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Amy Fox

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Postpartum Depression and Birth Experiences

by

Amy Fox, B.S.

MSW Clinical Research Paper

Presented to the Faculty of the

School of Social Work

St. Catherine University and the University of St. Thomas

St. Paul, Minnesota

in Partial fulfillment of the Requirements for the Degree of

Master of Social Work

Committee Members

Andrea Nesmith, Ph.D., (Chair)

Bethany Bertsch, LICSW

Erika Torkelson, CAPP

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. The project is neither a Master's thesis or dissertation.

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Postpartum Depression and Birth Experiences

By Amy Fox

Research Chair: Andrea Nesmith, PHD.

Committee Members: Bethany Bertsch, LICSW; Erika Torkelson, CAPPA

Postpartum depression negatively affects the lives of newborns and their mothers. This mental health concern can also affect the lives of fathers, partners, and older children. If left untreated, postpartum depression can be life-threatening for both mother and newborn. The importance of understanding the risk factors of postpartum depression is extremely important for the wellbeing expecting mothers and their families. A quantitative research study was conducted to understand if the type of birth experience affects a mother's chance of developing postpartum depression. Results from this study indicate the type of birth did have an impact on a mother's chance of developing postpartum depression. In addition, social and emotional support, planned versus unplanned pregnancy, single pregnancy versus multiple pregnancy, vaginal, planned Cesarean and unplanned Cesarean section, past and family history of generalized anxiety disorder and major depressive disorder all contributed to if a mother developed postpartum depression after giving birth.

Postpartum depression is widely considered a treatable mood disorder, however postpartum depression negatively affects the lives of mothers and their newborns. The American Psychological Association describes postpartum depression as, “a serious mental health problem characterized by a prolonged period of emotional disturbance, occurring at a time of major life change and increased responsibilities in the care of a newborn infant”(American Psychological Association, 2015). Mental health disorders can be described by The National Alliance on Mental Illness (NAMI) as, “A condition that impacts a person's thinking, feeling or mood and may affect his or her ability to relate to others and function on a daily basis” (NAMI, 2015). It is important to be aware that postpartum depression and mental health disorders can significantly impact the lives of Americans, and if left untreated, can be life-threatening.

The Centers for Disease Control has found that on average each year, 11 to 20%, or approximately 600,000 women, will develop postpartum depression in the United States (Centers for Disease Control, 2015). To put this in other words, one in seven women will experience postpartum depression after giving birth (Wisner et al., 2013). What is fascinating about postpartum depression is that this mental health disorder can affect any woman regardless of her age, race, ethnicity, or socioeconomic status. This makes postpartum depression a significant public health concern in the United States that needs to be discussed openly in order to shed light on the importance of this mental health disorder, the factors associated with this mental health disorder, and that help is available for those who are, or have had, experienced postpartum depression.

Postpartum depression typically begins before or any time after childbirth, but generally develops between one week and one month after delivery. Mothers experiencing postpartum depression describe feelings of extreme sadness, anxiety, and exhaustion (National Institute of

Medicine, 2015). In addition to affecting a mother's mental health, postpartum depression can interfere with a mother's ability to make a meaningful connection with her newborn and care for her newborn. This makes it difficult for mothers to complete activities of daily living for themselves, their newborn, and for others, which can result in feelings of detachment from their newborn and family.

Previous research has identified risk factors that can increase a woman's chance of developing postpartum depression. If there is a history of mental health disorders during or after a previous pregnancy, previous experience with mental health disorder, and a family history of depression or other mental health illnesses increases the chances of a mother developing postpartum depression (Mayo Clinic, 2015). Stressful life events during pregnancy or shortly after giving birth have also shown to be indicative of postpartum depression (Postpartum Support International, 2015). A lack of strong emotional support from a spouse, partner, family, or friends has also been significant in determining the development of postpartum depression. In addition, medical complications during the childbirth process or mixed feelings about the pregnancy have been found to increase the chances of a woman developing postpartum depression (Postpartum Support International, 2015).

Postpartum depression can create a wide range of severity of symptoms for mothers, therefore this mental health disorder usually requires treatment (National Institutes of Health, 2015). If left untreated, postpartum depression can last for a period of time, often months or years, sometimes becoming a chronic depressive disorder (Mayo Clinic, 2015). Postpartum depression can be stigmatizing and difficult to accept for some women, consequently many women do not seek help and ignore their postpartum symptoms. Not surprising, the potential long-term complications of postpartum depression are the same as other mental health disorders,

and if left untreated, postpartum depression may be life-threatening (Helpguide.org, 2015). Mothers who do not seek treatment for their postpartum depression potentially risk harming themselves or their baby (National Institutes of Health, 2015).

Successful treatment strategies for postpartum depression can include social support from other mothers, friends, and relatives. Making sure new mothers are getting sufficient rest, sleep, and cutting down on less important responsibilities has also been helpful (Mayo Clinic, 2015). According to Smith and Segal (2015), therapeutic strategies such as cognitive-behavioral therapy and interpersonal therapy have been effective in treating postpartum depression (2015). Support groups may also be helpful, but they should not replace medication or therapy (American Psychological Association, 2015).

Very little research has specifically looked at the significance and risk factors associated with having an unplanned Cesarean section and postpartum depression among women. It is known that Cesarean sections can be traumatic upon both the mother and baby, therefore future research needs to be conducted to further understand if there is a significance in developing postpartum depression among women who have had an unplanned Cesarean section. Furthermore, it is important to understand if there is a link between unplanned Cesarean sections and postpartum depression among women because prevalence estimates increase to forty-one percent among women who have already experienced postpartum depression following a previous pregnancy (American Psychological Association, 2015). It is imperative that additional research be conducted to educate mothers about the risk factors associated with having an unplanned Cesarean section.

Literature Review

The alarming rate of postpartum depression among American women has led researchers in the field of medical social work to conduct a variety of studies on this topic. Previous studies in the field of medical social work have revealed that postpartum depression is a global phenomenon that continues to be stigmatizing among new mothers often because mothers suffer in silence (Kantrowitz-Gordon, 2013). In addition, postpartum depression can have serious mental health consequences for populations that are of concern to social workers. These populations include financially vulnerable women, women of color, adolescent girls, and single mothers (Abrams & Curran, 2007). Little research has been conducted regarding unplanned Cesarean sections and the risks pre and postpartum. Consequently, the lack of limited research available in this field is partially due to postpartum depression being considered highly shameful and stigmatizing among mothers.

