Dissertations   UMSL Graduate Works

The Motherhood Crusade: Rural Low-Income Mothers, Support, and Empowerment

Christina Castellano
University of Missouri-St. Louis, cc82d@umsystem.edu

Recommended Citation

The Motherhood Crusade:
Rural Low-Income Mothers, Support, and Empowerment

Christina Castellano

Bachelor of Arts in Psychology, Saint Louis University 2010
Bachelor of Science in Nursing, Goldfarb School of Nursing 2014

A Dissertation Submitted to The Graduate School at the University of Missouri-St. Louis
in partial fulfillment of the requirements for the degree
Doctor of Philosophy in Nursing

May 2023

Advisory Committee:
Julie Bertram, PhD, RN
Chairperson
Anne Fish, PhD, RN, FAHA, FAAN
Roxanne Vandermause, PhD, RN
Kimberly Werner, PhD

ACKNOWLEDGEMENTS

DEDICATION

This dissertation is dedicated to my daughters, Cecelia, Madeline, Josephine, Sophia, and my husband, Paul. They have sacrificed their time with me over the last five years and provided endless love and support throughout my journey. If my girls ever become mothers, I hope for a brighter future for them and for all of the mothers that have touched my life. And to my husband, thank you.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

Abstract

Previous research has shown that postpartum women with untreated mental health conditions are more likely to fail to manage their own health, have inadequate nutrition, abuse substances, experience abuse, be less responsive to their baby's needs, have fewer positive interactions with their baby, experience difficulties breastfeeding, and question their abilities as a mother. Rural culture plays a complex role in the transition to motherhood, influencing whether mothers seek out and use resources. While more is known about location and access issues, less is known about how rural culture and, more specifically, how empowerment and social support impact postpartum experience. The frameworks of Empowerment Theory, Zauszniewski's Mid-range Theory of Resourcefulness and Quality of Life, and the Hage Framework guided the study through the concepts of support, cultural context, and empowerment. The study used a focused ethnography lens to give cultural context, and grounded theory analysis was used to understand the experiences of rural low-income mothers in Missouri. Data sources included observations of rural communities and semi-structured interviews with eighteen low-income women, the majority of whom identified as Black. Questions focused on support, wellbeing, and empowerment. From the analysis, five categories were developed: 1) "cultural context" (2) "social supports" (3) "perinatal mood" (4) "agency" and (5) "future oriented notions of contented mothering." The mothering journey included the distinct lens through which mothers perceived experiences (cultural context), aspects of support (social supports), and the volatile landscape of the perinatal mood. Mothers discussed some degree of empowerment in the context of resourcefulness (social supports and agency), and achievement (future oriented notions of contented

mothering). The new model was called Empowerment Framework for a Subculture of

Rural Low-income Missouri Mothers. Future research is suggested to a) expand the

understandings of immigrant postpartum mothers and their experiences in rural America

and b) explore the identity journey in order to build trusting relationships and

interventions post-birth.

<div align="center">**CHAPTER ONE**</div>

Introduction

       The purpose of this research study is to understand the distinct experiences of rural low-income mothers with postpartum outreach and empowerment. Women who live in rural Missouri experience the highest ratio of pregnancy associated deaths, and the ratio for those on Medicaid is more than eight times the ratio of those with private insurance (Davis et al., 2019). Implicating factors of rural postpartum outcomes that are focal to this chapter are the location of rural residence, accessing risk-appropriate care, and rural culture. While more is known about location and access issues, less is known about how rural culture, and more specifically, how empowerment and social support impact postpartum experience.

The Location of Rural Residence

       Primarily a rural state, Missouri has ten rural counties with the highest rates of maternal morbidity (Health in Rural Missouri Biennial Report, 2018-2019). Rates of maternal morbidity in rural Missouri increased between 2016 and 2017 by 10%, compared to a 2% increase in urban areas (Health in Rural Missouri Biennial Report, 2018-2019). Missouri did not meet the Healthy People 2020 target rate for maternal deaths during the years 2007 to 2017 (Health in Rural Missouri Biennial Report, 2018-2019). Rural rates for maternal deaths during the years 2007 to 2017 were three times higher than urban rates (Health in Rural Missouri Biennial Report, 2018-2019). Possible explanations for these rural and urban disparities include education, migration background and ethnicity, marital status, employment, income, challenges obtaining healthcare services, and local variations in culture.

Accessing Risk Appropriate Care

Adverse pregnancy outcomes of rural pregnant women are associated with inadequate access to prenatal care (Nethery et al., 2018). Women residing in rural counties experience challenges obtaining risk appropriate care specific to obstetrical needs (Health in Rural Missouri Biennial Report, 2018-2019). Perinatal regionalization, or risk-appropriate care, is a tool for increasing positive maternal and neonatal health outcomes that the March of Dimes proposed in 1976 (Catalano et al., 2017). Risk-appropriate care includes women and infants receiving services in a facility staffed with personnel and equipment that matches their morbidity (Catalano et al., 2017).

Access to care is further complicated by fragmented geographic availability and the growing number of hospital closures. From 2014 to 2020, 15 hospitals closed in Missouri, 10 of which are located in rural counties (Missouri Department of Health and Senior Services, 2021). Of note, between 2014 and 2018, more than one in four Missouri mothers did not begin prenatal care in the first trimester (Missouri Department of Health and Senior Services, 2021). Additionally, rates of chronic conditions such as obesity, diabetes, and hypertension continue to rise among women of childbearing age (Health in Rural Missouri Biennial Report, 2018-2019). Worse yet, many women do not have access to risk-appropriate primary care to manage their underlying health conditions that make pregnancy and childbirth ever more dangerous (Haltinner, 2021).

Lack of early initiation of care limits providers' abilities to address chronic conditions and particular risk factors related to maternal morbidity and mortality. However, the ability to obtain care is only one issue. Rural culture plays a complex role in the transition to motherhood, influencing whether mothers seek out and use resources.

While some mothers may desperately desire help, they feel unable to ask or take first steps (Cannon & Nasrallah, 2019). This phenomenon is often seen in individuals with depression, perinatal or otherwise. Individuals suffering from deep depression lack the energy to get out of bed, let alone go on a "wild goose chase" for a provider that exists two towns over, as is typical in rural counties.

Rural Culture

Rural Americans fall along a continuum of enculturation to mainstream culture. The degree to which rural community members adhere to typical rural values, traditions, and customs varies (Slama, 2004). The communtity's values, traditions, and customs are a treasured part of how people from that place think and act (Slama, 2004). Rural culture is comprised of: conservative attitudes, isolation, and low-income status (Slama, 2004).

Conservative Attitudes. Independence and self-sufficiency are survival principles when services and people exist miles away. These principles are instilled in rural community members inherently early and have produced conservative ways of approaching life. Rural community members become more careful and considered in their decisions when they depend so much on themselves (Slama, 2004).

Isolation. Rural people, by definition, live in less populous areas. Fewer services exist locally. According to Slama (2004), it is more difficult for rural people to share problems and feelings with strangers, and mental health professionals are few and untrusted.

Rural Low-income. Low income means the household income is no more than 185% of the federal poverty income guidelines. Historically, rural communities have higher rates of poverty than urban areas. For example, in 1999, one in six rural counties

had a poverty rate above 20% compared to one in five of urban counties. About 13% of

all counties had persistently high poverty rates and 95% of these counties were rural

(Dáil, 2015). These statistics highlight that poverty tends to be repetitive and cyclical;

people may move into and out of poverty throughout the course of their life (Dáil, 2015).

Additionally, the isolation between supporting institutions (schools, county offices, and

the existing labor market) plays a major role in creating and sustaining desperate

economic circumstances for the rural communities involved (Dáil, 2015).

WIC Safety Net

While rural culture fundamentally does not trust government-funded programs,

rural mothers have minimal social safety nets to fall on in hard times (Dáil, 2015). One

safety net that mothers can typically rely heavily on is Special Supplemental Nutrition

Program for Women, Infants, and Children (WIC) of Missouri. To be eligible for WIC,

mothers must have an income at or below an income level set by Missouri or be

determined income-eligible based on participation in certain programs. The household

income may be no more than 185% of the federal poverty income guidelines. In

Missouri, for a household of one (mother and unborn child), the mother is eligible if she

makes less than $23,828 (Missouri Department of Health and Senior Services, 2021). (To

give this number context, think for a moment, what you spend monthly on housing and

food and multiply it by twelve).

Needs for Peer Support

Peer support is aimed at individuals, or conducted in groups, with the goal of

fostering hope, emotional support, information exchange, companionship, reassurance,

and appraisal. In addition, peer support intends to enrich life experiences (Chien et al.,

2019; Ahmed 2015; Dennis, 2003; Dennis, 2005; Ibrahim, 2020; Mahlke et al., 2017; Oborn et al., 2019; Yeung et al., 2020). Social and peer support increases empowerment by providing the environment where agency may be increased, which may be otherwise lacking in certain communities. Furthermore, low empowerment is linked with negative economic and health outcomes (for example depression) in women (Baranov et al., 2020; Richardson, 2017). Conversely, increased empowerment and empowerment interventions decrease perinatal depression, preterm birth, low birthweight; and significant stress as well as minimize early adversity and inequalities in postpartum care, and is significantly associated with receiving antenatal care (Garcia et al., 2017; Lagendijk et al., 2020; Merrell et al., 2020).

No literature to date was found examining the relationship between support, empowerment, and rural postpartum women in the United States. Through Kabeer's (1999) framework in empowerment, this study sought to understand how rural low-income women experience the social component of resources and empowerment. Recorded observations and interviews were the qualitative data sources used to capture the mothers' perceptions of empowerment, support, and cultural ideologies that may otherwise be ill-represented in quantitative data. From the current study, healthcare and local organizations may have the necessary information to build an outreach program for rural low-income mothers to provide necessary resources throughout the change to motherhood.

Purpose

The purpose of this study is to understand (a) how rural low-income women describe their experiences with their support systems in the first two years of motherhood

and (b) how rural low-income women describe their experiences with empowerment. I have divided this dissertation into five chapters. First is an explanation of the overall design, including the specific approach and analysis, population, sampling, and sources of data. The second chapter includes a review of literature. The third chapter details the methods and analysis. The fourth chapter includes the findings. Finally, the fifth chapter is the discussion. Plausibility was obtained by accurately and wholly documenting the process used to acquire data, and the use of an analytical team aided in the rigor and trustworthiness of the analysis and results.

Research Questions

1. How do rural low-income women describe their experiences with their support systems in the first two years of motherhood?

2. How do rural low-income women describe empowerment?

Researcher Perspective

My personal experiences as mother of four daughters have largely influenced my research interests and motivations. I have a broad background in psychology, with specific training and expertise in women's health nursing and education. I spent most of my career as an educator on the Gynecology Oncology inpatient unit, then on Labor and Delivery. During this time, I birthed four daughters and experienced the necessity for both social and peer support and the role it played in the successful transition to my new role as mother.

I currently serve as a Peer Mentor and Group Facilitator for Sisters of St. Mary's MomsLine where I speak with mothers weekly to support, empathize, and hold space for childbearing women to express their needs and concerns. I also am a member and Peer

Mentor of Postpartum Support International. While similar to MomsLine, it serves women and men worldwide to promote psychological wellbeing. Furthermore, I have completed the training for Heartland and Postpartum Support International on Perinatal Mood and Anxiety Disorders. Using this foundational knowledge, I completed two qualitative pilot studies using grounded theory methods under the supervision of Dr. Julie Bertram. In the first study, I interviewed two perinatal women residing in rural counties of Missouri about their experiences with support and pregnancy. From this study, I developed an interest in understanding the intricate role culture plays in seeking out and obtaining support for mothers. In the second study, I held two focus groups and one interview with mothers from a virtual support group, Strength Through Story. From these interviews, the importance of support, in this instance peer support, became undoubtedly apparent.

Significance of the Study

A widely acknowledged indicator of the standing of women in society, the functioning of the healthcare system, and overall wellbeing of a population, is maternal mortality. The maternal mortality ratio (MMR), calculated as the number of maternal deaths per 100,000 live births, is used worldwide. In 2020, the MMR for the United States was 23.8, a ratio more than twice that of other high-income countries (Tikkanen et al., 2020). For example, the MMR was three in Norway, Netherlands, and New Zealand (Tikkanen et al., 2020). The MMR in the United States has increased by 58%, from 12 in 1990 to 19 in 2017; conversely, the global MMR has declined by 45%, decreasing from 385 in 1990 to 211 in 2017 (World Health Organization, 2019). Missouri was ranked 38th in the United States for maternal mortality in 2019 (Nickelson, 2023). Missouri's

MMR, including deaths within one year of pregnancy, was 39 from 2015 to 2017. Missouri rural communities have experienced a shortage of healthcare professionals and closures of healthcare infrastructures. Consequently, rural low-income perinatal women remain at higher risk for death related to pregnancy.

Postpartum women who use Medicaid lose healthcare coverage 60 days post birth, but the remmended amount of time for healthcare coverage is approximately 120 days (Nickelson, 2023). The loss of Medicaid coverage at day 60 postpartum leaves postpartum women without healthcare coverage for 60 days. Perinatal outreach programs are in a unique position to fill that gap by providing resources. Outreach programs can reduce health disparities through innovation, cultural competency, education, and telehealth technologies. By engaging communities in prevention efforts that build support and resiliency, patient–provider interaction, and health communication, health outcomes would likely improve (Hagiwara et al., 2019 & Howell, 2018). Significant components of the perinatal outreach programs include education, empowerment, and empathy. These same components are inherent in the nursing profession. However, due to the complexity of the rural culture and healthcare infrastructure, when a mother does interact with personnel in a healthcare setting, she can be overwhelmed both mentally and physically. Therefore, outreach and support programs must have the capacity to provide authentic, insightful, empathetic, and empowering encounters, alleviating stress placed on the healthcare system.

Perinatal outreach programs alone will not improve maternal mortality. Investments are needed to expand maternal healthcare, including a wide array of nursing roles-nurse midwives, nurse practitioners, community health nurses, and doulas. Doing so

may increase the size of maternal care, distribution, and diversity. Although midwives and nurse practitioners constitute a vital, safe, and cost-efficient solution to the shortage in maternity healthcare, hindrances to the practice endure across Missouri, such as regulation, certification, and licensing of nursing. While the above limitations exist, they will not be the focus of the proposed study.

Methods

Design

A qualitative research design with focused ethnography methods and grounded theory analysis were used for this study. Focused ethnography was a means to obtain thick description through a particular cultural lens, allowing me to uniquely capture how rural Missouri mothers lead their lives and the rituals and values that form their world (Muecke, 1994). I shaped the interview guide to include hallmarks of focused ethnography, "the ideas, beliefs, values, knowledge, social arrangements, and workings of power" (Wall, p.12, 2015).

Sample

The population for this research study included rural low-income (WIC eligible through Missouri) women who were within two years post birth and resided in rural Missouri (as defined as any county that does not have a population density over 150 persons per square mile). I employed a purposeful sampling strategy. The rural participants for this research study came from rural counties in Missouri. In addition, snowball sampling, the reliance on rural participants' referrals of friends, family, or acquaintances, was an additional approach used (Handcock & Gile, 2011). The number of rural participants used for this sampling was 18, which allowed for data saturation of

this particular cohort (Charmaz, 2006). Saturation was defined as no new information or insights were being discovered, or I was hearing the same information from each rural participant (Corbin & Strauss, 1990; Merriam & Tisdell, 2016).

Recruitment of Rural participants

The Project Director for a Health Resources and Services Administration Grant in the Bootheel Perinatal Network was instrumental in forming connections. She facilitated my collaboration with the county health department administrators that were working with the Rural Maternity and Obstetrics Management Strategies grant in Mississippi County, New Madrid County, Pemiscot County, Stoddard County, Scott County, and Dunklin County. In addition, the Director of Postpartum Support International served a vital role in forming connections. Finally, rural participants were offered a twenty-five-dollar incentive.

Focused Ethnography

To keep within the ethnographic philosophical stance, classic data collection strategies were adhered to, including observation and interviewing (Wolcott, 1999). The observations took place via physical observation of various communities from which some of the rural participants resided. These first-hand observations allowed me to paint a description of the context in which these mothers lived. In conclusion, focused ethnography was used as method, in the setting of rural low-income mothers, with the intention to a) discover cultural beliefs and practices that govern behavior and b) describe their holistic perspective of postpartum outreach and empowerment. More details about the observations and interview are described in Chapter Three.

Procedures

The procedures used for this research study included interviews via Zoom video conferencing. Interviews were scheduled for one hour and were audio recorded with the rural participants' verbal consent.

Analysis

The specialized qualitative method of grounded theory was used to analyze the data. Further in-depth description of the research design and methodology are explained in Chapter Three.

Theoretical Frame

In qualitative research, the theoretical framework is the use of theory to organize new knowledge while expressing the philosophies of the researcher (Collins & Stockton, 2018). The theoretical framework provides soundness and depth to the study (Collins & Stockton, 2018). Three functions of theory exist: theory of research model and technique (Glesne, 2011), theory construction from data collection (Jaccard & Jacoby, 2010), and theory as a guide (Anfara & Mertz, 2015). I used three theories as frameworks to steer the study. Empowerment Theory (Kabeer, 1999), Zauszniewski's Mid-Range Theory of Resourcefulness and Quality of Life (Zauszniewski, 2016), and the Hage Framework for Model Development (Hage, 1972) provided concepts relating to postpartum support, the impact of cultural context, and empowerment among rural low-income mothers, providing a lens for this research study. I was not attempting to confirm or deny these theories, but rather used them to form a baseline understanding of what a mother may endure during the postpartum period. While these frameworks provided the concepts social and peer support, it was my purpose to discern how mothers describe their

experiences with their support systems in the first two years of motherhood. These

frameworks will be further discussed in Chapter Two.

Summary

I sought to understand the experiences of rural low-income postpartum mothers

and their journey with support and empowerment. Increased empowerment and

empowerment interventions decrease perinatal depression, preterm birth, low

birthweight, and significant stress; minimize early adversity and inequalities in

postpartum care; and are significantly associated with receiving antenatal care (Garcia et

al., 2017; Lagendijk et al., 2020; Merrell et al., 2020). In addition, social support

facilitates interpersonal sharing, modeling, and encouragement. Social support increases

empowerment by providing the environment in which agency may be increased (Reyes et

al., 2021).

The next chapter examines contextual factors that frame this dissertation. First,

policies (Build Back Better Act, Medicaid Postpartum Coverage Extension, 2021

American Rescue Plan Act, Care for Her Act, MO HealthNet for Pregnant Women, and

Show-Me Healthy Babies) lay the foundation for maternal healthcare and will be

discussed in the context of perinatal health. Second, theoretical concepts (cultural

context, perinatal shift, resourcefulness, and achievement) inform the research questions

and will be explained. Chapter Three goes on to describe the qualitative design with

focused ethnography methods and grounded theory analysis that were used for this study.

Chapter Four explains the five main categories that were revealed from the analysis of the

interview data (cultural context, social supports, perinatal mood, agency, and future

oriented notions of contented mothering), and how these findings interact to inform

support and empowerment. Lastly, Chapter Five summarizes the findings of the study

briefly; discusses the research questions, methodologies, and procedures; compares the

findings to the literature review from Chapter Two; compares the initial theoretical model

to the updated model based on the findings from the study; notes study limitations; and

offers suggestions for future research, practice, and policy.

CHAPTER TWO: REVIEW OF LITERATURE

Introduction

This chapter examines contextual factors that frame this dissertation. First, policies (Build Back Better Act, Medicaid Postpartum Coverage Extension, 2021 American Rescue Plan Act, Care for Her Act, MO HealthNet for Pregnant Women, and Show-Me Healthy Babies) lay the foundation for maternal healthcare and will be discussed in the context of perinatal health. Second, theoretical concepts (cultural context, perinatal shift, resourcefulness, and achievement) inform the research questions and will be explained.

The academic literature detailing the psychological and physical challenges rural low-income postpartum women face, in the United States in particular, is scarce. In addition, postpartum outreach for rural low-income mothers and a possible link to empowerment have yet to be discovered. Due to the scarcity of academic literature, I drew on previously research studies to synthesize knowledge and seminal works (Dennis, 2002, 2003, 2005; Finfgeld-Connett, 2005; Helfer, 1987; Kabeer, 1999; Shumaker & Brownell, 1984; Zauszniewski, 1996). I relied on three frameworks for my theoretical model (see Figure 1) which provide a baseline understanding of the concepts in question-Empowerment Theory (Kabeer, 1999), Zauszniewski's Mid-range Theory of Resourcefulness and Quality of Life (Zauszniewski, 2016), and the Hage Framework for model development (1972). With the foundational knowledge of these three frameworks, I sought to explore how rural low-income mothers experience postpartum outreach and empowerment.

The chapter begins by discussing the political context of postpartum resources that contribute to the complexities of maternal mortality and maternal disempowerment. Next the chapter examines the following concepts: cultural context and its sub-concepts of: degree of rurality and level of income; perinatal shift (Hage, 1972) and its sub-concepts of: quality of mood, degree of stress, quality of sleep, extent of good nutrition, degree of physical activity, and perinatal mood and anxiety disorders; resourcefulness (Kabeer, 1999; Zauszniewski, 2016) and its sub-concepts of: extent of social support (Zauszniewski, 2016), extent of peer support (Zauszniewski, 2016), and degree of personal agency (Kabeer, 1999; Zauszniewski, 2016); all of which manifest in achievement (Kabeer, 1999) and its sub-concept: degree of empowerment.

