Some practices have found success in incorporating a group approach to prenatal care (DAWN program, Centering Pregnancy, etc.). Having a social worker who is trained in group therapy would be an important aspect to implementing this type of program in a way that allows for an

optimal experience for the women. Working within a women's health practice allows us access to patients who may not otherwise seek mental health treatment. Research shows that "...underserved women are more likely to go to their OB/GYN provider for help with their behavioral health needs than to a specialty behavioral health setting." (Poleshuck & Woods, 2014) Many barriers exist between women and access to behavioral health care including limited time and transportation. Research finds that when social workers are "...integrated directly into the OB/GYN practice, women are nearly four times more likely to follow up with behavioral health treatment..." (Poleshuck & Woods, 2014) Partnering with mental health specialists allows for greater access to mental health treatment, not only for women who are pregnant but also for any client of the OB/GYN practice.

As a society, we are becoming more aware of the link between behavioral and physical health (Poleshuck & Woods, 2014). There is a great deal of information that details the negative impacts that depression, anxiety, domestic violence, and substance use have on pregnancy and birth outcomes, and yet we continue to fall short in providing interventions for these issues (Poleshuck & Woods, 2014). The limitations that exists are not for a lack of caring, but most likely related to a lack of resources. Insurance companies play a major role in what is and what is not addressed during treatment. With practices under pressure to see as many patients as possible, PNCP's are stretched thin and often only have 15 minutes or so to meet with each patient. In this limited time frame, PNCP's must prioritize discussion of women's physical health. Given the largely bio-medical focus of these visits, women may not feel that it is appropriate to discuss their emotional concerns (Roter et al., 1999). In not paying adequate attention to the social and environmental aspects of a woman's life, we negatively impact the health of the woman and her child. Collaboration between social workers and PNCP's is a step

towards providing greater patient-centered care and improving the birth outcomes for women who are at-risk. Pregnancy is often a turning point in a woman's life, and if we are able to intervene during this stage we could potentially provide the tools for a woman to change both the course of her life and life of her child.

### **Recommendations for Future Research**

Given that research shows that rates of socio-emotional concerns and issues increase in at-risk populations (Tolman & Rosen, 2001), it would be important to replicate this study with a sample that includes more minority women, and women who are living in poverty. As stated in the methodology section of this thesis, a major limitation of this study is the lack of diversity in the sample. The researcher chose to use snowball sampling to collect participants due to the belief that this would be the most convenient way to collect a large number of responses. The use of snowball sampling is partially the reason for the homogeneity and lack of diversity of participants. Though the researcher was aware that the sampling method and the use of an internet-based survey would automatically bias the sample, it was not anticipated that the participants would be so overwhelmingly white and of high SES. Upon reflection, the sites that were used to advertise the study and collect participants are largely populated and geared toward middle-class women living in the Pioneer Valley. Aside from the sociocultural characteristics of the participants, the majority of women in this sample were people who had been planning and preparing for pregnancy. Most of the participants in this study stated that they felt they had adequate social and financial support already in place when they became pregnant. Given this information, it would be important to broaden the sample size so as to include a greater number of participants who may be facing additional stressors.

Future research should create a sample that allows for accurate comparisons between

different subsets of the population. In order to conduct a study that would be accurately reflective of the community in which the study was taking place, a researcher would need to utilize stratified random sampling. Stratified random sampling is “a method of sampling that involves the division of a population into smaller groups known as strata. In stratified random sampling, the strata are formed based on members' shared attributes or characteristics. A random sample from each stratum is taken in a number proportional to the stratum's size when compared to the population. These subsets of the strata are then pooled to form a random sample.” (Cadorette, 2015)

Had an individual with a more diverse group of acquaintances conducted this exact study, it is likely that the sample would have been more diverse. In retrospect, taking into account the lack of diversity in this researcher's acquaintances, greater measures should have been taken to include women from other sociocultural backgrounds. In order to avoid the limitation of non-generalizability, the researcher would have used different sampling methods in order to access other members of the population. For example, the researcher would have provided alternate forms of the survey (email, paper, etc.), and would have attempted to recruit participants through posting information about the survey in public spaces and additional online forums. There are also online programs (i.e., Survey Monkey), where you can request participants based on specific characteristics. The utilization of this type of program could be very helpful to future researchers who wish to examine differences in PNCP satisfaction based on income, race, or any other sociocultural characteristic.

