Perinatal Mood and Anxiety disorders among women in the African Diaspora: Knowledge and

Help-Seeking Behaviors

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By Paula Ugochukwu Ude

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ABSTRACT OF THE DISSERTATION

Perinatal Mood and Anxiety disorders among African Diaspora women: Knowledge and Help-

Seeking Behaviors

By

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Perinatal mood and anxiety disorder is a public health concern, and no evidence found that the number of women experiencing the issues is abating. Notwithstanding this, women's level of knowledge and help-seeking during perinatal periods were relatively few, especially among the immigrant women living in the United States of America, particularly the women in the African in diaspora. Therefore, this dissertation's interest was to explore perinatal mood and anxiety disorders among women in the African diaspora living in the United States to understand their level of knowledge and lived experience of help-seeking during their perinatal periods. To achieve this aim, phenomenological and grounded theory qualitative research traditions were utilized to collect and analyze data. The themes that emerged from data analysis suggest that participants have a fundamental knowledge of perinatal mood and anxiety disorders. However, this knowledge was acquired from their interactions with new cultural environments (United States). Emerging themes also reveal that participants were aware of the need for help-seeking during the perinatal periods; they sought help during these periods and encountered some barriers during their interactions with healthcare professionals during the help-seeking process.

This dissertation recommends the need for the social workers to being culturally competent and humble in their interpersonal relationships with participants so to help improve participants' help-seeking behaviors. The emerged themes also revealed that implementing a culturally sensitive program will enhance participants' help-seeking behaviors and will improve both their physical and psychological/emotional well-being.

Signature of Investigator: _Paula Ugochukwu Ude_   Date: 7/30/2021

List of Tables for Emerging Themes

Table 1

Codebook depicting knowledge about perinatal mood & anxiety disorders, help-seeking, and available maternal resources

Emerged Themes	Description	Files	References
knowledge about resources	***This overarching theme explored women's knowledge about perinatal resources, especially mental health resources***	**0**	**0**
Lack knowledge about the system	This describes lack of having knowledge about how the system function, e.g., how to drive or transport to the resource locations or navigate resource.	6	9
knowledge about symptoms	This theme describes the women's knowledge of mood and anxiety symptoms.	8	16
knowledge about the symptoms	***This overarching theme explored women knowledge about mood and anxiety symptoms.***	0	0
In denial	Being in denial and not wanting to accept the reality or facts about perinatal mood and anxiety disorders.	5	8
Knowledge	Has knowledge about perinatal mood and anxiety disorders	9	14
lack of education prior to pregnancy	Denied any professionals talk to her about the symptom during pregnancy, believe that it was because was unable to open up or talk to anybody how she is feeling.	3	4
No prior history	No prior history of perinatal mood and anxiety disorders.	6	9
prior knowledge symptoms	Have prior knowledge about the perinatal mood and anxiety disorders, may experience it or heard from someone or people	5	6
Screened for perinatal issues	knowledge about whether being screened during and after pregnancy.	1	2

Table 2

Codebook depicting the Codes\\Help-seeking behavior during perinatal periods

Emerged Themes	Description	Files	References
Barriers to Help-Seeking	***This overarching theme explores some of the factors that limit women from seeking and receiving help that has to do with perinatal mental healthcare.***	0	0
Ashamed	This subtheme is described as feeling uncomfortable sharing experience because of what other people will say, how they will react towards them, or fear of being ridiculed or mocked.	2	3
cultural barriers	This subtheme describes some of cultural barriers that impede women from seeking help (not immersed in the culture, acculturation issues, influence of their cultural belief system, etc.)	4	10
stigmatization	This subtheme describes feelings of being stigmatized, alienated, or discriminated against during the help-seeking process.	2	4
fear of unknown	This subtheme describes women's feeling of fear of what will happen (not knowing what people will say or the negativity they will bring, fear that something dreadful will happen even when there is no reason to feel that way, or that there is anything to worry or be concerned about.	5	17
Financial factor	This subtheme describes the financial constraint that limit women from receiving care or better care. Lack of finance to afford quality care (e.g., purchase good health insurance etc.)	5	7
Help-seeking and cultural interpretation	***This overarching theme, describes and explores how women from their cultural perspective define and interpret help-seeking in relation to perinatal care during and after pregnancy.***	6	8
Insurance	This subtheme describes the need of having insurance during perinatal periods to encourage women to receive care.	4	9
lack of trust	This subtheme describes issue of trust, especially women trusting that their baby will be well cared for when they leave the baby in the care of someone else.	5	7
Language issues	This subtheme explains the inability of the women and professionals to communicate effectively with each other so as to facilitate an effective and efficient intervention. This also describes and explores some of the issues women encountered that limited them from seeking help within their environment due to language.	8	18
No helping hand at home	This subtheme describes the need for help at home so that women can get some rest while caring for their baby—"having a physical person at home" other than having someone calling to check on women and baby.	10	13
no language issue	This subtheme defines women who denied that communication was an issue during the help-seeking process.	1	2
Stereotype	This subtheme describes situations where women felt they were stereotyped during the process of help-seeking because they belong to a particular group or different cultural group from the	2	3

	provider.		
Intervention	***This overarching theme describes strategies that be can put in place to encourage help-seeking or help women receive help during perinatal period.***	3	5
Available translation service	This subtheme describes some of the services (physical language translator,) or technology (language telephone or monitor) that can be put in place to encourage effective communication between the women and their providers/professionals during help-seeking process.	1	1
culturally appropriate program	This subtheme defines the need to provide resources and recommendation that are culturally appropriate to the women's perinatal needs.	3	3
education	This subtheme describes the need to provide education on perinatal mood and anxiety issues, childcare expectation, and demand, thus emphasizing on what women should expect and do when they were discharged from the hospital and have gotten home.	1	2
Spiritual intervention (faith)	This subtheme describes some of the personal spiritual belief and help that woman employed or held that helped them to cope with the process of survival. This comes in the form of trusting in God, in a Higher Power for intervention during perinatal periods.	9	19
Longing for home-like assistance	This subtheme describes the women's desire to have home-like assistance (things being done in a more cultural way)	2	2
Personal Interpretation of Help-seeking	***This overarching theme explored the personal interpretation women hold about receiving help and issues that hold back some women from seeking help during their perinatal periods.***	0	0
Acculturation	This subtheme describes women's ability to accept the culture into which they relocated (American culture or ways of doing things) now, particularly ability to accept American way of treating the perinatal issues,	1	1
an experienced helper	This subtheme describes women's desire to have someone who understands baby care or experienced motherhood in African context to provide care or assist them in caring for the baby, especially at home.	1	1
Comes to personal reality	This subtheme describes women's ability to recognize their innate tendency (protective process) to face and deal with their problems.	1	1
consciousness	This subtheme describes women's ability to recognize and being aware of outside threats and developing skills to avoid problems ensuing from the exposure.	1	1
Don't need help	women feeling that they don't need help, resources should be given to those who need them so as not to waste resources	2	2
husband is not present or supportive	This subtheme describes women lacking support from their partner.	1	1

Negative experience	This subtheme describes the women's negative encounter/experience with professionals/providers during help-seeking process.	2	2
Open up	This subtheme describes the women's ability to accept the reality about the issue/symptoms of perinatal mood and anxiety and their ability to be open to accepting help and communicating their needs without the fear of exposing themselves to danger or exposing family issue to outsiders.	7	23
protection of oneself	This subtheme is described as fear that something bad or dreadful will happen to mom or the baby, if women become so opened to communicate needs or problems.	1	1
Reaching out to mom	Identifying and reaching out to perinatal moms, not waiting for them, was for them to reach out for help.	1	1
restriction of information	ability to withhold information from a helper so as to protect self-identity.	1	2
satisfaction with family care	Ability to be satisfied with the help received from a family member, especially the spouse.	2	6
Shying away from accepting help	Inability to seek help due to avoidance of exposing self to shame and ridicule.	1	2
Socialization	Inability to move around and socialize with others due to COVID-19.	3	4
Turning away help offer	This subtheme describes the women's refusal to accept help offer from the professionals because they do not feel they need such help or resources and consider it a waste of resources	2	2
Uncomfortable seeking help	Women do not feel comfortable seeking help.	2	2
Professional Interaction	***This overarching theme explores the women's interactions with healthcare professionals/providers and their willingness to seek care.***	0	0
intercultural competency	This subtheme describes professional's' ability to communicate with women in the cultural contexts (terms) that they will be able to understand or conceptualized.	1	1
professional care	This subtheme describes women who receive professional care.	7	23
professional frustration	Professional/provider frustration during the process of attempting to provide care.	2	5
Receiving care from professional from cultural location	Receiving services from professionals/providers from similar cultural locations.	5	8
Satisfaction with professional care	Moms being satisfied with care they received from the professionals/providers.	5	13
Sought help	***The overarching theme is described as women's ability to recognize the need to seek help.***	6	8
No problem seeking help	Ability to ask for help notwithstanding cultural differences between women and providers.	3	5

| Reached out for help | Ability to asked for her help during perinatal periods | 2 | 3 |
| Seeking help | This subtheme describes women's willingness to seek or ask for help during and after pregnancy. Utilizing available help from support system. | 12 | 22 |

Note. See Appendix for the tables depicting codebooks for other themes and subthemes emerged from the study.

Table 3

Codebook depicting themes for perinatal mood and anxiety disorders symptoms as experienced by the women during their perinatal periods

Emerged Themes	Description	Files	References
Symptoms	***Overarching themes describing some of the themes women used to describe their how they felt during their perinatal mood and anxiety disorders.***	0	0
anxiety	Feeling of very anxious about situation.	5	6
Blame	Feelings blaming self and partner.	1	1
Crazy	Described as feeling unfocused, not relaxed	4	5
Crying	Describes a shading tears with no justification	1	1
Depression	Describes feeling depressed, lonely, down	7	12
Feeling dying	Having feelings of dying.	2	2
Frustration	Feeling frustrated over uncontrollable situations	1	2
Guilt	Laying blames on oneself or partner/spouse, or family member, etc.	2	3
Hopelessness	Not believing that symptoms or situation will get better	1	1
Isolation	Isolating from people and wasn't talking to or associated with people around them	2	3
Increase level of stress	Feeling uncontrollable stress level may be a trigger.	1	1
loss of desire to do stuff	Describes as not motivated to do things,	1	1
Miserable	Feeling of miserable, on at ease	1	1
moody	Describes as feeling moody, sad and depressed	3	5
nervous	Describes as feeling nervousness or anxious	2	2
not able to care for the baby	Questioning ability of motherhood or care for the baby can put mom at risk.	1	1
Overwhelm	Describes as feeling overwhelmed with caring for the baby and the information from provided by the providers/professionals	7	14
Sadness	feelings sadness, annoyed, angry toward self and other without any justifications	3	6
Scared	Describes as being afraid that something dread may happen to mom or baby e.g., fear that baby may be	4	5

	taken away from them by CPS.		
Sleep deprivation	Describes as lack or inability to sleep during perinatal periods	4	8
Tired	Describes as feelings of tiredness, and weakness	3	6
uneasy	Feeling of uneasy.	1	1
Worry	Feeling worried or scared about unanticipated situation	2	3

Table 4

A table depicting the demographic data collected from the participants

Participants Code	Age	Country of Origin	Level of Education	Employment	No. Yrs. in U. S	No. Of Children/Yr	Marital Status
WDA01	39	Nigeria	BA/LVN	LVN	8	2 (4, 7)	Married
WAD02	40	Nigeria	BSN	RN	11	3 (6, 4)	Married
WAD03	38	Ivory Coast	Doctorate	Pharmacy	20	3 (4, 7, 11)	Married
WAD04	37	Nigeria	MBA	Housewife	9	2 (4, 1)	Married
WAD05	32	Ivory Coast	MA	Accountant	14	1 (18 mons)	Married
WAD06	38	Ivory Coast	BA	PA	10	2 (11, 9, 4)	Married
WAD07	38	Ivory Coast	BA/RN	Nurse	11	3 (9, 4, 9 mons)	Married
WAD08	39	Ghana	BSN	RN	12	3 (5, 3, 1)	Married
WAD09	38	Nigeria	Doctorate	Pharmacy Student	10	2 (3, 6)	Married
WAD10	31	Nigeria	Diploma	PA	4	1 (5mons)	Married
WAD11	34	Nigeria	BA	Pharmacy Tech	2	1 (18mons)	Married
WAD12	22	Ivory Coast	Pre-Pharmacy	Student & Bank customer service	6	1 (5mons)	Single

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First of all, I thank God for bringing this doctoral journey to completion and leading me thus this far in my religious and professional careers.

This dissertation work is dedicated to my late mother, Mrs. Mabel Udeokorie. May her gentle soul continue to sleep in perfect peace. This work is also dedicated to perinatal women, especially women in the African diaspora and all other immigrant women, particularly those living in the United States whose lived experiences added meaning to this dissertation research work and provided good recommendations to the social workers and healthcare professionals on the best way to encourage help-seeking among women in the African diaspora.

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Chapter 1: Introduction

Statement of Problem

Perinatal Mood and Anxiety Disorders refer to mental health disorders that affect women during pregnancy and the immediate period following childbirth. Perinatal mood and anxiety disorders are both women's issues, and public health concerns (Bilszta et al., 2010; Corrigan, Kwasky & Groh, 2015; WHO, 2019), and the increasing rates of women experiencing these disorders point to a growing epidemic (Bennett et al., 2011; Bilszta et al., 2010; Corrigan, Kwasky & Groh, 2015). The available literature on this issue (between 2010 and 2015) notes that about 13 percent of women are affected by PMADs during perinatal periods (Bennett et al., 2011; Bilszta et al., 2010; Corrigan, Kwasky & Groh, 2015; WHO, 2019). However, the most recent report from the National Perinatal Association [NPA] indicates that this number has increased from 13 percent in 2015 to 21 percent as of the year 2018. Little research has been conducted on how this phenomenon affects immigrant women. Available perinatal mood and anxiety disorder studies on immigrant (diaspora) women reveal that this population is at even higher risk than their non-immigrant counterparts (Bandyopadhyay et al., 2010; Ganann et al., 2016; Miszkurka et al., 2010).

Perinatal mood and anxiety disorders affect women individually and have adverse effects on their mental, physical, social, and economic wellbeing (2020 Mom, 2019; NPA, 2018, Postpartum Support International (PSI), 2019; WHO, 2019), and (Garner et al., 2014). The most commonly reported mental and physical symptoms of perinatal mood and anxiety disorders include fatigue, anxiety, hopelessness, irritability, insomnia, sadness, sense of helplessness, tearfulness, and thoughts of harm to self or baby, as well as a lack of bonding with infants

(Albuja et al., 2017; Alves et al. 2018; Beniot et al., 2007; Cook et al., 2010; Dunford et al., 2017; Farr et al., 2013; Garner et al., 2014; Goodman et al., 2010). For some women, these symptoms may interfere with their ability to care for their infant/children, establish a positive relationship or interaction with their babies, and affect relationships with their families and other social supports (2020 Mom, 2019; Bilszta et al., 2010; Corrigan, Kwasky & Groh, 2015; NPA, 2018; PSI, 2019; WHO, 2019). Despite these facts and symptoms, some women do not seek help to address PMADs (Ko, Farr, Dietz, & Robbins, 2012 Guy, 2014; Nnaka, 2018; Ratzan & Parker 2000; Row & Harman, 2014). According to available literature, women's inability to seek help is explained as being due to lack of knowledge of PMADs symptoms (Nneka, 2018; Sampson et al., 2013), lack of knowledge about available resources, or where to access help (Ganann et al., 2015; Guy et al., 2014), previous negative experiences with professionals/providers (Acri et al., 2015; Negron et al., 2013), and stigmatization (Bilszta et al., 2010; Bodnar-Dere et al., 2017).

Description of the Focus Problem

Definitions of Maternal Mental Health Illness/Perinatal Mood and Anxiety Disorders)

Field, Moni & Wood (2019) define mental illness as a psychological or emotional condition that prevents a person from generally function over a period of time. They conceptualized mental health as an individual's emotional wellness and their ability to enjoy life. Perinatal mental health is defined as a mother's mental well-being during and after pregnancy, and perinatal mental health illness/disorders as those illnesses or disorders that occur during pregnancy and within the first year after childbirth (Field, Moni & Woods, 2019). The psychotic perinatal disorder is described as 'temporal madness' (Twomey, Bennett & Wisner, 2009). According to the National Institute of Mental Health (NIMH, 2017), an estimated 46.6 million adults, ages 18 and over (18.9% of all adults in the USA), live with a mental illness, and only

half of these adults receive treatment. The Center for America Progress (2010) estimates expenditures on mental health disorders to have been $57.5 billion in 2006 and $317 billion in 2008. The NIMH report (2017) also shows significant differences between genders and estimates that 22.3 % of females are battling mental health disorders, compared to 15.1% of males. Women with a history of mental health illness or disorders are at a higher risk of PMADs during and after pregnancy, which imposes substantial emotional and financial burdens on them, their infants, family, and society at large (Abrams & Curranm 2007; Bennett et al., 2011, DeLuca & Lobel, 2014; Fagan & Lee, 2010).