Political Context of Postpartum Resource

Maternal health is attracting increased interest by key stakeholders in the United States; they are attempting to change the dismal and increasing rates of maternal mortality. It is important to note that none of the acts below have passed; all are stalled and in some phase of democracy. The first policy proposed is the Build Back Better Act (BBBA) (passed House 11/19/2021). If this bill passes the Senate, it will provide funding for a variety of projects, some of which include free childcare for children six and under, free preschool, and up to four weeks of paid family and medical leave per year. The BBBA also promotes the maternal health home by incentivizing states through an increase on the federal match of 15% for two years if they use maternal health homes. Finally, the BBBA authorizes approximately one billion dollars in grant funding for the Black Maternal Health Momnibus Act to stop racial and ethnic maternal health disparities while improving birth equity (Ranji et al., 2021).

The second policy is Medicaid Postpartum Coverage Extension. More than 40% of births are insured under Medicaid. Federal law mandates that states lengthen Medicaid eligibility to pregnant women with household incomes up to 138% of the federal poverty level (FPL) through 60 days post birth. In Missouri and other non-expansion states, postpartum women lose pregnancy eligibility and must re-qualify as "parents of dependent children" to continue on Medicaid. Consequently, many mothers become uninsured due to lower Medicaid income eligibility. Further complicating matters, many mothers' incomes are too low to qualify for subsidized private plans (offered only to those with incomes above the poverty level) through the Affordable Care Act Marketplace. For example, in 2019, roughly four out of ten births were Medicaid births in non-expansion states like Missouri (Ranji et al., 2021).

The third federal policy closely related to Medicaid Coverage Extension is the 2021 American Rescue Plan Act. This policy would give states the opportunity to prolong Medicaid postpartum coverage to 12 months for up to five years. The BBBA further *requires all states* to extend Medicaid postpartum coverage to 12 months. Postpartum insurance transitions happen in all states, yet more mothers become uninsured in non-expansion states, such as Missouri (Ranji et al., 2021).

Finally, if passed, the Care for Her Act (referred to the Committee on Health, Education, Labor, and Pensions on 2/25/21) would establish the Pregnancy Support Collaborative, a clearinghouse of information on pregnancy support services and education opportunities for new parents and pregnant women. This bill would also direct the Department of Health and Human Services to award grants for mentoring pregnant

women and new mothers as well as enhance the availability of maternity housing (H.R.5163 - Care for Her Act., n.d.).

At the state level in Missouri coverage under the MO HealthNet for Pregnant Women (MPW) and Show-Me Healthy Babies (SMHB) programs ends 60 days postpartum. Missouri offers increased benefits to pregnant women compared to standard adult coverage. Under the extended coverage, mothers would be eligible for increased benefits through the end of the 12-month period, which permits mothers to stay insured even if they undergo changes in income. This new option became available on April 1, 2022, and states have five years to implement. Over 24,000 women (20,970 were enrolled in MPW and 3,606 were enrolled in SMHB), as of February 2020, would be newly eligible for continuous postpartum coverage for 12 months (Missouri Department of Health and Senior Services, 2021). Additionally, 4,500 mothers have incomes too high for expansion and would lose Medicaid or Children's Health Insurance Program coverage after 60 days post-birth (Missouri Department of Health and Senior Services, 2021). Extending postpartum coverage for both MPW and SMHB would fill this gap and provides all mothers with insurance post-birth. Postpartum health insurance can markedly decrease costs due to complications from untreated diabetes, perinatal mood and anxiety disorders, and cardiomyopathy. Extending postpartum coverage would likely decrease maternal mortality. Missouri's maternal mortality rates are double the national average, placing the state 38th in the United States (Nickelson, 2023). More than half of pregnancy-related deaths occur after 43 days postpartum, and most pregnancy-related mortality is considered preventable (up to 80%) (Missouri Department of Health and Senior Services, 2021; The Missouri Pregnancy-Associated Mortality Review, 2018).

Several bills were filed in 2022 to extend postpartum health care coverage for mothers on Medicaid to 12 months post-birth. Missouri is 1 of 13 states that has not made this policy change. A broad, diverse coalition of partners from across the state mobilized in support including Generate Health, Kids Win Missouri, Missouri Right to Life, Pro-Choice Missouri, and several health care industry associations. Missouri did pass, however, the Cora Faith Walker Doula Training Program and a prison nursery program. The bill would direct the Missouri Department of Corrections to establish a nursery within a women's prison by July 2025 (Generate Health, 2022). In order to reduce maternal mortality in Missouri, increasing access to postpartum health care is necessary. Postpartum care is an ongoing process that lasts up to two years and includes numerous follow-ups. Mothers who experienced pregnancy-related complications, chronic conditions, or perinatal mood and anxiety disorders are particularly vulnerable during this period.

Cultural Context

Degree of Rurality

The United States Census Bureau and various federal agencies use different definitions of rural. Each definition uses different criteria such as: population density, commuting patterns, population size, and focus on different geographical units. I used the same rural and urban definition as recent editions of Health in Rural Missouri. The degree of rurality is described as less than 150 people per square mile, and it does not contain any part of a central city in a Metropolitan Statistical Area (Health in Rural Missouri Biennial Report, 2018-2019).

Women residing in rural counties experience challenges obtaining risk-appropriate care specific to obstetrical needs (Health in Rural Missouri Biennial Report, 2018-2019). Access to care is further complicated by fragmented geographic availability and the growing number of hospital closures. Between 2014 and 2018, more than one in four Missouri mothers did not begin prenatal care in the first trimester (Missouri Department of Health and Senior Services, 2021). Rates of chronic conditions such as obesity, diabetes, and hypertension continue to rise among women of childbearing age (Health in Rural Missouri Biennial Report, 2018-2019). Adverse pregnancy outcomes among rural pregnant women are associated with inadequate access to prenatal care (Nethery et al., 2018).

Lack of early initiation of care limits the providers' and nurses' ability to address chronic conditions, education, and particular risk factors related to maternal morbidity and mortality including stress, perinatal mood, and anxiety disorders. Difficulties in accessing healthcare services, cultural practices, sociodemographic and life-style factors, and varying hazardous levels of environmental, occupational, and transportation conditions all influence pregnancy outcomes (Ginja et al., 2020). Social support and socioeconomic status are particularly focal because they are associated with many other important social factors (Ginja et al., 2020).

Level of Income

The level of income, the second element of cultural context, is consistent with the WIC definition. To be eligible for WIC, applicants must have income at or below an income level or standard set by Missouri or be determined automatically income-eligible based on participation in certain programs. The household income may be no more than

185% of the federal poverty income guidelines. In Missouri, for a household of one, the mother is eligible if she makes less than $23,828/ year (Missouri Department of Health and Senior Services, 2021).

Low-income mothers face greater overall life event stress (Hsu & Wickrama, 2018). Furthermore, younger primiparous postpartum mothers who had lower family incomes reported overall greater life stress at six months (Hsu & Wickrama, 2018). Those mothers exposed to more life stress at six months postpartum were more likely to experience poorer health and faster health decline over time, highlighting the relationship of stress exposure and stress increase to maternal health postpartum (Hsu & Wickrama, 2018). Adynski et al. (2018) noted that interpersonal violence, food security, poverty level, and origin of birth are significant predictors of elevated psychological distress, with interpersonal violence being the strongest predictor. According to Alhusen et al., (2015), between 3% and 9% of women in the general population experience abuse during pregnancy, and this rate is much higher (50%) when considering low-income women. Low-income mothers also have higher rates of depression and very few receive care (DeCou & Vidair, 2017).

A significant relationship exists between mothers' socioeconomic status (health insurance or income) and postpartum health care use (Wouk et al., 2021). Mothers with private insurance were significantly more likely to attend postpartum visits versus those mothers who were publicly insured or uninsured (Wouk et al., 2021). Certain barriers to treatment include transportation, childcare, cost, stigma, and distrust (DeCou & Vidair, 2017). Additionally, many mothers identify as self-sufficient, which deters their

intentions to receive care, as asking for help is inconsistent with their self-image (DeCou & Vidair, 2017).

Perinatal shift

In order to explain the perinatal shift that occurs during the transition to motherhood, I employed the Hage Framework (see Table 1), which provides a process for theory creation. Theory construction is necessary to clarify concepts prior to theory testing. Hage's Framework includes a comprehensive review of literature, which allows for the identification of what is known and not known. It is a method used to challenge thinking and stretch the mind. Hage (1972) provides tasks of theory construction that involve experimenting with thoughts to create theory. The five tasks of theory construction are narrowing and naming the concepts, specifying the definitions, creating the theoretical statements, specifying the linkages, and ordering the elements in preparation for model building (Hage, 1972).

Hage (1972) advises to first narrow and name each concept beginning with the most central. Such terms as extent, degree, number, severity, and frequency should be in the concept name, allowing for easier clarification and description. Next concepts are defined. Hage (1972) proposes two types of definitions, theoretical and operational. Creating theoretical statements, or propositions, is the third step. Theoretical statements connect two or more concepts, which is necessary to explain or predict a phenomenon. These statements allow the concepts to be tested and are connected in a continuous or categorical manner. The next step is to develop linkages that supply evidence for the statements and specify justification for joining concepts.

Two types of linkages exist according to Hage (1972), theoretical and operational. The theoretical linkage is used to conclude whether the statement is likely and provides evidence for why the concepts in the theoretical statement connect together. The operational linkage states how the concepts in a theoretical statement link together. This process is laborious and likely to yield reformulations in the ranking of concepts, produce new ideas, and expose inaccuracies. Finally, all conceptual work up to this point must be examined to achieve consistency and is a vital step in theory creation (Hage, 1972).

Degree of Stress and Quality of Mood

The framework used to guide this research (see Figure 1) demonstrates the mitigating effect of the extent of social and peer support on the degree of stress and quality of mood (Razurel et al., 2017). For many, the perinatal shift is complex and difficult to navigate (Mollard et al., 2016). The degree of stress that accompanies the transition impacts the postpartum woman's quality of mood (Hillerer, 2012; Razurel et al., 2017). The higher the stress, the greater the depressive symptoms and anxiety; stress is associated with low parental self-efficacy, which accentuates psychological pathologies (Hillerer, 2012; Razurel et al., 2017). Chronic perinatal stress affects the basal elevation in glucocorticoids and attenuates stress responsivity (Hillerer, 2012). However, support acts as a buffer (or a watering can) that produces a protection that regulates the relationship of stress and mental health (Razurel et al., 2017).

Extent of Support

The extent of support positively effects quality of mood. Support helps to decrease low mood and anxiety by conquering feelings of isolation, disempowerment, and stress (McLeish & Redshaw, 2017). Support improves feelings of self-esteem, self-

22

efficacy, and parenting proficiency (McLeish & Redshaw, 2017). The framework displays the buffering role of support, which indicates support would be a rational and convincing intervention for rural low-income postpartum women. It is important to note, the perinatal shift component of the framework uses social support in terms of the amount of advocative interpersonal exchanges between two individuals perceived to enhance the wellbeing of the recipient (Finfgeld-Connett, 2005; Shumaker & Brownell, 1984). This definition includes peer support. While the framework does not explicitly differentiate between social support and peer support, it is thought that a qualitative design would offer insights on how to define support best for this population of mothers.

Quality of Sleep, Extent of Good Nutrition, Degree of Physical Activity

The quality of sleep is positively related to the quality of mood. Mild sleep disturbances throughout the perinatal period are common. However, perinatal women who report poor sleep quality have the greatest risk of experiencing symptoms of low mood (Tomfohr, 2015). The extent of good nutrition is positively related to quality of mood. Maternal nutrient intake is important to the mother's mental state, as well as to the developing baby. Nutrient needs increase to meet the demands of pregnancy, placental and fetal development, and preparation for the postpartum period, making perinatal women vulnerable to the effects of poor diet. The combination of inadequate nutrient intake and increased nutrient demands increase the perinatal women's predisposition to a poor mental state (Leung et al., 2016). Finally, the degree of physical activity is positively related to the quality of mood. Physical activity during the perinatal period is associated with improved mood (Davis & Dimidjian, 2012). Physical activity supports

better health outcomes and provides physical and mental health benefits for postpartum women (Guardino et al., 2018).

Perinatal Mood and Anxiety Disorders

Another challenging component associated with the perinatal period includes perinatal mood and anxiety disorders, the term used to describe mental health disorders that affect women during pregnancy and postpartum. Perinatal includes the time one year before to two years after the birth of baby (Helfer, 1987). Perinatal mood and anxiety disorders are more prevalent in rural women compared to the general population (Ginja et al., 2020). Other negative outcomes, such as small-for-gestational-age and low birthweight infants, increase the risk of perinatal mood and anxiety disorders among rural perinatal women (Ginja et al., 2020). Perinatal women who do not have a diagnosed mood or anxiety disorder can experience sub-threshold symptoms as they adjust to the maternal role (McLeish & Redshaw, 2017). In addition, mothers are plagued with low self-esteem and feelings of inadequacy when confronting discrepancies between the socially conditioned expectations of motherhood and the challenging reality (McLeish & Redshaw, 2017). The combination of stress and negative emotions adversely affect the transitioning mother and the developing baby (Ginja et al., 2020). One avenue to navigate the changing perinatal landscape is through increased resourcefulness.

<div align="center">

Resourcefulness

</div>

Zauszniewski's Mid-Range Theory of Resourcefulness and Quality of Life states that resourcefulness and lack of depressive symptoms are influenced by perceived stress and social support, or process regulators (Zauszniewski, 2016). According to this theory, the skills constituting resourcefulness should center on helping oneself or the use of

resources to achieve health. It includes two types of resourcefulness: personal (self-help

or personal agency) and social (help-seeking or the extent of social and peer support, in

Figure 1). In my theoretical model, resourcefulness encompasses the ability to use

resources (see Table 2), including the extent of social support, extent of peer support, and

level of personal agency. Persons with increased resourcefulness are more equipped to

cope with trying circumstances. They tend to be more adaptive, constructive, have better

quality of life, and overall increased life satisfaction (Zauszniewski, 2016).

Extent of Social Support

The extent of social support is defined as the amount of advocative interpersonal

exchanges between two individuals perceived to enhance the wellbeing of the recipient

(Finfgeld-Connett, 2005; Shumaker & Brownell, 1984). Social support increases

empowerment by providing the environment in which agency may be increased. In a

qualitative research study, it was found that the intimate partner and mother's relatives

were major sources of support during pregnancy, and most women expressed a desire to

obtain social support from family and friends (Reyes et al., 2021).

Extent of Peer Support

The extent of peer support is defined as guidance from people who have like

experiences who are not rooted in the person's network (Dennis, 2003). The emphasis is

that peers are considered equals (Dennis, 2003). Peers possess experiential knowledge of

the targeted behavior (postpartum depression) and similar qualities (age, socioeconomic

status, ethnicity, residency) in order to help a person during a time of actual or potential

stress (Dennis, 2002). They have the unique opportunity to provide experience-based

informational, emotional, and practical support beyond the scope of health professionals

and their own embedded network (Dennis, 2003). Peer support persons have training in

nondirective counseling and promotion of person-centered recovery through

connectedness over shared experiences. Peer support is aimed at individuals or conducted

in groups with the goal of fostering hope, emotional support, information exchange,

companionship, reassurance, and appraisal. In addition, peer support intends to enrich life

experiences (Ahmed 2015; Chien et al., 2019; Dennis, 2003; Dennis, 2005; Ibrahim,

2020; Mahlke et al., 2017; Oborn et al., 2019; Yeung et al., 2020). Typically, peers

provide support by visiting, telephoning, attending group, or connecting online through

an internet forum. These interactions allow them to better relate and offer authentic

empathy and validation (McLeish & Redshaw, 2015). Interpersonal sharing, modeling,

and encouragement effectively combat hopelessness and negative behaviors (Chien et al.,

2019). When used, peer support provides a nonjudgmental and empathetic environment

to a mother who often experiences stigma from the wider community (Chien et al., 2019).

Three studies, in particular, report data surrounding peer support (see Table 3).

Consistent themes (see Table 4) from mothers emerged, including friend or a professional

friend, relationships of trust, avoiding dependency, and boundaries (Eapen, Wambach &

Domian, 2019; McLeish & Redshaw, 2015, 2017).

Degree of Personal Agency

The last component of resourcefulness, personal agency, is defining and acting

upon goals (Kabeer, 1999). Agency includes the meaning, motivation, and purpose

behind the activity or "the power within" (Kabeer, 1999). The degree of personal agency

is a component of resourcefulness that the postpartum woman experiences on her journey

to empowerment. Those who are high in both personal agency and social resourcefulness

have less anxiety and depression than those who are high on social or personal agency

resourcefulness alone (Zauszniewski, 2016). The cognitive and behavioral skills of

resourcefulness are balancing and proportionately important for achieving, sustaining, or

reclaiming health despite hostile situations (Zauszniewski, 2016).

<div align="center">

Achievement

</div>

Achievement, the goal of Kabeer's (1999) theoretical framework of

empowerment, is the possibility of living desired lives or accomplishing ways of "being

and doing" (Kabeer, 1999). Empowerment is a dynamic process that happens over time.

Empowerment is complicated by household, family, and gender dynamics (Kabeer, 1999;

Malhotra & Schuler, 2005; Mosedale, 2005).

Degree of Empowerment

The degree of empowerment, as described in Empowerment Theory, is the

process of improving one's ability to make intentional life choices. It is an intrinsic part

of human rights (Kabeer, 1999). Low empowerment is linked with negative economic

and health outcomes (for example depression) in women (Baranov et al., 2020;

Richardson, 2017). Conversely, increased empowerment and empowerment interventions

decrease perinatal depression, preterm birth, low birthweight and, significant stress;

minimizes early adversity and inequalities in postpartum care; and is significantly

associated with receiving antenatal care (Garcia et al., 2017; Lagendijk et al., 2020;

Merrell et al., 2020). Because of the unique and complex dynamics mothers face in

adding another life to their family unit, it is important to capture their subjective

experiences.

Summary

Women living in rural communities experience high rates of health disparities and poor pregnancy outcomes. The United States Preventative Services Task Force guidelines recommend necessary care and follow-up for women during pregnancy (Evans & Bullock, 2017). By effectively intervening in the rural low-income mother's journey, one can increase the chances for successful maternal and child outcomes. One intervention includes exploring outreach for rural low-income mothers. Rural mothers can be involved and empowered in changing their internal and external landscape.

Chapter Three describes the qualitative design with focused ethnography methods and grounded theory analysis that were used for this study. The grounded theory analysis process with assignment of meaning, codes, and categories is explained. Focused ethnography, characterized by a written account on how a selected group of people live, focuses on the shared behaviors and experiences of the rural participants, and the assumption that the rural participants share a similar cultural perspective (Wall, 2015). This ethnographic component will be thoroughly explicated in the next chapter and will lay the foundation for presentation of findings and discussion of results.

CHAPTER THREE: METHODOLOGY

Chapter Three describes the methodogies and methods that were used for this study. The academic literature detailing the physical and psychological challenges rural low-income postpartum women face, in the United States in particular, was scarce. In addition, postpartum outreach for rural low-income mothers, and a possible link to empowerment, have yet to be discovered. Due to the strong cultural influence of rural Missouri, the specialized methods of using a focused ethnography approach in combination with grounded theory analysis, were selected as the best methodologies to answer the research questions.

I intend to understand the experiences of rural low-income mothers with postpartum support and empowerment. This chapter explains the overall research design including the specific approach and analysis, population, sampling, and rural participants. I ensured plausibility by accurately and wholly documenting the process used to gather the data. Additionally, the use of an analytical team aided in rigor and trustworthiness. This study sought to answer:

1. How do rural low-income women describe their experiences with their support systems in the first two years of motherhood?

2. How do rural low-income women describe empowerment?

Research Approach

A qualitative design with focused ethnography methods and grounded theory analysis were used for this study. Qualitative research is a method that uses rich, detailed information from rural participants in efforts to understand how they interpret their experiences, build their worlds, and attach meaning to their experiences (Merriam &

Tisdell, 2016). Qualitative research is a process in which the data, concepts, and evidence are interrelated (Aspers & Corte, 2019). The data collected is systematically evaluated to assign meaning, codes, and categories (Corbin & Strauss, 1990; Corbin & Strauss, 2015).

Focused ethnography, provides thick description through a cultural lens allowing the researcher to uniquely capture how rural Missouri mothers make sense of their world. Broadly, ethnography is the science and art of explaining a population or culture (Fetterman, 1998). It is characterized by a written account on how a selected group of people lead their lives with each other in their environment, and the beliefs and customs that form their world (Muecke, 1994). Focused ethnography is based on the notion that cultures and subcultures are everywhere and may be somewhat boundless (Mayan, 2009). Focused ethnography usually includes a well-defined problem in a specific context and is conducted within a subcultural group that differs completely from that of the researcher (Wall, 2015). The researcher focuses on the shared behaviors and experiences of rural participants and the assumption that the rural participants share a similar cultural perspective (Wall, 2015).

In the study of rural low-income mothers, I shaped the research interview guide to capture the ideas, beliefs, values, knowledge, social arrangements, and workings of power (Wall, 2015). In addition, the design included the cultural impact of rurality on mothering. In conclusion, I intended to use focused ethnography, in the setting of rural low-income mothers, to describe the holistic perspective of postpartum mothers with support, and empowerment, as well as to discover cultural beliefs and practices that govern behavior.