Nevertheless, the literature does stress the need to understand past mental health histories of mothers. The literature also stresses the need to understand relationship adjustment pre and postpartum. Previous research has attempted to understand stress pre and postpartum and the effects stress can have upon women financially, physically, and with their spouse or partner. Finally, researchers have strived to find a link between support pre and postpartum for mothers.

Previous studies have identified several key themes that will be discussed in this literature review. These themes will include a mother's past history of mental health disorders, a mother's postpartum history of mental health disorders, the role of relationship adjustment pre and postpartum between spouses and partners, if a mother experienced a stressful pregnancy, if

there was a traumatic birth experience which resulted in an unplanned Cesarean section, and the type of support a mother experienced pre and postpartum.

Past History of Mental Health Disorders

A woman's past history of mental health disorders can be indicative of developing postpartum depression. Previous research has revealed that when a mother does have a past history of mental health disorder, she is significantly more likely to develop postpartum depression (Mayo Clinic Staff, 2015). Disorders such as major depressive disorder, prenatal anxiety, anxiety experienced postpartum, and depressive symptomology have been researched within this section of the literature review.

Major depressive disorder. Major depressive disorder can negatively affect a mother's ability to care for her newborn. Stein and colleagues (2012) studied the connection between maternal cognitions and mother-infant interactions among mothers who had postpartum depression. Their study of 57 women from the United Kingdom diagnosed with major depressive disorder indicates that mothers who have a past history of major depressive disorder prior to giving birth responded less to their child's vocalization (cries, coos, etc.) than mothers in the control group that had no prior history of a mental health disorder (2012).

Similarly, Weinberg and others (2001) analyzed depressive symptoms among 124 mothers that had major depressive disorder prior to giving birth. Mothers in this study had either experienced major depression prior to the birth, both pre- and post-birth, or had no known history of depression. Findings from this study show that when a woman has a past history of major depressive disorder, heightened psychiatric symptoms, higher levels of depressive symptomatology, and greater anxiety is observed (Weinberg et al., 2001).

Depressive symptomology among lesbian birth mothers and co-mothers is a topic that has widely been understudied in the field of medical social work. Maccio and Pangburn (2012) studied depressive symptoms in lesbian birth mothers and co-mothers. This study highlighted that partners can develop depressive symptoms if the birth mother experienced depressive symptoms postpartum. While this study was small, 37 individuals, the results are important regarding potential depressive symptoms in mothers and their partners. Their study shows that participants experiencing symptoms of depression after giving birth had partners that also experienced depression-like symptoms postpartum. This finding is similar to Zelkowitz and Milet's (1996) findings that when a woman experiences psychiatric symptoms postpartum, her partner is more likely to experience similar symptoms postpartum.

Prenatal anxiety. Anxiety before birth, otherwise known as prenatal anxiety, can take many forms. Symptoms of prenatal anxiety are commonly recognized as feelings of guilt, feelings of chronic anxiety, a lack of energy, persistent crying, isolation, and worries about the relationship (PANDAS Foundation, 2014). Prenatal anxiety symptoms can be an indicator of potential infant attachment.

To understand the significance of maternal anxiety, Leerkes, Parade, and Gudmundson (2011) studied the outcomes of maternal emotional reactions of mothers who were close to giving birth. Examining 119 mothers, the researchers wanted to determine if maternal anxiety in response to infant crying by watching videotapes of crying children had an effect on the future mother's ability of their infant to properly attach to their mother. Results from their study demonstrated that maternal anxiety in response to infant crying was shown to be linked with greater attachment resistance postpartum. This means that when mothers displayed higher levels

of prenatal anxiety to infant crying, they were more likely to have infants that had difficulty attaching to their mothers postpartum.

Depressive symptomology. The subject of depressive symptomology among postpartum women has been begun to be researched in medical social work. Weinberg and colleagues (2001) analyzed depressive symptomology among 124 postpartum women and found that those that had been designated in the subclinical depression group had elevated depressive symptoms two months postpartum. These women had more negative and less positive affect with higher depressive symptoms, higher anxiety levels, and greater psychiatric symptoms. Their results indicate that a past history of major depressive disorder, depressive symptomology, and anxiety prior to birth does tend to indicate higher levels of psychiatric symptoms among postpartum women.

Relationship adjustment. Relationship adjustment can be defined as the satisfaction, interactions, and behaviors between spouses and domestic partners (Fast Track Project, 2011). Depressive symptoms and relationship adjustment is a new topic in the field of medical social work that is gaining more attention. Using the Spanier Dyadic Adjustment Scale (1976), Whisman, Davila, and Goodman, (2011), analyzed depressive symptoms among 113 mothers who were experiencing depression immediately before or after giving birth. Their results indicate that depressive and anxiety symptoms are highly associated with relationship adjustment. This means when relationship adjustment was lower in this study, depressive and anxiety symptoms tended to be higher among mothers (Davila & Goodman, 2011).

The level of partner support a woman experiences throughout her pregnancy can be an indicator of high or low maternal stress. Tanner Stapleton and peers (2012) studied 272 pregnant women to understand if perceived partner support during pregnancy predicted lower maternal

and infant distress. They found when mothers received social support during pregnancy, mothers had lower emotional distress postpartum and reported less infant distress. However when mothers presented with maternal anxiety, their anxiety was directly related to infant distress. In addition, partner support was related with postpartum anxiety and depressive symptoms. This study indicates that when a mother does not perceive partner support, she is more likely to experience maternal anxiety and depressive symptoms.

Relationship adjustment, stress, and depression are topics within medical social work that have been gaining attention in recent years. This section will focus on a study by Flanagan and colleagues (2015) who analyzed mental health during pregnancy and postpartum and if mental health affected women's relationship adjustment stress and depression during pregnancy and postpartum. Examining 118 women, results concluded that there were distinct pregnancy stress, depression, and relationship adjustment outcomes in their sample. The higher severity group had higher postpartum scores, reported higher stress and depression symptom severity and poorer relationship adjustment during pregnancy compared to the lower severity group. These findings indicate that the relationship adjustment, stress, and depression a woman experiences does impact her mental health during pregnancy and postpartum.