Population Description—African Immigrants in the United States (Women in the African Diaspora)

        Definition and Statistics on the Population of African Diaspora. The African diaspora is defined as African descent or people who migrated from the African continent and are now residing in the United States and one of the United States' cultural groups. These individuals bring with them their unique culture, values, and morality. Their daily life is permeated and informed by their culture, religious beliefs, and moral values. Statistics show that the African diaspora population (immigrants) in the United States is not abating. For example, as from 2010 to 2015, the population of Africans living in the United States has increased from 723,000 to 1.7 million (New American Economy, 2018), and between 2010 and 2016, the number rose to 2.4 million (Migration Policy Institute [MPI], 2019). According to the Migration Policy Institute (MPI) 2019 statistics report, an estimate of 4.5 percent (over 2 million out of 44.7 million) of Sub-Saharan African immigrants resides in the United States (MPI, 2019). African immigrants are the fastest-growing immigrant and ethnic group in the United States (QuartzAfrica, 2019). This MPI report highlights that "between 2010 and 2018, the sub-Saharan African population

had increased by 52 percent, significantly outpacing the 12 percent growth rate for the overall foreign-born population during that same period" (MPI, 2019, n.p).

Figure 1

US foreign born population growth from 2010 to 2018 as reported by Migration Policy Institute (2019).
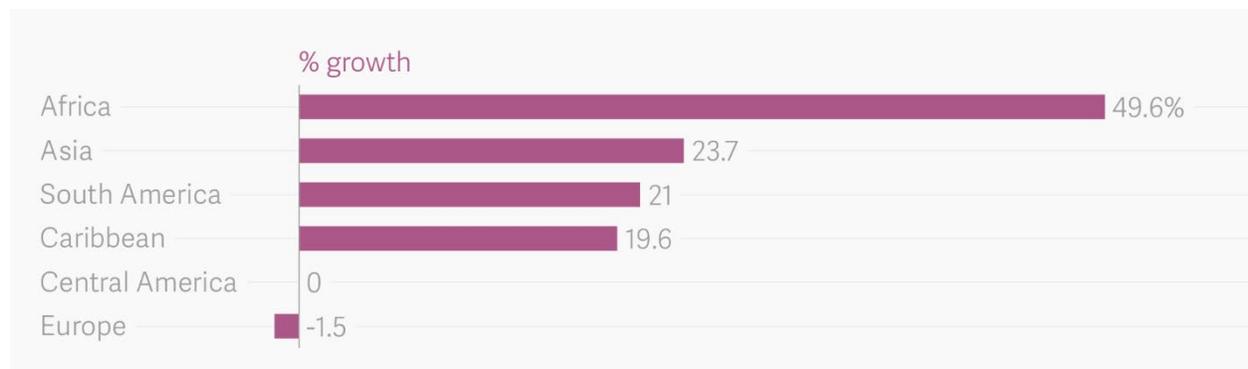
Figure 2

 Sub-Sharan African Diaspora residing in US population growth report as provide by Migration Policy Institute (2019) Statistics.
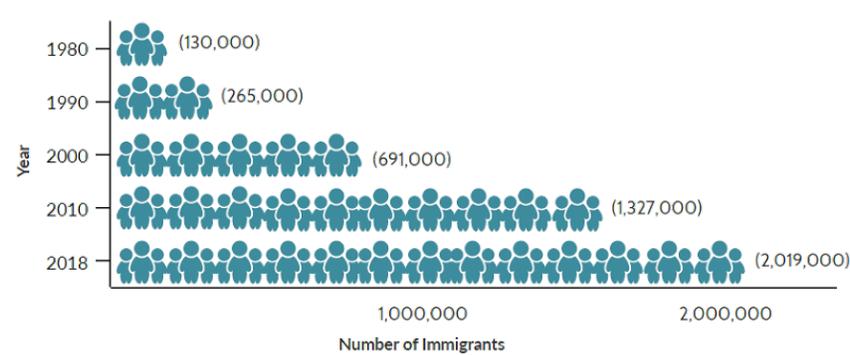
Migration Policy Institute (2019) statistics also report that about 81 percent of the Sub-Saharan African diasporas residing in the United States (as of 2018) come from Eastern and Western Africa.

Table 1

Distribution of Sub-Saharan African Immigrants by Country and Region of Origin as reported by Migration Policy Institute (2019).

Region and Country	Number of Immigrants	Share (%)
Sub-Saharan African Total	2,019,000	100.0
Eastern Africa	730,000	36.2
Eritrea	45,000	2.2
Ethiopia	278,000	13.8
Kenya	147,000	7.3
Somalia	103,000	5.1
Other Eastern Africa	157,000	7.8
Middle Africa	171,000	8.5
Cameroon	78,000	3.9
Other Middle Africa	93,000	4.6
Southern Africa	104,000	5.2
South Africa	100,000	4.9
Other Southern Africa	5,000	0.2
Western Africa	896,000	44.4
Cabo Verde	37,000	1.8
Ghana	195,000	9.7
Liberia	85,000	4.2
Nigeria	375,000	18.6
Sierre Leone	48,000	2.4
Other Western Africa	155,000	7.7
Africa, n.e.c.	117,000	5.8

African Worldview on Causes and Intervention of Illnesses and Impacts on Help-Seeking during Perinatal periods

Background Overview. To understand the perinatal mood and anxiety disorders and help-seeking behaviors among women in the African diaspora, examining African worldviews on causes of illnesses and help-seeking is of paramount importance. In African worldviews, the totality of life entails more than just the physical or biological, but rather, it embraces the whole of a person's existence—health, social, economic, political, cultural, and spiritual wellbeing as well as those of the community and the entire cosmic order (Njoku, 2012; Onongha, 2015). An essential dimension of the African worldview on illness and help-seeking is the belief that illness and health are connected to spirituality (Asare & Danquah, 2017; Onongha, 2015). The centrality of holism's concept to the African worldview means wellness and illness are not isolated from the physical and spiritual realm (Onongha, 2015). In other words, there is no duality between matter and spirit as the two concepts have an intimate interconnection. A basic assumption of

most African worldviews is that reality is interconnected or interrelated to a spiritual and physical sphere (Asare & Danquah, 2017; Horton, 1967; Njoku, 2012; Onongha, 2015).

One area in African worldviews that provides evidence of the human and spiritual worlds' interrelated character is in the diagnosis and treatment of disease. Such diagnosis and treatment are usually carried out by medical professionals and traditional practitioners or diviners through the process of divination. Diviners (*Nganga* in Bantu cultures, *Babalawo* in Yoruba, *Dibia* in Igbo, etc.) are believed to be possessed and empowered by medicinal divinity to restore health and cosmic balance. Robin Horton (1967) points out that diviners' knowledge is crucially important in understanding the interrelationship between the human/physical and spiritual realms in African worldviews on illness causes, diagnosis, and interventions. Horton (1967) aptly attempts to capture this interconnectedness by noting that:

> [S]ick or afflicted people go to consult diviners as to the causes of their troubles. Usually, the answer they receive involves a god or other spiritual agency, and the remedy prescribed involves the propitiation or calling-off of this being. But this is very seldom the whole story. For the diviner who diagnoses the intervention of a spiritual agency is also expected to give some acceptable account of what moved the agency in question to intervene. And this account very commonly involves reference to some event in the world of visible tangible happenings (p. 53).

Some authors concurred that while western or orthodox medicine views illnesses as a result of biopsychosocial and psychological causative agents, most African worldviews consider causation of illnesses/sickness not merely from a biological, physical, and psychological, but also deeply from the spiritual dimension (Asare & Danquah, 2017, Onongha, 2015). Onongha (2015) supports that "it is generally believed that in Africa nothing happens to a person without a

cause—usually a spiritual one [… and to treat an ailment in a patient, it is important to identify the source/cause of the problem, then, a proper diagnosis [and intervention] can be considered" (p.62).

   African Worldviews on the Causes and Treatment of Mental Illness. Views on the causes and treatment of mental illness have evolved over time, and have shaped cultural, religious beliefs and societal norms (Gardner et al, 2014; Stewart et al, 2003). Beginning in the 19th and 20th century, the explanation of the causes and treatment of mental illness or disorders have been drastically transformed as examined through the lenses of many theories (Jutras, 2017). Prior to this time, mental illness had been perceived as linked to supernatural and evil spirit forces. Trephination and/or exorcism were utilized to manage symptoms (Jutras, 2017; Thompson, 2007; Ude, 2011). In some countries and cultures today, causes of mental illness are still perceived as God's will and punishment, and are managed with prayer, exorcism and traditional herbs (Adewuya & Ogunadem, 2007; Ude, 2011). One recent qualitative study explored the views of Kenya's traditional healer practitioners on the causes and treatment of mental illness and found that traditional healers, (those categorized as traditional faith healers) describe the symptoms of mental illness as witchcraft (Musyimi et al., 2018).

   A study which investigated doctors' attitudes towards people with mental illness in Western Nigeria also supports these findings. It reveals that 50 percent of medical doctors investigated indicated evil spirits and sorcery among others as causes of mental illness (Adewuya & Ogunadem, 2007). Treatment of mental illness is influenced by beliefs and perceptions of causes, which shapes attitudes and help-seeking behaviors. Although perceptions of the causes and treatments of mental illness have evolved over time, the effects of past history on its causes are still lingering, especially in terms of perception and self-consciousness, and it is not unusual

for many African immigrants to embrace both traditional and contemporary explanations of the causes of mental illness.

African Worldview and Its Interpretation in Relation to Help-Seeking during Perinatal periods. There is no doubt that this African worldview shapes women's attitude toward childbearing, mental health issues, and help-seeking during perinatal periods, or the search for a cure/treatment for any particular illness. Without question, defining criteria for childbearing and perinatal mood and anxiety disorders will vary greatly from culture to culture and, therefore, cannot be resolved among women in African diaspora by focusing only on Western (or American) defining criteria and explanations (Stewart, et al., 2003). Women in the African diaspora who identify their health problems as rooted in supernatural causes may have a tendency to seek help or solution through supernatural or mystical means (e.g., prayer, divination, herbal, etc.). As highlighted in the section above on cultural perspectives regarding the causes, diagnosis, and treatment of illness, mental illness causality is an important area that is deeply influenced by the basic assumptions of African worldviews. Such a belief system shapes the attitudes and help-seeking behaviors of women in African diaspora. Although perceptions of the causes and treatments of mental illness has evolved over time, the influence of the basic assumptions of African worldviews, nonetheless, persists regarding its causes as rooted within the interlocking convergence of both the physical and spiritual realms.

Women who come from cultures or countries that are struggling to achieve a universal standard for diagnosis and treatment of mental illnesses may still hold to these beliefs, and hence may feel uncomfortable discussing their symptoms during their perinatal periods for fear of stigmatization (Benn & Howell, 2017; Jutras, 2017; Ude, 2011). Those who hold these views

may be more likely to seek spiritual help from their various religious spiritual leaders (pastors, Imams, herbalists, *Dibias*, *Babalawos*, *Ngangas*, etc.). Additionally, the professionals' ability to provide effective interventions or make proper referral is dependent on their competence in understanding the multicultural and intercultural determinants of illnesses across diverse cultural backgrounds.

Psychosocial Assessment and Intervention

Literature emphasizes the need for healthcare providers to incorporate psychosocial assessment of mothers for PMADs (Cross, 2016; King, 2014; Milgrom & Gemmil, 2015; NAPSW, 2016; NASW, 2016; Stewart et al., 2003). During the assessment process, it is imperative for social workers to conduct a holistic assessment, thus gathering biopsychosocial-spiritual information from mothers, or family members and medical staff (NASW, 2016). Employing biopsychosocial-spiritual perspectives during assessment processes aids social workers in understanding the emotional and/or psychological state of the mother, and her socioeconomic, physical, or medical conditions, sociocultural and spiritual needs and concerns that might be contributing to PMADs, and therefore impact help-seeking behaviors. Assessments are helpful in identifying strengths, as it constructs a map of the family's microsystem, mesosystem, exosystem and macrosystems (Cross, 2016). These strengths can include quality of social and other support systems, availability of resources where mothers are residing, among others.

Social Work in the Healthcare: Brief History and Role

Brief history of Social Work in the Public health

The practice of social work within the field of healthcare traces its origin to public health through the advocacy of Harry L. Hopkins, the director of the New York Tuberculosis Society

and a close adviser to President Franklin D. Roosevelt (Gehlet & Browne, 2019). Hopkins also served as an architect of the Franklin's New Deal. Hopkins social work advocacy began in the year 1926, when he argued and wrote that "fields of social work and public health are inseparable, and no artificial boundaries can separate them" (Gehlet & Browne, 2019, p. 93). Social work is interwoven in the whole fabric of the public health movement and has directly influenced it at every point (Ruth, & Marshall, 2017). However, social work did not fully evolve into public health until early the 20th century (Gehlet & Browne, 2019; Ruth, & Marshall, 2017). In this progressive era, social work and public health share common values and overlap in their commitment to health and social well-being (Gehlet & Browne, 2019; Ruth, & Marshall, 2017). The two fields collaborated and worked on the issues of influenza epidemic response, and venereal disease control (Gehlet & Browne, 2019; Ruth, & Marshall, 2017). Social work and public disciplines collaborated in promoting maternal and child health and settlement house movement, and achievements have been recorded to successfully contribute to decreasing maternal child mortality and morbidity throughout the era of 20th century and beyond (Gehlet & Browne, 2019; Ruth, & Marshall, 2017).

Brief History of Social Workers in Hospitals

Hospital social work in the United States was pioneered by the early work of social worker Ida Cannon and physician Richard Cabot in an effort to help address the rampant spread of tuberculosis and syphilis (Ruth, & Marshall, 2017). Notwithstanding the challenges these pioneers encountered from some of the doctors and nurses, the positive impact of assisting patients dealing with these illnesses eventually gave social work a place in the hospital. The first hospital social work department was established in 1910, by the founder of a Boston-area hospital (Ruth, & Marshall, 2017). Since then, hospital social work has grown rapidly to its

current state, creating the most common primary employment setting for health care social workers (Gibelman, 2005 as cited in Ruth, & Marshall, 2017). Hospital social workers serve in different capacities and provide frontline services to patients and their families with conditions spanning the entire health care continuum (NASW, 2011). Social worker specializations within various hospital departments and units include maternal and child, pediatrics, neonatal, women and baby wellness, oncology, nephrology, transplant, and emergency/trauma (NASW, 2011).

Social workers continue to make an impact in hospitals, specifically in the areas focusing on mothers and children. In order to help address the needs of their patients, social workers began to pay more attention to maternal and child health services (National Association of Perinatal Social Workers—NAPSW, 2016). NAPSW was initiated in 1974, as result of a tri-regional workshop on Maternal Child Health Services which included a workshop on perinatal social work. Although the idea to initiate NAPSW occurred in 1974, the organization was not officially established until 1980, by an interest group of neonatal intensive care unit social workers (NAPSW, 2016). NAPSW was instituted to promote, expand, and enhance the interests and role of social work in perinatal health care while continue to provide mothers and families with support, counseling, case management, advocacy, and guidance and resources (NAPSW, 2016).

Social Workers Roles in Healthcare Settings

Understanding social workers' roles in certain health settings can be very controversial, particularly in the hospital case management department where there are social worker and nurse case managers attempting to provide care to patients and their families. The *National Association of Social Workers* (2011) defined social worker roles, especially in the hospital, as helping patients and their families address and resolve the social, financial, and psychological problems

related to their health condition. NASW outlines general job functions for social workers working in the health care settings as:

> Providing initial screening and evaluation of patient and families, and comprehensive psychosocial assessment of patients; helping patients and families understand the illness and treatment options, as well as consequences of various treatments or treatment refusal; helping patients/families adjust to hospital admission; possible role changes; exploring emotional/social responses to illness and treatment; educating patients on the roles of health care team members; assisting patients and families in communicating with one another and to members of health care team; interpreting information; educating patients on the levels of health care.

These role descriptions center on helping patients and their families address and resolve the social, financial, psychological, and spiritual challenges related to their health conditions that could impact wellbeing. NAPSW (2016) adopts/embraces/accepts the NASW role definition and defined perinatal social worker's roles as ensuring that mothers, their babies and families are provided with support, counseling, case management, advocacy, guidance and resources. Doing so promotes resilience, wellness and improves holistic care—physical, psychological, and spiritual wellbeing of the mothers and their babies.