Population

The population for this research study included rural low-income (WIC eligible through Missouri) women who were within two years post-birth and resided in rural Missouri. As noted earlier, this research study used the same rural definition as recent editions of Health in Rural Missouri. A county was considered rural if there were less than 150 people per square mile and did not contain any part of a central city in a Metropolitan Statistical Area (Health in Rural Missouri Biennial Report, 2018). Rural low-income postpartum women in Missouri are an understudied vulnerable population with escalating risk factors and unmet needs (Health in Rural Missouri Biennial Report, 2018). It was the purpose of this study to capture their experiences of postpartum support and empowerment.

Sampling

For this research study, I used a purposeful sampling strategy. Purposeful sampling is rooted in the idea that the researcher chooses a sample from which she can discover, understand, and gain insight (Merriam & Tisdell, 2016). In addition, snowball sampling, the reliance on rural participants referrals of friends, family, or acquaintances to take part in the research, was used to obtain participants (Handcock & Gile, 2011). The number of rural participants used for this sample was 18, which allowed for data saturation of this particular cohort (Charmaz, 2006). Saturation was defined as no new information or insights being discovered, or I hear the same information from each rural participant (Corbin & Strauss, 1990; Merriam & Tisdell, 2016).

Rural Participants

The rural participants were recruited from a variety of WIC clinics, Postpartum Support International, and word of mouth. Rural participants were selected if they met the inclusion criteria: 18 years of age or greater, up to two years post birth, resided in rural Missouri, and low-income. The rural participants exclusion criteria were still pregnant, unable to consent, and non-English speaking. Recruitment of rural participants relied on the assistance of the healthcare staff at the WIC clinics, networking with Postpartum Support International, and flyers. I spoke with staff and volunteers by phone or Zoom video conferencing to explain the purpose of the research study and addressed any questions. IRB approval was obtained by the University of Missouri- St. Louis (UMSL).

Instruments and Sources of Data

Data were collected over a four-month time period and came from obsersations and interviews. Field observations were made to describe the towns where some of the rural participants resided. Structured observation tools and field jottings were used to capture data about the communities (see Appendix B). Field notes were fleshed out as soon as possible after the excursions and contained the components of focused ethnography. Such components included the date, location, time spent in the community, concrete sensory details of the scene, conversations, description of the people and structures, and reflection (Emerson et al., 2011).

In regard to the interview, an interview guide was created to unveil the distinct experiences of the rural participants (see Appendix A). The wording of questions was critical in obtaining the type of data desired while promoting trust and an atmosphere of

disclosure. It was necessary to ask questions using words and phrases that were understood by the rural participants (Merriam & Tisdell, 2016). Patton (2015) suggests six types of questions:

1. *Demographic questions:* Asks about information that is demographic in nature.

2. *Knowledge question:* Draws out knowledge about a circumstance or experience.

3. *Opinion and values questions:* Prompts a person's beliefs or attitudes.

4. *Feeling questions:* Elicits affective dimensions and feelings of human life.

5. *Experience and behavior questions:* Asks what a person does or did, their actions, manners, and activities.

6. *Sensory questions:* Asks about more information about what was seen, heard, or touched.

The interview guide included questions specific to rural experience, culture, support, and empowerment. These questions included six types of questions suggested by Patton (2015). Additional sources of data were memos, field notes, and direct field observation. It was important to note the differences between memos and field notes. Memos were written down after interviews take place, are lengthier than field notes, and include more in-depth in thinking. Additionally, during each interview, I took notes capturing initial thoughts and feelings known as field notes. These field notes contained information I felt it important to remember when analyzing the data (Corbin & Strauss, 2016).

Procedures

The field observations took place prior to the interviews to give context to the communities where the mothers lived. The observations informed the interviews, much like theory informed the concepts. The observations included a big-net approach (Fetterman, 2020). I mixed and mingled with everyone I could within the given community. As I visited more communities, I attempted to narrow to the specific portion of the population under study. This approach ensured a wide-angle view of events before the microscopic study of specific interactions began, which followed suit with the informal nature most ethnographers take (Fetterman, 2020). In addition, I employed judgmental sampling where I relied on my judgement to select the most appropriate members of the culture with whom to speak (Fetterman, 2020). Natural opportunities, luck, and convenience all played into this type of method (Fetterman, 2020). Due to the lack of time and nature of the study, I did not have the recommended six months to one year to immerse myself in rural culture (Fetterman, 2020). I therefore needed to be astute and complete in my data collection across communities. The goal of fieldwork in ethnography is to capture the panoramic view of the community, close in on the microscopic focus on details, and pan back out to the larger community, capturing the new insights with minute details (Fetterman, 2020). This process repeated itself throughout the fieldwork process to portray the cultural landscape (Fetterman, 2020).

After the field observations, I conducted interviews via Zoom video conferencing. Interviews ranged from 30 minutes to two hours and were audio recorded (Zoom video conference) as specified in the rural participants' verbal consent. All rural participants were provided with an opportunity to decline the audio recording, although no rural

participants did. Completion of the interview, regardless of the method, took place when the rural participants either chose to stop the interview, or I was satisfied with the data collected. Electronic data collected were kept confidential and password protected on my personal computer. Hardcopies of data such as notes, memos, and transcripts are confidential and protected in a locked file cabinet.

At the start of the interview, I reviewed the consent form with the rural participants and received verbal consent prior to beginning. (Per IRB protocol, this study classified as "Exempt" which meant minimal or no risk to subjects. Therefore, verbal consent was sufficient.) I announced to the rural participants that I will begin the audio recording and asked if they had any last-minute questions. I assigned a pseudonym that was used as one measure for the purpose of protecting the rural participants' identities. I then asked questions from the semi-structured interview guide. The intention of the interview guide was to drive data collection. After the audio recordings were transcribed, they were destroyed to protect the participants' identities. Finally, no women disclosed that they were thinking about harming themselves or others. However, if they did, I would have connected them to the necessary resources as stated on the interview guide (see Appendix A). In conclusion of the interview, the rural participants were sent a twenty-five-dollar gift card.

Data Analysis

Grounded theory involved a systematic method, yet flexible engagement with the data that led to a better understanding of the social processes studied (Aspers & Corte, 2019; Corbin & Strauss, 1990). This method sought to identify specific linkages between conditions, actions, and consequences, and aimed to yield change through process

(Corbin & Strauss, 1990). The rigorous process of detailed coding generated a set of interconnected concepts that can be used to create a substantive theory or lead to the development of well described categories (Aspers & Corte, 2019; Corbin & Strauss, 1990).

Grounded theory is unique in that the concepts are derived from the data collected, rather than prior to conducting the research. Data analysis and collection are interrelated and ongoing throughout the research process (Corbin & Strauss, 2015). Because analysis of the data begins immediately following the first interview, I was able to refine the interview questions more succinctly.

The initial step, open coding, included the analysis of preliminary data for patterns, similarities, and differences within and across data sets for concept and pattern development. Open coding was an explanatory process where the data is broken down systematically (Corbin & Strauss, 1990). During this process, words or short phrases were designated to various parts of the data for easy retrieval (Merriam & Tisdell, 2016; Tie et al., 2019). I reviewed the transcript line by line, grouped, and labeled important words with as many codes as possible (Corbin & Strauss, 1990; Tie et al., 2019). To ensure all meanings of the coded data had been explored, an analytical team was used. An analytical team aided in the rigor of the method by reviewing the coded data, catching any inadvertently placed data, and interpreting the data independently (Corbin & Strauss, 1990). Finally, analytic memos were used to document the process of coding and initial concept development.

The second step of grounded theory analysis included intermediate or axial coding. Axial coding examined how categories were related to their subcategories, which

36

were then tested against the data (Corbin & Strauss, 1990). The codes were grouped together to form preliminary concepts, which were then converted into more abstract concepts, forming categories. The naming of categories, subcategories, properties, and dimensions differentiated concepts according to importance. Properties were characteristics of categories and/or subcategories. Dimensions were ways that the data was discerned along a continuum (Merriam & Tisdell, 2016). Constant comparison of the data continued. It was important to note, the naming of categories was preliminary until the data had been scrutinized and analyzed by both the researcher and the analytical team. While the concepts were placed into categories, not all concepts became categories. During this step of the process, I used previous experiences to interact with the data (Corbin & Strauss, 1990; Merriam & Tisdell, 2016; Tie et al., 2019). Next, the categories were defined. Descriptive terminology provided rich detail of the connections between categories. Once again, the data was compared against the categories to add further clarification (Corbin & Strauss, 1990; Tie et al., 2019). The results of the analysis were organized into a codebook that was used to build the report of findings (see Appendix E).

Advanced coding or selective coding was the final step and included the way all categories were united around a core category. Additionally, incomplete categories were finalized by adding further explanation (Corbin & Strauss, 1990). The core category signified the central phenomenon in answer to the primary focus of the research (Corbin & Strauss, 1990).

Quality Standards

I sought to maintain certain quality standards. I moderated inherent bias through transparency and an audit trail of the data collection, methods used, and the analytic

process. It included journaling the thoughts, impressions, and challenges that arose during the study. Through this detailed account of storied information, an outsider can review and evaluate the processes and data independently. An audit trail increased both objectivity, reliability, and trustworthiness of the report that was generated (Merriam, 2002; Miles et. al., 2014).

Reliability, the second quality standard, meant consistently and judiciously employing unchanging data collection methods over time and across methods (Miles et al., 2014). Consistency was ensured in this qualitative study by maintaining that the research questions were clear, and the methods of data collection logically followed (Miles et al., 2014). Reliability was also achieved through reflexivity as discussed in Chapter One (Merriam, 2002).

Internal validity means an accurate and representative analysis of what happened during data collection (Merriam, 2002). The first way of establishing internal validity was through rural participants checks. During interviews, I clarified and reflected my understanding of rural participants' answers by repeating back to them my understanding of what they said. I did not use traditional time-intensive and laborious member checks in sharing transcripts or categories, as I had already taken participants' time and attention. I also did not want mothers revisiting past painful emotions, adding further burden. The second means to establish internal validity is through peer review. Peer review involved asking an expert to review the research to ensure it is reasonable (Merriam, 2002). Peer review was used via a multi-disciplinary team prior to data collection. The dissertation feedback and suggestions were given to strengthen the study. Next, it went through the Institutional Review Board. Third, weekly meetings with colleagues provided review of

the analytic process. Finally, the cumulation of the study was submitted to the dissertation committee, a multi-disciplinary doctoral prepared faculty, through which the entire process was subjected to review. The final way to ensure internal validity was through triangulation. Triangulation consists of theoretical frameworks, data sources, types, and collection and analysis methods (Merriam, 2002; Miles et al., 2014). For example, the previous literature, field observations, and interviews were triangulated in the analytical portion of the manuscript. By using multiple data sets to answer the research question, internal validity was ensured.

External validity was the degree to which a study's results can be generalized from a sample to a population or transferability in qualitative research. Transferability was the ability of the research results to be generalized (transferred) to another context. Rich and thick descriptions of the study's details allowed for comparison between other populations, settings, and theories. However, the onus is on the reader as to whether the findings can be applied or transferred to his or her setting (Merriam, 2009). Lastly, application was the extent to which the knowledge obtained was usable or meaningful (Miles et al., 2014). The information generated from this study led to recommendations for future practice and research.

Limitations

Several issues exist that result in poor analysis. The first of these is a failure to analyze the data at all (Braun & Clarke, 2006). The extracts in grounded theory analysis are illustrative of the analytic points the researcher makes about the data and should be used to support an analysis that goes beyond their specific content to make sense of the data. The second pitfall is using the data questions as the categories. In such a case, no

39

analytic work is done to identify categories across the entire data set or make sense of the patterning of responses. The third is a weak or unconvincing analysis, where the categories do not appear to work, where there is too much overlap between categories, or where the categories are not internally coherent and consistent. Finally, the interview guide serves as a tool for collecting complete data. When the interview guide fails to ask exhaustive questions, data can be lacking to form complete categories.

To avoid these pitfalls, I first assessed my own biases and assumptions regarding the data through journaling and conversing with my analytic team. Through initial coding, I set my expectations aside and analyzed the data as written. Second, once the data were analyzed, I asked my analytic team to analyze the categories derived from the text. Third, I provided examples in the findings section of this paper, which allowed the reader to derive his or her own thematic analysis. While I took measures to limit my personal biases tainting the study, it would be remiss not to acknowledge that bias can influence the study due to the researcher's selection of the rural participants, as well as my decisions about what information was included. Finally, the study can be too thick to be accessible for policy makers and practitioners (Merriam & Tisdell, 2016). I attempted to make my thinking process linear and easy to follow, in addition to offering insights and suggestions.

Summary

The impact of empowerment across cultures is well-documented. However, the body of knowledge was limited as it pertains to the experiences of social support and empowerment in rural low-income postpartum women. In this chapter, the methodology to explore postpartum outreach in the context of rural low-income mothers was

described. Discovering how cultural context, social supports, and the perinatal shift

intersect with empowerment were the emphases of this study.

CHAPTER FOUR: FINDINGS

Introduction

Agency and social supports are low-cost, low-barrier tools to empower mothers to navigate perinatal moods in attempts to achieve the future oriented notions of contented mothering. The research questions were:

1. How do rural low-income women describe their experiences with their support systems in the first two years of motherhood?

2. How do rural low-income women describe their experiences with empowerment?

I used a focused ethnography lens to provide insight and depth to the complex rural culture. I then employed grounded theory analysis to understand the mothers' distinct experiences. The analysis revealed that the mothering journey is a complex transition that includes: perceived experiences (cultural context), aspects of support (social supports), and the labile perinatal mood. Mothers discussed some degree of empowerment in the context of resourcefulness (social supports and agency), and achievement (future oriented notions of contented mothering).

The study used a focused ethnography lens to give cultural context and grounded theory analysis to understand the experiences of rural low-income mothers in Missouri. Data sources included observations of rural communities and semi-structured interviews with eighteen low-income women, the majority of whom identified as Black. Questions focused on the concepts: support, wellbeing, and empowerment. Additionally, demographic data were collected and presented, followed by comprehensive descriptions of the observations of rural communities interwoven with the exhaustive accounts of the analytic categories.

Demographic Data

Demographic data was collected during the interviews. A total of 11 demographic questions were asked to gather information on age, self-identified gender, county of residence, birthplace, race, language spoken, highest level of education, relationship status, number of children and ages, and number of times pregnant. The rural postpartum (up to two years post-bith) participants' ages ranged from 22 to 40 years old. All 18 rural participants identified as female. Rural participants resided in rural communities of southern Missouri (n=8), western Missouri (n=8), and northern Missouri (n=2). The rural participants stated their race as Black (n=16) and White (n=2). The majority of rural participants declared English as a first language (n=17) with one stating South African (n=1). Nearly half (n=8) of the rural participants immigrated from other countries (Africa n=6, Southern Asia n=1, Caribbean n=1). Seven rural participants were employed full-time, four employed part-time, and seven unemployed. Their education level varied from high school to some degree of college: bachelor's degree (n=7), some college (n=10), or high school graduate (n=1). Relationship status included single (n=2), domestic relationship (n=2), married (n=12), or separated (n=2). All rural participants had living children ranging in ages from one month to 17 years. The number of children living in the home varied from one to four.

Categories

From the analysis, five categories were developed: (1) "cultural context" (2) "social supports" (3) "perinatal mood" (4) "agency" and (5) "future oriented notions of contented mothering." Rurality, ethnicity, and ethos comprise the cultural context that provide the experience of resourcefulness (agency and social supports). Agency and

social supports are low-cost, low-barrier tools to empower mothers navigate perinatal moods in attempts to achieve the future oriented notions of contented mothering.

Category 1: Cultural Context

Cultural context included the remoteness and geographical influence (rurality), places of origin and influential family heritage (ethnicity), and values and Black womanhood identity expression (ethos). Cultural context laid the foundation for agency and the experience of social support. Table 5 outlines Category 1.

Table 5
Category 1: Cultural Context

Subcategories	Properties	Dimensions
Rurality	Remoteness	Low to high degree of remoteness
	Geographical influence	Low to high degree of geographical influence
Ethnicity	Place of origin	Degree of proximity to current residence
	Influential family heritage	Low to high degree of influential family heritage
Ethos	Values	Individualism to collectivism
	Black womanhood identity expression	Low to high degree of identity expression

Subcategory: Rurality

Mothers lived in three regions of Missouri (South, West and North) and found their way to these parts because of immigration or familial ties. The geography of southern and western regions is mountainous due to the Ozark Plateau, while the southeastern part of the state (bootheel) is low and flat because it is part of the Mississippi River's embayment. Northern Missouri has low rolling hills, while there are many river bluffs along the major rivers of the state, the Mississippi, Missouri, and

Meramec Rivers. Natural resources in these regions include rich flora and fauna, lead

production (the state leads all other United States in lead production), fire clay, lime,

montmorillonite, Tripoli production, crushed stone, cement, zinc, common clay,

industrial sand, gravel, copper, dimension stone, gemstones, and silver, along with small

amounts of oil and gas (Missouri Department of Natural Resources, 2001). Missouri

produces livestock, poultry, forest products, and crops. Among crop production, Missouri

ranks in the top ten nationwide for soybeans, corn, cotton, and rice. According to dollar

value, soybeans are Missouri's number one crop (Missouri Department of Agriculture,

2023). The narrative description below was the result of focused ethnography methods

that comprised an acknowledgement of interpretation of the significance and purpose of

human behavior (Atkinson & Hammersley, 1998). This snapshot of data was meant to

give perspective to the geography where rural mothers live.

      Brown flatness. The experience began by traveling south on highway 55. I left

the rolling green tree-filled landscape of St. Louis and entered flat, brown topography.

For 190 miles, my eyes scanned for Missouri's money-making crops (soybeans, corn,

cotton, and rice) along the main highway that connected the bootheel to central Missouri,

seeking some sort of life. Finally, upon nearing the town of Steele in Pemiscot County, I

saw two newer communities each with 10 to 15 houses, to the left of the highway. The

houses looked out of place and towered above the brown flatness of the surrounding land.

I exited the highway and came upon a McDonalds, Deerfield Inn, Deerfield Chicken, and

a Shell. Continuing down the two-lane road, I was greeted with two big well-cared for

two story homes. Fields of white cotton plants erupted across the street,

200 Miles from Home. Leaving the first sign of life in 200 miles along with the vibrance and hope it elicited in me, I continued to the Dollar General. Now the homes were single-story and close together. After a mile of noting the old appliances, cars, and furniture that littered lawns, a stark difference between the two homes that greeted us, we came to vacant and boarded up buildings. With cotton as the main income for Pemiscot, I felt as though the 21st century had forgotten about this much needed county and its people.

"Not much here." Bee acknowledged the barrenness she felt in her community; she described her community as being nice and quiet. She talked about having a Walmart Supercenter, but everything else was one and a half hours away…She went on to ask if I had been there and then candidly expressed that there was not much there. Bee went on to explain the how the lack of healthcare infrastructure stained her perinatal experience. She described how she had to travel one and a half hours with her other children for all of her pre- and post-partum appointments. She acknowledged how stressful it was especially being pregnant. Additionally, she talked about how terribly stressful it was to think about labor when she was that far away from the nearest hospital, especially when she had horrible pregnancies and was in a domestic violent situation.

Bee recounted this experience as if she was still feeling the angst that the lack of healthcare left her. Portraying the bleakness Bee may have felt, two women came slowly walking down the road, one on each side, each smoking a cigarette.

The Dollar General. The women were thin and appeared to be older. As they neared my car, their faces looked worn and tired: their hair was thin and blonde. Right past the women, Dollar General appeared on the right. Three cars were in the parking lot,

which had no lines and no designated ramp in or out. Across the street was the Laundry Mat and the Steele Cooter (a garden shop). Inside the Dollar General, three middle-aged white men appeared to be grocery shopping for the week ahead. This experience was much different than mine when grocery shopping, as I tend to fill my cart with 90 percent fruits and vegetables, none of which could be found in the refrigerators of the Dollar General. Two older Black women did the same, in addition to picking up other odds and ends. The cashier, a younger overweight Black woman, wore a mask. She was the only employee in the store. She was quiet and polite. She did not have any children but was grateful to have a job and work. She almost seemed timid to speak to me as though someone was watching and judging her.

Thick Haze and Deep Trenches. Traveling westward to Kennett in Dunklin County, down a four-lane highway, crops to one side with farming equipment and powerlines to the other. Of the 24-mile trek, 20 miles were filled with a thick haze, making it impossible to see across the fields. Rather than the stark white of the cotton fields, the grounds were charred Black with deep trenches surrounding the perimeters. Finally, I saw a pick-up truck with two older men and a large barrel of water. They were filling the trenches to protect the other life-giving fields. Another couple miles active fires were suffocating the crops to make way for new soil and life the following year. The fires continued until we hit town. The smokey fog followed us.

Then almost as a mirage, a golf course appeared, men and women in carts hitting golf balls and socializing, not at all phased by the deep fog that engulfed the previous miles. As I made my way into Kennett, bigger houses with more yard lined the streets. The community housed a Dollar Tree, Burger King, Auto Zone, and many banks.

Kennett, as compared to Steele, revealed bigger, more commercialized stores and more well-kept spaces. Still yet, the feeling of entrapment loomed. I saw no sidewalks, bus stations, or fresh produce to nourish the body.