Understanding in what way social support, positive or negative, affects a woman's adjustment postpartum is important when determining how a mother is adjusting to motherhood. Tietjen and Bradley (1985) studied twenty-three women at thirty-five weeks during their pregnancy and three months postpartum to understand if social support affected maternal adjustment during the transition to parenthood. Their findings indicate that support from husbands was found to be associated with positive adjustment during pregnancy and with positive postpartum marital adjustment. Additional findings revealed that women who were

experiencing difficult adjustment turned to friends and family members for support, however, family and friend support was not effective in promoting better postpartum adjustment during the time frame studied. These findings suggest that positive support from husbands or partners has a more positive effect on mothers than support from friends and family members does. This study has value to the field of medical social work given that results do indicate that positive support from partners has a positive effect on mothers.

The birth of a child can be a predictor of marital satisfaction between spouses. Zelkowitz and Milet (1996) sought to understand adjustment and marital satisfaction among spouses with postpartum psychiatric disorders among 100 couples. Marital satisfaction and changes in family functioning since the birth of their infant were indicated by less satisfaction in marriages, increased worry about family responsibilities, and greater dissatisfaction in changes in household routines, recreation, and intimacy with their partners. Mothers were more dissatisfied with perceived changes in family functioning than were fathers, indicating less satisfaction with parenthood and more concerned about changes in intimacy with their spouses.

While marital behaviors are different than relationship adjustment, the two are similar in that they can predict how successfully a family functions postpartum. Frosch, Mangelsdorf, and McHale (1998) studied marital behaviors among 104 spouses six months postpartum. Spouses that reported greater marital adjustment demonstrated more positive engagement during couple discussion and more harmony during family play. Findings observed from older spouses indicated less positive engagement during couple discussions than younger spouses. Findings from this study suggest that marital behavior after the birth of a baby can determine how successfully the family functions.

Behavioral Problems in Children with Mothers with Postpartum Depression

New research in the field of postpartum depression has begun to explore behavioral problems in children with mothers who had experienced postpartum mental health disorders. A longitudinal Australian study of 4,953 mothers conducted by Brennan and colleagues (2000) found higher maternal depression resulted in higher behavioral problems in children five years old. Mothers that had experienced moderate levels of depressive symptoms at six months postpartum or at five years postpartum also reported behavioral problems in their children. Moreover, significantly higher behavioral problems in children were observed in children who had mothers that reported severe depressive symptoms only at age five. It appears there does seem to be a relationship between child behavioral problems and depressive postpartum symptoms experienced by the mother, however more information from this study needs to be provided to understand what type of behavioral problems children experienced and the reasons why mothers experienced postpartum depression several years after giving birth.

Stress During Pregnancy

It is well known that stress can cause physical, emotional and behavioral problems that can negatively affect a person's mind and health, in addition to negatively affecting their personal and professional relationships (Mental Health America, n.d.). Stress during pregnancy can cause similar negative effects upon mothers. Interestingly, stress can also negatively affect newborns. Smaller birth weight, increased risk for miscarriage, infant temperamental problems and fussiness, and emotional problems in girls and boys can be a factor in an newborn's potential future development of mental health disorders such as schizophrenia and severe depression

(Emory University, n.d.). This section of the literature review will focus on maternal related stress and financial, spousal, and physical stress.

Maternal-related stress. Several studies within the field of medical social work have found that maternal related stress can be an indicator of a woman developing postpartum depression (Feske, et al. 2001; Misri, Reebye, Milis, & Shah, 2006; La Marca-Ghaemmaghami & Ehlert, 2015). Misri, Reebye, Milis, and Shah (2006) examined parenting stress among twenty-three depressed mothers. Their results found that mothers experiencing parenting stress before giving birth were more likely to develop postpartum depression. This study does indicate that prior to giving birth mothers had a diagnosis of mood or anxiety disorders, however, what is interesting is that mothers did not perceive their depression or anxiety disorders as stressful; instead the mothers in this study perceived their ability to mother their child stressful. This study indicates that while a diagnosis of a mental health disorder can have a potential effect on a mother, the actual stress a mother experiences can have the same, if not more, of an effect on the mother.

Similarly, Feske and others (2001) examined severe life-related stress among 38 depressed mothers and 62 depressed non-mothers. In order to analyze the impact of child-related stress on mothers, the researchers excluded child-related stressors in a portion of their analyses. Once the child-related stressors were removed, no significant difference was found in findings between depressed mothers and depressed non-mothers. This demonstrates that mothers experiencing higher stress levels and depression are attributable to child-related stress. These findings do suggest that when a mother experiences higher stress levels, stress can be accounted for by child-related stressors.

Systematic reviews can be helpful when understanding the link between stress and pregnancy. La Marca-Ghaemmaghami and Ehlert (2015) conducted a systematic review with previous literature on experienced stress and stress hormones during pregnancy. Their findings indicate common knowledge that stress levels and stress hormones do increase during pregnancy. Acute or severe maternal stress responses were found to be predictive of neonatal birth outcome and maternal well-being postpartum, indicating that stress can have a negative impact upon mother and child.

Financial, spousal, and physical stress. Financial, spousal, and physical stress can be incredibly difficult to manage and often overwhelms individuals. Several studies have shown that these types of stressors while pregnant can lead to an increase in depressive symptoms among mothers. Grote and Bledsoe (2007) studied the effects of financial, spousal, and physical stress among 179 married women. They found that women who had experienced financial, spousal, and physical stress were more likely to develop clinically significant depressive symptoms than mothers who were not experiencing financial, spousal, or physical stress. These results indicate that a woman's optimism during pregnancy can decrease depressive symptoms and severity six to twelve months postpartum.

Spousal stress can also negatively affect a woman during pregnancy. Hobfoll, Ritter, Bloomfield, and Shaham (1991), studied 64 Israeli women's satisfaction with social support during pregnancy and the aid they received from their partner. Results from their study found that when women experienced more intimacy and less discomfort seeking support, greater satisfaction with the social support being received was found. Not surprising, when experiencing high stress, women that were less comfortable seeking help did not receive social support.