Policy – Medicaid Perinatal Service Delivery to Maternal and Child

Insurance coverage is an important aspect of perinatal mental health care as it serves as an important determinant to help-seeking; and not having any insurance for healthcare coverage during and after pregnancy can put reproductive women at risk of medical and mental health complications. Medicaid insurance is the largest perinatal care payer, which provides insurance privileges to low-come women or women whose income is below the federal poverty level or

threshold (MACPAC, 2018; Medicaid.gov, 2020; National Women Center, 2015; Swartz et al., 2017). Funded by the state, Medicaid eligibility criteria can differ from state to state, and one state may have better coverage plan than another. In the state of Texas, for example, the eligibility criteria to qualify for Medicaid is a household income greater than 198 percent of federal poverty level and at or below 202 percent of the federal poverty level (Texas Department of Health and Human Services, 2020), while States of Oregon eligibility criteria falls under 138 percent of federal poverty level (MACPAC, 2018). Four in ten perinatal women receive Medicaid coverage during and after pregnancy (MACPAC, 2018; Medicaid.gov, 2020). Children's Health Insurance Program (CHIP) Medicaid) a program that offer children from ages birth to 18 years health coverage, expanded to give access to prenatal health care to unauthorized perinatal women living with United States (MACPAC, 2018; Medicaid.gov, 2020; Swartz et al, 2017; Texas Department of Health and Human Services, 2020). Swartz et al. (2017), in order to highlight how far the Medicaid program has come in assisting low-income mothers and their children achieve their healthcare goals noted that:

> An "unborn child" option in the Children's Health Insurance Program (CHIP) enacted in 2002 and the Child Health Insurance Program Reauthorization Act (CHIPRA) enacted in early 2009, gave states new options to provide prenatal care coverage with federal matching funds for extending coverage to immigrant children and pregnant women, regardless of their legal status or date of entry to the US" (Texas Department of Health and Human Services, 2019).

The expansion of Medicaid extends insurance coverage opportunity to unauthorized or undocumented immigrant women, which helps reduce the risks of maternal and child mortalities and morbidities (Fabi, 2020; Wherry et al., 2017). However, notwithstanding this testimony

about Medicaid service expansion, some studies reveal that women with this insurance are less likely to receive prenatal care during their first trimester (National Women Center, 2015; Swartz et al., 2017). Compared to private insurance, mothers with Medicaid are less likely to receive adequate care, which leads to lack of late or insufficient perinatal care during and after pregnancy; and are more likely to have a cesarean section and low birth weight babies (National Women Center, 2015; Swartz et al., 2017). In addition, although Medicaid has improved immigrant women's access to perinatal care without any observable negative changes in the mother and infant health or mortality, it only covers certain perinatal conditions and coverage ceases for the mother a few weeks after childbirth (Swartz et al, 2017; Wherry et al., 2017).

The Purpose of the Study

This dissertation study specifically addresses the following research objectives to help fill the gaps identified in the literature review: (1) gathering knowledge and interpretations by women in the African diaspora about a mother's vulnerabilities and/or adaption to perinatal mood and anxiety disorders during perinatal periods; (2) the diasporic contextual experiences of African women and their personal interpretations on their vulnerabilities to perinatal mood and anxiety disorders; and (3) the women in the African diaspora's lived experience on help-seeking, especially how they make meaning of their interactions with healthcare professionals during and after pregnancy. To achieve the above stated research aims/objectives, this study explored and developed knowledge on perinatal mood and anxiety disorders among women of the African diaspora living in the United States, focusing specifically on knowledge about perinatal mood and anxiety disorders and their help-seeking lived experiences. This researcher explored in depth African immigrant women awareness and knowledge of this phenomenon and solicited information about their experiences with professionals during pregnancy and after childbirth (a

factor that has been shown to affect help-seeking). The knowledge gained from this study

contributes to the scant research available on this phenomenon as it affects this population. It will

also assist in developing and evaluating socio-culturally sensitive social work interventions that

would enhance the psychological/emotional well-being and quality of life for women in the

African diaspora and their infants, especially those vulnerable to perinatal mood and anxiety

disorders.

Relevance to Social Work

In any field of social work, practice, education, research, and leadership are vital.

Therefore, to understand the relevance of this dissertation topic to the social work profession, it

is essential to specifically explore its relevance to social work practice, education, research, and

leadership, especially as it relates to the population in question.

Social Work Practice and Evidence-based practice

The research findings of this study can be utilized to evaluate the effectiveness of

perinatal mental health practice in which perinatal social workers engage with women and

implement intervention, mostly as it relates to women in the African diaspora

population. Knowledge of how to work effectively with vulnerable perinatal individuals,

families, and groups is vital to the success of the social workers. The social work profession not

only sanctions its members to engage in promoting activities sensitive to cultural and ethnic

diversity, but also mandates them to have knowledge of their diverse population and their

presenting problems in order to demonstrate cultural competence and humility in the service

provision (NASW, 2018). Professionals with a low level or lack of cultural competence can lead

to frustration when attempting to assess, screen or care for perinatal immigrant women (Gardner

et al., 2014; Miszkurka et al., 2010; Skoog, 2018). This topic is relevant to social work because it

discusses perinatal mood and anxiety disorders that are crucial to social work perinatal practitioners in all social work practice fields. Therefore, a study in this area will help improve, among social work professionals, the practice knowledge and intervention suitable to work with women in the African diaspora. The knowledge gained from this research will also inform practice in both micro, mezzo and macro levels.

Education

Education is an important aspect of social work intervention (NASW, 2018), as it increases knowledge of a social problem and the skills/competencies needed for best intervention outcomes. It also helps perinatal women to develop better knowledge about PMADs and available resources that can help them meet their needs during their perinatal periods. This research will be vital, not only to social work professionals with this population, but also other providers who administer service to perinatal women during these periods. The findings of this research will help professionals/healthcare providers to gain new skills/competencies about clients' presenting problems and how to integrate them with the clients' system and other agents of change to effectively meet their needs, especially with perinatal African diaspora women (NASW, 2018; NAPSW, 2019). It will also provide knowledge and understanding about how to develop and interpret policy that impacts perinatal women of this ethnicity. This topic is relevant to social work because it will increase the knowledge about PMADs among African diaspora women living in the United States on their lived experiences regarding help-seeking.

Leadership

The social work profession embraces and promotes diversity and dynamics of culture and works to reduce vulnerability and oppressions (National Association of Social Workers [NASW], 2018). Immigrant women are among those found to be vulnerable to perinatal mood

and anxiety disorders and help-seeking (Gardner et al., 2014; Skoog, 2018). The key to promoting diversity and improving culturally sensitive programs to give voice to the vulnerable is the social work leadership advocacy. Social work leaders affect change on social problems through awareness or acquiring cultural knowledge about that phenomenon. Cultural knowledge about perinatal mood and anxiety disorders among women in the African diaspora can be garnered through research and education. This research is relevant to social work because the topic is not only crucial to social workers, but it highlights one of the most vulnerable populations and their cultural views on help-seeking when social work leader. According to literature, immigrant women are vulnerable to perinatal mood and anxiety disorders and help-seeking (Firth & Haith-Cooper, 2018; Gardner et al., 2014; Miszkurka et al., 2010; Skoog, 2018). Also, because of immigration and other factors, they are highlighted to be at a higher risk of vulnerability and may need social workers to give them voice so as to function effectively in the midst of adversity. Perinatal social workers' advocacy for leadership roles or positions in the healthcare settings is needed, especially in this topic area and population. Therefore, the findings of this dissertation will help improve cultural awareness and competency, particularly as relates this population.

Chapter 2: Literature Review

This author utilized both quantitative and qualitative inquiry methods to understand research conducted in perinatal mood and anxiety disorders among women in the African diaspora and their help-seeking behaviors. Before extracting the articles related to this topic, the author consulted with the author's university subject librarian, who helped gather articles related to the topic and immigrant populations. The librarian recommended using studies on immigrant women as a starting point to expand the search to similar studies conducted on this broader population. The author also employed distinguished authors' recommendations on conducting literature reviews (Siddaway, Wood & Hedges, 2018). These authors suggested applying systematic search processes when conducting both a literature review and literature review, believing that it improves the quality of findings (Siddaway, Wood & Hedges, 2018). These authors defined review of literature as a "process that involves selectively discussing literature on a particular topic to make an argument, or a new important contribution to existing knowledge"(Siddaway, Wood & Hedges, 2018, p. 751). They explained that "literature reviews comprise a distinct research design and type of article in their own right and provide a comprehensive synthesis of available evidence to allow the researcher to draw broad and robust conclusions" (p. 751).

For this study's purpose, this researcher systematically conducted both literature review and review of the literature. Review of literature helped this author write the introduction and other chapters of this dissertation, while the literature review helps this author understand the intricacies of the research conducted on this topic and the population in question. In conducting the literature review, this author utilized Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines and gathered articles from academic library journals,

ebooks, and printed books. In accessing academic library journals, this author searched topic-related articles published between 2000 and 2019 on the SocINDEX, CINAHL (Cumulative Index to Nursing and Allied Health Literature), PsycINFO, and Pubmed databases. This author also conducted Google, and Google Scholar searches to locate articles and books. Some of these articles were examined more in-depth, and tables were created separately to help provide virtualization. Quotative empirical research articles were summarized under the following headings: the author's name, the year the article was published, the study's topic and purpose, investigation method, variables, measurement, theory utilized, and the studies' findings. Explanatory articles were annotated under headings: author's name/year/title, and annotation. See Appendix A for the tables with the articles and diagrams depicting some of the search results.

Since this is a qualitative study, this researcher utilized a qualitative method to examine and analyze literature extracted from the database deeply. During this process, this author was able to code and develop overarching themes and subthemes (nodes) through Nvivo 12 software. Utilizing this software, this researcher performed word frequency and text-search queries, mind and concept maps to explore, analyze, create, and present themes and subthemes identified from the articles/studies. The general search result shows that most abstracted articles discuss postpartum depression, postpartum support, and postpartum treatment. These results were explored further to understand which of these articles specifically conducted complete studies on perinatal mood and anxiety disorders, primarily related to women in the African diaspora and their help-seeking behaviors and experiences. From this analysis, the following overarching themes and subthemes emerged: perinatal mood and anxiety disorders among Africa diaspora women, knowledge of perinatal mood and anxiety disorders, help-seeking behaviors, and intervention of perinatal mood and anxiety disorders. See below the diagram depicting the

visualization of the themes and subthemes. Additionally, a review of literature continues throughout this dissertation process as necessary. These themes are discussed individually below.

Diagram 1

A diagram showing the visualization of literature search result.
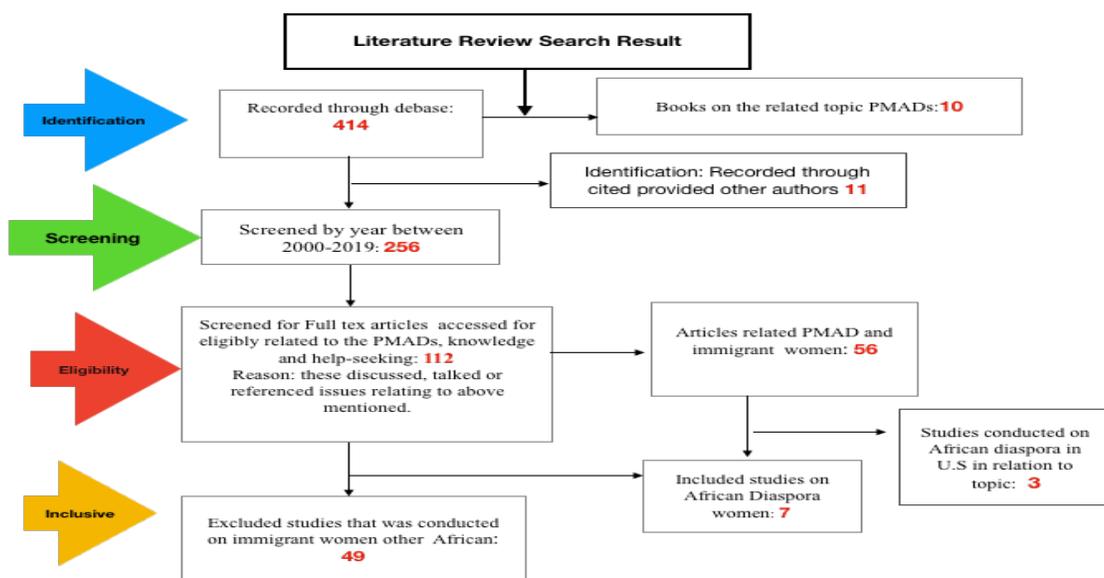
Diagram 2

A diagram showing a word cloud of the initial search and the visualization of overarching themes and subthemes
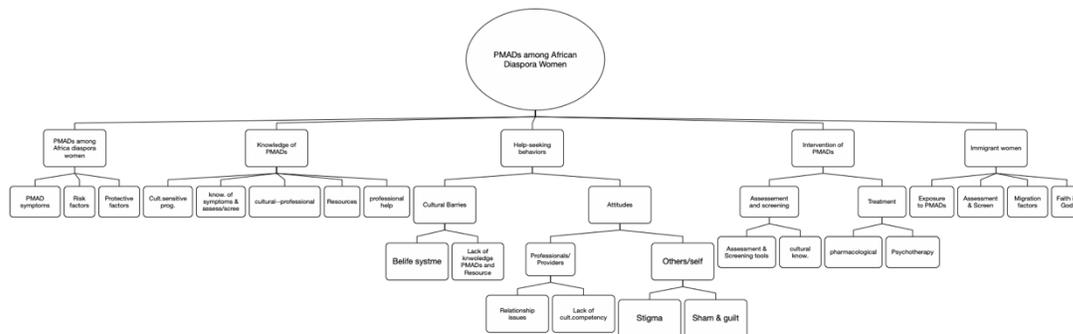
Perinatal Mood and Anxiety Disorders (PMADs)

Symptoms

Perinatal mood and anxiety disorders are symptoms that occur during and after pregnancy (PSI, 2019). According to the empirical literature, commonly reported symptoms of perinatal

mood and anxiety disorders to include fatigue, feeling of anxiety, hopelessness, irritability, sadness, sense of helplessness, tearfulness, and thoughts of harm to self or baby (Alves et al. 2018; Beniot et al. 2007; Cook et al., 2010; Dunford et al., 2017; Farr et al., 2013; Garner et al., 2014; Goodman et al., 2010; Guy et al., 2014; Nnaka, 2018; Skoog, 2018; Swanson et al., 2011; Wisner et al., 2013; Park, 2017). Depressive and anxiety symptoms are found to be more prevalent during the postpartum period as opposed to the antepartum period (Bennett et al., 2011, DeLuca & Lobel, 2014; Goodman et al., 2010). A study that screened and evaluated perinatal women for depression during the postpartum period to determine the timing for episode onset, rate, and intensity of self-harm, found that 40.1 % of episodes began postpartum compared to33.4% during pregnancy (Wisner et al., 2013). This study also revealed that 19.3% of their participants reported self-harm ideation.

While Psychosis symptoms have been reported as a rare illness during and after pregnancy, a number of other studies found that women who experience severe symptoms report hallucinations, suicidal ideation, or attempted suicide (Beniot et al., 2007; Templeton et al., 2013; Wisner et al., 2013). Shame and guilt emerged across the literature. A recent study that investigated whether maternal feelings of shame and guilt were associated with postnatal depressive symptoms and attitudes towards help-seeking found that shame proneness significantly predicts postnatal depressive symptoms once demographics and social support had been accounted for (Dunford & Granger, 2017). Dunford and Granger's (2017) findings also indicate that guilt-proneness was not a significant predictor of postnatal depressive symptoms or attitudes towards help-seeking. These findings highlight the potential negative consequences of maternal feelings of shame in the postnatal period (Dunford & Granger, 2017).

Risk and Protective Factors for Perinatal Mood and Anxiety Disorders

Literature highlights that some factors increase perinatal women's vulnerability to perinatal mood and anxiety disorders. These factors include psychosocial, psychological, and biological elements (Anderson et al., 2017; DeLauca & Lobel, 2014; Fagan & Lee, 2009; Ganann et al., 2016; Gardner et al., 2014; O'Mahony & Donnelly, 2010; Templeton et al., 2003). Psychosocial risk factors are labeled as lack of a social support system, which includes family and friend supports, lack of practical mothers (mother figure), providers/professional supports, limited or financial constraints, lack of community resources, and family issues (Gardner et al., 2014; Row & Harman, 2015). Community support is described as not having access to community resources due to a lack of available resources and means to access these resources (Row & Harman, 2015). Bilszta et al. (2010) investigated the prevalence and psychosocial risks for perinatal depression among Black Caribbean women. Their study showed that "whether or not women configure depressive feelings as 'symptoms' requiring external validation and intervention is a reflection both of the social embeddedness of those individuals and of how 'help-givers' perceive them and their particular needs" (p. 93). However, a recent qualitative study that explored the experiences of mothers with depression from pregnancy and childbirth found that, though mothers may have a good support system that reduces vulnerability, 'experienced problems,' 'unmet expectations, and psychological distresses (Kazemi et al., 2018), they will be unsatisfied with the care received from their social support.

While some studies found psychosocial issues are a factor that can exacerbate women's vulnerability to perinatal mood and anxiety disorders (Gardner et al., 2014; Row & Harman, 2015), other studies highlight psychological issues as putting women at a higher risk for perinatal mood disorders. Psychological factors are described as having a history of mental health

disorders, history of perinatal depression or anxiety, emotional distress, or feelings of dissatisfaction with the caregiver and provider care (Benoit et al., 2007; Dunford & granger, 2017; Gross & Marcussen, 2017; Kazemi et al., 2018). Some researchers argue that some mothers may have a good support system and knowledge about how to access community resources, but they may not be satisfied with their interactions with healthcare providers or the care they receive from their support persons (DeLauca & Lobel, 2014). Immigrant stressors, such as immigration experiences, emotional disconnection from support persons or family member is established to put women at risk perinatally (Ganann et al., 2016; O'Mahony & Donnelly, 2010).