Casey's General Store. I finally came to the Casey's General Store. Opposed to the dark and gloomy Dollar General, it was bright and clean. When I pulled in the parking lot, I was one of eight cars. Upon entering, I noted four white overweight middle-aged women and two white older overweight men. The women were frequenting the bathroom and stalking the aisles. The men were in line waiting at the counter to pay. The person at the counter was an older lady with the years of hardship shown in the lines of her face. She was gruff and to the point. She did not make time for small-talk and when asked how she was doing and if she enjoyed Kennett, she scoffed at me and said "next." Normally, in my community, I would take offense to this, but here it seemed customary, like I was being intrusive and sarcastic in my genuine curiosity.

Agriculture. I arrived in New Madrid around dinner time. I had a lightness in me upon entering the town. Perhaps it was due to the blooming cotton fields that surrounded me like a fresh fallen snow. Electrical wires were strung overhead signifying connection to one another and the outside world. It was obvious, unlike with the others, this town lived and breathed agriculture. A John Deere store sat across from what appeared to be a plant used for mill or grain. One-story houses sat on large plots of freshly mowed plots of land. Pick-up trucks and SUVs were in the driveways. It was quiet, almost peaceful. Wreaths were hung from street signs. Still yet, no sidewalks, bus stations, or grocery stores were to be found. In my search for the Family Dollar, I came to a stop light. A white woman in her late thirties wearing big Black oversized sunglasses was driving a

Black SUV talking on her phone. I wondered if I was still in the bootheel or if I had transported back to St. Louis. It was a pointed reminder of the generalizations I had made and continue to make about rural communities. Upon entering the Family Dollar (much like a Dollar General), I was one of two cars in the lot. I went in and ambled slowly along the aisles. Silence. It, too, was clean and well-lit. Desperate for interaction, I went to the counter. An older stout woman with dark hair sat on a stool. She was missing teeth and had on bright blue eyeliner and poorly applied dark red lipstick. I put a toy on the counter for my daughters at home, handing her my credit card.

> Castellano-is that Italian? I had three sisters and my dad, when we lived in New
> York, we never went out. And one day he says Maria, get your dress on we are
> going out. So, my momma she gets her makeup on and says girls time to get your
> dresses on, Pappa says we are going out. So, we all put on our dresses and do our
> hair. And we get in the car. And we go to McDonald's. My mother, I have never
> seen her so mad. She says, "we never go out and you want us to go to
> McDonalds." My father. He was a funny man. He never liked to go out. And we
> never did…

I asked her how her experience in New Madrid was. She simply stated, "It could be worse." I got the sense from her she was deeply homesick and lonely. She went on.

> My sister ended up being in the wrong place at the wrong time in New York. She
> was shot and killed in a convenience store…Yep. So, I left…

Subcategory: Ethnicity

Ethnicity, a subcategory of cultural context, included the degree of proximity to current residence and the degree of influential family heritage. Immigrant mothers talked

of their current residence as a town, the physical infrastructures required to successfully live. Other mothers, who had strong ties to the area, referred to their residence as their community. The language used to describe the mothers' residences denoted a degree of emotional attachment or detachment depending on their particular family heritage. For example, one immigrant mother described her community as, "yeah, it has a library. It also has a place for a workout. A place I go for walks. I have a few friends here and we meet" (Jennifer B, lines 128-131). Jennifer may not expect anything from her community because it was not her home, rather a place she lived for now. However, the degree of attachment to current rural residence was largely influenced by previous physical environment. Mary immigrated from Southern Asia. She described her community with a great sense of pride believing she, to some degree, was living the American dream. Mary adopted her community as her new home with great pride and gratefulness.

> I'm by a little river. You can actually drive on the streets. Well, it is quite different from what we had before because where we were in Southern Asia before was much more rural. This is an achievement. I get to meet friends with and all that stuff. Another thing there is that you know, getting somewhere… some grocery shops…but here you get to drive in a car like a drive home from 10 minutes or so (lines 57-61).

Subcategory: Ethos

Ethos, a subcategory of cultural context, was characterized by values and Black womanhood identity expression. Ethos was the emotional and cognitive core of each mother, the underlying sentiment that informed her way of being. Ethos included the subjective historical and present experiences of the mother.

Property: Values. Mothers spoke of values that governed their way of thinking and acting. Some mothers shared the individualistic culture that is engrained in the American way of being. The philosophy of Individualism viewed people as unique individuals rather than as members of a community. As a worldview, Individualism stresses the value of autonomy, individuality, and independence. For example, one mother described her experience within the rural culture as overtly unconnected:

> I feel like my community could support me more. The community is a place where people really care about themselves. People care about themselves, everyone for themselves. That is what happens currently in the current world in the current community that I live in (Ann, lines 54-56).

Another mother described her experience with the community as:

> It is a rural area, but I don't think anyone knows that rural areas are more connected than urban. I'll take this to the bank, and I'm sure going to see…it is very well connected, they (are) more connected. They have a sense of belonging. They have a good sense of belonging. So, because it is a rural area, everyone sees themselves as one, and people tend to care for each other. So, I'm really thankful that I find myself here (Pricillia, lines 149-153).

This mother experienced the profound connectivity or sense of collectivism within her rural community. She identified herself with her personal interdependence within her community.

Property: Black womanhood identity expression. The Black woman identity expression was a race and gender representation that included both cognitive characteristics and stress-coping behaviors. For example, Beth immigrated to the United

States from South Africa. Her family settled on the west coast before making their way to Missouri. Beth perceived her current community based on her past experiences on the west coast. Beth felt stigmatized as being a Black woman. It was difficult to discern where her experiences in California ended versus where in Missouri they began.

> I have tried to seek help, but I have experienced barriers in class and race. I feel like I do not belong in that circle where I can seek professional help for my mental health or my personal health (lines 101-103)… Like I wouldn't get the help I need and maybe I'll be looked down on like I'm less of a person or less of a human (lines 108-109)…I have friendly health care providers here. I feel like I wouldn't have had that if I were in California because there, we had…it was like a mess. There were, you know, many persons and people around California. But over here I feel like I get the healthcare service I need. And for my son, too (lines 160-163)…I feel like this this stereotype around Blacks and mental health issues. So, I just feel like that's the difference okay (lines 168-169).

Jessica felt a sense of captivity as a Black mother. She described her experience as:

> Well, for me community is, actually, yes, I know as a Black human, as long as you allow me to leave and come in peace, and stuff yes, live in peace, and as long as my loved ones are safe, and I'm safe…(lines 101-104).

Beth also described what captivity looked like, "[In regard to discrimination] I mean being able to move freely without being harassed by the police and security officials" (lines 201-202). Lucy described her race being tied to her fate as a human, along with gender inequities undermining her ability to make decisions.

I think even if I felt it (power) from within, because I'm married, the way I was brought up, I was told to respect my husband, and then there are some certain decisions I can't just make them by myself. I need to tell him, even if I need to do it… so then he will give me the go ahead (lines 37-40)…Well, as a Black American I don't know all the way. We were told to, you know, accept our fate. We believe it so much. Believe in faith. You so much believe in the world. You believe it's right (lines 46-49).

Summary

Cultural context was the hand holding rurality, ethnicity, and ethos (see Figure 2). This hand offered up how rural postpartum mothers experienced and interacted with their world. Mothers had a variety of unique stories, all of which serve as a dynamic lens for their postpartum experiences. The category of social supports will be discussed next.

Category 2: Social Supports

Social supports included advocative roles of adults and being present (family), common experiences and shared beliefs (community), and therapy utilization and government programs (professionals). Mothers described these different supports as being influential to their wellbeing throughout their journey. Table 6 outlines category 2.

Table 6

Category 2: Social Supports

Subcategories	Properties	Dimensions
Family	Advocative roles of adults	Degree of advocative role
	Being present	Low to high degree of presence
Community	Common experiences	Low to high degree of common experiences
	Shared beliefs	Low to high degree of shared beliefs
Professional	Therapy utilization	Degree of utilization
		Degree of perceived benefit
	Government program involvement (WIC, First Steps, Building Blocks)	Degree of involvement

Subcategory: Family

Family was an integral part of the mothers' supportive experiences. Often mothers described family as the first advocative or present encounter they received on their mothering journey, as family was typically present at the bedside in labor or shortly thereafter. It is important to note that family here was not defined as the nuclear family, rather the chosen individuals that surrounded the mothers.

Property: Advocate role. The supportive relationship of family included the advocative role that mothers experienced. For example, Carley described her relationship with her aunt as being a driving force of stability. This advocative relationship provided both emotional and financial encouragement on her journey.

> But, you know, I do have good support within my family, friends. That's all I've ever had…And then, the biggest supporter in my life is my mom's oldest sister, who is still living. And she's been kind of my angel my whole life. Because we had a hard childhood, my mom had a hard time parenting and providing and she's

54

always been our angel that swoops in and saves the day (lines 196-200)…And if it

wasn't for my aunt, and she's financially supported me, and emotionally supported

me, she's my cheerleader, she's everything. Of course, I have friends, also and

family. But she's been my consistent support system. My aunt, she, and my uncle.

They're farmers. So, they've always, you know, had a little extra to kind of help

me out my whole life. While my mother was not able to…(lines 233-237).

Another mother explained her experience with her sister as being the catalyst for

pursuing professional support.

So, my sister came, and during her time she really helped me with the way I do

things. During this time frame, she introduced me to some programs which were

really helpful and helped me find peace (Marie, lines 41-43).

Both Carley and Marie had high degrees of advocative experiences during postpartum.

This social support helped them navigate their perinatal mood and sense of agency. These

early relationships were pivotal on their mothering journey.

Property: Being present. Other mothers recounted the experiences of family

being present in their journey. Nichole described the physical help of her family watching

her daughter to free up time to spend with her husband.

But my family all lives really close to me, so I have like emotional support of that

(lines 60-62)…They'll ask if they can just take Lorie overnight…so that my

husband and I can do something together (lines 78-80).

Her family was physically present enough to understand the need to maintain a strong

connection with her husband in order to be successful as a parent. Pricillia described the

uncertainty of mothering and the sense of relief she felt to have her family nearby.

I will be honest with you. It which was a big experience because I think it was

something very new. So, I didn't know how to go about it but thankfully, my

family was there. I've been hearing stories about how motherhood is not a child's

play, how motherhood is not a place where you play dumb, a movie or something.

No sir…So I think I, you know, I prepared my mind to this with my family (lines

116-120).

Mothers also took notice of the support they received from their husbands. Jessica

described the support she felt from a group of individuals close to her, "I feel supported

from my friends, my cousins, and my husband. I feel really supported from them…and

(they) get me through trying times and I'm thankful for that..."(lines 66-69). While Elisa

specifically referenced her husband, "My family was supporting me. My husband was

supporting me…" (line 9). Mary, too, noted her husband, "Just like when before I had my

first miscarriage, although it was very difficult, I got support from my family, especially

my husband" (lines 11-12).

Subcategory: Community

The second type of support that mothers described was support within their

defined community. Community was not the physical boundaries where a mother resided,

but rather a feeling and sense of connection among acquaintances with shared beliefs that

influenced their environments and one another.

Property: Common Experiences. Each community that a mother assigned

herself to has a low to high degree of common experiences. One mother described her

experiences with community support as being quite influential in her development of

agency as a mother.

Yeah, Okay, we have a support group right now. We talk through a group on

social media. But I feel like I have adequate support from other moms (Mellisa,

lines 12-13). Because it's awesome, someone doesn't know something, or you

aren't sure about something, you aren't sure about a certain thing, especially when

you're a new mom so you need to ask some questions. Maybe about

breastfeeding, about even feeding the baby, shopping, and everything. So, you

need to ask some other people who have been moms earlier before you were one.

And it was even much better when I heard from other moms. That's the source of

assurance I needed because they have been through this, so they are the source of

assurance, and I trusted them more because they have had this experience

(Mellisa, lines 19-23).

Another mother described her experiences with a group on social media as:

I went to a group when I was pregnant. I was on this social media group. Well, we

have about more than a 100 people. We have somebody that is a doctor in the

group to tell us what to do. So, I really see that as a support-you go there and tell

whatever you're going through. Whatever the feeling, how you feel what other

questions you have (Lucy, lines 12-16).

Mothers identified with and chose a community of peers with similar backgrounds or

experiences. For example, one mother described her experiences with her sons with

autism.

Good support is like a lot of these groups for mothers with kids with autism (Kim,

line 174). I don't know I feel like there are a lot of support groups out here in the

world. I feel like we need more help with like if your kid has any type of issues. There're no resources for that (Kim, lines 276-277).

Property: Shared Beliefs. While these experiences provided examples of online supportive communities of mothers, physical communities provided supportive experiences as well. For instance, one mother identified her church as her community, "Some of the few (members of church) came by the house. Other members started calling me to set up a time to maybe visit" (Lucy, lines 84-85). Even though this was a physical community, this mother had chosen to be a part of it due to shared beliefs. Common experiences, beliefs, and backgrounds united these mothers to others which encouraged their sense of agency.

Subcategory: Professional Support

Another type of support that mothers described was professional support. Professional support included the experiences with trained certified person(s) that provided varying degrees of guidance. While some mothers described the lack of professional support, other mothers considered how the professional supportive encounters influenced how they experienced healing during motherhood.

Property: Therapy Utilization. Therapy utilization included the process of meeting with a qualified individual to take care of the mental and emotional health of the mother. Some mothers reflected on the lack of therapists in their towns, "Currently, I do not have a professional to you know talk to about my problems and about how I feel about issues and things that are currently bothering me. So, I feel like that's missing" (Beth, lines 95-97). Other mothers noted therapy as being a part of their supportive experience. However, it was important to consider the degree of perceived benefit that

58

therapy had on the mothers. For example, only one mother recounted the beneficial influence that therapy had on her, "you know where I could open up my heart" (Jessica, line 37).

Property: Government Program Involvement. Government program involvement included the state organized systems that were designed for the care and wellbeing for low-income mothers and infants. While it was unknown the degree of perceived benefit that therapy had for many mothers, most mothers referred to the high degree of involvement from government programs. In some cases, mothers spoke of the programs providing unintended counseling and mental health support. For example, one mother spoke of the employees of First Step as helping her on the lowest of her days.

> Providers, doctors, and nurses and I appreciate that (Kim, line 179). I love all the ladies they come from First Step…So it's like a set of sisters (Kim, line 312)…like I love them to death. And they help me on my lowest days…and then we have been in Building Blocks since they were like babies…(Kim, lines 317-318)

Another mother describes her experience with WIC as helping her "mindset and my mental talk" (Marie, lines 15-17).

Summary

Social support acted as a watering can, fostering and aiding in the development of agency and thus resourcefulness to effectively navigate the perinatal mood (see Figure 2). More often than not, seeing the same faces on set days week after week provided a sense of stability and reassurance which helped to build trusting relationships. Before long,

mothers took mental refuge in these relationships relying on them to cultivate their belief in self. The next category that is described is perinatal mood.

Category 3: Perinatal Mood

Perinatal mood was a marked experience of becoming a mother. Perinatal mood was characterized by a rollercoaster of emotions, development of disorder, and stressors. Depending on the degree of the mood, mothers often sought some extent of support. However, some mothers did not anticipate needing the extent of support that was required to help them return to baseline functioning. Perinatal mood included any mood that accompanies the perinatal period. A perinatal mood could last minutes to years and was often measured by how much it disrupted day-to-day life. The perinatal mood was influenced by various life stressors and the pre-pregnant mental health of the mother. Table 7 outlines category 3.

Table 7
Category 3: Perinatal Mood

Property	Dimensions
Rollercoaster of emotions	Low to high degree of severity
	Positive to negative
	Expected versus unexpected
Development of disorder	Diagnosed versus undiagnosed
Stressors	Extent of good nutrition
	Quality of sleep
	Environmental
	Chronic versus acute

Property: Rollercoaster of Emotions

Pricillia described her experience as waves of emotions that rendered her unable to think lucidly "It is a rollercoaster, feelings upon feelings, emotions upon emotions.

They clouded me, you know, as I was thinking, I was depressed. I was very unstable. It was a problem" (lines 84-86).

Property: Development of Disorder

Beth went on to describe the severity of her perinatal mood and the impact it made on her life.

> And nothing was fun to me anymore. And after pregnancy. I feel like nothing that could, you know, make me happy. Or, you know, give me this kind of joy that comes…with motherhood. So, I feel like I don't know, I just felt this kind of sadness. More like depression, and I couldn't get anything or anyone to cheer me up at the time (lines 130-134).

Jessica recounted the terrible pain she experienced when she did not want to be around her child.

> I knew I needed to seek out help because now I couldn't even face the baby. I was kind of like abstaining from my kid, which was crazy because most of my friends tell me stuff like, you know-like I am so glad to see my child. Everything I wanted, every ounce of blood in my body. I wanted to see my child (lines 23-25)…but in my own case it was weird I didn't want to see anybody. I wanted to be alone most of the time. So okay, I knew I knew something was up (lines 44-49).

Property: Stressors

Perinatal mood transcended the varying components of the perinatal shift. For example, Nichole described her experience with perinatal mood being influenced by

various stressors-sleep, exercise, and nutrition. These stressors were so intractably woven with each other, each involving the next.

> The baby was here I didn't feel prepared at all, just as far as like lack of sleep goes, and sickness, and I do think that lack of sleep had a huge part in playing like with my hormones and my mental health and my ability to like to get through a day with a positive attitude. But yeah, I definitely struggled at first to not have any time to myself, to not feel like I was like I was myself anymore. I felt like a different person, and at first that was not okay (lines 115-119)…But my best friend joined a gym, and I joined with her, and so we both started going to the 5:30am classes. And I started noticing that, like I was in a better mood the rest of the day, even if I still was sleep deprived. So, I started kind of seeking alternative ways to help myself to feel better (122-125)…

Mellisa described her experience as:

> Mentally, you're in a place that there is a lot of unknown. There is a lot to the emotional like shift. Okay. Sometimes you're happy, sometimes your sad. Yeah, you're so stressed because of several things. Sometimes you are struggling financially…sometimes they're struggling to catch up with the new changes that are happening in their bodies... Now the additional responsibilities are so stressful because the responsibilities were adding up. I struggled because it's not just myself. Now it's me and the baby. So, my emotions well, though somehow the emotional change, and I compared my life currently to my life the previous 2 years (lines 35-46)…(It is) very, very different as compared to the life before I was a mom, because it's so overwhelming right now, because there are other

responsibilities you have that you didn't used to have. Oh, it's really different for sure, it's so different. You start learning how to save money. The way you spend (money) changes. The way you change your behaviors, changing your interaction in social life because you're not…yeah, it's overwhelming (lines 69-74)…Maybe just to say that the mental health of a mother especially, or a parent. And even after pregnancy is so important, cause yeah just as I said, it's overwhelming to raise a kid from pregnancy. So, the mental health is so important. Concentrate on, give attention to, the mother (lines 118-121).

Jennifer described the emotional load that mothers carry when having multiple children.

I did. I did have emotional shifts doing my pregnancies, and especially after the second one. This one that is just 5 months it was a very tough period for me. I experienced so much emotional shifts, even after my postpartum ended (lines 78-81)…I had hormonal shifts also. In this case, there are times I cannot, I feel I felt I wasn't ready. I wasn't ready for another child. The stress I went through…postpartum stress. I felt alone…I thought I wasn't having enough support that I needed, and the stress was mentally affecting me (lines 85-89).

Summary

Reflecting on the experiences that were impacted by the mothers' perinatal moods, it was apparent that without some sort of supportive intervention, many of these mothers may have fallen deeper into despair. Perinatal mood transcended the entire perinatal (conception to two years post birth) experience. Agency is described next.

Category 4: Agency

Agency was defined as control, choice, and change. Mothers described agency as having the internal proponents for choice and having the power to execute those choices. These mothers described themselves as actively choosing to live life a particular way. Additionally, they described their community as providing support to those choices with little to no degree of influence. Table 8 outlines category 4.

Table 8
Category 4: Agency

Property	Dimension
Control	Low to high degree of control
Choice	Low to high degree of choice
Change	Low to high degree of change

Mothers further described agency as control or power over decisions; choice or power to make decisions; and change or power coming from within. Amiel described agency in these three aspects as:

> The best, the best gift God gives to us on earth is the gift of choice. So, you have the choice to either do good or do bad. Have the choice to either marry or not. Yeah, I have the choice to either attend this interview or not attend…I have the proponents of power to make choice (lines 172-175).

*Property***:** *Control*

While Amiel personified agency, Lucy was at the other end of the spectrum, believing that she was a passive spectator in life. Lucy felt that she had no control or power over decisions.

> Well, as a Black American I don't know all the way. We were told to, you know. accept our fate. We believe it so much. Believe in faith. You so much believe in

64

the world. You believe it's right I believe it that's how it wants to be so. I will go

with the way life is happening to me (lines 46-49).

Property: Choice

Additionally, Lucy felt no sense of choice, or power to make decisions, due to

normalized gender standards.

I think even if I felt it from within (power), because I'm married the way I was

brought up I was told to respect my husband, and then there are some certain

decisions I can't just make them by myself. I need to tell him, even if I need to do

it. I need to tell him, and if you let him know, so then he will give me to go ahead

(lines 50-53).

Property: Change

Another mother described the role of the community in her experience of agency,

particularly how power came from within to create change.

Making decisions are on a personal level, and I feel the responsibility of the

community is just to give you advice or promote the power within you. So, the

role of the community is to advise you, to show you the right way. But it's your

personal responsibility to make choices because the choices effect you…(Mellisa,

lines 80-85).

Summary

Upon reflection agency was a core component of resourcefulness that contributed

to empowerment, the other being social support. Mothers described the power to choose

how to live, and the choices that contributed to their desired life, as self-directed. The

final category that is described is future oriented notions for contented mothering.