Future researchers may also want to examine other factors that may influence a woman's experience with her PNCP. Women's partners could potentially play a role in how positive or negative an individual would rate her PNCP experience. Perhaps an area for future study would

be taking a closer look at the role of family and support during pregnancy.

There is still a great deal of work that needs to occur in providing greater access to quality care to all women. Pregnancy is a time of growth and change, and in many ways, the birth of a child presents the opportunity for new life. Social workers can join hands with health care professionals and communities to take active steps in ensuring a better future for families, and society as a whole.

### **Reflection on Thesis Process**

I would now like to take a step back to consider how this thesis process has impacted me as a student and a future clinician. I learned a great deal about the nuances of collecting and analyzing data. Furthermore, it became clear to me that the format of the survey, and the specific way questions are phrased have a major impact on the results. Though this experience was challenging, it was also extremely rewarding. To pose a research question and watch how it is answered by a group of individuals was exciting and educational. It was also enlightening to see how similar participants were, and how that shaped their experiences with their PNCP. This project also shed light on the lack of diversity that exists in my social circle, and the privilege that I have experienced as a white, middle-class woman through pregnancy and beyond.

Conducting this research has influenced my future career goals. Learning about women's experiences and reading about the gaps that exist in providing access to quality mental health care for women has made me want to be a part of the solution. Working with women and their families, particularly during pregnancy, is a career I would feel extremely passionate about. Beyond developing my writing and research skills, working through this process has also taught me to stretch my critical thinking skills, and to explore many different perspectives of an issue. These are skills that I will carry with me as I look toward graduation and joining the field of

social work as a professional.

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APPENDIX A  
HSRB APPROVAL LETTER



November 5, 2014  
Elizabeth du Toit

Dear Ellie,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

*Please note the following requirements:*

**Consent Forms:** All subjects should be given a copy of the consent form.

**Maintaining Data:** You must retain all data and other documents for at least three (3) years past completion of the research activity.

*In addition, these requirements may also be applicable:*

**Amendments:** If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

**Renewal:** You are required to apply for renewal of approval every year for as long as the study is active.

**Completion:** You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.  
Co-Chair, Human Subjects Review Committee

CC: Laurence Cadorette, Research Advisor

APPENDIX B  
INFORMED CONSENT

**Title of Study:** It Takes a Village: A Survey of Women’s Experiences of Emotional Support during Prenatal Care Visits

**Investigator(s):** Elizabeth du Toit, MSW Candidate

**Email:** [edutoit@smith.edu](mailto:edutoit@smith.edu)

.....

**Introduction**

- You are being asked to be in a research study of women’s attitudes about their prenatal care experience, and to what degree they felt their prenatal care provider addressed emotional concerns that arose throughout pregnancy
- You are eligible to participate in this study if you are a woman who has experienced a pregnancy, received prenatal care, you are over the age of 18, and you do not currently have an active mental health diagnosis, for which you are under current treatment.
- We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

**Purpose of Study**

- The purpose of the study is determine the extent to which traditional prenatal care providers (PNCP) are able to support pregnant women who experience mental health issues.
- This study is being conducted as a research requirement for my Masters in Social Work degree.
- Ultimately, this research may be published or presented at professional conferences.

**Description of the Study Procedures**

- If you agree to be in this study, you will be asked to do the following things: Complete a survey that will include 49 multiple choice questions, and answer two open ended questions. In total, the survey will take no more than 15 minutes to complete.

**Risks/Discomforts of Being in this Study**

- The study has the following risks: It is possible that participants may feel stressed or saddened when recalling times of difficulty during their pregnancy. You may exit the survey at any point, for any reason. After you complete the survey, you will be directed to a referral list of mental health centers in the area.