Adolescent support postpartum is a relatively new topic within medical social work that is gaining attention. Gee and Rhodes (2003) examined the relationship between adolescent mothers and fathers in their sample of 218 low-income, minority mothers and fathers. Their study researched social support, social strain, and relationship stability to understand the role, if any, adolescent fathers played in their child's life. Their results indicate that although father support was not associated with adolescent mothers' psychological adjustment, the absence of a father had negative psychological adjustment for the mothers. Interestingly, further results from this study indicated that more social support from fathers immediately before giving birth and immediately after giving birth, in addition to less social support from a new male partner three years postpartum, predicted relationship stability between adolescent mothers and their child's biological father three years postpartum.

Unplanned Cesarean Sections

Unplanned Cesarean sections can be extremely traumatic for mothers and fathers. The risks associated with this type of surgery for mothers can include infection, blood loss, anemia due to blood loss, injury to organs surrounding the uterus, extended hospital and recovery times, and in extreme cases, maternal mortality ("Risks of a Cesarean Procedure," 2015).

Durik, Shibley Hyde, and Clark (2000) examined the psychosocial outcomes of mothers and infants that were born either vaginally or by Cesarean section. Researching 167 mothers, women who delivered by unplanned Cesarean section were more likely to be delivering their first child and viewed their delivery less favorably than planned or vaginal births. Similarly, Cesarean mothers experienced less immediate and long-term satisfaction after giving birth, were less likely to breastfeed, had a longer time initiating first interaction with their newborn,

experienced less positive interactions after the birth, and interacted less at home with their newborn. This study indicates that when a woman delivers her child via an unplanned Cesarean section, a greater chance of negative interactions between mother and newborn could be experienced.

Postpartum Support

Medical social work research has indicated that paternal support during the postpartum period can have an effect on new mothers. Smith and Howard (2008) examined paternal support among 582 first-time mothers to understand if there is a link between paternal support and maternal depressive symptoms. Smith and Howard found that paternal support did decrease at four and twelve months postpartum, however, maternal depression symptoms and scores also decreased over time. While paternal support did decline during the first year after birth, paternal support eventually stabilized by the child's second birthday, which was shown in the mothers' decreased depression scores and symptoms. This indicates that while paternal support did decrease over time, depression scores for mothers decreased indicating that mothers possibly became accustomed to a lack of support. This study suggests that increased paternal support can be related to lower depressive symptoms in mothers.

Maternal stress and support postpartum is a topic that is gaining attention within medical social work. Sampson, Villarreal, and Padilla (2015) researched if there is an association between maternal stress and support postpartum by studying 2,412 mothers. This study found mothers diagnosed with major depressive disorder one year postpartum and mothers who had a child with a fussy temperament reported the highest stress levels. Interestingly, mothers who had a high school degree or had some college experience indicated lower maternal stress one year

postpartum, whereas mothers who had a college degree or additional education did not report significantly influenced maternal stress levels. Mothers with a college education had higher levels of all types of support except household, while mothers with the least amount of education reported lowest social support from family and friends. This study demonstrates that partner support can contribute to lower maternal stress with emotional support being the strongest contributor to lower stress experienced by mothers.

How much social support a woman receives after a complicated pregnancy can be an indicator of how the mother will utilize her support system. Hobfoll, Nadler, and Leiberan (1986) analyzed social support among 113 Israeli women following normal and medically complicated pregnancies. Results from their study found greater intimacy with the mother's spouse and her friends to be related to greater satisfaction with support received after the traumatic birth. In addition, women with low self-esteem did have greater intimacy with family, however this intimacy was related to lower satisfaction with support if these women were found to lack intimate ties with their spouse or a friend. While this study did not examine support among mothers who had experienced an unplanned Cesarean section, it does indicate that support after a traumatic birth experience is indicative of how a mother is able to utilize support after the traumatic birth experience.

Studies have revealed that support postpartum can be a positive experience for mothers experiencing postpartum depression. Thomas, Scharp, and Paxman (2014) collected and analyzed online stories from women experiencing postpartum depression. In order to understand the role support played in their study, the researchers analyzed help-seeking actions and cues from the mothers' online stories. These actions and cues found online were demonstrated by women as being more likely to seek support postpartum when other women encouraged they

seek help for their postpartum depression. Midwives, support groups, their mothers, and even God played a role in seeking support for the women in this study.

Conceptual Framework

The purpose of the conceptual framework is to define and guide the background of this study design. Family systems theory and the strengths perspective of social work were chosen to guide the outline for this research topic. Family systems theory and the strengths perspective were most applicable when researching the risks of unplanned Cesarean sections pre and postpartum.

The first theory related to unplanned Cesarean sections and postpartum depression is Dr. Murray Bowen's family systems theory. Introduced in the 1950s, family systems theory seeks to understand the family as an emotional unit where the interactions of each member of the family impact the entire family unit (The Bowen Center for the Study of the Family, 2015). Creating eight core values that intertwine with each other, Bowen sought to connect human behavior and the idea that the family is an emotional unit (Miley, O'Melia, & Dubois, 2012). Two of Dr. Bowen's eight core values, the nuclear family emotional process and the family projection process, will be described in the conceptual framework as it applies to the research topic.

Based on the concept of an emotional system, family systems theory believes the influence of the nuclear family is intensely emotionally connected (The Bowen Center for the Study of the Family, 2015). Family members can profoundly affect each other's thoughts, feelings, and actions by needing attention, approval, and support from each member. Issues of conflict, distance, and emotional unavailability can lead to dysfunction in a spouse, child, and the family unit (Vermont Center for Family Studies, 2015). This theory believes that family

functioning is considered healthy when members are able to balance a sense of independence from each other, and can effectively control their emotional lives. Family systems theory is appropriate in this research project because oftentimes emotional connectedness and unsatisfying relationship patterns may be found when a family system is experiencing the strain of postpartum depression (The Bowen Center for the Study of the Family, 2015).