Category 5: Future Oriented Notions of Contented Mothering

Mothers described what their hopes and desires were to have a happy life. These dreams were future oriented perceptions of what achievement was in the context of mothering. Future oriented notions of contented mothering were defined as connection, money status, safety, and health. The subcategories that follow were listed in order of importance as described by the mothers. Table 9 outlines category 5.

Table 9
Category 5: Future Oriented Notions of Contented Mothering

Subcategories	Properties	Dimensions
Connection	Joyful moments with children	Low to high degree of joyful moments
		Degree of disclosure
	Peer disclosure	
Money Status	Amount of money	Low to high quantity of monies
Safety	Security	Low to high degree of security
Health	Physical	Low to high degree of physical condition
	Psychological	Low to high degree of psychological condition

Subcategory: Connection

First mothers explained, in order to have a contented mothering experience, interpersonal connection was paramount. Mothers spoke of connecting in ways they currently did experience. These connections included interacting in joyful moments with children and establishing peer disclosure.

Property: Joyful Moments with Children. Mothers discussed the experience of joyful connections with their children that fostered a fulfilled mothering identity. Marie

described how the act of watching her child develop brought her joy and inner peace. She explained that through watching her child grow, she felt happy.

> See my baby talking to me like giving me back the expressions I'm actually creating. And you know when you see your child like working like you know you got you get this type of joy like you'd be happy… (lines 48-50).

Another mother expressed her desires to " have a bond between my kids and myself…" (Jessica, line 73). Mothers were looking for fulfilling connections with their children, whether they had them currently.

Property: Peer Disclosure. Peer disclosure included the trustful and meaningful relationship between mothers. Mothers described a want and need for peer support groups. Peer meant mothers who provided guidance and encouragement along the mothering journey. Mothers voiced a need for peer groups that included an inherent trusting environment where mothers could share and be validated. Beth described her wishes for a "group where I have different moms from different backgrounds come together and talk about the issues they are facing" (lines 174-175). Jennifer explained the lack of peer fellowship she felt when she had her children and a longing to have had peer support groups in her community.

> So, I wish support groups could be in my community. Helping nursing mothers and depression, so we could come together and discuss the feelings, the postpartum feelings, and emotions. To try to see how to help each other through conversation and help each other get through the challenges we are going through (lines 135-140)…Yeah, so mothers like us, postpartum mothers, pregnant women. Mother can come together; talk about things they feel- the emotions. What, as in

advise each other, how to go about being a mother. Because trust me, from what I

experience the number of times you've had kids. There are different kinds of

experiences. There are times that you feel you haven't been through this journey

before you start. You are safe. You are new in that view. You know nothing about

being a mother, and you need someone to talk to, people who could share their

experiences with, and you could get some vital information, some vital tips, some

support from such information (lines 151-165)…Have little or no empowerment

for mothers like us. No support for mothers (line 128).

Jen candidly stated, "send me a support program I can go to" (line 92). Even mothers

who seemed contented, expressed a desire for more. Ann explained that she craved the

reassurance throughout her child's development.

Yeah, yes, okay, I still need to learn other ways to help the baby, despite the

fact…The baby in a whole has grown emotionally, physically, behavior wise,

mentally and everything. Yeah, being there for the baby and ensuring that the

baby develops in all aspects of life (lines 18-20)... from moms with kids that are

older (line 25)… Just to think about women. Education is important. It helps us

build a better society because kids depend really much on what they receive from

their parents. Especially when I was so young. It's good to educate mothers, so

that you have to bring up a healthy, happy society (lines 90-93).

Subcategory: Money Status

While mothers described the different lives that money would afford them, not a

single mother spoke of wanting excess. Each mother wanted enough money, enough to

eat, live and care for herself and children. Financial limitations placed a large degree of stress on rural mothers which how that impacted every aspect of their life.

Property: Amount of Money. Mothers expressed a desire to live without financial worry. This desire included having the money necessary to live comfortably within their means, primarily for the wellbeing of their children. For example, Elisa described in order to be happy, she needed financial stability.

> Maybe I'm looking for more happiness for me and my family. We need more and more financially to be financially stable, to be able to raise my kid…Well, in the best ways…more and more happiness (lines 23-25)… I need to make some payment I don't have that cash. I need this, for my boy (line 40).

Jenifer, on the other hand described financial support as being afforded the opportunity to stay home with her son.

> The perfect life is being home together for a significant amount of time (lines 144-145). But you have to have financial freedom to be able to manage that, whether it's a maternity package, or your husband makes enough money, or you find a way to work from home, But that. that's what it would be like for me to be able to be home comfortably, financially, and separately at times (lines 149-152).

Subcategory: Safety

In describing what the future looked like in terms of a contented life, mothers described the safety of their children. Safety is defined by security or the protection from physical harm. Fundamentally, mothers wanted their children to grow up in a place that would afford them the opportunity to thrive.

Property: Security. Mothers narrated the importance of a feeling of sanctuary that allowed for the wellbeing of their children. Some mothers even described how the rural community provided this safety experience that they wished for. Mary described a contented mothering experience as, " being comfortable that you know, a rural area where my children are going to stay in a very safe environment" (lines 56-57). Similarly, Bee described it as when the kids have the ability to feel safe and secure.

Subcategory: Health

Mothers defined health in terms of being in good condition. In the context of the postpartum period, mothers considered the importance of psychological, as well as physical wellbeing. In order to have a contented mothering experience, both mother and children needed to be in good health, both physically and emotionally.

Property: Physical and Psychological Condition. One mother described how she sees a happy life, "Oh, yeah, a happy life is the right emotional, psychological, physical self. When both mental needs and spiritual needs were met for both the mom and the baby. That's a happy life for sure yeah" (Mellisa, lines 63-64). Another mother explained this same sentiment differently.

A happy life for me, is when my daughter is healthy actually. Happy life is a healthy life for us…When everything is okay. Our health is okay. No one is sick. Just okay, yeah, emotionally, physically we're healthy (Ann, lines 44-46).

Summary

Many mothers expressed what future perceptions of a happy life entailed. The primary concept discussed was a form of positive and supportive relationships, either being able to relish in the joy of seeing their children grow or finding a group of mothers

to share and bond with. Money status was another concept that came through in the discussions with mothers. Mothers spoke of the inability to raise children successfully due to the constraints of finances. In addition, mothers acknowledged having to rely on the good will of others to support their children. Even fewer mothers discussed the impact of health and security in their ideal future mothering experiences but noted that the impact of these two concepts were important in living contented lives.

Summary

The five major categories demonstrated (cultural context, social supports, perinatal mood, agency, and future oriented notions of contented mothering) thoroughly answered the two research questions. Cultural context provided the experience of resourcefulness (agency and social supports). Agency and social supports are low-cost, low-barrier tools to empower mothers to navigate perinatal moods in attempts to achieve the future oriented notions of contented mothering. The final chapter, Chapter 5, provides a discussion of the findings from this study. The findings are compared to the literature review and the previous theoretical model. In addition, a new model showing how the findings related to one another will be illustrated and described. Finally, the limitations and implications are addressed.

CHAPTER FIVE: DISCUSSION

Introduction

This research study aimed to give voice to rural low-income Missouri mothers and understand their distinct experiences with support and empowerment. A systematic analysis, rooted in grounded theory, demonstrated that the perinatal shift sparked this cohort of postpartum women to seek a sense of community (a feeling among a set of relationships with people) empowering them to be intentional mothers. This treasured feeling of community came from shared experiences as mothers. From the analysis, mothers described their experiences during the postpartum period in terms of their cultural context, social supports, and their perinatal mood. Rural low-income Missouri mothers described empowerment in terms of agency and future oriented notions for contented mothering. Cultural context provided the experience of resourcefulness (agency and social supports). Agency and social supports are low-cost, low-barrier tools to empower mothers to navigate perinatal moods in attempts to achieve their future oriented notions of contented mothering.

This chapter summarizes the findings of the study briefly. Next, the research questions, methodologies, and procedures are discussed. Then the findings are compared to the literature review from Chapter Two. The initial theoretical model is compared and contrasted to the updated model based on the findings from the study. Subsequently, study limitations are noted. Finally, the study implications are offered including ideas for future research, practice, and policy.

Research Questions, Methods, and Procedures Summary

The research questions were:

1. How do rural low-income women describe their experiences with their support systems in the first two years of motherhood?

2. How do rural low-income women describe their experiences with empowerment?

Data sources included observations of rural communities and semi-structured interviews with eighteen low-income women, the majority of whom identified as Black. Grounded theory methods were used to analyze the data.

Discussion of Key Findings

The research questions focused on how rural low-income Missouri mothers experienced social support and empowerment. As discussed in Chapter Four, five main categories were revealed from the interview data: cultural context, social supports, perinatal mood, agency, and future oriented notions of contented mothering. The findings from this cohort of mothers suggested that cultural context set the stage for how mothers understood their social supports when encountering perinatal mood. Additionally, when describing empowerment mothers referenced two of the three aspects of Empowerment Theory-agency and future oriented notions of contented mothering (achievement).

Comparison to Literature

Category 1: Cultural Context

Cultural context, as described in the literature, included rurality and level of income. Rurality was described as less than 150 people per square mile and did not contain any part of a central city in a Metropolitan Statistical Area (Health in Rural Missouri Biennial Report, 2018-2019). Level of income (defined as the household income may be no more than 185% of the federal poverty income guidelines) determined eligibility for WIC. While these aspects of cultural context served as a foundation for the

study, mothers described it with greater color. The study found cultural context to mean the rurality, ethnicities, and ethos among this cohort of mothers. It included the rurality of where the mothers lived, the ethnicity of the mothers interviewed, and the mothers' ethos in terms of values and their Black womanhood identity expression.

Mothers noted the lack of healthcare resources in their communities, particularly mental health resources. Furthermore, some mothers mentioned that they lived in particular communities because it was, in fact, more affordable than the bigger metropolitan areas. This relationship suggested, as noted by previous research, that social support and socioeconomic status were focal because they were associated to many other social factors that linked to perinatal health outcomes (Ginja et al., 2020).

Category 2: Social Supports

As suggested by the literature, support was a major influence on the mothers' abilities to cope and thrive despite stress (Zauszniewski, 2016). Mothers described three aspects of support-family, community and professional. Resourcefulness and lack of depressive symptoms were influenced by perceived stress and social support (Zauszniewski, 2016). As evidenced by the study, social support increased empowerment by providing the environment in which agency was increased. The intimate partner and mother's relatives were identified as major sources of support during pregnancy. Most women expressed a desire to obtain social support from family and friends, which the literature also noted (Reyes et al., 2021).

As described by Kabeer (1999), the theoretical framework of empowerment, or the ability to exercise choice, included resources, agency, and achievement. Resources included the material, human, and social means that fostered the ability to choose. In my

newly developed theoretical model, as evidenced by the study, resourcefulness included family, community, and professionals. Social support was defined in the literature as the amount of advocative interpersonal exchanges between two individuals perceived to enhance the wellbeing of the recipient (Finfgeld-Connett, 2005; Shumaker & Brownell, 1984). The mothers from the study described support similarly, as interactions perceived to improve her wellbeing.

Category 3: Perinatal Mood

Many mothers described some degree of depressive symptoms. Maternal mental health conditions are the most common complications of the perinatal period and affect one in five mothers in the United States each year (World Health Organization, 2022). As described in the study, mothers are at an increased risk of a mental health conditions if they lack social supports, experienced trauma, and live in poverty (American College of Obstetricians and Gynecologists, 2018; Taylor, 2019). More than half of the mothers described the perinatal mood experienced and recalled in great depth the impact it had on them throughout their journey. Taylor (2019) confirmed that women in poverty and women of color are less likely to receive care for mental health conditions due to lack of access to healthcare, including culturally appropriate mental health care; cultural and racial biases within the healthcare system; barriers to healthcare; and fear that their children will be taken away (Taylor, 2019). This study, and literature, suggested that perinatal mood and anxiety disorders were more prevalent in rural women compared to the general population (Ginja et al., 2020). Furthermore, this study echoed that low-income mothers also have higher rates of depression (diagnosable or not) while very few receive professional care (DeCou & Vidair, 2017).

The framework used to guide this research (see Figure 1) demonstrated the mitigating effect of the extent of social and peer support on the degree of stress and quality of mood. While many mothers desired peer support, there was no doubt that this cohort of mothers survived the perinatal mood due to the overall social support they received. Research suggested that support acted as a buffer that produced a protection that regulated the relationship of stress and mental health (Razurel et al., 2017). In addition, the extent of support positively affected quality of mood. Support helped to decrease low mood and anxiety by conquering feelings of isolation, disempowerment, and stress (McLeish & Redshaw, 2017). Support improved feelings of self-esteem, self-efficacy, and parenting proficiency (McLeish & Redshaw, 2017). The study validated the buffering role of support. The qualitative design of this study offered insights on how mothers defined support in their current state and in their future hopes.

Category 4: Agency

The research described agency as defining and acting upon goals which included the meaning, motivation, and purpose behind the activity or "the power within" (Kabeer, 1999). In the research study, mothers described agency as the power of choice being inherent. Six out of 18 mothers described some degree of intentional power. The level of personal agency was a component of the resourcefulness that the postpartum woman experienced on her journey to empowerment. Agency was also seen in to Zauszniewski's Resourcefulness and Quality of Life theory (2016) as personal resourcefulness or self-help. However, in the current study even those mothers who were high in both personal and social resourcefulness, noted the same degree of negative perinatal mood than those

76

who were high on social or personal resourcefulness alone, contraindicative of the literature (Zauszniewski, 2016).

Category 5: Future Oriented Notions of Contented Mothering

Finally, achievement, the final component of Kabeer's (1999) theoretical framework of empowerment, was the possibility of living desired lives or of accomplishing valued ways of "being and doing" (Kabeer, 1999). Achievement suggested a finality, a goal that had been reached. No mothers described achievement, rather future oriented notions for contented mothering. Motherhood was a journey. The children were constantly changing and evolving, as too, the mother must change and evolve. Along this journey, the core values of one mother would not waver, while life circumstances may alter another's. It was this unending journey that required support from peers; support on how to parent during that developmental stage; support on how not to lose their own identity; support on how to find joy; support in the quietness and stillness. Eight out of 18 mothers described relationships as paramount in this future mothering experience. This cohort of mothers voiced a desire for active outreach during the journey as opposed to passive support that many experienced.

<div align="center">

Theoretical Model Comparison

</div>

The first framework (as seen in Figure 1) was used as a guide for the study. It illustrated the theories that provided context for the study. The second framework (as seen in Figure 2) illustrated the outcomes from this cohort of mothers using grounded theory analysis. As shown, cultural context provided the lens for how mothers perceived social supports and agency (the components of resourcefulness) during the journey of motherhood. Perinatal mood, rather than the facets of the entire perinatal shift, was

described on a continuum by various mothers. The degree of empowerment included

various achievements (connections, financial, safety, and health) rather than one specific

goal. Mothers described these goals as necessary to feel empowered. The cultural context

hand (rurality, ethnicity, and ethos) offered up the experience of the postpartum period.

Social supports (family, community, and professional) acted as the watering can that

helped to fill the space left empty by agency to make resourcefulness whole in the

mother. The barometer on the perinatal mood was able to swing from one end to the other

based on a mothers perceived resourcefulness. If a mother had an adequate degree of

resourcefulness, she was able to navigate the perinatal mood and achieved her future

oriented notions for contented mothering, at least during that brief phase of her child's

life.

Figure 1

Empowerment Framework
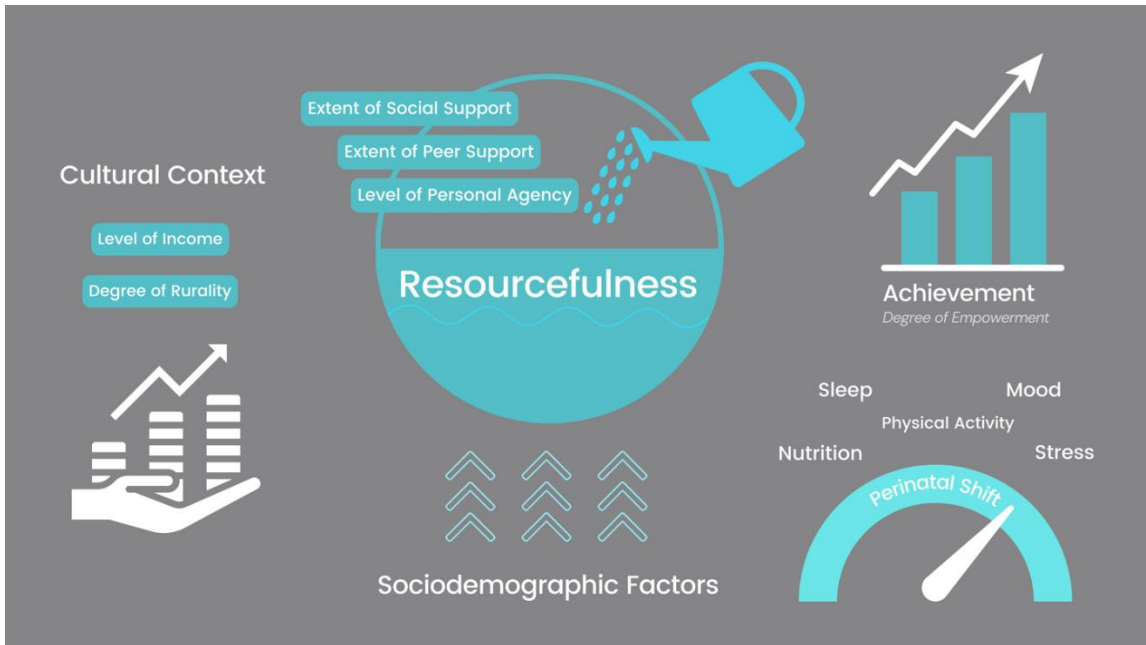
Figure 2

Empowerment Framework for a Subculture of Rural Low-income Missouri Mothers
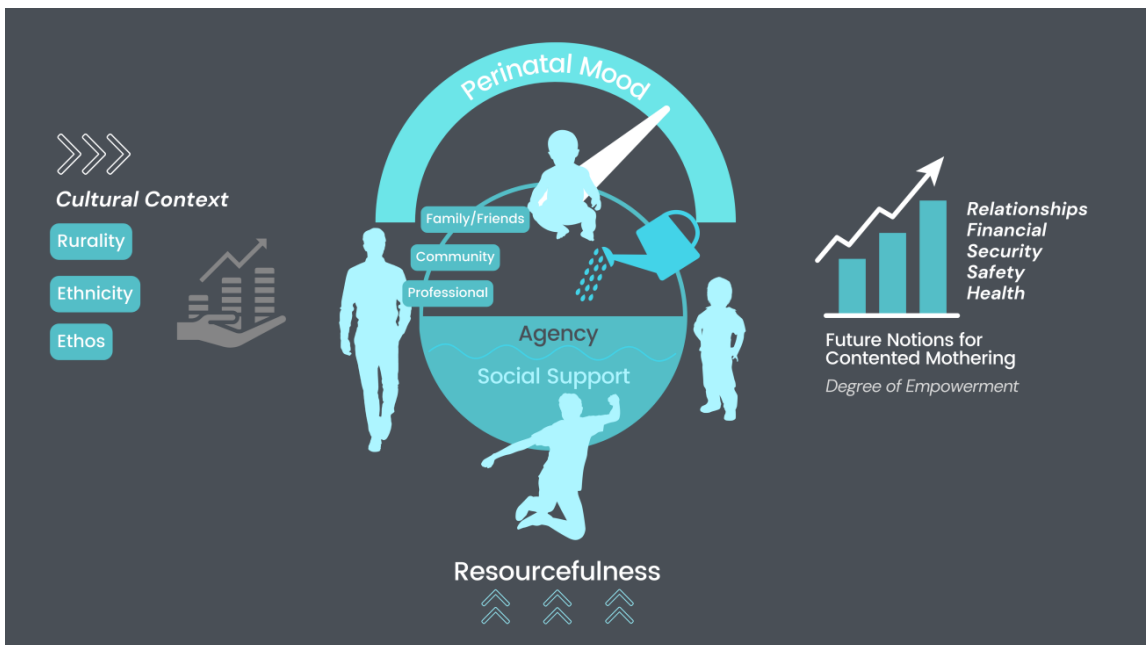
Limitations

Characteristics of the design and methodology limited the interpretation of findings. The research design was focused ethnography methods with grounded theory analysis. This design was thought to be the best for capturing the subjective experiences of rural mothers, but other data sources, focus groups, chart review, and storytelling would strengthen these results. For example, while providers were not interviewed from WIC clinics that women frequented, this alternate viewpoint would have allowed for deeper understanding in the lacking rural mental health resources. Additionally, the majority (n=16) of this cohort of mothers were Black; in order to capture the full picture of social support and empowerment, a more diverse cohort would have been ideal. Finally, the language used and the questions asked on the interview guide, pertaining to culture, were not sufficient to capture the desired extent of cultural context.

Implications

Suggestions for future research, practice, and policy will be discussed in the following section. If additional rural postpartum women are included, greater insights of mothers' unique experiences with healthcare and support, in particular peer support, would better serve policy makers and practitioners. Access to more data would unveil loopholes and possible interventions to serve mothers and thus the children of the future.