A study that investigated the helpful strategies to meeting the mental health needs of the immigrant and refugee women during the post-partum period found that migration factors such as feelings of social isolation, stress caused by war or persecution from the country of origin, and loss of family through immigration negatively impacts the perinatal period (O'Mahony & Donnelly (2010). Another risk factor associated with perinatal mood and anxiety disorders is biological factors (Nnaka, 2018; Prady & Kieman, 2013; Stewart et al., 2003). While psychological and psychosocial factors are highlighted to contribute to perinatal mood and anxiety disorders, some studies found that these factors are not the major risk factors (Stewart et al., 2003), but biological and genetic factors are major risk factors. The biological and genetic include complicated medical conditions—diabetes, blood pressure issues, complicated cesarean section (Bennett et al., 2011; DeLauca & Lobel, 2014; Gross & Marcussen, 2017), and family history of psychosis (Brockington et al., 1990; Dowlatshahi & Paykel, 1990; Stewart et al., 2003).

Protective factors decrease women's vulnerability to mood and anxiety disorders during perinatal periods (Garmezy & Rutter, 1983; Werner & Smith, 1992). While psychosocial,

biological, and psychological factors mitigate women's ability to manage or cope with perinatal mood and anxiety disorders, certain psychosocial and psychological factors were found to increase adaptation (Anderson et al., 2017; Ganann et al., 2016). Family support is found not only as a preventive measure but also as a factor that helps women manage symptoms effectively (Gardner et al., 2014; Kazemi et al., 2018; Park et al., 2017; Corrigan, Kwasky & Groh, 2015). Some studies also reveal that while family support has a higher predictable factor in helping women cope with postpartum depression, it loses its predictability power when it is undermined by other social factors such as immigration and family issues (Gardner et al., 2014; Row & Harman, 2015; O'Mahony & Donnelly, 2010). Some immigrant women lose their family connections through migration (O'Mahony & Donnelly, 2010).

Gardner et al. (2014) study that investigated perinatal West African women living in the United States and the United Kingdom reveals the importance of having a helper during perinatal periods to care for the baby and assist household chores and cooking. In this study, they found that the lack of a mother figure increases vulnerability to perinatal mood and anxiety disorders, especially during the postpartum period, as having such a figure helps alleviate the stress and pressure of being a new mother (Gardner et al., 2014). Gardner et al., 2014) also found that connecting with a women's social group, receiving services from friends will serve as a replacement or mitigation. Supporting this, Gardner et al. (2014) presented their study which explored the lived experience of postnatal depression in six (6) West African mothers living in the United Kingdom (UK) and where a participant stated, "[when you start going to the group] you know that you are not alone, so many mothers are going through what you are going through" (p.761). A mixed-method study that examined "the association between social factors, the organization of maternity care services, and the prevalence of depression among a purposive

sample of new mothers at 3 – 4 weeks and 4 – 6 months postpartum," also demonstrates financial constraint is linked to help-seeking issue (Beniot et al., 2007). In this study, Beniot et al. (2007) found that lack of income increases a mother's vulnerability to postpartum depression.

Knowledge of Perinatal Mood Anxiety Disorders

Several subthemes emerged from this overarching theme knowledge of perinatal mood and anxiety disorders and helping-seeking behaviors. These include knowledge about symptoms and assessment/screening; and knowledge about help-seeking (available resources and professional help). Knowledge of perinatal mood and anxiety disorders helps mothers recognize mood and anxiety symptoms during pregnancy and after childbirth and encourages help-seeking (Guy, 2014; Nnaka, 2018; Row & Harman, 2014). Some studies found that a mother's level of knowledge of perinatal mood and anxiety symptoms, treatments and resources improve literacy and provides women with the capacity to obtain, process, and understand the mental health information needed to make appropriate decisions for themselves and their newborn during perinatal periods (Guy et al., 2014; Ratzan & Parker 2000). Studies also reveal that caregivers' level of knowledge of perinatal mood and anxiety disorder's symptoms, resources, and how to navigate these resources is lacking (Acri et al., 2015). Improving knowledge or health literacy about mood and anxiety disorders during perinatal periods is found to encourage women to seek help and know where to obtain community resources that meet their needs (Schimied et al., 2017). Programs that will educate and train both mothers and their caregivers on perinatal screening, treatment, and resources are needed to help decrease the level of perinatal mental health illiteracy among mothers and their caregivers.

In their study, Acri et al. (2015) found that engaging caregivers in screening, education, and empowerment (SEE) programs increases caregiver knowledge about perinatal depression

and available resources, as well as link them to needed services and help them understand more about maternal feelings. Another theme that emerged from the knowledge of perinatal mood and anxiety disorders is the professional level of knowledge of cultural diversity and how to work with immigrant women. Literature highlights that this knowledge needs to be improved among professionals and how to work with perinatal immigrant women (Gardner et al., 2014; Miszkurka et al., 2010; Skoog, 2018). As Skoog (2018) found, a professional low level or lack of cultural competence can cause frustration when attempting to assess, screen, or care for perinatal women, which can deter women from opening up to talk about their symptoms.

Help-Seeking During Perinatal Periods

During this literature review, three major themes (Knowledge, cultural barriers, and attitudes) emerged regarding help-seeking behaviors and experiences. Help-seeking among African diaspora women living in the United States is a captivatingly under-researched topic. A few studies were found that investigated poor help-seeking behaviors among immigrant women (Bilzsta et al., 2010; Callister, Beckstrand & Corbett, 2011; Edge & MacKian, 2010; Gardner et al., 2013; Park et al., 2017; Miszkurka et al., 2010). In these studies, policy advance issues as such as lack of insurance, low coverage or high premiums, and immigration issues were found to be barriers to help-seeking among women in the African diaspora (Benoit et al., 2007; Bilszta et al., 2010; Daw, Benjamin & Sommers, 2019; Ganann et al., 2016). While some studies show that knowledge about perinatal mood and anxiety symptoms and available resources increase help-seeking behaviors among immigrant women, other studies reveal contrary results. Some studies found that few immigrant women seek help during perinatal periods even with the knowledge about the disorders and resources (Miszkurka, Goulet & Zunzunegui, 2010; Park et al., 2017).

Attitudes and beliefs influence help-seeking during perinatal periods. These attitudes and belief systems include not coping with and fear of failure, motherhood expectations, stigma and denial, poor mental health awareness and access, interpersonal support, baby management, help-seeking, treatment experience, and relationship with health professionals. Bilzsta et al. (2010) explored mothers' experiences after having a baby, recognizing symptoms, seeking help, treatment experiences, and ideal options found that not coping and fear of failure, stigma, and symptoms denial discourage perinatal women from seeking help. Other literature findings indicate that women who experience clinically significant levels of distress and experienced stigmatization do not feel comfortable disclosing symptoms and are less likely to accept treatment (Bodnar-Deren, 2017; Prevatt & Desmarais, 2018; Price et al., 2021). Further, several studies highlight different factors that impede help-seeking (Blizsta et al., 2010; Bodnar-Dere, 2017; Callister, Beckstrand & Corbett, 2011; Garner et al., 2014; Mukherjee et al., 2018; Park et al., 2017). There is supporting evidence that perinatal immigrant women prefer not to seek help during perinatal periods due to unavoidable circumstances such as lack of insurance, language and immigration issues (Bilszta et al., 2010; Daw, Benjamin & Sommers, 2019; Ganann et al., 2016).

Some studies reveal cultural impacts (belief systems on mental health issues) on help-seeking during perinatal periods. These studies found that stigma associated with beliefs on the causes and treatment of mental illness, perception that perinatal mood and anxiety symptoms are not severe enough to require help, and cultural differences between provider and mothers contribute to lack or limited help-seeking among immigrant women (Gardner et al., 2013; Park et al., 2017; Prevatt & Desmarais, 2018). A study by Blizsta et al. (2014) also supports the above findings. For example, in their study that examined "mothers' experiences after having a baby,

'recognition of symptoms, seeking help, 'treatment experiences, options, and ideal treatment,' they found a relationship between associated attitudes and belief systems as creating significant barriers to help-seeking during the postpartum period (Blizsta et al., 2010). Another study by Park et al. (2017) confirmed Blizsta et al.'s (2010) findings and found that isolation and sadness prevent mothers from seeking professional help (Park et al., 2017).

Cultural beliefs and language barriers are highlighted as impeding help-seeking during perinatal periods among immigrant women (Schimied et al., 2017, Callister, Beckstrand & Corbett, 2011). Feelings of shame and guilt are also seen as a predictor of perinatal PMADs and increase vulnerability to emotional disorders and impede help-seeking. Dunford and Grange (2017) explored maternal feelings of shame and guilt and found that they were associated with postnatal depression and attitudes toward help-seeking. The result of this study revealed, "that shame proneness significantly predicted less positive attitudes towards help-seeking … and] guilt proneness was not a significant predictor of postnatal depressive symptoms or attitudes towards help-seeking" (Dunford & Granger, 2017, p. 1692). However, other previous studies have found that women who view the transition to motherhood as complex and challenging may perceive themselves as failures or bad mothers, which leads to a sense of shame, guilt, and self-criticism (Cree, 2010 as cited by Dunford and Granger, 2017).

Relationships between professionals/providers and immigrant women are also highlighted in the literature as correlating with help-seeking (Blizsta et al., 2010; Edge & MacKain). In support of this, some studies found that immigrant women who lost trust from healthcare professionals or the medical system and experienced stigmatization or stereotyping during the help-seeking process are more likely to restrain from seeking help (Bodnar-Deren, 2017; Huebner et al., 2013; Garner et al., 2014; Mickelson et al., 2017; Park et al., 2017). There

is also evidence from other studies that healthcare professionals or providers' inability to communicate effectively with perinatal immigrant women due to cultural differences and language barriers hinder immigrant women from continuing care after childbirth (Edge & MacKain, 2010; Stone et al., 2015). Many perinatal women are more likely to depend on their support system and prefer help-seeking within the family system instead of getting help from professionals or providers, especially immigrant women who may have cultural, language, and health literacy problems (Corrigan, Kwasky & Groh, 2015; Schimied et al., 2017; Park et al., 2017; Templeton et al., 2003).

Interventions for Perinatal Mood and Anxiety Disorders

Assessment and Screening

Assessing and screening women during prenatal and postnatal periods for PMADs symptoms are of paramount importance, as it helps in the early detection of risks and will improve care for mothers and their infants (Milgrom & Gemmil, 2015; Olin et al., 2015). The literature consistently highlights the need for social workers and other health and mental health professionals to assess and screen women for PMADs during and after pregnancy (King, 2014). Whist assessment and screening for perinatal mood and anxiety disorders improve preventive measures and determines the best treatment options, screening with structured assessing tools negatively affects the rate of detection, treatment, and referral (Goodman & Tyler-Viola, 2010; King, 2014; Stewart et al., 2003). Lack of disclosure can affect the results of perinatal mood and anxiety disorder assessment and screening (Prevatt & Desmarais, 2018). Prevatt and Desmarais (2018) study explored perceived barriers and facilitators to disclosing perinatal mood and anxiety disorder symptoms to healthcare professionals. In this study, they found that one in five (over

half of 211) women surveyed experienced clinically significant distress levels but did not disclose their PMAD symptoms to their healthcare providers (Prevatt & Desmarais, 2018).

Clinical Assessment and Screening Tools

Suggested scales in screening women for perinatal mood and anxiety disorders include the *Edinburgh Postpartum Depression Screen (EPDS)*, Patient Health Questionnaire -9 (*PHQ-9),* *Center for Epidemiologic Studies of Depression instrument* (CES-D), and *Postpartum Depression Screening Scale* (PDSS) (Firth & Haith-Cooper, 2018; Guedeney & Fermanian, 1998; Milgrom & Gemmil, 2015; Miller, 2012). The PHQ-9 and EPDS instruments are widely used in healthcare settings (Firth & Haith-Cooper, 2018; Skoog, 2018). A study finding also supports that 61 percent of perinatal social workers mostly use validated instruments (EPDS and PHQ-9) in screening women for perinatal depression (Polmanteer, Keefe & Brownstein-Evans, 2016). Milgrom & Gemmil (2015) explicated different PMADs screening tools but discussed their validity and liability in evidence-based practice. PHQ-9 sale is recommended for screening women for perinatal mood and anxiety disorders during pregnancy (Milgrom & Gemmil, 2015; Sit & Wisner 2009), while the *EPDS* scale is most commonly used to screen mothers after childbirth (Milgrom & Gemmil, 2015; Sit & Wisner 2009). The brief version of the *Patient Health Questionnaire -9 (PHQ-9)* contains nine items of self-reported responses on depression, measured with four levels (not at all, several days, more than half the days and nearly every day) to understand how mothers feel over 2-week periods during pregnancy prior to prenatal visits and to screen mothers for prenatal mood disorders (Sit & Wisner,2009).

As noted above, the *Edinburgh Postpartum Depression Screen (EPDS)* is a 10-item scale commonly used to identify mothers with postnatal mood disorders and measure at 4 level responses (0, 1, 2, 3 scores) (Corrigan, Kwasky & Groh, 2015). The EPDS tool can also be used

to screen women during pregnancy (Sit & Wisner,2009; Corrigan, Kwasky & Groh, 2015). Some healthcare providers set score thresholds as low as 9/10, but the score of "of 12/13 or higher is suggestive of "probable" depression and "possible" depression at a score of 9/10" (Corrigan, Kwasky & Groh, 2015, Gibson et al., 2009). Setting lower threshold scores is recommended to catch possible depression in women during and after pregnancy (American College of Obstetricians and Gynecologists, 2008; Corrigan, Kwasky & Groh, 2015). An elevated score does not always suggest a diagnosis of postpartum depression; however, detecting a score greater than 13 confirmed significant depressive symptoms (Corrigan, Kwasky & Groh, 2015, Gibson et al., 2009; Sampson, Zayas & Seifert, 2013; Sit & Wisner, 2009). Higher threshold scores can be justified due to transient stress ensued from normative experience of pregnancy, social or economic issues that are unrelated to mood disorders (Sit & Wisner, 2009).

It is recommended that women with high scores be referred for clinical evaluation to rule out suspected factors as the peripartum mood disorders have their onset during pregnancy or occur within four weeks after delivery (American Psychiatric Association, 2013). The EPDS has been validated in different languages such as English, Spanish (Alexander et al., 2013), French (Guedeney & Fermanian, 1998), and other languages. A systematic review that explored the validity and reliability of EPDS found that the scale was validated in different English-speaking women and their results show internal consistency of coefficient alpha 0.84 and interquartile range 0.71-0.87 (Alexander et al., 2013). Also, a study that sampled 87 French-speaking women in their first four months of postpartum periods notes "reliability study confirms the good internal consistency of the global scale (Cronbach's alpha: 0.76) and its good short-term test-retest reliability (0.98)" (Guedeney & Fermanian, 1998, p. 83).

Social Worker knowledge and Use of Assessment and Screening Tools

Lack of professional knowledge on perinatal mood and anxiety disorders, assessments, and screening may undermine appropriate referral and intervention provision. Social worker knowledge on utilizing and interpreting perinatal mood and anxiety scores from the instruments mentioned above is needed to appropriately screen women during perinatal periods. Literature shows that many perinatal social workers are screening women for perinatal mood and anxiety with validated instruments; however, their expertise in interpreting these scores or scales is questionable. Polmanteer et al. (2016) study support this claim in their study investigating 261 perinatal social workers' expertise in screening mothers with postpartum depression. In this study, they found that: more than half (approximately 57%) of participants responded that they neither learned how to screen nor how to diagnose postpartum depression during their undergraduate or graduate school education; 25% of participants indicated not used any screening instruments before; and many indicated they do not consult professional literature on postpartum depression from social work and other disciplines to guide practice (Polmanteer, Keefe & Brownstein-Evans, 2016).

Cultural Assessment Application

Another area of concern about assessment and screening for perinatal mood and anxiety disorders is understanding how reliable psychometric instruments can address cultural issues. Although EPDS and other screening tools prove effective in detecting depression during pregnancy and after childbirth in women, it poses a challenge for healthcare professionals and is considered an inadequate tool for immigrant women (Skoog, 2018). Skoog (2018) argues that instruments lack culture-specific questions. As relates to this study, no literature validates these recommended screening tools in women in the African diaspora. Scant data exist on the

comprehensive validity of perinatal depression screening tools across racially and ethnically diverse groups of women with low socioeconomic status (Lee & King, 2012, 2014). This insufficient data may lead to potential biases in screening on perinatal mood and anxiety disorders across racial and ethnic groups, as screening items may be interpreted differently across women from various backgrounds (Lee & King, 2014). "Somatization of symptoms also makes the EPDS a difficult instrument to use" (Templeton et al., 2003 p. 215).