Family systems theory also emphasizes the functioning of an individual shapes the functioning of a family, therefore if the family system is negatively functioning, the functioning of the family system can create pathology within an individual (The Bowen Center for the Study of the Family, 2015). Bowen describes this phenomenon as the family projection process. When a woman experiences postpartum depression, the family is greatly impacted by postpartum depression given this disorder not only affects the woman, but the functioning of the family. Family systems theory is important when working with families that are impacted by postpartum depression because the diagnosis influences and affects everyone within the family system. When working with women and families experiencing postpartum depression, social workers would benefit from applying this approach because how appropriately a family functions plays a specific role within the family system (Miley, O'Melia, & Dubois, 2012).

Related to unplanned Cesarean sections and postpartum depression is the strengths perspective of social work. The strengths perspective of social work promotes that each individual possesses innate strengths, resources, and capabilities that will help them overcome the struggles they are faced with (Saleebey, 1996). Recognizing our clients are resilient, they possess innate strength, and they have the resources and the ability to change is crucial when working with women and families experiencing postpartum depression. Similarly, Weick, Rapp, Sullivan, & Kisthardt believe the strengths perspective supports positive attributes and

capabilities that people inherently express, and when social workers utilize the strengths perspective, we help our clients reclaim their inner personal power and strength (1989). This would mean when social workers utilize the strengths perspective when working with women experiencing postpartum depression, social workers would be able to help women overcome their symptoms of postpartum depression by empowering women to see their full potential.

Saleebey states that it is helpful for social workers to regard their profession through a different lens when applying the strengths perspective (Saleebey, 1996). This means as social workers, we need to continue to help people discover their own internal power and the strengths they possess. By recognizing individual strengths, social work interventions must identify each person as an individual. In addition, Saleebey (1992) proposes that social workers need to be aware of the language they use when applying the strengths perspective. Encouraging words such as empowerment and resiliency should be applied (Saleebey, 1992). When social workers apply words such as empowerment and resiliency, this helps give our clients the ability to overcome the many challenges and obstacles they face in their daily lives.

When working with women experiencing postpartum depression, it is easy to identify several risk factors and limitations. Poor support from a woman's partner, family, and friends, lack of bonding or attachment with the newborn, the stigma associated with a diagnosis, the physical, mental, and financial stress of delivering a baby, and a previous history of mental health disorders are some risk factors and limitations faced by women experiencing postpartum depression. A social worker utilizing the strengths perspective would concentrate on identifying the client's strengths and skills in order to assist them with their problems and goals (Saleebey, 2006). The social worker would want to empower the client by focusing on the skills the client possesses to help draw upon these strengths by building on and obtaining new resources and

skills through the interactions within her social environment. This would mean the social worker would want to identify that the client possesses the strengths within her to overcome her postpartum depression.

Methods

Research Design

In this section, the methodology that is used to explore postpartum depression and the risks pre and postpartum of unplanned Cesarean sections is explored. Quantitative and exploratory methods were used to complete this study. Online survey questions allowed for a deeper understanding of postpartum depression and the risks associated with unplanned Cesarean sections. Online surveys permitted for information to emerge in a non-stigmatized, confidential manner. This information enabled an understanding of how shaming and stigmatizing a postpartum depression diagnosis can be to a woman and to her family. Additional research in this area could lead to changes and improvements in the way clinical social workers understand and treat postpartum depression.

Sample Population

Participants in this study were a group cohort of women between the ages of 18 and 45 who have, or currently are, experiencing postpartum depression. Women who have had unplanned Cesarean sections were encouraged to participate in this study due to their unique birthing experience. Individuals who have not given birth were excluded from this survey as they have not given birth. Participants were obtained by searching online for postpartum depression support groups in the Twin Cities area. Participants were also obtained by searching on the social media website Facebook for support or parenting groups for mothers.

Measurement Strategy

A survey was created which consisted of questions regarding the research topic. Questions were asked regarding the birth experience, if the birth was a vaginal, planned, or unplanned Cesarean section, if the birth was a single or multiple birth, if the mother felt emotionally prepared to give birth, a previous history of mental health disorders among the mother or her family members, the role of support from partners, family, and friends immediately after giving birth, what type of support the mother has experienced postpartum, the age of the participant, and what race the participant identifies with. Surveys allowed for the researcher to ask detailed questions about postpartum depression on a faster scale to a large group of subjects. The survey was administered online so participants remained confidential. All participants interested in contributing to the study were informed the survey will remain confidential and no identifying information was collected.

Protection of Human Subjects

In order to protect all participants involved in this research study, approval from the Institutional Review Board, IRB, from St. Thomas University was sought. Confidentiality of each human subject was kept by password protecting online survey results. Results were read only on the researcher's computer, which also has password protection. Results from the survey were destroyed after they were analyzed in Qualtrics. Data will be kept until May 16, 2016 when the results will then be deleted from the researcher's computer. Information about confidentiality, such as first and last names, was explained to each participant before they took the survey so that participants will be encouraged to take the survey as the survey will not

include any identifying information. This presented participants a non-stigmatizing, nonthreatening manner in which to take the survey.

Data Collection

Upon approval from the IRB, the researcher began data analysis of the survey from the group cohort of adult women who have or are currently experiencing postpartum depression. A survey was conducted in order to collect data. Before the survey, participants received an informational flier regarding the survey by their support group leader. As stated before, results were kept confidential by utilizing a secure password on the researcher's computer.

Analysis

As previously mentioned, quantitative statistics was analyzed in this research project to examine the traits of postpartum depression among women. Descriptive statistics were used to examine data collected that unplanned Cesarean sections could have potentially negative affects among women who are experiencing postpartum depression. Data collection included survey questions that were scaled on a Likert scale from 1 to 5, with 1 representing strongly disagree and 5 representing strongly agree. Ranking the survey questions from 1-5 allowed the researcher to analyze the data on a deeper level.

T-tests were used to compare scale scores pre-and postpartum between those with a history of mental health disorders and those who do not have mental health disorder histories. Additional t-test scores compared birth experience scores to determine if the mother described the birth experience as traumatic. T-test scores comparing emotional preparedness scores pre-and postpartum were also used. Support t-test scores were compared to understand how supported a mother felt pre and postpartum. The average means of the t-test were then examined

to show that characteristics associated with unplanned Cesarean sections are statistically different than planned Cesarean sections among women who are experiencing postpartum depression.