Future Research

Future research would include immigrant postpartum mothers and their experiences in rural America. The qualitative data that can be gathered from this population is underwhelming in the current literature. In addition, focus groups could serve as an invaluable source that may provide a sense of safety among mothers who

have certain insecurities and distrust in the systems. One way to ascertain this data would be to hold online support groups across rural communities. By holding one forum where mothers are able to converse with other mothers in different counties, they may be able to gain a broader perspective and form new connections. Another facet to this research would include connecting rural mothers to urban mothers. St. Louis offers rich resources in the way of perinatal peer support. Immigrant mothers in St. Louis would be a valuable asset and, if willing, could be trained in peer support and connected to rural mothers. Additionally, research around the stigmas mothers experience would allow for more effective interventions. Finally, expanding the data set to include a more diverse population of rural mothers would paint a more complete picture of the experiences of social support and empowerment. Another aspect to explore is the critical threshold in mothering, at what point do mothers seek help. Motherhood is not only a nine-month `journey with a start and stop time. While the ultimate goal is to have a healthy mother and child, the identity of the mother shifts dramatically with each childbirth. Research surrounding the identity journey that mothers experience, and how we can positively impact that journey pre-birth may help establish trusting relationships and interventions post-birth.

Practice

In order to best serve rural low-income mothers, healthcare providers need to take a wholistic approach. This is an ideal time to connect mothers with resources to meet mothers' needs for themselves and their children. The cohort of mothers studied offered insights into the rural immigrant population, and their desires and needs to be heard during the perinatal experience. Healthcare practitioners do this subculture of mothers a

disservice by assuming they are of one race or nationality. In addition, national medical organizations recommend screening for maternal mental health conditions, yet the screening tools do not address the range of maternal mental health conditions or the diverse cultural and racial populations. Further complicating matters, little to no formal training in maternal mental health exists for providers. Providers may not know about or have access to resources for patients impacted by these conditions. Finally, and unfortunately, providers are not adequately or easily reimbursed by insurance or other payers for addressing these conditions which may or may not impact their desire to heal.

Policy

The United Sates is one of the top three countries in the world with the most expensive childcare, not providing any subsidies to working families. This widens the gender equity gap as well as the Black equity gap (MomCongress, 2020). Finally, the United States has the highest maternal mortality rate of any high resource country, with Black women being three times more likely to die in childbirth than white women, and it is the only country (outside of Afghanistan and Sudan) where the rate is rising (MomCongress, 2020).

The Momnibus Package was introduced to Congress in 2021 where it stalled. It included the Quality Care for Moms and Babies Act to improve the quality, health outcomes, and value of maternity care under Medicaid by developing maternity care quality measures and supporting maternity care quality collaboratives. The Momnibus Package also included the MOMS Act (Modernizing Obstetric Medicine Standards) to reduce maternal mortality and morbidity by standardizing the use of best practices and supporting quality improvement initiatives. Third, it included the MOMMA's Act to

assist states adopting best practices in maternal mortality review, extend Medicaid

coverage to a year following childbirth, expand maternity care quality improvement

initiatives, and establish Centers of Excellence for implicit bias and cultural competency

education. Finally, it contained the MOMMIES Act to extend Medicaid coverage to a

year following childbirth; pilot Maternity Care Homes, a model that provides

coordinated, comprehensive, and culturally appropriate services and care; and assess and

recommend strategies to expand Medicaid coverage of doula care. Policy must move

forward to initiate change.

Conclusion

The cost of NOT treating mental health conditions was $32,000 per mother and

infant pair, adding up to $14 billion nationally (Luca, 2020). Women with untreated

mental health conditions were more likely to fail to manage their own health, had

inadequate nutrition, abuse substances, experience abuse, were less responsive to their

baby's needs, had fewer positive interactions with their baby, experienced difficulties

breastfeeding, and questioned their abilities as a mother (Sriraman, 2017). Consequently,

babies born to mothers with untreated mental health conditions were at increased risk for

low birth weight or smaller head size, preterm birth, longer stays in NICU, excessive

crying, and behavioral, cognitive, and emotional delays (Sriraman, 2017).

One low-cost low-barrier intervention to fight maternal mortality was through

support, in particular peer support. Support during the postpartum experience increased

the intentionality and resilience in mothers, promoting both personal (agency) and social

resourcefulness (social support), two aspects of empowerment. Increased empowerment

and empowerment interventions decreased perinatal depression, preterm birth, low

birthweight, significant stress, minimized early adversity and inequalities in postpartum care, and was significantly associated with receiving antenatal care (Garcia et al., 2017; Lagendijk et al., 2020; Merrell et al., 2020). As described by Kabeer (1999), the theoretical framework of empowerment, or the ability to exercise choice, included resources, agency, and achievement. In the theoretical model (Figure 2), resourcefulness included social support and agency. After performing 18 semi-structured interviews, the mothering journey for this cohort of mothers included the distinct lens through which mothers perceive experiences (cultural context), aspects of support (social supports), and the volatile landscape of the perinatal mood. Mothers discussed some degree of empowerment in the context of resourcefulness (social supports and agency), and achievement (future oriented notions of contented mothering). In conclusion, agency and social supports acted as tools to empower mothers to navigate perinatal moods in attempts to achieve their future oriented notions of contented mothering.

The motherhood crusade is a movement to make the United States the best country in the world to have a baby. We must fight for changes at every level (federal, state, healthcare system, practice, provider, and parent) to ensure no further lives are lost. Future research is necessary to expand the understandings of immigrant postpartum mothers and their experiences in rural America and to explore the identity journey in order to build trusting relationships and interventions post-birth. By effectively intervening in the rural low-income mother's journey, we can address control, choice, and change.

References

Adynski, H., Zimmer, C., Thorp, J. & Santos, H.P. (2018). Predictors of psychological
distress in low-income mothers over the first postpartum year. *Residential
Nursing Health*. 2019(42), 205–216. https://doi.org/10.1002/nur.21943

Ahmed, A. O., Hunter, K. M., Mabe, A. P., Tucker, S. J., & Buckley, P. F. (2015). The
professional experiences of peer specialists in the Georgia mental health
consumer network. *Community Mental Health Journal, 51*(4), 424-436.
doi:10.1007/s10597-015-9854-8

Alhusen, J. L., Ray, E., Sharps, P., & Bullock, L. (2015). Intimate partner violence during
pregnancy: Maternal and neonatal outcomes. *Journal of Women's Health*, *24*(1),
100–106. https://doi.org/10.1089/jwh.2014.4872

American College of Obstetricians and Gynecologists. (2018, November). Screening for
Perinatal Depression. *American College of Obstetricians and Gynecologists*.
Retrieved from https://www.acog.org/clinical/clinical-guidance/committee-
opinion/articles/2018/11/screening-for-perinatal-depression

American Psychological Association. (2020). APA Dictionary of Psychology.
In *American Psychological Association* . Retrieved from
https://dictionary.apa.org/mood

Anfara, V. A., & Mertz, N. T. (2015). *Theoretical frameworks in qualitative research
(2nd ed.).* Thousand Oaks, CA: Sage.

Aspers, P. & Corte, U. (2019). What is qualitative in qualitative research. *Qualitative
Sociology, 42,* 139-160. https://doi:10.1007/s11133-019-9413-7

Atkinson, P., & Hammersley, M. (1998). Ethnography and rural participants observation. *In Strategies of Qualitative Inquiry*. London: Sage.

Baranov, V., Bhalotra, S., Biroli, P., & Maselko, J. (2020). Maternal depression, women's empowerment, and parental investment: Evidence from a randomized controlled trial. *American Economic Review, 110*(3), 824-859. doi:10.1257/aer.201805111

Barger, M. K. (2010). Maternal nutrition and perinatal outcomes. *Journal of Midwifery & Women's Health, 55*(6), 502-511. https://doi.org/10.1016/j.jmwh.2010.02.017

Bloom, T. L., Bullock, L. F., & Parsons, L. (2012). Rural pregnant women's stressors and priorities for stress reduction. *Issues Mental Health Nursing, 33*(12), 813-819. doi:10.3109/01612840.2012.712087

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology, 3*(2), 77-101.

Buysse, D. J., Reynolds, C. F., Monk, T. H., Berman, S. R., & Kupfer, D. J. (1989). The Pittsburgh sleep quality Index: A new instrument for psychiatric practice and research. *Psychiatry Research, 28*(2), 193–213. https://doi.org/10.1016/0165-1781(89)90047-4

Cannon, C., & Nasrallah, H. (2019). A focus on postpartum depression among African American women: A literature review. *Annals of Clinical Psychiatry: Official Journal of the American Academy of Clinical Psychiatrists, 31*(2), 138-143.

Caspersen, C. J., Powell, K. E., & Christenson, G. M. (1985). Physical activity, exercise, and physical fitness: Definitions and distinctions for health-related research. *Public Health Reports (1974), 100*(2), 126-131.

Catalano, A., Bennett, A., Busacker, A., Carr, A., Goodman, D., Kroelinger, C., Okoroh,

    E., Brantley, M., & Barfield, W. (2017). Implementing CDC's level of care

    assessment tool (LOCATe): A national collaboration to improve maternal and

    child health. *Journal of women's health (2002)*, *26*(12), 1265–1269.

    https://doi.org/10.1089/jwh.2017.6771

Centers for Disease Control and Prevention . (2020, July 2). Maternal, Infant & Toddler

    Nutrition, Physical Activity & Healthy Growth. *Division of Nutrition, Physical*

    Activity, and Obesity. Retrieved from

    https://www.cdc.gov/nccdphp/dnpao/resources/maternal-infant-toddler-

    resources.html

Charmaz, K. (2006). *Constructing grounded theory: A qualitative guide to practical*

    analysis. London: Sage.

Chien, W. T., Clifton, A. V., Zhao, S., & Lui, S. (2019). Peer support for people with

    schizophrenia or other serious mental illness. *Cochrane Database of Systematic*

    Reviews. doi:10.1002/14651858.cd010880.pub2

Collins, C. S., & Stockton, C. M. (2018). The Central Role of Theory in Qualitative

    Research. *International Journal of Qualitative Methods, 17*(1).

    https://doi.org/10.1177/1609406918797475

Corbin, J., & Strauss, A. (1990). Grounded theory research: Procedures, cannons, and

    evaluative criteria. *Qualitative Sociology, 13*(1), 3-21.

Corbin, J., & Strauss, A. (2015). *Basics of qualitative research: Techniques and*

    procedures for developing grounded theory. (4th ed.) Sage.

Dáil, P. Vw. (2015*). Hard living in America's heartland: Rural poverty in the 21st*
century midwest. Jefferson: McFarland & Company.

Davis, K. & Dimidijan, S. (2012). The relationship between physical activity and mood
across the perinatal period: A review of naturalistic and clinical research to guide
future investigation of physical activity–based interventions for perinatal
depression. *Clinical Psychology: Science and Practice, 19*(1), 27-48.

Davis, N.L., Smoots, A.N., Goodman, D.A. (2019). Pregnancy-related deaths: Data from
14 U.S. maternal mortality review committees, 2008-2017. In Centers for Disease
Control and Prevention, U.S. Department of Health, and Human Services.

DeCou, S. E. & Vidair, H.B. (2017). What low-income, depressed mothers need from
mental health care: Overcoming treatment barriers from their perspective. *Journal
of Child and Family Studies, 2017*(26), 2252-2265.

Dennis, C. (2003). Peer support within a health care context: A concept analysis.
International Journal of Nursing Studies, *40*(3), 321.

Dennis, C. (2002). Breastfeeding initiation and duration: A 1990-2000 literature review.
Journal of Obstetric, Gynecologic, and Neonatal Nursing, 31(1), 12.

Dennis C. L. (2005). Psychosocial and psychological interventions for prevention of
postnatal depression: Systematic review. *BMJ (Clinical research ed.)*, *331*(7507),
15. https://doi.org/10.1136/bmj.331.7507.15

Eapen, D. J., Wambach, K., & Domian, E. W. (2019). A qualitative description of
pregnancy-related social support experiences of low-income women with low-
birth-weight infants in the Midwestern United States. *Maternal Child Health
Journal, 23*(11), 1473-1481. doi:10.1007/s10995-019-02789-2

Emerson, R. M., Fretz, R., & Shaw, L.L. (2011). *Writing ethnographic fieldnotes.* Chicago: The University of Chicago Press.

End of Session Overview. (2022, June 20). In Generate Health: Champions of Family and Community. Retrieved from https://generatehealthstl.org/end-of-session-overview/

Evans, E.C., Bullock, L. (2017). Supporting rural women during pregnancy. *The American Journal of Maternal/Child Nursing*, *42*(1), 50.

Ezenwanne, E. (2011). Current concepts in the neurophysiologic basis of sleep: A review. *Analysis of Medical and Health Sciences Research, 1*(2), 173-179.

Fetterman, D. M. (1998). *Ethnography: Step by step*. Thousand Oaks, CA: Sage.

Fetterman, D. M. (2020). *Ethnography: Step by step (4th ed.).* Thousand Oaks, CA: Sage.

Finfgeld-Connett, D. (2005). Clarification of social support. *Journal of Nursing Scholarship, 37*(1), 4-9.

Garcia, E. R., & Yim, I. S. (2017). A systematic review of concepts related to women's empowerment in the perinatal period and their associations with perinatal depressive symptoms and premature birth. *BMC Pregnancy Childbirth, 17*(Suppl 2), 347. doi:10.1186/s12884-017-1495-1

Ginja, S., Jackson, K., Newham, J., Henderson E. J., Smart, D. & Lingam, R. (2020). Rural-urban differences in the mental health of perinatal women: A UK-based cross-sectional study. *BMC Pregnancy and Childbirth 20*(464), 1-11. doi.org/10.1186/s12884-020-03132-2

Glesne, C. (2011). *Becoming qualitative researchers: An introduction*. Boston, MA: Pearson.

Guardino, C. M., Hobel, C. J., Shalowitz, M. U., Ramey, S. L., & Dunkel Schetter, C..

> (2018). Psychosocial and demographic predictors of postpartum physical
>
> activity. *Journal of Behavioral Medicine*, *41*(5), 668–679.
>
> https://doi.org/10.1007/s10865-018-9931-x

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N.

> K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105–
>
> 117). Sage Publications, Inc.

Hage, J. (1972). *Techniques and problems of theory construction in sociology*. NY:

> Wiley & Sons.

Hagiwara N., Elston Lafata, J., Mezuk, B., Vrana, S.R., & Fetters, M.D. (2019).

> Detecting implicit racial bias in provider communication behaviors to reduce
>
> disparities in healthcare: Challenges, solutions, and future directions for provider
>
> communication training. *Patient Education Counsel*. 102, 1738–1743.

Haltinner, K. (2021). *No perfect birth: Trauma and obstetric care in rural United States*.

> London: Lexington Books.

Handcock, M. S., & Gile, K. J. (2011). Comment: On the concept of snowball

> sampling. *Sociological Methodology*, *41*(1), 367-371.

Harvard T.H. Chan School of Public Health. (2016, September 13). *Harvard willett food*

> *frequency questionnaire*.

Health in Rural Missouri Biennial Report 2018-2019. Retrieved

> from https://health.mo.gov

Helfer, R. E. (1987). The perinatal period, a window of opportunity for enhancing parent-

 infant communication: An approach to prevention. *Child Abuse & Neglect, 11*(4),

 565-579. doi.org/10.1016/0145-2134(87)90082-2

Hillerer, K. (2012). From stress to postpartum mood and anxiety disorders: How chronic

 peripartum stress can impair maternal adaptations. *Neuroendocrinology, 95*(1),

 22-38. doi://10.1159/000330445

Howell, E.A. (2018). Reducing disparities in severe maternal morbidity and mortality.

 Clinical Obstetrics and Gynecology, *2018*(61), 387–399.

H.R.5163 - Care for Her Act. (n.d.). In *CONGRESS.GOV*. Retrieved from

 https://www.congress.gov/bill/117th-congress/house-

 bill/5163?q=%7B%22search%22%3A%5B%22care+for+her+act%22%2C%22ca

 re%22%2C%22for%22%2C%22her%22%2C%22act%22%5D%7D&s=8&r=1.

Hsu, H.C. & Wickrama, K. A.S. (2018). Maternal life stress and health during the first 3

 years postpartum. *Women Health 58*(5), 565-582.

Ibrahim, N., Thompson, D., Nixdorf, R., Kalha, J., Mpango, R., Moran, G., . . . Slade, M.

 (2020). A systematic review of influences on implementation of peer support

 work for adults with mental health problems. *Social Psychiatry and Psychiatric

 Epidemiology, 55*(3), 285-293. doi:10.1007/s00127-019-01739-1

Jaccard, J., & Jacoby, J. (2010*). Theory construction and model- building skills: A

 practical guide for social scientists*. New York: Guilford Publications.

Kabeer, N. (1999). Resources, agency, achievements: reflections on the measurement of

 women's empowerment. *Development and Change, 30*(3), 435–464.

Kamarck, T., Mermelstein, R., & Cohen, S. (1983). A global measure of perceived stress. *Journal of Health and Social Behavior, 24*(4), 385-396. https://doi.org/10.2307/2136404

Lagendijk, J., Sijpkens, M. K., Ernst-Smelt, H. E., Verbiest, S. B., Been, J. V., & Steegers, E. A. P. (2020). Risk-guided maternity care to enhance maternal empowerment postpartum: A cluster randomized controlled trial. *PLOS ONE, 15*(11), e0242187. doi: 10.1371/journal.pone.0242187

Lazarus, R. S. (2006). Emotions and interpersonal relationships: Toward a person-centered conceptualization of emotions and coping. *Journal of Personality, 74*(1), 9-46. https://doi.org/10.1111/j.1467-6494.2005.00368.x

Leung, B., Giesbrecht, G.F., Letourneau, N., Field, D., Bell, R., & Dewey, D. (2016). Perinatal nutrition in maternal mental health and child development: Birth of a pregnancy cohort. *Early Human Development*, 93, 1-7.

Luca, D. L., Margiotta, C., Staatz, C., Garlow, E., Christensen, A., & Zivin, K. (2020). Financial toll of untreated perinatal mood and anxiety disorders among 2017 births in the United States. *American Journal of Public Health*, *110*(6), 888–896. https://doi.org/10.2105/AJPH.2020.305619

Mahlke, C. I., Priebe, S., Heumann, K., Daubmann, A., Wegscheider, K., & Bock, T. (2017). Effectiveness of one-to-one peer support for patients with severe mental illness - a randomized controlled trial. *European Psychiatry, 42,* 103.

Malhotra, A. & Schuler, S. R. (2005). Women's empowerment as a variable in international development. *Measuring Empowerment: Cross-Disciplinary Perspectives*, 71–88.

March of Dimes. (2017). Prenatal care check-ups. *March of Dimes.* Retrieved from

https://www.marchofdimes.org/find-support/topics/planning-baby/prenatal-care-

checkups.

Mayan, Maria. (2009). *Essentials of qualitative inquiry*. Walnut Creek, CA: Left Coast

Press.

McLeish, J., & Redshaw, M. (2015). Peer support during pregnancy and early

parenthood: a qualitative study of models and perceptions. *BMC Pregnancy

Childbirth, 15*, 257. doi:10.1186/s12884-015-0685-y

McLeish, J., & Redshaw, M. (2017). Mothers' accounts of the impact on emotional

wellbeing of organized peer support in pregnancy and early parenthood: A

qualitative study. *BMC Pregnancy Childbirth, 17*(1), 28. doi:10.1186/s12884-

017-1220-0

McNair, D.M., Lorr, M., & Droppleman, L.F. (1971). *Manual for the profile of mood

states*. San Diego: Education & Industrial Testing Service.

Merrell, L. K., & Blackstone, S. R. (2020). Women's empowerment as a mitigating factor

for improved antenatal care quality despite impact of 2014 Ebola outbreak in

Guinea. *International Journal Environmental Research in Public Health, 17*(21).

doi:10.3390/ijerph17218172

Merriam, S. B. (2002). *Qualitative research in practice: Examples for discussion and

analysis.* San Francisco, CA: Jossey-Bass.

Merriam, S. B. (2009*). Qualitative methods: A guide to design and implementation

revised and expanded from qualitative research and case study applications in

education.* San Francisco, CA: John Wiley and Sons.

Merriam, S. B., & Tisdell, E. J. (2016*). Qualitative research: A guide to design and implementation. (4th ed.)*. Jossey-Bass. San Francisco, CA.

Miles, M. B., Huberman, A. M., & Saldaña, J. (2014). *Qualitative data analysis: A methods sourcebook*. Thousand Oaks, CA: Sage.

Missouri Department of Agriculture. (2023). Missouri's major crops. Retrieved from https://agriculture.mo.gov/abd/intmkt/pdf/missouri-major-crops-snapshot.pdf.

Missouri Department of Health and Senior Services. (2021).Welcome to WIC. *Missouri WIC Income Guidelines – April 1, 2021*. Retrieved from https://health.mo.gov/living/families/wic/

Missouri Department of Natural Resources. (2001). Land and geology. Retrieved from https://dnr.mo.gov/land-geology.

Missouri Pregnancy Associated Mortality Review 2018 Annual Report. Missouri Department of Health and Senior Services. (June 2021).

Mollard, E., Hudson, D. B., Ford, A., & Pullen, C. (2016). An integrative review of postpartum depression in rural U.S. communities. *Archives of Psychiatric Nursing*, *30*(3), 418–424. https://doi.org/10.1016/j.apnu.2015.12.003

Mom Congress (2021). Our Issues. *MomsCongress.* Retrieved from https://www.mom-congress.com/our-issues.