In determining evidence-based practice, the procedure to which data is collected matters to ensure quality. Tobin et al. (2015) emphasize the importance of using different assessment methods and screening that encourage and engage mothers in talking about their symptoms. They demonstrated that screening immigrant women with an appropriate culturally relevant tool are necessary, as psychometric tools lack cultural relevance. Some researchers have also confirmed that PHQ-9 and EPDS tools cannot be relied on as they cannot adequately identify depressive and anxiety symptoms in vulnerable migrant women (Brealey et al., 2010; Skoog, 2018; Tobin et al., 2015). This realization suggests that having well-trained and culturally competent perinatal social workers will improve perinatal mood and anxiety disorders assessment, screening, referral, treatment, and in turn, positively impact help-seeking behaviors (Tobin et al., 2015). A study that explored barriers and facilitators to the disclosure of postpartum depression to healthcare professionals in a community-based sample found that of the more than half of the participants who reported postpartum mood disorders symptoms, one in five did not disclose to a healthcare provider (Prevatt & Desmarais, 2017). In supporting this finding, Skoog (2018), in their qualitative study that explored 13 nurses' experiences on screening for PPD in non-native-speaking immigrant mothers, found that "to be able to interpret a mother's mood a transcultural caring relationship needed to be established and deepened"

(p.7). The results of that study also indicated that providing effective screening for PPD to immigrant mothers poses challenges for health care professionals due to language barriers (Skoog, 2018).

Treatment of Perinatal Mood and Anxiety Disorders

Perinatal mood and anxiety disorders are treatable if help is sought, and proper assessment and screening are conducted (PSI, 2019), with the help of medications and therapy for severe symptoms. Effective pharmacological and nonpharmacological treatments exist for perinatal depression and anxiety disorders (Goodman & Tyer-Viola, 2010). Due to the clear evidence of the adverse effects of untreated perinatal depression and anxiety issues, Kimmel et al. (2019) suggested the need to treat women who exhibit symptoms during their perinatal periods. medications, therapy, or the combination of the two (Goodman & Tyer-Viola, 2010). Many studies suggest treating severe, acute, or psychosis perinatal mood and anxiety symptoms with medications and recommend treating with an antidepressant (Kimmel et al., 2019; O'Mahony & Donnell et al., 2010). Several research findings reported antidepressant medications to effectively manage severe postpartum depression symptoms during and after pregnancy, less harmful effects and highlight serotonin reuptake inhibitors as commonly described (Bodnar-Deren et al., 2017; Kimmel et al., 2019; O'Mahony & Donnell et al., 2010). Serotonin reuptake inhibitors found to be commonly used among perinatal women include Kfluoxetine (Prozac), sertraline (Zoloft), paroxetine (Paxil), and tricyclic antidepressants such as to Tofranil (imipramine) and Elavil (amitriptyline)" (O'Mahony & Donnell et al., 2010, p. 921).

Many literature findings also demonstrated that selective serotonin reuptake inhibitors (SSRIs) as a first line treating mild to severe perinatal depression and anxiety and indicated neonatal toxicity and/or withdrawal, pulmonary hypertension of the Newborn, which may occur

as result of exposure during pregnancy (Bodnar-Deren et al., 2017; Kimmel et al., 2019; McCall-Hosenfeld et al., 2016; O'Mahony & Donnell et al., 2010). Serotonin norepinephrine reuptake inhibitors (SNRIs) medications can also be used to treat depression and anxiety symptoms during perinatal periods, however, when compared to SSRIs, their risks are higher (Kimmel et al., 2019). Cognitive–behavioral, interpersonal, and group therapies are reported to be efficacious treatments for mild to moderate perinatal depression, and it should be delivered individually whenever possible (Goodman & Tyer-Viola, 2010; Kimmel et al., 2019). Providing mothers with extra support, particularly with childcare responsibilities, will help reduced symptoms (McCall-Hosenfeld et al., 2016). A study, in comparing Black and White perinatal women in regard to perinatal mood and anxiety disorders treatment, found that Black postpartum mothers were less likely than whites to accept prescription medications and more likely to accept spiritual counseling (Bodnar-Deren et al., 2017).

Theories Utilized in the Previous Literature

Among the literature this author reviewed, five (5) explicitly stated that they utilized theories to investigate their research problems (Anderson et al., 2013; Corrigan et al., 2015; Gardner et al., 2014; Guy, 2014; Nneka, 2018). These theories utilized include empowerment (Nneka,2018), Wiedenbach's helping art (Corrigan et al., 2015), muted group theory (Anderson et al., 2013), mental health literacy (Guy, 2014). Two authors utilized phenomenology design (Anderson et al., 2013; Nneka, 2018). Abrams and Curran (2007) outlined and provided a detailed explanation of several theories such as biological, stress, and coping psychosocial, feminist, and biological perspectives that can best explain perinatal mood and anxiety disorders' etiology help-seeking. However, research suggests that using a biomedical model may not be appropriate in understanding perinatal depression in African women as it may neglect their

spiritual or cultural experiences (Gardner et al., 2014). In this light, this researcher views resiliency and constructivism as best approaches create a framework that will help conceptualize perinatal mood and anxiety and help-seeking behaviors among women in the African diaspora, thus highlighting the spiritual and cultural experience. Qualitative research theoretical tradition, phenomenology, and grounded were used to operationalize these research participants' lived experience on the phenomenon in question. These theories were discussed below.

Theoretical Frameworks

Social work deals with many practices and educational theories, which helps the profession understand the intricacy of human development. This section examines two theories that can help conceptualize perinatal mood and anxiety disorders among women in the African diaspora—their knowledge and help-seeking behaviors. The two theories that were utilized in this work are resiliency and social constructivism.

Definition and Understanding of the Role of Theory in Social Work Education and Practice

A theory is defined as a tool used to describe, explain, explore, predict, and assess human behavior, phenomena, situations, or environments. It provides a basis on how a social worker should interpret and intervene with any social problem or phenomenon (Teater, 2014; Gentle-Genitty et al., 2014). Theory serves as "an essential ingredient in practice that guides the way in which social workers view and approach individuals, groups, communities and society" (Teater, 2014, p. 1). Social work theory helps social workers conceptualize human development issues and different appropriate and effective intervention modalities. Social work theories provide not only conceptualization on methods of acquiring new information, but they also provide a method of interpreting new knowledge to create a new meaning that helps improve social work practice, education, and research (Gentle-Genitty et al., 2014; Teater, 2014). Theory in social work

education perspective serves as a source of verified explanatory and instructional strategies tactics or techniques and provide a foundation for intelligent and reasoned strategy selection; and allows for the integration of selected strategies and reliable prediction based on research (Ertmer & Newby, 1993; Robbin, Chatterjee & Canda, 1999). From the social work practice standpoint, the theory provides conceptual frameworks and vocabulary that enable a phenomenon to be interpreted and understood, leading to the appropriate selection of intervention modality best suited to a particular phenomenon or problem (Robbin, Chatterjee & Canda, 1999).

Social Work Theory Evaluation

Evaluating a theory is essential in the social work profession as doing so provides a clear understanding of how robust a theory is in explaining not only human behavior, social environment, and social problem or phenomenon but also help us to understand how well its concepts align with the social work professional mission values. Theory evaluation also offers a better understanding of effective methods of interpreting social problems and the most appropriate strategies/interventions that can be utilized to effect change in both clients and agents of change's systems. Robbin, Chatterjee and Canda (2012), in highlighting the vital role of social work theory evaluation, stressed the importance of evaluating a theory to understand its alignment with social work professional values. They suggested and advised on the need to follow these six guidelines when evaluating the robustness of a social work theory. These include aspects of human development and relations; relevance and application to individuals, families, groups, organizations, institutions, and communities; consistency in social work values and ethics; philosophical underpinnings; methodological issues; and evidence for empirical support. In this regard, assessing and evaluating resiliency and constructivism theories is

imperative for understanding their robustness and alignment with the social work profession mission values.

Assessing the human development and relations aspects of a theory is essential as it provides conceptualization with the biological, psychological and spiritual aspects of the human person and the social, economic, and cultural dimensions. Resiliency and constructive theories provide explanations of different angles of human development. The early theorists of resiliency made a huge contribution to human development through their studies that explored resilience in at-risk children, adolescents, and adults from different socioeconomic and ethnic groups who adapted successfully to stressful environments (Hunter, 2012; Luthar, Cicchetti & Becker 2000; Garmezy & Rutter, 1983 The theorists and scholars have expanded resiliency theory to include spirituality construction—finding meaning in life. They explained how individuals, families, groups, and communities cope with stressful life events by finding purpose in their lives (King et al., 2003). Constructivists, addressing human development's social and cultural aspects, see both individual and community meaning interpretation as collaborative (Franklin, 1995). In other words, the individual's interpretation of a problem is shaped by how the society to which the individual belongs defines that problem. Thus, their appraisals are subject to society's definition of this phenomenon, and the knowledge they live by as is constructed around the phenomenon in question (Exploratorium, 2019). Constructivists view learning as something that intimately associates with people's connection with other human beings.

Examining philosophical underpinnings of constructivism and resiliency theories helps to conceptualize the perspective on how both theories originated. Both theories have their roots within behavioral and cognitive theoretical foundations (Adom, Yeboah, & Ankrah, 2016; Fleck-Henderson, 1994; Ertmer & Newby, 1993; Masten & Obradovic, 2006). For constructive theory,

it shifted to the philosophical ideology that centers on the belief that people construct new understanding and knowledge of the world around them (Adom, Yeboah, & Ankrah, 2016; Ertmer & Newby, 1993). The premise of constructivism is that reality is socially constructed, but the language is an essential means by which individuals interpret their experiences. Resiliency focus and its early research work originated from the history of medicine, psychology, education, and its philosophical orientation construct also leaned on system theory, ecosystem, and ecological perspective (Smith-Osborne, 2007; VanBreda, 2018). Constructivism, therefore, is rooted in the field of philosophy, education, psychology, and sociology. (Bredo, 1994; Ertmer & Newby, 1993; Olusegun, 2015).

Constructivism and resiliency theorists also attempted to address some methodology issues, which provided the theories grounds for empirical support for acceptance as theories. Constructivism utilized a qualitative method of interpretation or research to provide predictions and explanatory construct relevant to students' experiential learning (Adom, Yeboah, & Ankrah, 2016). As compared to constructive theory, resiliency theory is shown to be a "promise in offering a predictive and explanatory construct relevant to healthy developments in the face of adversity" (Smith-Osborne, 2007, p. 160). Resiliency theory has also gained support for being grounded in an empirical methodology in its current wave. (Hooper, 2009, Luthar, Cicchetti & Becker, 2000). Literature also reveals resiliency theory's consistency in using empirical frameworks (such as quantitative, qualitative, mixed research, and meta-analysis method of study) to test the capacity of individuals, family, and community for resilience (Smith-Osborne, 2007; VanBreda, 2018).

Resiliency Theory

Brief history. Resilience theory focuses on understanding individuals' adaptation to adversity—their ability to adapt and function well in their stressful and traumatic experience or environment (Gardezi & Rutter, 1983; Hunter, 2012; Werner & Smith, 1992). Norman Garmezy and Michael Ruther's ideology and early research with children and young adults shape the resiliency theory, which centers on the conceptualization of how individuals cope with trauma and psychological stress (Garmezy & Rutter, 1983). Emmy Werner and Ruth Smith's research also significantly impacted resiliency theory's expansion through their work with young adults affected by economic, psychological, physical, and mental health adversities (Werner & Smith, 1992; Hunter, 2012). Additionally, some recent theorists have made significant contributions to resiliency theory's current developmental stage and have applied and used the resiliency theory to interpret different social problems (Hooper, 2009; King, Brown, & Smith, 2003; Luthar, Cicchetti & Becker, 2000).

Key Concepts. Adversity, vulnerability, and adaptation are among the key elements or concepts of resiliency theory. Resilience developmentalists characterized adversity as stressful life events which people encounter in a trajectory that seriously disrupts their normal functioning (Rutter, 2012). They defined vulnerability as factors that increase the level of risk. The assumption on vulnerability centers on the belief that certain environmental stressors and personal characteristics expose an individual to a high-stress level (Hunter, 2012; Werner & Smith, 1992). The following environmental stressors do increase vulnerability: health, economic, and social issues. Werner and Smith's early longitudinal empirical research on adults in Hawaii focused on economic, social, and health risk factors that can predispose individuals to

environmental risks in the adversities (Hunter, 2012; Luthar, Cicchetti & Becker 2000; Werner & Smith, 1992).

The resiliency theorists stipulate that certain factors (risk/protectives) determine how vulnerable or adaptive people are in their adversities (Hooper, 2009; Luthar, Cicchetti & Becker, 2000; King, Brown, & Smith, 2003). Likewise, certain factors increase people's vulnerability, reduce vulnerability and increase adaptation (King, Brown, & Smith, 2003; Luthar, Cicchetti & Becker, 2000). The theorists of resiliency believe that people are resilient when they demonstrate an ability to bounce back or function better in any adversities and ascertain that certain factors determine people's adaptation level in the midst of adversities (Hunter, 2012; Werner & Smith, 1992). They emphasize that having strong socioeconomic and religious support and good health mitigates individual vulnerability and enhances individuals' resilience or adaptation to adversity (Rutter, 2012; King, Brown, & Smith, 2003). For risk factors (socioeconomic, biological, and psychological issues), resiliency theorists assume that increase in people's vulnerability to adversities reduces their ability to function well, while the protective factors enhance their ability to function well even in the midst of adversity (Hunter, 2012; Rutter, 2012; Werner & Smith, 1992).

Resilience theorists emphasize the need to assess individuals' adaptative power as certain factors increase functioning even amid adversities. They consider this an adaptive power and protective process and outline its components to include problem-solving ability, social competency, belief, and expectation that shape an individual's understanding of adversity (Hooper, 2009; Luthar, Cicchetti & Becker, 2000). This concept assumes that individuals with specific biological, psychological, and social characteristics adapt to adversity (Cicchetti & Becker, 2000). They view these qualities as internal locus, which include self-esteem, and self-

efficacy determines individuals' capacity to adapt to adversity (Werner & Smith, 1992). Life experiences, family, and cultural dynamics determine individuals' level of self-esteem, self-concept, self-efficacy, and how resilient an individual becomes in the midst of adversity (Hooper, 2009; Luthar, Cicchetti & Becker, 2000).

Constructivism Theory

Brief History. Social constructivism traces its origin from constructive learning perspectives developed by Jean Piaget, who stipulated those human beings experience and develop knowledge through interaction between their experience and ideas (Brau, 2020). Early constructivists centering on cognitive learning recently shifted from the cognitive-developmental objectivistic assumption on making knowledge meaningful to a new understanding that draws attention to how meaning is negotiated, interpreted, and communicated socially (Ertmer & Newby, 1993; Fleck-Henderson, 1994). Lev Vygotsky is the pioneer of social constructivism, whose ideas centralized those human beings create and acquire knowledge through social environment interaction (Brau, 2020). Social constructivism explained how individuals create and interpret meaning influenced by their culture rooted in societal norms and traditions (Brau, 2020; Ertmer & Newby, 1993; Fleck-Henderson, 1994). In other words, this theory emphasized the vital role and impact of culture in learning and meaning interpretation (Kim, 2001). The constructivist, John Dewey, also shares a similar idea with Vygostsky on "the role of culture and meanings in perpetuating higher forms of human thought" (Brau, 2020).

Key Concept. The assumption of constructivism is based on three broader key concepts or constructs, which include reality, knowledge, and learning. Different theorists of constructivism have different assumptions and interpretations about reality, knowledge and learning, and these depend on the phenomenological context from which these theorists are

writing. When it comes to reality, constructivists, in general, hold the ideology that objective reality is unknown before the human view of it. Writing in the social context, constructive theorists, like the social constructivists, perceive reality as something that is constructed through human activity, as something that does not exist before the social invention and influenced by individuals' cultural and social environment (Brau, 2020; Fishe & Mawr, 2015; Fleck-Henderson, 1994; Kim, 2001). Social constructivists also conceived knowledge as a human product, which is socially and culturally constructed (Ertmer & Newby, 1993; Fleck-Henderson, 1994; Kim, 2001). Individuals, in quest for knowledge, create meaning through personal and interpersonal interactions in their social environment (Kim, 2001). Learning is an essential key concept of constructivism which is assumed as a social process and can only meaningfully occur during social activities, interactions, and engagement (Dean, 1994; Kim, 2001). Also, it is contextualization as a process of creating knowledge, which can only be determined by a learner's life experiences (Dean, 1994).

Six Core Social Work Mission Values, Resiliency, and Constructivism Theories

Understanding whether or not a theory is aligned with social work values requires examining the issues the theory attempts to address to determine if the theory is embedded within the core social work mission ethical values. The social work profession "seeks to enhance the effective functioning and well-being of individuals, family, and communities through its work and advocacy" (NASW, 2008, n.p), especially as it pertains to minorities, oppressed, marginalized, and vulnerable populations. The core of social work promotes services, social justice, dignity and worth, and the importance of human relationships, integrity, and competence (NASW Code of Ethics, 2013). Social work education embraces any theories whose predictions and constructs address these professional values as they are the reflection of the unique social

work profession. Resiliency and constructivism are highly congruent paradigms with social work values (Allen, 1994). In what follows, the paper unpacks what the aforementioned social work core values entail.