**Benefits of Being in the Study**

- The benefits of participation are: having the space to reflect and offer information on your pregnancy experience. An additional benefit is knowing that your voice is contributing to a movement toward improving mental health services for pregnant women.
- The benefits to social work/society are: This research could potentially show local prenatal care providers the ways that they might better attend to the needs of their patients. This research will potentially identify the need for social workers and mental health practitioners within the traditional prenatal care setting. It may also identify areas for future research and provide insight to the ways in which prenatal care providers, and mental health providers can collectively offer the best possible support for women who are pregnant.

**Confidentiality**

- This study is anonymous. We will not be collecting or retaining any information about your identity.

**Payments/gift**

- You will not receive any financial payment for your participation.

**Right to Refuse or Withdraw**

- The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* (up to the date noted below) without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely up to the point noted below. If you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone by May 1<sup>st</sup>, 2015. After that date, your information will be part of the thesis, dissertation or final report.

**Right to Ask Questions and Report Concerns**

- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Elizabeth du Toit at [edutoit@smith.edu](mailto:edutoit@smith.edu). If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

**Consent**

- Your electronic signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You may print a copy of this form to keep. You will also be given a list of referrals and access information if you experience emotional issues related to your participation in this study.

## APPENDIX C SURVEY

This is a survey that asks women to reflect on their prenatal care experience during their **most recent** pregnancy. The first section of this survey is a multiple choice demographics section. During this section, participants will be asked questions related to their geographic location, race, age, income, employment, and number of pregnancies and births they have experienced. Next, participants will be asked a series of rating questions related to their prenatal care experience. In this section, questions will be posed as statements and participants will be asked to rate, on a scale of 1 to 5, how much they agree or disagree with each statement. Participation is completely voluntary and individuals are free to exit the survey at any point, for any reason. Following the survey, participants will be directed to a referral list of local mental health centers. If participants have any questions regarding the survey, the study as a whole, or they would like more information regarding mental health clinics outside of Northampton, they can contact the researcher by email at [edutoit@smith.edu](mailto:edutoit@smith.edu). Thank you for your time!

### **Demographics (10 Questions):**

State where you are currently living?

State where you received prenatal care?

Race:

- White (Non- Hispanic)
- African American
- Latino/a
- Native American
- Asian
- Other: \_\_\_\_\_

Age:

- 15-25 years old
- 25-35 years old
- 35-45 years old
- 45-55 years old
- 55 years old and up

Household Income:

- < \$20,000
- \$20,000 – 30,000
- \$30,000 - 40,000
- \$40,000 – 50,000
- \$50,000 – 60,000
- >\$60,000

How many times have you given birth?

- 1
- 2
- 3
- 4
- 5+

How many times have you been pregnant?

- 1
- 2
- 3
- 4
- 5+

Employment?

- Full-time
- Part-time
- Student
- Unemployed
- Other: \_\_\_\_\_

Gave birth in the last:

- Year
- Last 2 years
- Last 3 years
- Last 4 years
- Last 5 years
- Other: \_\_\_\_\_

Received Prenatal Care at a:

- OB/GYN Office
- Midwifery Office
- Other: \_\_\_\_\_

Rate the following statements on a scale of 1-5(1= strongly disagree, 5= strongly agree)

*If you have experienced multiple pregnancies, for the purpose of this survey, please reflect only on your latest pregnancy.*

**Terms**

**PNCP:** Pre Natal Care Providers – this refers to the team of doctors, nurses, medical employees that worked with you throughout your pregnancy.

**Depression:**

- Feeling sad, blue, or moody.
- Experiencing changes in appetite or sleep habits due to emotional state.
- No longer enjoying activities that you used to enjoy.

**Anxiety:**

- Feeling nervous, uncertain, or worried.
- Preoccupied with distressing thoughts.
- Impacting sleep and eating habits.

**Pregnancy Complications:** Any medical issues that arose throughout the course of your pregnancy related to your physical health, or the physical health of the fetus.

**Interpersonal Violence:** Physical, emotional, or sexual abuse that occurred throughout the course of your pregnancy.

**Mental Health Counseling:** Psychotherapy provided by a licensed mental health provider to address issues of emotional distress that occurred throughout your pregnancy.