Mosedale, S. (2005). Assessing women's empowerment: towards a conceptual framework. *Journal of International Development, 17*(2), 243–257.

Muecke, M. A. (1994). On the evaluation of ethnographies. In Janice M. Morse (Ed.), *Critical Issues in Qualitative Research Methods* (pp.187-209). Thousand Oaks, CA: Sage.

Nethery, E., Gordon, W., Bovbjerg, M. L., & Cheyney, M. (2018). Rural community

 birth: Maternal and neonatal outcomes for planned community births among rural

 women in the United States, 2004-2009. *Birth, 45*(2), 120-129.

 doi:10.1111/birt.12322

Nickelson P. F. (2023). Missouri's public health at a glance. *Missouri Medicine*, *120*(1),

 4–7.

Oborn, E., Barrett, M., Gibson, S., & Gillard, S. (2019). Knowledge and expertise in care

 practices: The role of the peer worker in mental health teams. *Sociology of Health*

 & Illness, 41(7), 1305-1322. https://doi.org/10.1111/1467-9566.12944

Patton, M. Q. (2015). *Qualitative research and evaluation methods. (3rd ed.).* Sage.

Ranji, U., Frederiksen, B., Salganicoff, A. & Long, M. (2021). Women, work, and family

 during COVID-19: Findings from the KFF women's health survey. In *Kaiser*

 Family Foundation. Retrieved from https://www.kff.org/womens-health-

 policy/issue-brief/women-work-and-family-during-covid-19-findings-from-the-

 kff-womens-health-survey/.

Razurel, C., Kaiser, B., Antonietti, J. P., Epiney, M. & Sellenet, C. (2017) Relationship

 between perceived perinatal stress and depressive symptoms, anxiety, and

 parental self-efficacy in primiparous mothers and the role of social support.

 Women & Health, 57(2), 154-172. doi://10.1080/03630242.2016.1157125

Reyes, A. M., Akanyirige, P. W., Wishart, D., Dahdouh, R., Young, M. R., Estrada, A., .

 . . Simon, M. A. (2021). Interventions addressing social needs in perinatal care: A

 systematic review. *Health Equity, 5*(1), 100-118. doi:10.1089/heq.2020.0051

Richardson, R. A. (2017). Measuring women's empowerment: A critical review of current practices and recommendations for researchers. *Social Indicators Research, 137*(2), 539-557. doi:10.1007/s11205-017-1622-4

Roper, J. M., & Shapira, J. (2000). *Ethnography in nursing research*. Sage Publications.

Sallis, J. F., Haskell, W. L., Wood, P. D., Fortmann, S. P., Rogers, T., Blair, S. N., & Paffenbarger, R. S., (1985). Physical activity assessment methodology in the five-city project. *American Journal of Epidemiology*, *121*(1), 91–106. https://doi.org/10.1093/oxfordjournals.aje.a113987

Shumaker, S. A., & Brownell, A. (1984). Toward a theory of social support: Closing conceptual gaps. *Journal of Social Issues, 40*(4), 11-36. doi.org/10.1111/j.1540-4560.1984.tb01105.x

Slama, K. (2004). Rural culture is a diversity issue. *Minnesota Psychologist, 53,* 9-13.

Sriraman, N. K., Pham, D.-Q., & Kumar, R. (2017). Postpartum depression: What do pediatricians need to know? *Pediatrics In Review, 38*(12), 541-551. https://doi.org/10.1542/pir.2015-0133

Tapal, A., Oren, E., Dar, R., & Eitam, B. (2017, 2017-September-12). The sense of agency scale: A measure of consciously perceived ontrol over one's mind, body, and the immediate environment. *Frontiers in Psychology, 8*. https://doi.org/10.3389/fpsyg.2017.01552

Taylor, J. K. (2020). Structural racism and maternal health among Black women. *The Journal of Law, Medicine & Ethics, 48*(3), 506-517. https://doi.org/10.1177/1073110520958875

Tie, Y.C., Birks, M., & Francis, K. (2019). Grounded theory research: A design
framework for novice researchers. *SAGE Open Medicine, 7,* 1-8.
https://doi:10.1177/205031211882 2927

Tikkanen, R., Gunja, M. Z., FitzGerald, M., & Zephyrin, L. (2020, November 18).
Maternal Mortality and Maternity Care in the United States Compared to 10 Other
Developed Countries. In *The Commonwealth Fund*. Retrieved from
https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-
mortality-maternity-care-us-compared-10-
countries#:~:text=In%202018%2C%20there%20were%2017,%2C%20Norway%
2C%20and%20New%20Ze.

Tomfohr, L. M., Buliga, E., Letourneau, N. L., Campbell, T. S., & Giesbrecht, G. F.
(2015). Trajectories of sleep quality and associations with mood during the
perinatal period. *Sleep, 38*(8), 1237-1245. https://doi.org/10.5665/sleep.4900

Yeung, W. S., Hancock, N., Honey, A., Wells, K., & Scanlan, J. N. (2020). Igniting and
maintaining hope: The voices of people living with mental illness. *Community
Mental Health Journal, 56*(6), 1044–1052. https://doi.org/10.1007/s10597-020-
00557

Wall, S. (2015). Focused ethnography: A methodological adaptation for social research in
emerging contexts. *Forum: Qualitative Social Research*, *16*(1), 1-15.
https://doi.org/10.17169/fqs-16.1.2182

Wolcott, Harry F. (1999). *Ethnography: A way of seeing*. Walnut Creek, CA: AltaMira
Press.

World Health Organization (2019). Trends in maternal mortality, 2000 to 2017: Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Geneva. *WHO Press, 2019.*

World Health Organization (2022). Launch of the WHO guide for integration of perinatal mental health in maternal and child health services. Retrieved from https://www.who.int/news/item/19-09-2022-launch-of-the-who-guide-for-integration-of-perinatal-mental-health.

Wouk, K., Morgan, I., Johnson, J., Tucker, C., Carlson, R., Berry, D.C., & Stuebe, A.M. (2021). A systematic review of patient, provider, and health system-level predictors of postpartum health care use by people of color and low-income and/or uninsured populations in the United States. *Journal of Women's Health*, *30*(8), 1127-1159

Zauszniewski, J. A. (2016). Resourcefulness. *Western Journal of Nursing Research, 38*(12), 1551-1553. doi:10.1177/0193945916665079

Zimet, G. D., Dahlem, N. W., Zimet, S. G. & Farley, G. K. (1988). The multidimensional scale of perceived social support. *Journal of Personality Assessment*, 52, 30–41.

Figure 1
Empowerment Framework
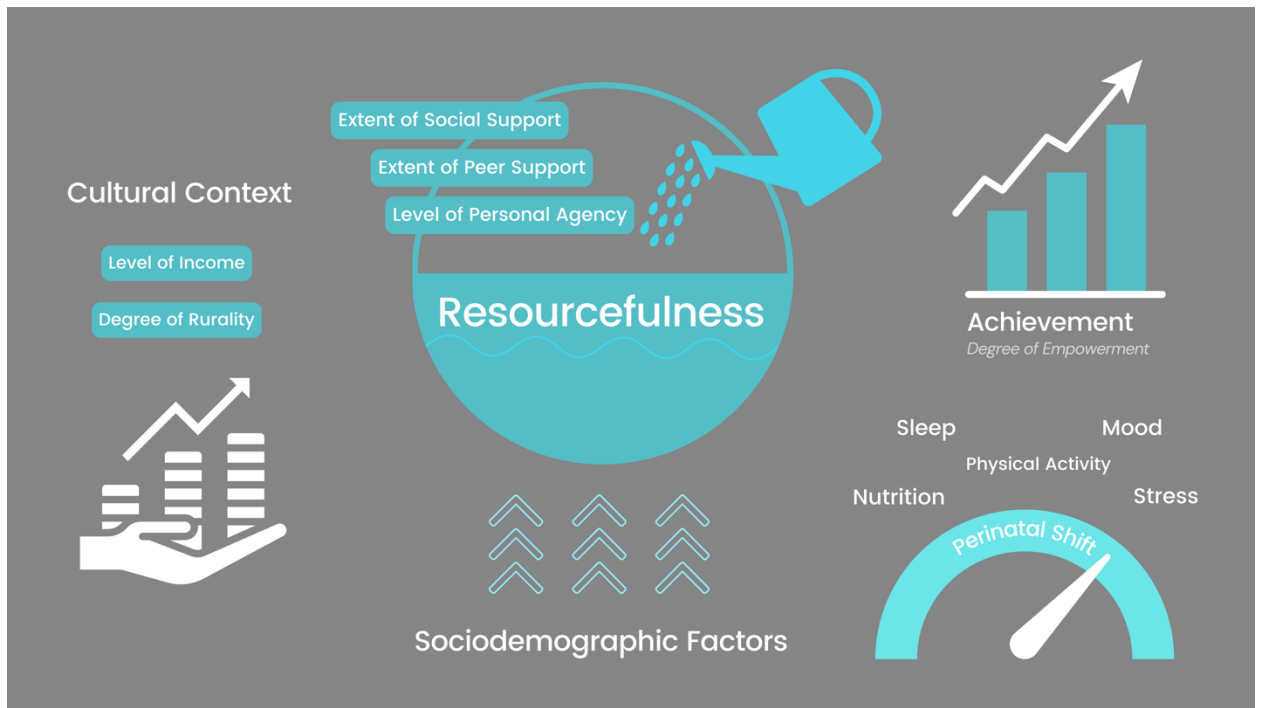
Figure 2

Empowerment Framework for a Subculture of Rural Low-income Missouri Mothers
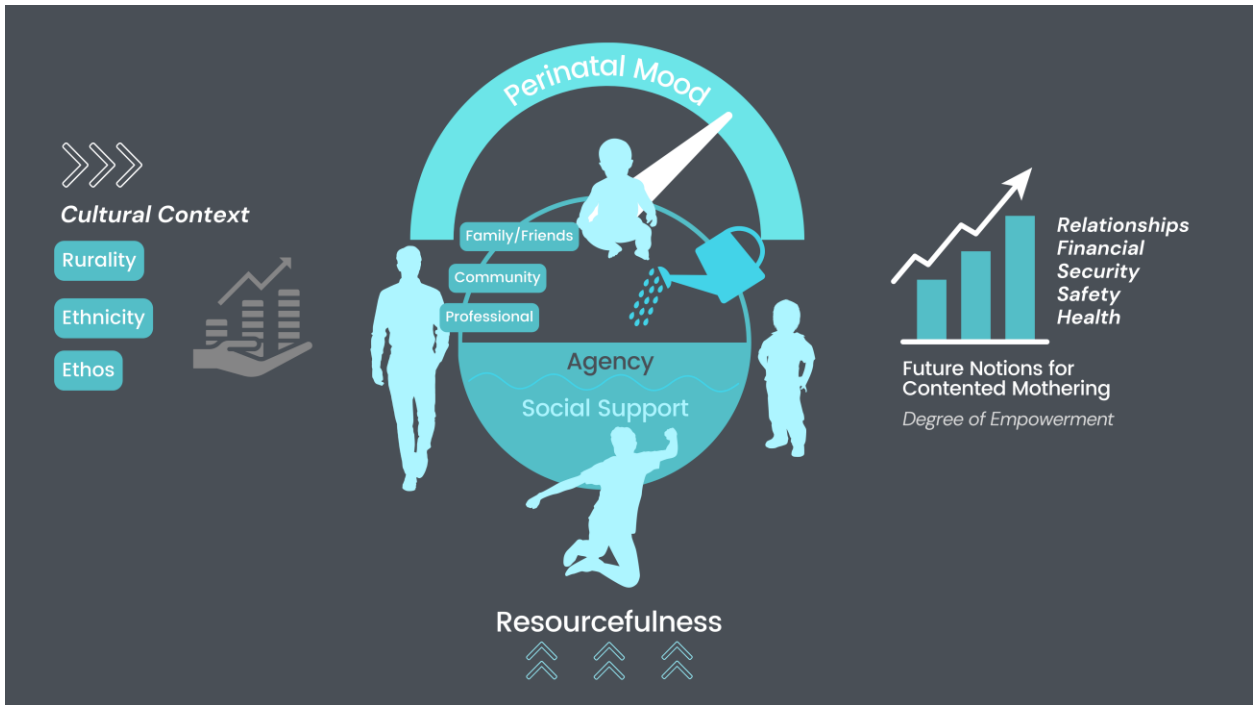
Table 1

Hage Framework for Concept Development

Main Concept
Concept: Degree of Empowerment
Theoretical Definition: The process of women improving their ability to make intentional life choices (Kabeer, 1999).
Operational Definition: The total score as measured by the Personal Progress Scale-Revised (Richardson, 2017).

Resources
Concept: Extent of Social Support
Theoretical Definition: The amount of advocative interpersonal exchanges between two individuals perceived to enhance the wellbeing of the recipient (Finfgeld-Connett, 2005; Shumaker & Brownell, 1984).
Operational Definition: The total score as measured by the self-reported Multidimensional Perceived Scale of Social Support (Zimet et al., 1988).

Concept: Extent of Peer Support
Theoretical Definition: Guidance from people who have like experiences who are not rooted in the person's network (Dennis, 2003).
Operational Definition: The total score as measured by the self-reported Multidimensional Perceived Scale of Social Support (Zimet et al., 1988).

Perinatal Shift
Concept: Quality of Mood
Theoretical Definition: The disposition to respond emotionally in a particular way, or any short-lived emotional state (American Psychological Association, 2020).
Operational Definition: The total score as measured by the self-reported Profile of Mood States (McNair, Lorr & Droppleman, 1971).

Concept: Degree of Stress
Theoretical Definition: The number of appraised situational demands that exceed available resources (Lazarus, 2006).
Operational Definition: The total score as measured by the self-reported Perceived Stress Scale over a 1-month time interval (Kamarck, Mermelstein, & Cohen, 1983).

Concept: Quality of Sleep

Theoretical Definition: The degree to which the naturally recurring state of relatively suspended sensory and motor activity, characterized by total or partial unconsciousness and nearly complete inactivity of voluntary muscles is restful and sound (Ezenwanne, 2011).

Operational Definition: The total score as measured by the self-reported Pittsburgh Sleep Quality Index over a 1-month time interval (Buysse et al., 1989).

Concept: Extent of Good Nutrition

Theoretical Definition: The amount that the diet and patterns of eating that affect physiologic function reflect a variety of healthy foods (Barger, 2010; CDC, 2021).

Operational Definition: The total score as measured by the self-reported Harvard Willett Food Frequency Questionnaire (Harvard University, 2015).

Concept: Degree of Physical Activity

Theoretical Definition: The amount of bodily movement produced by skeletal muscles that resulted in energy expenditure above resting level (Caspersen, Powell & Christenson, 1985).

Operational Definition: The amount of energy expenditure above resting level resulting from bodily movement as measured by the 7 Days of Physical Activity Recall (Sallis et al., 1985).

Cultural Context

Concept: Degree of Rurality

Theoretical Definition: An area that does not contain any part of a central city in a Metropolitan Statistical Area and has less than 150 people per square mile (Health in Rural Missouri Biennial Report, 2018-2019).

Operational Definition: The location a person is living.

Concept: Level of Income

Theoretical Definition: The household income may be no more than 185% of the federal poverty income guidelines. In Missouri, for a household of one, the mother is eligible if she makes less than $23,828 (Missouri Department of Health and Senior Services, 2021).

Operational Definition: The amount of money a person declares as income.

Concept: Degree of Agency

Theoretical Definition: Defining and acting upon goals. Agency includes the meaning, motivation, and purpose behind the activity or `the power within' (Kabeer, 1999).

Operational Definition: The total score as measured by the Sense of Agency Scale (Tapal et al., 2017).

Table 2

Resourcefulness Versus Resources

Resourcefulness (Zauszniewski, 2016)	Resources (Kabeer, 1999)
Skills centering on helping oneself or the use of resources to achieve health.	Material, human, and social means that foster the ability to choose
Intrinsic forces	Extrinsic forces
It includes two types of resourcefulness: personal (self-help) and social (help-seeking)	
The cognitive-behavioral skills are complementary and equally important for attaining, maintaining, or regaining health despite adverse situations.	

Table 3

Research Studies: Peer Support

Citation and Country	Aim	Sample	Methods	Key Findings	Recommendation	Level of Evidence
Eapen et al. (2019), USA	Social support may minimize the impact of adverse life situations.	Women who had given birth to a LBW infant within the past 9 months. (*n*=15)	Interviews	Three themes emerged: women's experience of pregnancy; challenges faced by women during pregnancy; and availability of essential supports for women during pregnancy.	Healthcare services need to prioritize social support needs and should implement individualized interventions at the primary healthcare level. Providers need education and training to identify social support needs and implement interventions. A peer group support model that constitutes pregnant women with similar health or economic issues could be implemented. Social support could also be integrated into the WIC program.	IV

McLeish & Redshaw (2015), England	Explore peer support for women experiencing a range of vulnerabilities during pregnancy and the postnatal period.	Volunteers (*n*=47) and mothers (*n*=42) from peer support projects	Interviews	The overarching themes identified were (1) What is peer support? (2) Who is a peer supporter? And (3) The peer support relationship.	Individual projects should give clear information about what kind of model is in operation and what they actually offer to care professionals who may refer mothers, and to mothers who may benefit from support, without losing the flexibility and individuality of their response. It is also important for evaluation that the characteristics of the models are fully described to enable meaningful comparison.	VI
McLeish & Redshaw (2017), England	Explores peer support and the emotional wellbeing of moms.	Disadvantaged Black and ethnic minority moms (*n*=47)	Interviews	Two key themes emerged: (1) mothers' self-identified emotional needs and (2) how peer support affects mothers. Women described how peer support contributed to	Care provision and funding for pregnancy and postnatal peer support projects should recognize the positive impact of receiving face to face, organized support from trained supporters. Research should explore, both qualitatively and quantitatively, the extent and ways in which perceptions of peer support and its impact on	VI

	reducing their low mood and anxiety by overcoming feelings of isolation, disempowerment, and stress, and increasing feelings of self-esteem, self-efficacy, and parenting competence.	emotional wellbeing differ for mothers from a range of different cultural and socioeconomic backgrounds, with diverse and varying challenges in their lives, and with varying degrees of severity of mental illness.	

Table 4
Outcomes of Peer Support

Themes	Subthemes	Definition	Implication
Pregnant Mother:			
Self-identified emotional needs'	Emotional distress'	A collapse in self-confidence when compared to idealized	Current difficult circumstances had affected emotional

		images of 'perfect' motherhood	wellbeing during pregnancy or afterwards and past traumas continued to weigh on their minds.
	Stressful circumstances	Emotional effects of difficult life experiences	
Perceived challenges	Physical and emotional Work/Financial Low-birthweight infant	Circumstances that give rise to hardship or strife, emotional or physical.	Manifests physical and emotional stress to mother and infant.
Availability of essential supports	Intimate partner relationship and availability Family relationships and availability Healthcare experiences/provider support Other supports	Lack of emotion/physical infrastructure or beings.	Feelings of overwhelm by situation and lacked the resources to cope, feelings consistent with low self-efficacy, lack of social support, and unwilling to be open with professionals.
Experience of pregnancy	Women's feelings and readiness for pregnancy	The physical and emotional changes associated with growing a baby	Need for physical and psychological supports.

Peer Support on Mothers:			
Social connection	Practical support	Personalized and responsive nature of the encounters between peer and mother.	Stress reduction through ability to connect through experience.

Empowerment		Confidence, value and being heard due to the relationship of trust between peer and mother.	Peer supporters had been trained in non-directive listening and this was the aspect of their support that was most valued. Emotional release of being able to talk openly, particularly about feelings of emotional distress.
Significance of mental health		Focus on care for self, mind, and body.	Reducing low mood and anxiety by overcoming feelings of isolation, disempowerment, and stress, and increasing feelings of self-esteem, self-efficacy, and parenting competence

Eapen, Wambach & Domian, 2019; McLeish & Redshaw, 2015, 2017

Table 10

Field Notes

Location	Time Spent (hours)	Description of Setting
Steele, Pemiscot: Dollar General	2	Dark inside, quiet, desolate, 3 middle-age white men and 2 older Black females inside Across the street from the laundromat

		No sidewalks 2 thin middle-aged white women carrying bags and smoking cigarettes walking on opposite side of the street outside. No houses nearby
Kennett, Dunklin: Casey's General Store	1	Well-lit, clean, quiet 4 white overweight middle-aged women and 2 white older overweight men inside 8 cars parked outside
New Madrid, New Madrid: Family Dollar	1	Well-lit, quiet, 3 elderly white women perusing the aisles slowly

Appendix A

Interview Protocol & Questions

Thank you for allowing me the opportunity to speak with you. It will take up to an hour to complete the interview, but we can stop at any point.

As you know, I am interested in learning about how support has impacted your postpartum journey. I would like to learn all that I possibly can about your experiences so that I can describe your journey. With your permission I will be audio recording this conversation and will tell you before I begin the recording.

I want you to take all the time you need to think about the questions before answering. I am happy to repeat any questions. If for any reason you are not comfortable with a question, please let me know and we will skip that question.

The audio recording will be typed up word for word. In order to maintain confidentiality all personal identifying information will be removed such as your name, the names of others, or anything unique that could identify you will be removed. Do you have any questions about this process? What pseudonym would you like me to refer to you as?

Finally, it is my obligation to help you get the help you need if you disclose that you are thinking about harming yourself or others. Emergency Hotlines are available all the time. It is very important that you reach out right now and find the support and information you need to be safe. The National Maternal Mental Health Hotline, call or text 1-833-9-HELP4MOMS or 1-833-943-5746 OR 988, the National Prevention Suicide Hotline, from anywhere in the USA, anytime, about any type of crisis.