Service

The goal of social work in both the practice and education field is to help people in need or the vulnerable population identify and address their social problems (NASW Code of Ethics, 2019). This social work value can be applied to social work practice, and education, thus classifying women in the African diaspora as persons-in-need and learners. Resiliency theory asks pathological questions about vulnerability, adversity, risk, and their negative impact on the population that social workers serve (Van Breda, 2018). The question about pathology helps social workers see the need to bring a change in social problems and assess for clients' strengths and factors that can improve resilience when providing services to clients. Constructivism, especially the social aspect, is also parallel to these social work values, mission and goal. It addresses the needs of human knowledge development and the importance of actively engaging learners in their knowledge development process to help them actualize their full potential (Dean, 1994; Kim, 2001). Parallel to the social work value of service, a social worker takes the role of a facilitator and educator whose responsibility is to guide women through the process of achieving their learning potentials about maternal mental health and community resources that will help them and their babies. Therefore, creating the best learning environments allows social workers to effect change regarding women's maternal and child needs. Social work's professional standards highlight the need to respect and promote the clients' self-determination and assist them in identifying and clarifying their goals (NASW Code of Ethics, 2019). Constructive theorists at the angle view a learner as an active seeker of knowledge, the center of

attention, a constructor of viable knowledge (Kantar, 2013). They emphasize the importance of appreciating and respecting learners' experience, and expertise in the learning process as this creates efficiency in learning and allows them to tackle their problems.

Social justice and human dignity and worth

Social work profession values social justice and respect for the person's inherent dignity and worth (NASW Code of Ethics, 2019). The profession challenges social injustice to promote change, especially among the vulnerable and oppressed in a culturally and ethnically diverse society and treats them respectfully (NASW Code of Ethics, 2019). Social justice in resilience theory has been an area of controversy and has also been criticized for emphasizing individuals' social justice and power. Social justice discourse was later introduced into resiliency theory to eliminate vulnerability (Van Breda, 2018). Recognizing that certain factors put or increase people's vulnerability, resiliency theory's failure to address social injustice and power differences originally perpetrated vulnerability. Resiliency theory, however, focuses on examining innate characteristics (protective processes) that people who are vulnerable to adversity can possess to overcome vulnerability (Hooper, 2009, Luthar, Cicchetti & Becker, 2000). In other words, resiliency theorists contend that, notwithstanding having the protective factors, individuals have to possess a protective process (psychological characteristics, e.g., self-esteem, self-efficacy, etc.) to effectively adapt to adversity (Hooper, 2009, Luthar, Cicchetti & Becker, 2000). While theorists of resiliency need to engage more in the research or work that will center on power imbalances that conduce to vulnerability, the theorists have engaged in work that centered on helping individuals remain resilient to improve human dignity and worth (Garmezy & Rutter, 1983). Constructivists address social justice, human dignity, and worth when they confront the oppression and marginalization of vulnerable individuals or learners who have learning issues,

especially as it relates to their rights to define who they are and express the learning interests and the methods of which they want to learn (Gallagher, 2004). In this case, women may be having difficulty understanding their professionals during their interactions due to language barriers and differences in ascents, or they may lack knowledge about how to use a computer to access available information.

Importance of human relationships

The Social Work Code of Ethics (2019) mandates a social worker to recognize the importance of human relationships as this serves as a vehicle for change. Constructivists stressed the importance of human relationships and interactions in the social and cultural environment and viewed learning to occur through sensory experiences and interactions with the environment. Constructivism holds that learners discover how meaning is constructed as they integrate ideas expressed by others into their explanations (Dean, 1994). Constructivism emphasizes that the environment in which learners create knowledge impacts their learning during the learning process (Fisher & Mawr, 2015; Kantar, 2013; Saleh, 2013). Moreover, learning occurs meaningfully during social activities, interactions, and engagement (Dean, 1994; Kim, 2001). The human relationship remains an integral part of resiliency theory. Resiliency theory lays a great emphasis on the social support system and sees having a robust social support system as a hallmark of people being resilient in the midst of adversity (Luthar, Cicchetti & Becker, 2000).

Integrity and Competency

The social work code of ethics obligates social workers to adhere to a trustworthy manner to act honestly and responsibly to the practice consistent with the profession's mission, values, ethical principles (NASW Code of Ethics, 2019). The resilience theory focuses on understanding individuals' resilience and their social agents of change (human service system, organizations, or

agencies that work with the vulnerable and disadvantaged population). Resilience theorists incorporate community into their framework as a way to understand how community can impact individual's risk to adversity, or how having access to community resources can enlarge individual's protective factors that encourage adaptation. For example, theorists of resiliency in their early research demonstrate how not having access to community resources can decrease individuals' resilience (Werner and Smith, 1992). Constructivism contends that to enhance integrity in learning, an educator has to assume the role of a facilitator and guidance to help a learner build knowledge (Ertmer & Newby, 1993). Highlighting the importance of engagement as a viable way to help learners achieve their learning goals, constructivists encourage educators to not only maintain integrity in helping individuals and their family develop explicit knowledge of the resources they need to achieve their potential but also to safeguard the sensitive cultural experience and knowledge the learners bring with them (Fisher & Mawr, 2015).

For professionals working with the vulnerable and disadvantaged population, being competent is paramount in social work practice, education and research. Social work's mission sanctions social workers to practice within their areas of competence, develop and enhance their professional knowledge and expertise (NASW Code of Ethics, 2019). In viewing a learner as an expert, constructivists emphasize that expertise is not the exclusive domain of an educator (Dean, 1994). Recognizing the importance of a learner's lived experience, they believe that reflecting and incorporating these experiences into learning will provide the learner with the means to create novel and situation-specific understandings (Ertmer & Newby, 1993). Therefore, the educator facilitating and guiding the learners through assembling prior knowledge from the appropriate to the problem at hand will help them develop a piece of new knowledge (Dean, 1993; Ertmer & Newby, 1993). While constructivists do not view professionals (educators) as

experts, resiliency theorists, on the contrary, view both clients and professionals as experts. They believe that for an individual to be resilient or maintain resilience, the individual must have the capacity to handle difficulties (Luthar, Cicchetti & Becker, 2000; Masten & Obradovic, 2006). Likewise, resiliency theorists stress the importance of the agent of change (professionals) in developing competence and resilience that will offer a toolbox of strategies to effect change in the client system, enhance clients' resilience and help improve their wellbeing (Hunter, 2012; Masten, & Obradovic, 2006; Werner & Smith, 1992).

Theory Application

Examining Perinatal Mood Anxiety Disorders and Help-Seeking Among African Diaspora Through Resiliency and Constructivism Theory Lenses

Resiliency Theory. Perinatal mood and anxiety disorders among women in the African diaspora and their help-seeking behaviors can be viewed through the lens of resiliency theory. The theorists of resiliency perspective may argue that women in the African diaspora who are exposed to economic, social, psychological, and health difficulties are more likely to experience the adversity of mood and anxiety disorders during perinatal periods, and the level of severity of these issues increases women's vulnerability and vice versa (Kafumbe, 2010; Peterman, 2012; Lowe & McClement, 2010). Resiliency theorists may as well sustain that even in the midst of increased vulnerabilities, some women will bounce back or adapt effectively to their situation and may also believe that how they will adapt depends on the individual woman's characteristics (Hunter, 2012; Luthar, Cicchetti & Becker 2000; Werner & Smith, 1992). Resiliency theorists may argue that while these factors may increase the women's vulnerability to perinatal disorders and hinder help-seeking during the perinatal periods, having protective factors and the process can moderate and improve adaptation or functioning during perinatal periods (Hunter, 2012;

Luthar, Cicchetti & Becker 2000; Werner & Smith, 1992). Using family support as an example, women who, as a result of financial constraints, cannot afford immigration papers that will allow their family members to be with them for support may be at higher risk of perinatal mood and anxiety than their counterparts.

Additionally, there is a tendency that women in the African diaspora who experienced relationship issues with their spouse, family members, or women who are single mothers might be at higher risk as they may be overwhelmed with caring for their babies alone. Inability to develop functional interaction with healthcare providers/ professionals during help-seeking due to language barriers or cultural differences may be considered a risk/vulnerability factor by resiliency theorists. Such difficulty may limit their sense of belonging and reduce the women's desire to access available community resources. As related to this research topic, resiliency theorists may operationalize lack or limited knowledge about perinatal mood and anxiety disorders and help-seeking, lack of knowledge about or limited resources, immigration status, language barrier, lack of insurance issues as variables under the construct of vulnerability/risk factors. Protective factors and processes are interpreted in this research as the behaviors associated with increased positive resilience outcomes in women in the African diaspora during perinatal periods. Resiliency theorists may explain that women in the African diaspora's adaptation to perinatal and anxiety disorders depend on the protective factors and processes they acquire. The theorists may argue that women who have substantial individual and community supports and acquire specific positive psychological characteristics adapt and function better than their counterparts (Hunter, 2012; Luthar, Cicchetti & Becker 2000; Werner & Smith, 1992). The protective factors and process construct operationalized here as having strong social support (family, friends, and professionals support); knowledge about and access to resources (level of

understanding about where to access resources, having access to insurance, other community resources); attitudes/beliefs about the self (positive self-esteem, self-confidence, self-efficacy); decision-making ability and power to deal with personal issues (conflict resolution skills, emotional and spiritual health).

    Constructivism Theory. Examining perinatal mood and anxiety among women in the African diaspora through the constructivism lens provide explanations about how to conceptualize mood and anxiety; beliefs they hold about the disorders, their interpretation of help-seeking; and how their interactions with their social environment impact or sustain their help-seeking behaviors during and after pregnancies. As discussed above, reality as considered from a constructivist perspective centers on the activities between individuals and their cultural and social environment. Constructivists may hold the notion that women in the African diaspora's definition of the reality of perinatal mood and anxiety symptoms are structured around their individual cultural and societal definition of mental health issues/disorders (Brau, 2020; Ertmer & Newby, 1993; Fisher & Mawr, 2015; Kim, 2001). In recognizing the presence of culture and diversity as normative, constructivists may also hold interpretations that human beings are situated within a culture and make constructions that reflect the knowledge and values of their cultural and social environment (Fisher & Mawr, 2015). Reality is conceptualized and operationalized here as a personal and cultural belief system that shapes women in the African diaspora's definition and understanding of perinatal mood and anxiety symptoms and their cultural view about help-seeking pregnancy.

    Knowledge is an essential aspect of the constructivist concept. This research is about how such knowledge helps women in the African diaspora understand the perinatal mood and anxiety disorders, the importance of help-seeking, the available community resources, and how to utilize

them. Constructivism may believe that women with knowledge of perinatal mood and anxiety disorders and the need for help-seeking will create meaningful interpretations about the need for them to seek help during perinatal periods. Theorists may also interpret that the meaning the women create through the knowledge acquired about maternal mental health is influenced by their social environment interactions, such as healthcare providers/professionals, families, and friends (Kim, 2001). Additionally, constructivists may agree that the level of knowledge women in the diaspora develop about perinatal mood and anxiety disorders and help-seeking will improve their literacy and provide them with the capacity to obtain and process the mental health information they need to make appropriate decisions for themselves and their babies (Guy et al., 2014; Kim, 2001; Ratzan & Parker, 2000). Knowledge construct or variable is also conceptualized and operationalized in this research as women in the African diaspora personal knowledge or awareness about perinatal mood and anxiety disorders, help-seeking and available community resources.

Learning, as a concept of constructivism, highlights what goes on between a learner and an educator. In this regard, the constructivists will concentrate more on women in the African diaspora experience and view them as experts who bring unique and new knowledge as "women-in-the-experience." The constructivist may also see professionals/providers as facilitators of the learning process and view their roles as providing information and guidelines that would allow women to attain their potential in the maternal and child arena. As women-in-the-cultural-experience, women in the African diaspora bring with them cultural knowledge about pregnancy and care, which was instilled in them through their interaction with the family and cultural environment (e.g., mother, sister, or mother figure from cultural location). Constructivists may suggest that a provider puts these experiences in perspective when interacting with or educating a

woman in the African diasporas about perinatal mood and anxiety disorders and help-seeking.

Also, the constructivists may recommend creating a warm social environment that would allow

women in the African diaspora to engage meaningfully in their interactions with such an

environment (Ertmer & Newby, 1993; Fishe & Mawr, 2015). The construct of learning here is

conceptualized and operationalized as the meaningful interpretation that women gain from their

interaction with their cultural and/or social environment (mothers, sisters, mother figure,

healthcare providers/professionals, etc.) during perinatal periods. See below diagram, the

theoretical framework that helps conceptualize perinatal mood and anxiety disorders and help-

seeking behaviors among women in the African diaspora.

Diagram 3

Diagram depicting theoretical framework utilized to conceptualized perinatal mood and anxiety

disorders and help-seeking among women in the African diaspora.
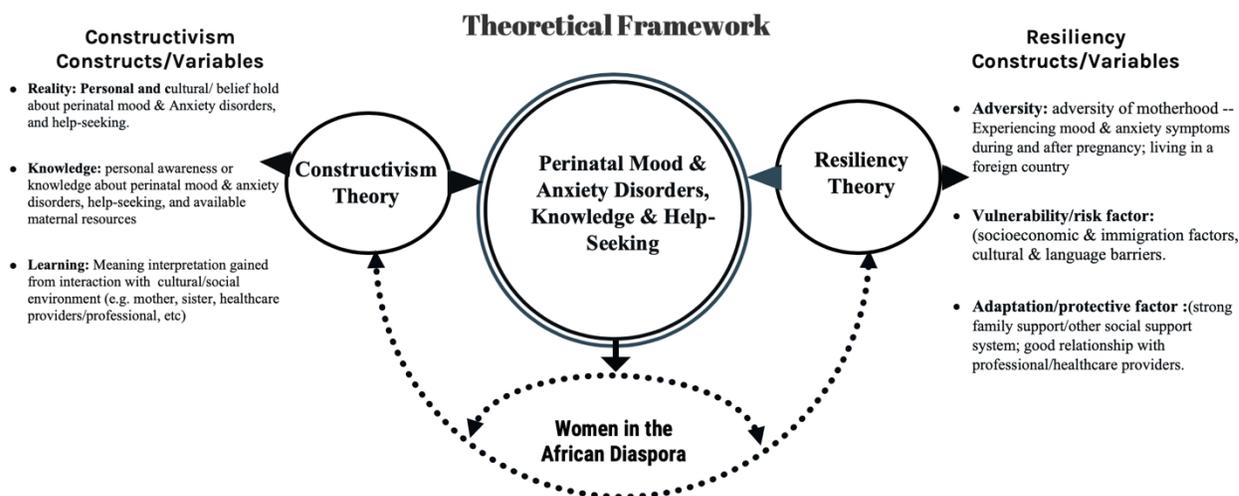
Gaps in the Literature

Gap in the Literature Related to Phenomenon of perinatal mood and anxiety disorders

The result of this literature review reveals a paucity of research on perinatal mood and anxiety disorders, especially in relation to women in the African diaspora population. This researcher found sixty (60) empirical studies on this topic, however, only 8 of them were specifically focused on immigrant women (Bandyopadhyay et al, 2010; Clark et al, 2018; Gardner et al, 201 4; Hill et al, 2019; Madeira et al, 2019; Miszkurka et at, 2010; Nneka, 2018). Further, six (6) studies of these eight (8) studies were conducted on women in the African diaspora living in the United States (Bandyopadhyay et al, 2010; Clark et al, 2018; Gardner et al, 2014; Hill et al, 2019; Madeira et al, 2019). Upon further review, three (3) of these six (6) studies specifically sampled African women living in the United States; two (2) of these three (3) studies were conducted on Somalian African women (Clark et al, 2018; Hill et al, 2019). One (1) was conducted on West African women (Gardner et al, 2014). The result of this literature review reveals a paucity of research on perinatal mood and anxiety disorders, especially in relation to women in the African diaspora population. This researcher found sixty (60) empirical studies on this topic. However, only eight of them specifically focused on immigrant women in the African diaspora (Bandyopadhyay et al., 2010; Clark et al., 2018; Gardner et al., 201 4; Hill et al., 2019; Madeira et al., 2019; Miszkurka et al., 2010; Nneka, 2018). Further, six (6) studies of these eight (8) studies were conducted on women in the African diaspora living in the United States (Bandyopadhyay et al., 2010; Clark et al., 2018; Gardner et al., 2014; Hill et al., 2019; Madeira et al., 2019). Upon further review, three (3) of these six (6) studies specifically sampled African women living in the United States. Among these three, two (2) of the studies investigated issues related to perinatal mood and anxiety disorders in Somalian African women (Clark et al., 2018;

Hill et al., 2019); and one (1) on the West African women (Gardner et al., 2014). The literature review also reveals that most of these studies were conducted on postpartum depression, with just a few exploring both antepartum periods. This research study will focus on both of these periods. The literature review also shows a gap in the direction of research study related to perinatal mood and anxiety disorders. For example, out of seventy-five (75) articles on mood and anxiety disorders during and after pregnancy, only fifteen (15) of these studies investigated anxiety during perinatal periods as well.