Chi square analysis were also used to compare scores of emotional preparedness and type of delivery to understand the role, if any, between emotional preparedness and the type of delivery. Additional chi square analysis tests compared the type of birth (vaginal, planned Cesarean, or unplanned Cesarean) and the chances of a mother developing postpartum depression. In addition, a crosstabulation of postpartum depression, generalized anxiety disorder, and major depressive disorder was conducted to understand if a past history of family history of mental health disorders increased a woman's chances of postpartum depression. Furthermore, social support nearby and postpartum depression at most recent birth was analyzed to understand if social support nearby after giving birth increased or decreased a mother's chances of developing postpartum depression.

Strengths and Limitations

Within the field of medical social work, very limited information regarding postpartum depression and the risks pre and postpartum of unplanned Cesarean sections is available. This study aimed to provide contributions of valuable information on this subject. Unplanned Cesarean sections and the risks pre and postpartum of postpartum depression is an emerging area of study within medical social work that is severely impacted by a lack of research. This research study provided valuable information when addressing women who are experiencing postpartum depression after an unplanned Cesarean section. Additionally, this study also provided a non-

stigmatizing, non-threatening, and non-judgmental approach when collecting data regarding women who have or currently are experiencing postpartum depression.

The limitations of this research study included a potentially small sample size of women. Despite several postpartum support groups in the Twin Cities metro, there could possibly be a small sample size due to a lack of communication from support group leaders to attendees about the online survey. A lack of communication could also arise about this research project. Another limitation is the diversity in the sample. This study included women experiencing postpartum depression and did not research the partner's, or if applicable, other children's experiences with a mother experiencing postpartum depression. Future research in this field would benefit from a partner's or other children's experiences with postpartum depression. Additionally, this study did not include individuals who have not sought support for their postpartum depression. It is important that future research seek to gain a better understanding of how a lack of support can negatively affect individuals who are experiencing postpartum depression.

Findings

Sample Characteristics

There were 123 participants who gave consent to participate in the researcher's survey. Of the 123 respondents, 121 surveys were completed. The current age of participants was a mean of 34.15 years, while the mean age of respondents at their most recent birth experience was 30.32 years. On the whole, participants were Caucasian middle class earning at least \$90,000 (See Table 1).

Table 1 *Family Income Level*

Answer		Response	%
\$10,000 or less		0	0%
\$10,000 to \$30,000		6	5%
\$30,000 to \$50,000		17	14%
\$50,000 to \$70,00		20	16%
\$70,000 to \$90,000		20	16%
\$90,000 or above		60	49%
Total		123	100%

During their most recent birth experience, 83% of mothers were married, while 17% of mothers were single. There were no participants that indicated they were divorced or separated at the time of birth (See Table 2).

Table 2 *Marital Status at time of Birth*

Answer		Response	%
Single		21	17%
Married		102	83%
Divorced		0	0%
Separated		0	0%
Total		123	100%

This survey explored the type of delivery and if the pregnancy was planned versus unplanned at the most recent birth experience. Vaginal delivery was highest with three fourths of mothers (75%), delivering vaginally. Mothers who gave birth via planned surgical birth were the smallest group with 10% of mothers delivering via planned surgical birth. Surprisingly, mothers

delivering via unplanned cesarean section was significant, with 15% of mothers delivering via unplanned cesarean section. The vast majority of mothers (76%), described their most recent birth experience as planned. Of those mothers, (98%) had a single pregnancy.

This survey also explored mothers' emotional preparation, decision making throughout their birth experience, and social support nearby after the birth. Exploring mothers' emotional preparation for the delivery indicated high emotional preparedness, with 81% of mothers indicating they felt emotionally prepared to give birth. Decision making during the birth experience was also high, with one hundred and fourteen (94%), of mothers feeling they were included in decision making throughout the birth. Social support revealed that more than three fourths (78%), of mothers indicated they had social support nearby after the birth.

To further understand the significance of emotional preparation and type of delivery, a crosstabulation of emotional preparation and type of delivery was conducted. Results indicate that mothers who had given birth vaginally, 80 mothers, and mothers who gave birth via planned Cesarean section, 10 mothers, felt more emotionally prepared to give birth. Women who gave birth via unplanned Cesarean section, 8 mothers, did not feel emotionally prepared to give birth. These findings are significant and consistent with the literature conducted by Tanner Stapleton et al., (2012) which indicates women who give birth via unplanned Cesarean section do not feel emotionally prepared to give birth.

Table 6 *Crosstabulation of Delivery and Emotional Preparation*

	Emotionally Prepared	Not Emotionally Prepared	Total
Vaginal	80%	11%	91%
Planned C	10%	2%	12%
Unplanned	8%	10%	18%
Total	98%	23%	121%

In addition, this survey explored if participants had a doula and/or a midwife present during their most recent birth experience. A majority of mothers, close to three fourths (74%), did not have a doula present at their most recent birth experience. Nearly one third of mothers (32%), had a midwife present at their most recent birth. Approximately two thirds (69%), of mothers indicated not having a midwife present during their most recent birth experience.

Postpartum depression surfaced in a substantial number of respondents. Nearly one-third (27%), of mothers did experience postpartum depression during their most recent birth experience. There were a number of mothers (15%), indicating they were not sure if they experienced postpartum depression during their most recent birth experience (See Table 7). Significantly, seventeen mothers (14%), did experience postpartum depression during additional pregnancies. These findings are important as they indicate women who did not experience postpartum depression during their most recent birth experience also did not experience postpartum depression during their last pregnancy. These findings are significant as they indicate mothers from this survey did experience postpartum depression, with several mothers indicating they were not sure if they experienced postpartum depression.

Table 7 *Postpartum Depression After Pregnancy*

Postpartum After Pregnancy		Response	%
Yes		33	27%
No		70	58%
Not sure		18	15%
Total		121	100%

Previous history and family history of generalized anxiety disorder or major depressive disorder has indicated mothers who had experienced depressive symptomology prior, pre, and postpartum had heightened psychiatric symptoms (Weinberg et al., 2001; Stein et al., 2012). The researcher found one quarter of mothers (25%), indicating they did have a previous history of generalized anxiety disorder or major depressive disorder. Similarly, close to half of mothers (42%), indicated there is a family history of generalized anxiety disorder or major depressive disorder. More than half of mothers (58%), indicated no family history of generalized anxiety disorder or major depressive disorder. Likewise, three quarters (75%), of mothers indicated they did not have a previous history of generalized anxiety disorder or major depressive disorder.