**General Mental Health Questions (6 Questions)**

- I experienced depression over the course of my pregnancy.
- I experienced anxiety over the course of my pregnancy.
- I experienced pregnancy complications that caused me emotional distress.
- I experienced interpersonal violence during my pregnancy.
- I sought mental health counseling outside of my prenatal care provider during my pregnancy.
- My PNCP asked me if I wanted to talk to a counselor.

**Attitudes regarding Pregnancy (8 Questions)**

- I was surprised to find out I was pregnant.
- I felt unsure of whether I wanted to continue my pregnancy.
- I chose to terminate my pregnancy.
- I was happy to find out I was pregnant.
- I had been trying to get pregnant.
- I felt like I was emotionally prepared to become a parent.
- I felt like I was financially prepared to become a parent.
- I felt that I had enough social supports to become a parent.

**Relationship with Prenatal Care Providers (PNCP) (25 Questions)**

- I felt emotionally supported by my PNCP.
- My PNCP asked me if I had any past or present mental health diagnoses.
- My PNCP asked me if I was currently experiencing any significant life stressors (deaths, job loss, etc.)
- I felt that my PNCP was attuned to my moods.
- My PNCP was usually able to see when I was feeling sad/stressed/anxious etc.
- I felt comfortable discussing my emotional health with my PNCP.
- My PNCP always asked me how I was feeling.
- I feel like my PNCP didn't really care about how I was feeling emotionally.
- I always saw the same doctor/midwife throughout my pregnancy.
- I felt like I had time to build a solid relationship with my PNCP.
- I felt like I had time in my appointments to talk about how I was feeling with my PNCP.
- My PNCP always seemed in a hurry.
- My PNCP was friendly and easy to talk to.
- My PNCP asked me if I was using any drugs.
- My PNCP asked me if I was smoking.
- My PNCP asked me if I was drinking.
- My PNCP asked me if I was feeling sad/anxious/etc.
- My PNCP asked me if I had any concerns about being able to provide for a child.
- My PNCP asked me if I was experiencing any fears about becoming a parent.
- My PNCP asked me how I was feeling about becoming a parent.
- My PNCP asked me if I had any fears about giving birth.
- My PNCP asked me about my birthing preferences (ex. Do you want an epidural/water birth/ C-section, etc.)



- I felt that my prenatal care provider was respectful of the choices I made throughout my pregnancy.
- I felt that my prenatal care provider was supportive of the choices I made throughout my pregnancy.
- My prenatal care provider helped me make decisions throughout my pregnancy.

**Open Ended Questions (2 Questions)**

1) Describe in your own words how sensitive and effective your PNCP was to your emotional needs during the course of your pregnancy.

2) Please include any other thoughts or information they would like to share about how prenatal care may be able to better attend to women's mental health needs.

APPENDIX D  
REFERRAL LIST

**Mental Health Clinics – Northampton**

**ServiceNet, Inc.**

129 King Street  
Northampton, MA 01060  
Telephone: 413.585.1300  
Fax: 413.582.4252  
Email: [info@servicenet.org](mailto:info@servicenet.org)

**BHN Northampton**

518 Pleasant Street, Suite 100  
Northampton, MA 01060-3997  
Telephone: 413.582.7961  
Fax: 413.582.7963

**Clinical & Support Options**

**Administrative Office**

8 Atwood Drive, Suite 301  
Northampton, MA 01060  
Telephone: 413.773-1314  
Fax: 413.774.1197  
Email: [info@csoinc.org](mailto:info@csoinc.org)

APPENDIX E  
RECRUITMENT STATEMENT & SURVEY WEB LINK

As many of you know, I am a candidate for a Masters in Social Work and am working on a research project that asks women to reflect on their prenatal care experience. Specifically, the aim of this survey is to establish women's satisfaction with their prenatal care provider's ability to attend to their emotional and mental wellbeing during pregnancy. If you are a woman over the age of 18 who is not currently pregnant but has previously been pregnant, received prenatal care, and does not have an active mental health diagnosis, for which they are under current treatment, I would greatly appreciate your participation in this survey. It would also be of great help to me if you would share this link so that we can get as many women's voices as possible on this important topic! For further questions, you can contact me by email (edutoit@smith.edu.), or by sending me a Facebook message. Thank you in advance for your time and participation!

<https://www.surveymonkey.com/s/PLDCD88>