Gap in Social Work Empirical Literature

The literature review also revealed a gap in social work empirical studies on perinatal mood and anxiety among women in the African diaspora. This gap posits the need for social workers to get involved in perinatal mental health research and pay attention to women in the African diaspora population. Of all the empirical research studies extracted by this researcher, only eight (8) were conducted by social work researchers are related to African immigrant women (Fagan & Lee, 2010; Bentley, Price & Cummings, 2014; Gair, 1998; King, 2014; Sampson, Zayas & Seifert, 2012; Walther, 1997; Gjesßeld et al., 2010; Keefe et al., 2018). These authors hold a Ph. D in social work and also serve as social work researchers at their various universities. Among these first authors, only King (2014) and Sampson, Zayas and Seifert, (2012) focus on maternal mental health in their practice experiences. King (2014) has 20 years of practice and practice experiences on maternal and child mental health.

As relates to this dissertation topic, King (2014) explored the similarities and differences in perinatal experiences between women with low socioeconomic status (SES) by race, ethnicity, and nativity. The purpose of this study was to "understand sociocultural and environmental contexts of perinatal experiences and potential implications for screening and assessment among

women with low SES" (p. 211). Sampson and colleagues (2012) also hold Ph. D in social work and Assistant Professors at their various universities. Sampson's primary practice and research experiences focus on maternal health promotion with specific interests in intervention development for postpartum depression and obesity during pregnancy. Fagan and Lee (2010) research interests center on fathers, adolescent parents, and families at risk. In their study, they examined the "associations between adolescent mothers' postpartum depressive symptoms and their perceptions of amount of father care giving and satisfaction with father involvement with the baby" (p. 119).

Social work empirical literature conducted by the authors whose practice experience focuses on maternal mental health is needed in perinatal mood and anxiety disorders. Having more empirical research encourages social workers to continue to engage in program/intervention development, implementation, and evaluation. This researcher has experience working with women suffering from perinatal mood and anxiety disorders and women in the African diaspora. The population of women in the African diaspora in the United States has grown significantly in the past few decades and this population is underserved. Therefore, more social work research efforts will develop new knowledge and lead to policy implementation and development of more culturally sensitive programs/interventions that would benefit women in the African diaspora.

Gap in Qualitative Research Literature

In reference to the literature review findings, fifty-four (54) reference the term "qualitative" and only twenty (20) of these research studies utilize qualitative methods to explore perinatal mental health disorders among women and four (4) utilized qualitative methods (Clark et al, 2018; Hill et al, 2016; Gardner et al, 2014; Nneka, 2018). More qualitative research on the

African diaspora is imperative as little is known about this population, especially in relation to perinatal mood and anxiety disorders and their help-seeking behaviors. Qualitive research is an effective methodology for obtaining in-depth data from the participants, especially in phenomenon in which little is known (Padgett, 2017).

Chapter 3: Methodology

Qualitative research methodology determines "how the researcher conceptualizes a study, how decisions about the study are made and how researchers position themselves to engage with research participants" (Bloomberg and Volpe, 2019, p. 99). This chapter documents all the steps undertaken to design, collect and analyze this dissertation research study. Qualitative research traditions informed this methodology, specifically phenomenology and grounded theory.

Phenomenology was utilized to explore women in the African diaspora's knowledge about perinatal mood and anxiety disorders and their lived experience with help-seeking during and after pregnancy, while grounded theory was utilized to guide the data analysis (generating a theory and developing open themes or categories). Before delving into an examination of these qualitative research elements in depth, it is imperative for this researcher to discuss some of the gaps identified during the literature review process that this study sought to fill, the research aims, the questions, and the purpose of this study.

This researcher incorporated some elements and concepts suggested by Bloomberg and Volpe (2019) for qualitative dissertation methodology. These elements include but are not limited to the type of information to collect (demographics), data collection methods and tools, data analysis, ethical considerations, issues of trustworthiness, and limitations and delimitations. Bloomberg and Volpe (2019) also recommend using these concepts to help researchers reflect more on the nature of the phenomenon to be studied.

Research Design

Research Study Purpose

This study specifically addressed the following research objectives: (1) knowledge and interpretations by women in the African diaspora about a mother's vulnerabilities and/or

adaption to perinatal mood and anxiety disorders during perinatal periods; (2) the diasporic contextual experiences of African women and their personal interpretations on their vulnerabilities to perinatal mood and anxiety disorders; and (3) the women in the African diaspora's lived experience with help-seeking, especially how they make meaning of their interactions with professionals during and after pregnancy. To achieve the above stated research aims/objectives, the following research questions were explored:

- What knowledge about perinatal mood and anxiety disorders do the women in the African diaspora (living in the United States) possess and what are their interpretations about a mother's vulnerabilities/adaption to perinatal mood and anxiety disorders during perinatal periods?

- How do the contextual experiences of women in the African diaspora impact their personal interpretations of vulnerabilities/adaptations to perinatal mood and anxiety disorders during perinatal periods?

- What are the lived experiences of women in the African diaspora about help-seeking during perinatal and postnatal periods?

As such, the purpose study seeks to explore and develop knowledge on perinatal mood and anxiety disorders among women in the African diaspora living in the United States, focusing on knowledge about perinatal mood and anxiety disorders and lived experience on help-seeking for this population. This researcher explored in depth their awareness and knowledge of this phenomenon and solicited information regarding their lived experiences with professionals during pregnancy and after childbirth (a factor that has been shown to affect help-seeking). The knowledge gained from this study would contribute to the scant research available on this phenomenon as it affects this population. It would also assist in developing and evaluating socio-

culturally sensitive social work interventions that would enhance the psychological/emotional well-being and quality of life for women in the African diaspora and their infants, especially those vulnerable to perinatal mood and anxiety disorders.

Research Design

Qualitative Methods

As noted above, a qualitative research methodology was utilized to conduct this study. Bloomberg and Volpe (2019) provide a statement that captures what a qualitative research method is and the researcher's role in the qualitative study. They note that:

> qualitative research is grounded in a philosophical position that is essentially constructivist in the sense that it is concerned with how the complexities of the social and cultural world are experienced, interpreted, understood in a particular context and at a particular point in time. The intent of qualitative research is to examine social situations or interactions, with the researcher becoming immersed in the world of others in an attempt to achieve a *holistic* understanding of a phenomenon or experience (Bloomberg & Volpe, 2019 p.42).

Simply put, a qualitative research method involves the collection, analysis and interpretation of narrative and visual data so as to understand a particular phenomenon (Bloomberg &Volpe, 2019; Durdella, 2019). In utilizing this qualitative methodology, the qualitative researcher plays an important role in interpreting participants' subjective experiences of phenomena based on the meaning participants assign to these experiences (Bloomberg &Volpe, 2019). A qualitative research method allows a researcher to unpack the historical meanings that are embedded in a particular phenomenon and describe findings from participants'

perspectives. As discussed previously in the literature review, this methodology has been used in similar studies with similar populations (Clark et al, 2018; Gardner et al., 2014; Hill et al., 2016). The nature of this research study, the research questions and the topic under study therefore supports the adoption of this research methodology.

Justification for selecting qualitative method. The descriptions and definition of qualitative research method provided by Bloomberg and Volpe (2019), as well the nature of the phenomenon under study, points to qualitative methodology as the best fit for data collection. Bloomberg and Volpe (2019) describe qualitative research methods as a good fit for research studies seeking to understand the complexity of a social and cultural problem as experienced and interpreted by the study participants. The aims of this current study align with the above stated definition and description of qualitative research, as it is focused on understanding the complexity of how perinatal mood and anxiety disorders are experienced, interpreted, and understood among women in the African diaspora from their cultural contexts. Additionally, qualitative research is said to be an appropriate method to collect and interpret narrative (interview) data. This phenomenon and population have seldom been studied, and the nature of this study therefore calls for the need to gain a rich understanding of the topic from the perspective of this population. This fits within the underpinnings of qualitative research (Padgett, 2017). Minimal research or insufficient research has previously been conducted on perinatal mood and anxiety disorders in relation to women in the African diaspora living in the United States. This study would add to that knowledge.

Research Traditions: Phenomenology and Grounded Theory

Phenomenology

A phenomenological qualitative research tradition was utilized for this study. Phenomenology is defined as a traditional qualitative approach that is used to describe and explore participants lived experiences and the interpretation of these experiences (Creswell, 2013; Hohn et al., 2017). This approach was used to explore, describe, and interpret the three phenomenological research questions stated above. This section briefly discusses the key concepts, philosophical underpinnings, application, and method of phenomenology.

Key Concepts Overview. Phenomenology is viewed as both a philosophy and a research method. The purpose of qualitative research design is to investigate meaning of the lived experience of a study participants to identify the core essence of human experience or phenomenon as described by them (Bloomberg &Volpe, 2019). Emphasizing on the lived experience of human interaction in relation to their phenomenon, qualitative researchers use this approach to explore the meaning the study participants attribute to their experiences in their social world (Yin, 2011). The essence and epoche /self-bracketing are major key concepts of the phenomenological qualitative approach (Bloomberg &Volpe, 2019; Durdella, 2019; Yin, 2011; Umanailo, 2019). Phenomenological theorists assert that there are some commonalities in the human experience—participants lived experience and researcher's self-bracketing (Bloomberg &Volpe, 2019; Durdella, 2019; Yin, 2011; Umanailo, 2019). The stance of phenomenological approach centers on description and interpretation and views a researcher as a writer who attempts to capture participants' essential characteristics of a phenomenon through in-depth interviewing (Bloomberg &Volpe, 2019; Durdella, 2019; Yin, 2011; Umanailo, 2019).

Philosophical Underpinnings, Application and Method. The phenomenological approach holds its philosophical origin from the work of Husserl (1889-1938); Heidegger (1889-1976) and Merleau-Ponty (1908-1961) focused on descriptive approach and their recent work expanded to interpretative phenomenological analysis (Bloomberg &Volpe, 2019; Durdella, 2019; Creswell & Poth, 2018; Yin, 2011; Umanailo, 2019). The focus of phenomenology qualitative research is obtaining rich data from a small number of participants. It encourages the study of a "small number of subjects through extensive and prolonged engagement to develop patterns and relationship of meaning" (Bloomberg &Volpe, 2019, p. 101). Studying a small sample of subjects helps the researcher to describe the common meaning several participants hold about their lived experiences.

The philosophical perspective of Husserl (1889-1938) emphasizes the core element of phenomenology approach— bracketing (Bloomberg &Volpe, 2019; Durdella, 2019). This concept allows a qualitative researcher to bracket their own experience so as to understand participants lived experience on a particular phenomenon through phenomenological reduction (Bloomberg &Volpe, 2019; Durdella, 2019; Yin, 2011). While Husserl's classical perspective sees phenomenology as descriptive, Husserl's pupils, Heidegger (1889-1976) and Merleau-Ponty (1908-1961) view it as also interpretative (hermeneutic perspective). In an effort to explain the importance of interpretative phenomenological analysis in phenomenology approach, Heidegger and Merleau-Ponty argue that human existence is always embedded within a work of meanings and utilizing an interpretative analysis aids to unpack these meanings (Bloomberg &Volpe, 2019).

In summary, the stance of the current phenomenology method utilizes and incorporates both descriptive and interpretative aspects. It sees a researcher as a writer who attempts to

capture meanings through in-depth interview to understand participants' essential characteristics of a phenomenon (Bloomberg &Volpe, Durdella, 2019). This dissertation study chooses to explore the lived experience of not more than 20 African diasporas of perinatal mood and anxiety disorders to understand, describe, and interpret their experience of help-seeking during pregnancy and after childbirth.

Phenomenology Approach Selection Justification and What this Research Borrowed from Phenomenologists

Phenomenology Approach Selection Justification. Creswell & Poth (2018) recommend assessing for the goodness of fit before using any approaches in a qualitative study. The phenomenology is an approach to use when a researcher wants to understand, explore, describe and interpret individuals' lived experiences of small subject of individual and understanding what their experiences mean to them (Bloomberg &Volpe, 2019; Padgett, 2017). Phenomenology as an approach not only suits a phenomenon that recognizes several individuals' common or shared experience of a phenomenon, but it is also a fit for qualitative research studies whose purpose is to explore the meaning or lived experience of participants so as to identify the core essence of their experience (Creswell & Poth, 2018; Bloomberg &Volpe, 2019; Durdella, 2019; Padgett, 2017).

A phenomenological approach had been used in the previous studies to explore meaning of the lived experience of studies' participants and to identify the core essence of their human experience as described by the participants (Bloomberg &Volpe, 2019; Durdella, 2019; Yin, 2011). In this light, a phenomenology design is suitable for this current study as the aim of this study is to explore the phenomenon of perinatal mood and anxiety disorders among women in the African diaspora. Thus, exploring their knowledge and lived experience on help-seeking

during and after pregnancy and what these experiences mean to them. Phenomenology design also is suitable to this research problem and questions because it captures the lived experience from the perspective of those (women in the African diaspora) who live it. Additionally, the approach is also a good fit for exploration of topics of which little is known (Padgett, 2017). When it comes to research on perinatal mood and anxiety disorders among women in the African diaspora little is known, especially understanding their interpretation of their lived experience. Using phenomenology, this study will help provide in-depth understanding about the meanings that women in the African diaspora hold about their help-seeking experience during antepartum and postpartum periods. Phenomenology approach has been used by the previous researchers on similar studies with different population and found it to be good fit and credited as the best method for exploring and interpreting mothers' lived experience on help-seeking during antepartum and postpartum periods (Bilzsta et al., 2010; Gardner et al., 2013). For example, the Gardner et al. (2013) study used qualitative interpretative phenomenological analysis to explore the lived experience of postpartum depression among West African mothers living in the United Kingdom.

Therefore, this researcher's rationale for using this approach was because it is a good qualitative approach to use when a researcher wants to understand, explore, or describe individuals' lived experiences of a study participants and what these experiences mean to them (Creswell & Poth 2018). This research study focuses on understanding the lived experiences of women (mothers) who have experienced childbirth and in the same cultural location. In other words, the study participants do not only experience the phenomenon of "motherhood," but they also share the similar experience of being a mother in a country other than their country of origin.

What this research study borrowed from the phenomenologists. This research study borrowed two methods from phenomenology: in-depth interview and epoche or bracketing to allow for effective and appropriate design and data collection procedures (Bloomberg &Volpe, 2019; Durdella, 2019; Yin, 2011). This researcher designed and utilized in-depth interview questions to collect data. Phenomenological in-depth interview design allowed this researcher not only to put each participant lived experience into perspective— where this research asked each participant to narrate the detail of their lived experience in the light of this dissertation topic but also asked them to reflect on what their lived experience means to them (Durdella, 2019; Yin, 2011). Epoche is an essential procedure to achieving quality qualitative research as it helps the researchers set aside their natural attitudes about what they are accustomed to thinking about a research topic and participants (Creswell, 2013; Durdella, 2019). To bracketing self (epoche) to "move closely to the essence of the research topic] and/or] what the participants shared" (Durdella, 2019, p. 108), this researcher utilized reflexivity/positionality statement to allow the researcher to account for researcher's assumptions, value, biases, attitudes, and belief hold about the topic and participants' cultural location. In providing a reflexivity/positionality statement, this researcher explicitly brought these assumptions, values, biases, attitudes, and beliefs to consciousness and highlighted ways they can be managed. A copy of this reflexivity statement is included in this document.

Grounded Theory

Grounded theory was applied to enhance the quality and rigor of this dissertation research study. This approach was utilized during data collection, analysis, interpretation, and presentation. Understanding the robustness of grounded theory is imperative and this can be done by examining its methodology, philosophical underpinnings, application, and method.

Key Concepts Overview. Grounded theory remains one of the most popular research traditions used to methodologically guide the dissertation research studies and serves as a suitable tradition when examining a research study where little is known about the phenomenon of interest (Bloomberg &Volpe, Durdella, 2019). It helps a researcher to inductively generate theory base on concepts from data collection, analysis and interpretations (Chun-Tie et al., 2019; Bloomberg &Volpe, 2019; Durdella, 2019). Grounded theory also allows a researcher to move beyond data description to analytical and interpretative of a phenomenon as viewed by participants to uncover the pattern of interrelated action or events (Bloomberg &Volpe, 2019). The focus of grounded theory is on data collection and analysis, and different steps of coding, is employed to generate emerging ideas and patterns of how concepts link and how categories are associated with codes (Durdella, 2019).

Philosophical Underpinnings, Application and Method. Grounded theory history can be traced from the early work of Glaser and Strauss, which later developed and extended to different methodological genres, such as symbolic interactionism, and constructivism (Chun-Tie et al., 2019; Bloomberg &Volpe, Durdella, 2019). Glaser's original traditional grounded theory focuses on generating a conceptual theory that accounts for a pattern of behavior or event (Chun-Tie et al., 2019). Strauss and colleagues, writing from the sociological perspective, focused on symbolic interactionism methodological underpinning with an emphasis on relationships between the symbolic meaning and social interaction — the meaning people place on their experienced phenomenon (Chun-Tie et al., 2019; Bloomberg &Volpe, Durdella, 2019). Grounded theory also has its root in constructivist perspective, as discussed and explicated by Charmaz. This methodological underpinning focuses on how participants construct meaning in relation to the area of inquiry (Chun-Tie et al., 2019). In this perspective, Charmaz posits that a

researcher co-constructs experience and meaning with the study participants to analyze the meaning that data conveys, to generate theory and to integrate categories into a theoretical framework (Chun-Tie et al., 2019; Bloomberg &Volpe, 2019; Durdella, 2019). Development of grounded theory includes three key methods or processes: concurrent data collection and analysis; theoretical sampling and constant comparative method (Bloomberg &Volpe, Durdella, 2019; Chun-Tie et al., 2019; Durdella, 2019).