Let's begin our conversation; I will now start the audio recording…First I will begin with brief demographic-type questions.

Demographic Survey
1. What is your age?

2. What is your self-identified sex?

3. What County do you reside in?

4. Which race/ethnicity describes you?

5. Is English your first language?

6. What is your employment status?

7. What is the highest level of school you have completed or the highest degree you have received?

8. Which of the following best describes your current relationship status?

9. How many children do you have and what are their ages?

10. How many times have you been pregnant?

Next, we will move forward with the questions surrounding your postpartum journey.
Questions surrounding **<u>support</u>**:

For example:

Thinking back to before you got pregnant, what did support mean to you?
　　(Social and peer support)

Now that you are a mother, can you tell me what social support looks like or feels like.

Please provide examples of supportive encounters.

What is missing from these encounters?

What are you looking for that you did not have?

Now shifting to questions of **<u>wellbeing</u>**.

For example:

When I was pregnant, I noticed a shift in my emotional, physical, and spiritual self. (I wonder what it has been like for you.) Pause and listen for response.

Tell me what a happy life looks like in terms of mom and baby.

What are your experiences with thoughts and feelings that have emerged with becoming a mom?

Finally, questions about your **<u>community</u>** and **<u>your ability to make intentional choices in your life</u>** (empowerment).

For example:

Describe your community.

Please paint a picture of your community as if I were to step inside your home.

Please describe the perfect environment for your child to thrive and grow.

Describe your experiences between the support you have received and your feelings of choice.

Do you have the experience that life is happening to you versus you choosing life? Please explain.

Do you think empowerment comes from you or do you feel empowered by your support network? Please explain.

Is there anything more you would like to share that I did not ask?

Thank you so much for your time and for sharing your honest experiences. The information you shared with me today will certainly be appreciated by postpartum moms and those in health.

Appendix B

Fieldnotes of Rural Communities

1. Date:

2. Location:

3. Time Spent:

4. Description of Setting (concrete sensory details the basic scene, settings, objects, people, and actions) (Emerson et al., 2011):

5. Dialogue in Setting (conversations that occur among community members):

6. Characterization (description of persons encountered-acts, talks, and relates to others) (Emerson et al., 2011):

7. Reflection:

Appendix C

Informed Consent for Participation in Research Activities

University of Missouri–St. Louis
Informed Consent for Participation in Research Activities

Project Title: Maternal support and empowerment among rural WIC-eligible women
Principal Investigator: Christina Castellano, BA, BSN, RN, and Dr. Julie Bertram PhD
IRB Project Number: 2093163 SL

1. You are invited to participate in a research study. The purpose of this research is to understand the distinct experiences of rural WIC-eligible mothers with postpartum outreach and empowerment.
2. Your participation will involve meeting virtually for up to 60 minutes for an audio-recorded interview about your experiences as a mother.
3. For your time and effort, we will be offering compensation in the amount of a $25 Visa gift card.
4. There is a loss of confidentiality risk associated with this research. This will be minimized by using a protected interview platform, having you chose a fake name to protect your identity, and storing contact information separate from interview data. You may experience emotional/psychological discomforts from questions asked during the interview or difficult memories. You may skip any questions you do not want to answer. If you experience distress during the study, please inform the researcher right away to discuss further steps. In addition, it is the researcher's obligation to help you get the help you need if you disclose that you are thinking about harming yourself or others. Emergency Hotlines are available all the time. It is very important that you reach out right now and find the support and information you need to be safe. The National Maternal Mental Health Hotline, call or text 1-833-9-HELP4MOMS or 1-833-943-5746 OR 988, the National Prevention Suicide Hotline, from anywhere in the USA, anytime, about any type of crisis.
5. There is no direct benefit to you from taking part in this study. However, the information we learn from you during this study may help us learn more about the impact of support on postpartum women.
6. Your participation is voluntary, and you may choose not to participate in this research study or withdraw your consent at any time. You will NOT be penalized in any way should you choose not to participate or withdraw.
7. We will do everything we can to protect your privacy. As part of this effort, your identity will not be revealed in any publication that may result from this study. In rare instances, a researcher's study must undergo an audit or program evaluation by an oversight agency (such as the Office for Human Research Protection) that would lead to disclosure of your data as well as any other information collected by the researcher.
8. If you have any questions or concerns regarding this study, or if any problems arise, you may call the Investigator, Christina Castellano at (314) 677-8827 or the Faculty Advisor, Dr. Julie Bertram at 314-516-8612. You may also ask questions or state

concerns regarding your rights as a research participant to the University of Missouri–St. Louis Office of Research Compliance, at 314-516-5972 or irb@umsl.edu.

Flyer

SHARE YOUR VOICE

University of Missouri–St. Louis, College of Nursing

Did you have a baby within the last 2 years? Please join us in sharing your experiences of motherhood.

You qualify if you:
- Are over the age of 18 years
- Had a baby in the last 2 years
- Live in a rural area
- Qualify for WIC

Potential Benefits:
Participation in this study may improve your postpartum experience, give voice to postpartum women, and strengthen empowerment programs for all perinatal women.
$25 Gift Card upon completion

Participation Involves:

Attending a phone call or zoom meeting at a designated time for up to one hour.

Please contact Christina at 314-677-8827 or cc82d@umsystem.edu for more information

Appendix E

Abbreviated Codebook

CATEGORY	Cultural Context
SUBCATEGORY	**Rurality**
PROPERTY	**Remoteness**
DIMENSION	Degree of remoteness
TEXT EXAMPLE	Brown flatness 200 hundred miles from home Thick haze and deep trenches Casey's General Store
Property	**Geographical influence**
DIMENSION	Low to high degree of geographical influence
TEXT EXAMPLE	Agriculture
SUBCATEGORY	**Ethnicity**
PROPERTY	**Place of origin**
DIMENSION	Degree of proximity to current residence

TEXT EXAMPLE	"Yeah, it has a library. It also has a place for a workout. A place I go for walks. I have a few friends here and we meet" (Jennifer B, lines 128-131)
SUBCATEGORY	**Ethnicity**
PROPERTY	**Influential family heritage**
DIMENSION	Low to high degree of influential family heritage
TEXT EXAMPLE	"I'm by a little river. You can actually drive on the streets. Well, it is quite different from what we had before because where we were in Southern Asia before was much more rural. This is an achievement. I get to meet friends with and all that stuff. Another thing there is that you know, getting somewhere… some grocery shops…but here you get to drive in a car like a drive home from 10 minutes or so" (Mary, lines 57-61).
SUBCATEGORY	**Ethos**
PROPERTY	**Values**
DIMENSION	Individualism to collectivism
TEXT EXAMPLE	"I feel like my community could support me more. The community is a place where people really care about themselves. People care about themselves, everyone for themselves. That is what happens currently in the current world in the current community that I live in" (Ann, lines 54-56). "It is a rural area, but I don't think anyone knows that rural areas are more connected than urban. I'll take this to the bank, and I'm sure going to see…it is very well connected, they (are) more connected. They have a sense of belonging. They have a good sense of belonging. So, because it is a rural area, everyone sees themselves as one, and people tend to care for each other. So, I'm really thankful that I find myself here" (Pricillia, lines 149-153).

SUBCATEGORY	**Ethos**
PROPERTY	**Black womanhood identity expression**
DIMENSION	Low to high degree of identity expression
TEXT EXAMPLE	I have tried to seek help, but I have experienced barriers in class and race. I feel like I do not belong in that circle where I can seek professional help for my mental health or my personal health (lines 101-103)… Like I wouldn't get the help I need and maybe I'll be looked down on like I'm less of a person or less of a human (lines 108-109)…I have friendly health care providers here. I feel like I wouldn't have had that if I were in California because there, we had…it was like a mess. There were, you know, many persons and people around California. But over here I feel like I get the healthcare service I need. And for my son, too (lines 160-163)…I feel like this this stereotype around Blacks and mental health issues. So, I just feel like that's the difference okay (Beth, lines 168-169). Well, for me community is, actually, yes, I know as a Black human, as long as you allow me to leave and come in peace, and stuff yes, live in peace, and as long as my loved ones are safe, and I'm safe…(Jessica, lines 101-104). "[In regard to discrimination] I mean being able to move freely without being harassed by the police and security officials" (Beth, lines 201-202). I think even if I felt it (power) from within, because I'm married, the way I was brought up, I was told to respect my husband, and then there are some certain decisions I can't just make them by myself. I need to tell him, even if I need to do it… so then he will give me the go ahead (lines 37-40)…Well, as a Black American I don't know all the way. We were told to, you know, accept our fate. We believe it so much. Believe in faith. You so much believe in the world. You believe it's right (Lucy, lines 46-49).
CATEGORY	**Social Supports**

SUBCATEGORY	Family
PROPERTY	**Advocative roles of adults**
DIMENSION	Degree of advocative role
TEXT EXAMPLE	"But, you know, I do have good support within my family, friends. That's all I've ever had…And then, the biggest supporter in my life is my mom's oldest sister, who is still living. And she's been kind of my angel my whole life. Because we had a hard childhood, my mom had a hard time parenting and providing and she's always been our angel that swoops in and saves the day (lines 196-200)…And if it wasn't for my aunt, and she's financially supported me, and emotionally supported me, she's my cheerleader, she's everything. Of course, I have friends, also and family. But she's been my consistent support system. My aunt, she, and my uncle. They're farmers. So, they've always, you know, had a little extra to kind of help me out my whole life. While my mother was not able to…"(Carley, lines 233-237). "So, my sister came, and during her time she really helped me with the way I do things. During this time frame, she introduced me to some programs which were really helpful and helped me find peace" (Marie, lines 41-43).
SUBCATEGORY	**Family**
PROPERTY	**Being present**
DIMENSION	Low to high degree of presence

TEXT EXAMPLE	"But my family all lives really close to me, so I have like emotional support of that (lines 60 62)…They'll ask if they can just take Lorie overnight…so that my husband and I can do something together" (Nichole, lines 78-80). "I will be honest with you. It which was a big experience because I think it was something very new. So, I didn't know how to go about it but thankfully, my family was there. I've been hearing stories about how motherhood is not a child's play, how motherhood is not a place where you play dumb, a movie or something. No sir…So I think I, you know, I prepared my mind to this with my family" (Pricillia, lines 116-120). "I feel supported from my friends, my cousins, and my husband. I feel really supported from them…and (they) get me through trying times and I'm thankful for that..."(Jessica, lines 66-69). "My family was supporting me. My husband was supporting me…" (Elisa, line 9). "Just like when before I had my first miscarriage, although it was very difficult, I got support from my family, especially my husband" (Mary, lines 11-12).
SUBCATEGORY	**Community**
PROPERTY	**Common experiences**
DIMENSION	Low to high degree of common experiences

TEXT EXAMPLE	"Yeah, Okay, we have a support group right now. We talk through a group on social media. But I feel like I have adequate support from other moms" (Mellisa, lines 12-13). "Because it's awesome, someone doesn't know something, or you aren't sure about something, you aren't sure about a certain thing, especially when you're a new mom so you need to ask some questions. Maybe about breastfeeding, about even feeding the baby, shopping, and everything. So, you need to ask some other people who have been moms earlier before you were one. And it was even much better when I heard from other moms. That's the source of assurance I needed because they have been through this, so they are the source of assurance, and I trusted them more because they have had this experience" (Mellisa, lines 19-23). "I went to a group when I was pregnant. I was on this social media group. Well, we have about more than a 100 people. We have somebody that is a doctor in the group to tell us what to do. So, I really see that as a support-you go there and tell whatever you're going through. Whatever the feeling, how you feel what other questions you have" (Lucy, lines 12-16). "Good support is like a lot of these groups for mothers with kids with autism" (Kim, line 174). "I don't know I feel like there are a lot of support groups out here in the world. I feel like we need more help with like if your kid has any type of issues. There're no resources for that" (Kim, lines 276-277).
SUBCATEGORY	**Community**
PROPERTY	**Shared beliefs**
DIMENSION	Low to high degree of shared beliefs
TEXT EXAMPLE	"Some of the few (members of church) came by the house. Other members started calling me to set up a time to maybe visit" (Lucy, lines 84-85).
SUBCATEGORY	**Professional**

PROPERTY	Therapy utilization
DIMENSION	Degree of use Perceived benefit
TEXT EXAMPLE	"Currently, I do not have a professional to you know talk to about my problems and about how I feel about issues and things that are currently bothering me. So, I feel like that's missing" (Beth, lines 95-97). "(In speaking about therapy) you know where I could open up my heart" (Jessica, line 37).
SUBCATEGORY	**Professional**
PROPERTY	**Government program involvement (WIC, First Steps, Building Blocks)**
DIMENSION	Degree of involvement
TEXT EXAMPLE	"Providers, doctors, and nurses and I appreciate that" (Kim, line 179). "I love all the ladies they come from First Step…So it's like a set of sisters" (Kim, line 312)…"like I love them to death. And they help me on my lowest days…and then we have been in Building Blocks since they were like babies"…(Kim, lines 317-318) "(speaking of WIC) mindset and my mental talk" (Marie, lines 15-17).
CATEGORY	**Perinatal Mood**
PROPERTY	**Rollercoaster of emotions**
DIMENSION	Low to high degree of severity Positive to negative Expected versus unexpected

TEXT EXAMPLE	"It is a rollercoaster, feelings upon feelings, emotions upon emotions. They clouded me, you know, as I was thinking, I was depressed. I was very unstable. It was a problem" (Pricillia, lines 84-86).
PROPERTY	**Development of disorder**
DIMENSION	Diagnosed versus undiagnosed
TEXT EXAMPLE	"And nothing was fun to me anymore. And after pregnancy. I feel like nothing that could, you know, make me happy. Or, you know, give me this kind of joy that comes week with motherhood. So, I feel like I don't know, I just felt this kind of sadness. More like depression, and I couldn't get anything or anyone to cheer me up at the time" (Beth, lines 130-134). "I knew I needed to seek out help because now I couldn't even face the baby. I was kind of like abstaining from my kid, which was crazy because most of my friends tell me stuff like, you know-like I am so glad to see my child. Everything I wanted, every ounce of blood in my body. I wanted to see my child (lines 23-25)…but in my own case it was weird I didn't want to see anybody. I wanted to be alone most of the time. So okay, I knew I knew something was up" (Jessica, lines 44-49).
PROPERTY	**Stressors**
DIMENSION	Extent of good nutrition Quality of sleep Environmental Chronic versus acute

TEXT EXAMPLE	"The baby was here I didn't feel prepared at all, just as far as like lack of sleep goes, and sickness, and I do think that lack of sleep had a huge part in playing like with my hormones and my mental health and my ability to like to get through a day with a positive attitude. But yeah, I definitely struggled at first to not have any time to myself, to not feel like I was like I was myself anymore. I felt like a different person, and at first that was not okay (lines 115-119)…But my best friend joined a gym, and I joined with her, and so we both started going to the 5:30am classes. And I started noticing that, like I was in a better mood the rest of the day, even if I still was sleep deprived. So, I started kind of seeking alternative ways to help myself to feel better" (Nichole, 122-125). "Mentally, you're in a place that there is a lot of unknown. There is a lot to the emotional like shift. Okay. Sometimes you're happy, sometimes your sad. Yeah, you're so stressed because of several things. Sometimes you are struggling financially…sometimes they're struggling to catch up with the new changes that are happening in their bodies... Now the additional responsibilities are so stressful because the responsibilities were adding up. I struggled because it's not just myself. Now it's me and the baby. So, my emotions well, though somehow the emotional change, and I compared my life currently to my life the previous 2 years (lines 35-46)…(It is) very, very different as compared to the life before I was a mom, because it's so overwhelming right now, because there are other responsibilities you have that you didn't used to have. Oh, it's really different for sure, it's so different. You start learning how to save money. The way you spend (money) changes. The way you change your behaviors, changing your interaction in social life because you're not…yeah, it's overwhelming (lines 69-74)…Maybe just to say that the mental health of a mother especially, or a parent. And even after pregnancy is so important, cause yeah just as I said, it's overwhelming to raise a kid from pregnancy. So, the mental health is so important. Concentrate on, give attention to, the mother" (Mellisa, lines 118-121). "I did. I did have emotional shifts doing my pregnancies, and especially after the second one. This one that is just 5 months it was a very tough period for me. I experienced so much emotional shifts, even after my postpartum ended (lines 78-81)…I had hormonal shifts also. In this case, there are times I cannot, I feel I felt I wasn't ready. I wasn't ready for another child. The stress I went through…postpartum stress. I felt alone…I thought I wasn't having enough support that I needed,

	and the stress was mentally affecting me" (Jennifer, lines 85-89).
CATEGORY	**Agency**
PROPERTY	**Control**
DIMENSION	Low to high degree of control
TEXT EXAMPLE	"Well, as a Black American I don't know all the way. We were told to, you know. accept our fate. We believe it so much. Believe in faith. You so much believe in the world. You believe it's right I believe it that's how it wants to be so. I will go with the way life is happening to me" (Lucy, lines 46-49).

PROPERTY	**Choice**
DIMENSION	Low to high degree of choice
TEXT EXAMPLE	"I think even if I felt it from within (power), because I'm married the way I was brought up I was told to respect my husband, and then there are some certain decisions I can't just make them by myself. I need to tell him, even if I need to do it. I need to tell him, and if you let him know, so then he will give me to go ahead" (Lucy, lines 50-53).
PROPERTY	**Change**
DIMENSION	Low to high degree of change
TEXT EXAMPLE	"Making decisions are on a personal level, and I feel the responsibility of the community is just to give you advice or promote the power within you. So, the role of the community is to advise you, to show you the right way. But it's your personal responsibility to make choices because the choices effect you…"(Mellisa, lines 80-85).
CATEGORY	**Future Oriented Notions of Contented Mothering**
SUBCATEGORY	**Connection**
PROPERTY	**Joyful moments with children**
DIMENSION	Low to high degree of joyful moments
TEXT EXAMPLE	"See my baby talking to me like giving me back the expressions I'm actually creating. And you know when you see your child like working like you know you got you get this type of joy like you'd be happy… " (Marie, lines 48-50).

	"(To) have a bond between my kids and myself…" (Jessica, line 73).
SUBCATEGORY	**Connection**
PROPERTY	**Peer disclosure**
DIMENSION	Degree of peer disclosure
TEXT EXAMPLE	"(A) group where I have different moms from different backgrounds come together and talk about the issues they are facing" (Beth, lines 174-175). "So, I wish support groups could be in my community. Helping nursing mothers and depression, so we could come together and discuss the feelings, the postpartum feelings, and emotions. To try to see how to help each other through conversation and help each other get through the challenges we are going through" (Jennifer, lines 135-140). "Yeah, so mothers like us, postpartum mothers, pregnant women. Mother can come together; talk about things they feel-the emotions. What, as in advice each other, how to go about being a mother. Because trust me, from what I experience the number of times you've had kids. There are different kinds of experiences. There are times that you feel you haven't been through this journey before you start. You are safe. You are new in that view. You know nothing about being a mother, and you need someone to talk to, people who could share their experiences with, and you could get some vital information, some vital tips, some support from such information" (Jennifer, lines 151-165). "Have little or no empowerment for mothers like us. No support for mothers" (Jennifer, line 128). "Send me a support program I can go to" (Jen, line 92). "Yeah, yes, okay, I still need to learn other ways to help the baby, despite the fact…The baby in a whole has grown emotionally, physically, behavior wise, mentally and everything. Yeah, being there for the baby and ensuring that the baby develops in all aspects of life" (Ann, lines 18-20). "From moms with kids that are older" (Ann, line 25). "Just to think about women. Education is important. It helps us

	build a better society because kids depend really much on what they receive from their parents. Especially when I was so young. It's good to educate mothers, so that you have to bring up a healthy, happy society" (Ann, lines 90-93).
SUBCATEGORY	**Money status**
PROPERTY	**Amount of money**
DIMENSION	Low to high quantity of monies
TEXT EXAMPLE	"Maybe I'm looking for more happiness for me and my family. We need more and more financially to be financially stable, to be able to raise my kid…Well, in the best ways…more and more happiness" (Elisa, lines 23-25). "I need to make some payment I don't have that cash. I need this, for my boy" (Elisa, line 40). "The perfect life is being home together for a significant amount of time (Jennifer, lines 144-145). "But you have to have financial freedom to be able to manage that, whether it's a maternity package, or your husband makes

	enough money, or you find a way to work from home, But that. that's what it would be like for me to be able to be home comfortably, financially, and separately at times" (Jennifer, lines 149-152).
SUBCATEGORY	**Safety**
PROPERTY	**Security**
DIMENSION	Low to high degree of security
TEXT EXAMPLE	"Being comfortable that you know, a rural area where my children are going to stay in a very safe environment" (Mary, lines 56-57).
SUBCATEGORY	**Health**
PROPERTY	**Physical & psychological condition**
DIMENSION	Low to high degree of physical condition; low to high degree of psychological condition
TEXT EXAMPLE	"Oh, yeah, a happy life is the right emotional, psychological, physical self. When both mental needs and spiritual needs were met for both the mom and the baby. That's a happy life for sure yeah" (Mellisa, lines 63-64). "A happy life for me, is when my daughter is healthy actually. Happy life is a healthy life for us…When everything is okay. Our health is okay. No one is sick. Just okay, yeah, emotionally, physically we're healthy" (Ann, lines 44-46).