Unplanned Cesarean Sections and Emotional Preparedness

Women who had given birth via unplanned Cesarean section were significantly more likely to not feel emotionally prepared to give birth (See Tables 9 and 10). Measures of emotional preparedness and delivery varied greatly among mothers. Findings from this study indicate mothers who gave birth vaginally felt more emotionally prepared to give birth. Similarly, mothers who had given birth via planned Cesarean section were also more likely to feel emotionally prepared. Consistent with the literature, mothers who had given birth via

unplanned Cesarean section did not feel emotionally prepared to give birth. These findings are significant as previous research conducted by Durik, Shibley Hyde, and Clark (2000) indicated mothers who had given birth via unplanned Cesarean section experienced less immediate and long-term satisfaction after giving birth, experienced less positive interactions after the birth, and interacted less at home with their newborn, all indicators of emotional preparedness.

Table 9 *Crosstabulation of Delivery and Emotional Preparedness*

Count	Emotional Preparedness		Total
	Yes	No	
Vaginal	80%	11%	91%
Planned Cesarean	10%	2%	12%
Unplanned Cesarean	8%	10%	18%
Total	98%	23%	121%

Table 10 *Analysis of Delivery and Emotional Preparedness*

Chi-Square Tests			
	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	18.491 ^a	2	.000
Likelihood Ratio	15.052	2	.001
Linear-by-Linear Association	16.441	1	.000
N of Valid Cases	121		

a. 2 cells (33.3%) have expected count less than 5. The minimum expected count is 2.28.

Type of Birth and Postpartum Depression

Previous research within the field of medical social work has indicated the type of birth may have an impact on a mother's chance of connecting with her infant (Durik, Shibley Hyde, and Clark, 2000). Connecting or not connecting with a newborn can be an indicator of postpartum depression. Durik, Shibley Hyde, and Clark (2000) examined the psychosocial outcomes of mothers and infants that were born either vaginally or by Cesarean section. Their results indicated mothers who had given birth via unplanned Cesarean section experienced less immediate and long-term satisfaction after giving birth, less positive interactions after the birth, and interacted less at home with their newborn. These results are similar to the researcher's results which indicate the type of birth does have an influence on the chances of a mother developing postpartum depression (See table 11).

Table 11 *Crosstabulation of Type of Birth and Postpartum Depression during Most Recent Birth*

	Postpartum Depression During Most Recent Birth			Total
	Yes	No	Not Sure	
Vaginal Birth	23.1%	61.5%	15.4%	100.0%
Planned Cesarean Section	50.0%	50.0%	0.0%	100.0%
Unplanned Cesarean Section	33.3%	44.4%	22.2%	100.0%
Total	27.3%	57.9%	14.9%	100.0%

Generalized Anxiety Disorder and Major Depressive Disorder

The vast majority of women in this study indicated no previous history of generalized anxiety disorder or major depressive disorder. As well, the majority of women indicated no family history of generalized anxiety disorder and major depressive disorder. The findings from this study are significant to the field of medical social work as a previous study conducted by Weinberg and colleagues (2001) indicated when women have a past history of major depressive disorder, heightened psychiatric symptoms, higher levels of depressive symptomatology, and greater anxiety is observed (Weinberg et al., 2001). The findings from the present study contradict Weinberg and colleagues (2001), in that the participants in this survey did not indicate heightened psychiatric symptoms, higher levels of depressive symptomatology, or great anxiety postpartum (See Table 12).

Table 12 *Crosstabulation of postpartum depression, generalized anxiety disorder, and major depressive disorder*

	History of Generalized Anxiety Disorder or Major Depressive Disorder		Total
	Yes	No	
% within Postpartum Depression After most Recent Birth	36.4%	63.6%	100.0%
% within PPD at Most Recent Birth	18.6%	81.4%	100.0%
% within Postpartum Depression After most Recent Birth	27.8%	72.2%	100.0%
% within Postpartum Depression After most Recent Birth	24.8%	75.2%	100.0%

Social Support Nearby and Postpartum Depression at Most Recent Birth

More than three quarters of mothers in this study indicated they did not experience postpartum depression and that they did have social support nearby after giving birth. These findings are relevant to previous research by Tanner Stapleton and colleagues (2012) who found when mothers received social support during and after their pregnancy, mothers had lower emotional distress postpartum and reported less infant distress. Similarly, the researcher’s findings are comparable to Tietjen and Bradley (1985) who found social support did affect maternal adjustment during the transition to parenthood and support from husbands was found to be associated with positive adjustment during and after pregnancy. However the researcher’s results found a little over a quarter of mothers who did experience postpartum depression indicated they did not have social support nearby after giving birth (See Tables 13 and 14). Future research should examine how not having social support nearby after giving birth can impact a mother’s chance of developing postpartum depression.

Table 13 *Social Support and Postpartum Depression at Most Recent Birth*

	Postpartum Depression During Most Recent Birth			Total
	Yes	No	Not Sure	
% within Social Support Nearby	24.5%	63.8%	11.7%	100.0%
% within Social Support Nearby	37.0%	37.0%	25.9%	100.0%
% within Social Support Nearby	27.3%	57.9%	14.9%	100.0%

Table 14 *Analysis of Social Support nearby and Postpartum Depression*

Chi-Square Tests			
	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	6.670 ^a	2	.036
Likelihood Ratio	6.508	2	.039
Linear-by-Linear Association	.014	1	.906
N of Valid Cases	121		

a. 1 cells (16.7%) have expected count less than 5. The minimum expected count is 4.02.

Discussion

The overall goal of this study was to understand the role, if any, the type of birth experience has upon a mother's chances of developing postpartum depression. Utilizing online quantitative surveys to explore women's birth experiences pre-and postpartum, the researcher obtained several key connections among variables. Consistent with the researcher's hypothesis, mothers who did not have social support nearby after the birth, who had experienced a stressful pregnancy and traumatic birth experience, who have a personal or family history of generalized anxiety disorder or major depressive disorder, did experience postpartum depression. Additional results indicated mothers who had a planned, single, vaginal birth, who were emotionally prepared, had social support nearby after the birth, with no history of generalized anxiety disorder or major depressive disorder were more likely to not experience postpartum depression.

Literature within medical social work has shown that if a mother has a history of mental health disorders during or after a previous pregnancy, previous experience with mental health disorders, or a family history of depression or other mental health illnesses can increase the chances of a mother developing postpartum depression (Weinberg et al., 2001). Similarly, a lack of strong emotional support from a spouse, partner, family, or friends has also been significant in determining the development of postpartum depression (Sampson, Villarreal, and Padilla, 2015).

In the current sample, postpartum depression was indicated by mothers, with the rate of postpartum depression high. Overall, the results of this study support the need for additional quantitative and descriptive statistical testing of postpartum depression and birth experiences.

This research study had several strengths and limitations that are important to identify and discuss. When discussing strengths, this survey utilized online quantitative studies, which allowed for a deeper understanding of postpartum depression and the risks associated with unplanned Cesarean sections. Information from mothers was given in a safe environment where the mother felt comfortable. In addition, online surveys permitted for information to emerge in a non-stigmatized, confidential manner, which enabled an understanding of how shaming and stigmatizing a postpartum depression diagnosis can be to a woman and to her family. An additional strength of this research study is the sample size. A large sample size of 121 mothers allowed for a vast amount of information to be revealed.

When discussing limitations, this research study had several limitations. First, the average income level for participants was above \$90,000. A more diverse socioeconomic background may have produced different results. Second, the researcher's population was predominately Caucasian, therefore the researcher does not know if results from the survey would generalize to more diverse population. Third, the vast majority of participants were married. Results may have been more varied if more mothers had not been married during their most recent birth experience. Fourth, more than three quarters of pregnancies were planned. A larger percentage of participants indicating an unplanned pregnancy may have resulted in more participants not feeling emotionally prepared to give birth.

Fifth, three quarters of births were vaginal births. Additional unplanned Cesarean births may have resulted in even more significant postpartum depression findings. Sixth, more than half of mothers did not experience postpartum depression during their most recent birth experience and almost 90% of participants did not experience postpartum depression after additional pregnancies. Seventh, three quarters of participants did not have a personal history of generalized anxiety disorder or major depressive disorder. Results may have been more significant if more mothers had experienced generalized anxiety disorder or major depressive disorder. Finally, results may have been slightly different if the researcher was able to sample more mothers via social media or face-to-face support groups.

Implications for Social Work Research

Findings within this study indicate a significant number of mother's experienced postpartum depression, with many mothers indicating they were not sure if they experienced postpartum depression. Mothers who had indicated they were not sure if they experienced postpartum depression was significant, as mothers may not have been aware if they were experiencing symptoms of postpartum depression. In addition, findings from this study indicate social support nearby after giving birth is often not enough for the mother. Mothers in this study did indicate postpartum depression despite having social support nearby after giving birth; this is significant as previous research has indicated social support nearby after giving birth can reduce the chances of a mother developing postpartum depression (Tietjen and Bradley, 1985; Tanner Stapleton et al., 2012). It is important to recognize the findings from this study should not be generalized to the overall population of mothers who have given birth. Findings from this study should be relevant only to this study.

Social workers need to be aware of the many challenges and uncertainties mothers can face throughout their pregnancies and birth experiences. Many mothers in this study indicated they were not sure if they experienced postpartum depression. This is significant as social workers can provide more postpartum assessments after a mother has given birth so that the mother can understand if she is experiencing postpartum depression. Additionally, social workers can be more prepared to serve this population by understanding not all mothers who have a history of mental illnesses such as generalized anxiety disorder or major depressive disorder are indicative of the development of postpartum depression. Furthermore, social workers should be aware that even if a mother has social support nearby after giving birth, social support may not be enough for the new mother. Social workers should be able to provide psychological help for the mother.

There are several actions social workers can take to better understand the importance of a mother's birth experience and her chances of developing postpartum depression. Social workers should recognize the significance of providing additional postpartum assessments, empathy, a judgement-free perspective, and collaboration with other providers to better understand this highly stigmatized population. In order to provide best social work practice, social workers should encourage the mother to talk openly about her experiences postpartum, promote psychotherapy, discuss potential psychopharmacological interventions, and advocate for joining a support group. Utilizing the mentioned perspectives can assist social workers in providing best social work practice to mothers who are experiencing postpartum depression.

Implications for Research

Despite the study's limitations, the researcher's findings are important within medical social work. Research that has explored postpartum depression and unplanned Cesarean sections was primarily conducted in the 1980s, which is outdated. Given research on postpartum depression is outdated, currently there is significantly little research on postpartum depression and birth experiences, specifically unplanned Cesarean sections. Future research within medical social work is needed to effectively understand the mother's birth experience and if the birth experience does or does not contribute to a diagnosis of postpartum depression. More research within the field of medical social work should highlight the importance of birth experiences and postpartum depression, specifically for women who do not have social support during their pregnancy and after giving birth and who have experienced an unplanned Cesarean section.

This study advocates the need for understanding postpartum depression, birth experiences, and the significance of preparedness pre-and postpartum. The researcher's study has demonstrated the need for future research to be conducted regarding postpartum depression and birth experiences. Future research on the topic of postpartum depression and birth experiences should consider the many factors such as social support, emotional preparedness, history of mental health disorders, and type of birth that may contribute to the development of postpartum depression.

FIGURES*Figure 3 Planned versus Unplanned Pregnancy*

Answer		Response	%
Planned		94	76%
Unplanned		29	24%
Total		123	100%

Figure 4 Vaginal, Planned Surgical, Unplanned Surgical Birth

Answer		Response	%
Vaginal birth		91	75%
Planned surgical birth		12	10%
Unplanned surgical birth		18	15%
Total		121	100%

Figure 5 Single Versus Multiple Pregnancy

Answer		Response	%
Single		119	98%
Multiple		3	2%
Total		122	100%

ADDITIONAL FIGURESFigure 8 *Additional Pregnancies Experienced Postpartum Depression*

Answer		Response	%
Yes		17	14%
No		104	86%
Total		121	100%

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