Concurrent data collection and analysis process is viewed as concurrent and continuous activities. To achieve the goal of this process, Chun-Tie et al. (2019) suggest utilizing an open-ended (in-depth) interview when collecting data and to start with an open coding during data analysis (Bloomberg &Volpe, 2019). Durdella (2019) stresses that concurrent data collection and analysis allow the researcher to "see the insertion of data analysis early in the fieldwork process as a mechanism or tool to start to link concepts to coded segments and allows the production of linked codes to inform the direction of an emerging model" (Durdella, 2019, p. 103).

The next process for developing grounded theory is theoretical sampling. Theoretical sampling method is defined as a 'process of identifying and pursuing clues that arise during analysis in a grounded theory study" (Chun-Tie et al., 2019, p. 5). The researcher in this process endeavors to verify that raw data reflected or grounded in the final theory produced by identifying and following clues from analysis, filled gaps, elucidate uncertainties and test interpretations throughout data collections and analysis (Chun-Tie et al., 2019; Bloomberg &Volpe, 2019). The final process is constant comparative data analysis— the key element of grounded theory which is used in coding and category development (Chun-Tie et al., 2019; Durdella, 2019). This process emphasizes on the original way of generating, organizing, analyzing, and interpreting data (Chun-Tie et al., 2019; Durdella, 2019). The researcher, through

initial data analysis through segmenting, coding, categorizing and thematizing to develop a

theory or an explanation about what is happening in the data (Chun-Tie et al., 2019; Bloomberg

&Volpe,2019; Durdella, 2019). Coding (open, initial, axial, selective coding) and memoing are

the two key strategies of constant comparative analysis and the foundation for grounded theory

(Chun-Tie et al., 2019; Bloomberg &Volpe, 2019; Durdella, 2019).

Rationale for Selecting Grounded Theory and What was Borrowed from Grounded Theorists

Rationale for selecting grounded theory. The overall purpose of grounded theory is to

generate an explanatory theory which assists in conceptualizing a phenomenon of interest (Chun-

Tie et al., 2019; Bloomberg &Volpe, 2019; Durdella, 2019; Padgett, 2017). For this reason, this

researcher used grounded theory to engage in grounded theory development that provided an

explanation and interpretation about perinatal mood and anxiety disorders among women in the

African diaspora. Utilizing grounded theory allows this researcher to co-construct meaning with

the participants. This researcher co-constructing meaning with the study participants allows

researcher to construct an explanatory theory that help conceptualize help-seeking among

women in the African diaspora during and after pregnancy. Utilizing grounded theory improves

the quality and rigor of this research and permitted this researcher to determine what aspects of

data are most important and the kind of data needed to be collected as relates to perinatal mood

and anxiety disorders among women in the African diaspora (Bloomberg &Volpe, 2019;

Durdella, 2019).

What this study borrowed from grounded theorists. This study borrowed two

grounded theory procedural steps: concurrent data collection and analysis; and theoretical

sampling methods. Employing these methods permits this researcher to systematically sample

participants, conduct and transcribe few interviews, segment and code transcribed interviews,

and then use emerging patterns from the coded transcribed interviews to sample additional participants for interviews (Durdella, 2019). Grounded theory is also an appropriate method to use in research utilizing purposive-snowball sampling (Chun-Tie et al., 2019; Durdella, 2019). Thus, this researcher utilized grounded theory theoretical sampling (purposeful snowball) procedural step to sample, recruit participants and collect data.

Research Sampling

The section of this methodology seeks to cover selection of participants, methods and rationales for selection, sample size and recruitment of the participants. Research sampling is a method used by qualitative researchers to select their study participants and/or site. Purposeful or judgment sampling approach is used to guide the selection process (Bloomberg &Volpe, 2019; Durdella, 2019; Creswell & Poth 2018; Padgett, 2017). The goal of utilizing this research sampling strategy is to allow the research questions to guide the researcher on how to locate specific participants or empirical units (Durdella, 2019).

Participants, Method, and Selection Rationale

This study sampled women in the African diaspora who experienced motherhood or delivered a baby in the United States. To select these participants, purposeful or judgement sampling was employed. Purposeful sampling is defined by Bloomberg and Volpe (2019) as "a strategy for accessing appropriate data that fits the purpose of the study, the resources available, the question being asked, and the constraints and challenges being faced" (p. 186). This method of sampling is highlighted as the appropriate method to be used when conducting qualitative phenomenological research studies as was the case for this study (Durdella, 2019; Creswell & Poth 2018; Padgett, 2017). This method allows the qualitative researcher to select information-rich cases and emergent that yielded insight and in-depth understanding of the phenomenon

under investigation (Bloomberg &Volpe, 2019). Utilizing this purposeful sampling method allowed this researcher to select only diaspora African women who have experienced motherhood in the United States of America and those who have children between 0 to 5 years old.

Five different purposeful sampling approaches are highlighted as vital during participants or site selection process so as to allow the researcher to remain consistent with the research goals (Durdella, 2019). These include heterogenous, representative or typical sample, and convenient sample (Durdella, 2019; Creswell & Poth 2018; Padgett, 2017). This study used maximum variation technique of heterogenous sampling to help this researcher capture heterogeneity across study population—to sample only women in the African diaspora living in the United States and had delivered their babies in the United States, instead of sampling those who delivered their babies in their own countries (Creswell & Poth 2018; Padgett, 2017).

This study is also guided by criterion-based sampling, Criterion-based sampling techniques helped this researcher to sample study participants who represent participants who have experienced the same phenomenon (Bloomberg &Volpe, 2019; Durdella, 2019). The rationale for choosing this sampling strategy is that it is well suited to this definition of criterion-based sampling. In other words, all the individuals (participants) to be studied in this study represented people (women) who have experienced the same phenomenon (pregnancy and childbirth in the United States and are of African descent and have immigrated to the United States). Criterion-based sampling strategy is not only used to compare participant groups who meet or did not meet the study criteria, but it is also used as a strategy to effectively apply criteria

for inclusion in a sample and exclusively examine individuals who meet the criteria" (Durdella, 2019, p. 186).

In this study, this researcher compared any participant groups, but used this criterion-based sampling to examine the participants who meet the criteria of this study. This study's inclusive and exclusive criteria for selecting the participants are as follows: *inclusive*— (a) Only African immigrant mothers who have been pregnant and delivered a child in the United States, and were the primary caretakers of that child for the first 5 years of life were considered; (b) only diaspora African women residing in the United States at the time they delivered their baby; and (c) only women in the African diaspora who speak English (women in the African diaspora with French colonial identity who speak English were included). *Exclusive:* (a) Anyone who does not identify as an African immigrant; (b) and anyone who does not fit the criteria discussed above. This study sampled women who are between the ages of 18-49. According to World Health Organization, 18 years is the age of consent; and defined reproductive age for African women is between ages 15-49 (WHO, 2020).

The rationale for selecting only women who have a child or children at ages between 0-5 years is because this researcher believes that since these participants recently experienced the phenomenon of (pregnancy and childbirth) it would be much easier for them to remember what those experiences were/are and be able to share them. That is, their experiences were still relatively fresh, and much easier for them to reflect, interpret and share what these experiences meant to them.

Sample Size and Data Saturation

In qualitative research, the sample size is small, as the goal is to obtain rich data (Bloomberg &Volpe, 2019; Durdella, 2019; Creswell & Poth 2018; Padgett, 2017). In

conducting a phenomenological study, 3 to 35 participants are generally recommended (Creswell & Poth 2018; Padgett, 2017). However, to obtain richer data that encourages relationship management of a smaller sample, 5-15 participants are recommended (Durdella, 2019).

Data saturation was used to determine the number of participants within these parameters (no less than 10 participants or no more than 20 people). Data saturation is vital in qualitative research as it helps phenomenology researchers to establish and maintain content validity (Fusch & Ness, 2015). Saunders et al. (2018) defined data saturation as a method a phenomenology researcher uses to judge when to stop sampling the different groups pertinent to a category. In other words, "data saturation is reached when the ability to obtain additional new information from participants has been attained, and when further coding is no longer feasible" (Fusch & Ness, 2015, p. 1409). In many cases, researchers stopped sampling when information being obtained from participants start to become redundant and no new themes are emerging from any additional participants. This means that no additional data was found whereby a researcher can develop properties of the category (Saunders et al., 2018). Data saturation is necessary in this current dissertation study as it helped this researcher to ensure that content validity is not hampered and that all possible themes have been captured.

Outlining ways to which qualitative researcher attain data saturation is emphasized as an important factor as it helps prevent hampering content validity (Brod, Tesler & Christensen, 2009; Fusch & Ness, 2015; Saunders et al., 2018). As defined by Brod, Tesler and Christensen (2009), content validity is ''the extent to which one can generalize from a particular collection of items to all possible items in a broader domain of item ... the intention is ... to obtain as representative a collection of item material and relevant content as possible'' (p. 1263). Data saturation in phenomenological qualitative studies can be reached through the use of probing

questions (in-the- moment probes) and creating a statement of epoche or self-bracketing (Brod, Tesler & Christensen, 2009; Creswell & Poth, 2018). This researcher created probing questions (in-the-moment probes) to allow for collection of in-depth and rich interview responses from the study participants; and researcher's positionality statement—reflexivity (statement of epoche) which help the researcher recognize and be aware of bias (Creswell & Poth, 2018; Padgett, 2017). Creswell and Poth (2018) position that the researcher bracketing self out of the researcher's study by discussing the researcher's personal experiences with the phenomenon to be investigated would not take the researcher entirely away from the study.

Researcher's self-bracketing helps the researcher identify some of the personal experiences related to the phenomenon; focus on the experiences of the participants to be studied; and reduce biases in that particular study (Bloomberg &Volpe, 2019; Brod, Tesler & Christensen, 2009; Creswell & Poth, 2018; Durdella, 2019). In this study a total of 12 women of the African diaspora were interviewed. It was no longer necessary to continue to interview additional women as data saturation was reached. The interview ran from November 21, 2020, through January 27, 2021.

Recruitment of Participants Plan

To gain access to participants, this study utilized a convenient snowball sampling method. Utilizing this sampling method, this researcher relied on respondents-driven and subsequent sampling, where participants were asked to participate, and then requested to refer their friends or family members that meet the eligibility criteria for this study (Mario et al. 2017). Respondent-drive and subsequent sampling strategies were found to be effective for recruiting participants from hidden populations such as the one under study (George, Duran & Norris, 2014; Mario et al., 2017; Shedlin et al., 2007). This researcher reached out to women in the

African community who fit the sample description, and participants were asked to refer other African women they know who fit the sample characteristics. The researcher reached out and solicited for participation and obtained consents for participation from a total of 15 women. The participants declined to be interviewed face-to face due to COVID-19 pandemic precautions and the researcher conducted zoom videoconference interviews with the participants.

Prior to the interview, prerecruitment for baseline assessment were conducted. According to Mario et al. (2017), prerecruitment adequately prepared researchers to gain a successful entry and helped maximize the participants' recruitment, retention, and interview. During this prerecruitment, the researcher identified and talked to the four seeds (3 women organizations/association leaders and a church pastor) known to this researcher and then introduced self and the purpose of the study to them. This researcher also asked that they inform the community and help with identifying participants. See below diagram depicting Seeds and participants referred.

Diagram 4.

Diagram depicting research seeds and participants referred (women in the African diaspora—WAD)
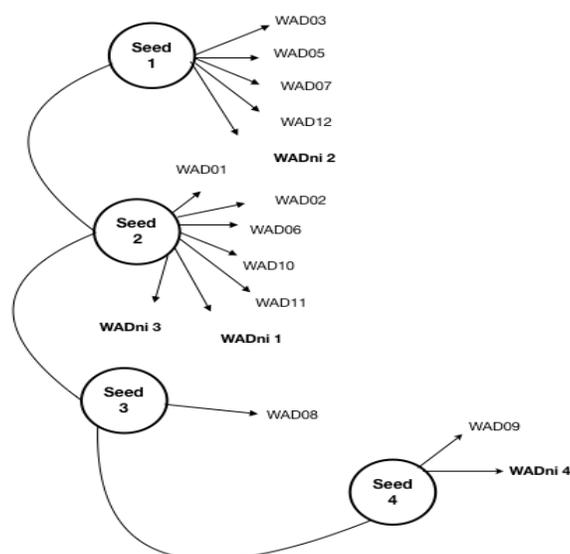
Data Collection

In-Depth Interview

This researcher utilized in-depth unstructured interviews to collect data for this study. Phenomenology theorists recommend using unstructured or in-depth interview as it produces a high-quality interview with linchpins of success for qualitative research (Dana et al., 1992; Padgett, 2017; Wildemuth, 2017). The Interview method is highlighted as a favorable qualitative research methodological tool for phenomenological studies (Dana et al., 1992), and an ideal method to use when utilizing phenomenological approach in a qualitative research study (Creswell & Poth 2018; Dana et al., 1992; Padgett, 2017; Wildemuth, 2017). Unstructured interviews are appropriate when a researcher wants to explore an in-depth of understanding of a particular research problem within a specific cultural context (Wildermuth, 2017).

Interview guide questions. This study is a phenomenology qualitative research study, and therefore does not require instruments such as rating scales or questionaries' (Dana et al., 1992; Padgett, 2017). This study, however, utilized an interview guide to ensure the same general questions were posed to the different participants for uniformity of data collection. Interview guide questions are unstructured questions that direct informal conversational interview between a qualitative researcher and the study participants (Durdella, 2019). In-the-moment probes/follow-up questions were utilized to help this researcher obtain rich descriptions of the phenomenon. The interview guide questions, and in-the-moment probes/follow-up were created to serve as a guide to the interview and each participant was interviewed individually. Probe/follow-up questions (in-the-moment probes) helped the researcher obtain in-depth and richness of answers from the participants (Durdella, 2019; Padgett, 2017). For the interview guide questions, six questions are suggested (Durdella, 2019; Padgett, 2017), though Padgett

(2017) posits that the fewer the interview questions the better. In this light, this researcher created and used five interview guide questions in this study. During the interview some in-the-moment questions emerged. The following are the interview guide questions utilized: See table depicting interview guide questions and the in-the moment questions that emerged during the interviews.

Table 1

Table depicting interview guide and in-the-moment/follow up questions

Topic Area	Purpose of Asking the Question	Interview Guide Questions	In-the-Moment Probes Questions
Knowledge about perinatal mood and anxiety disorders	To explore diasporas women knowledge about perinatal mood and anxiety disorders during perinatal periods	What is/are your knowledge about perinatal mood and anxiety disorders?	- What do you know about perinatal mood and anxiety symptoms? - How can you describe the thoughts and feelings you had during and after pregnancy? - What is/are your understanding about the causes and treatment of perinatal mood and anxiety disorders?
Cultural belief about mental illness and perinatal mood and anxiety disorders	To explore the diasporas African women's cultural belief system	What is/are your cultural belief(s) about mental health issues/illnesses?	In your culture, (hometown/country) how do people interpret causes and treatment of mental health illness/issues, especially as relates to pregnancy and delivery?
Self-interpretation about vulnerability and adaption factors during perinatal periods	To explore the women's interpretation of vulnerability and adaption to perinatal mood and anxiety disorders	What is/are your interpretation(s) of vulnerability and adaption to PMADs?	- what does it mean to you when you hear that a mother has PMADs? - what factors do you think that cause a mother to experience PMADs?
Self-recognition and interpretation of help-seeking	To explore the women's self-interpretation of help-seeking	What is/are your interpretation(s) about help-seeking PMADs periods?	What help did you have after your baby was born?

			• What was it like for you seeking help during and after your pregnancy?
Personal experience with barriers to help-seeking	To explore women's interpretation about barriers to help-seeking.	What is/are your interpretation(s) about barriers to help-seeking?	• What factors do you feel most affected your motivation to seek help if you did? • What barriers were there to getting support you wanted?

Data collection tools and software. To collect data, the following tools and software were used: Zoom, NVivo, Quick Time audio and cell phone. Zoom software was used to interview participants geographical distance and COVID-19 pandemic restrictions. It was also used to record and transcribe the interviews. The Zoom software has been found to be effective and efficient in conducing qualitative health research studies and also found to be secured and satisfactory in conducting health research (Archibald, 2019). Regarding confidentiality concerns, zoom videoconference interviews were found to be secure and satisfactory in conducting health research (Archibald, 2019). NVivo software was also utilized to transcribe, code, and analyze interviews and also used for continuous coding, review, and analysis of interviews and emerging themes. Literature has highlighted that using NVivo software enhances efficiency, multiplicity, and transparency in data coding (Hoover & Koerber, 2011; Zamawe, 2015). Quick Time audio recorder was used to record the interviews. Based on this researcher's experience using this tool, Quick Time recorder recognizes and captures voice efficiently. Quick Time audio is an in-built software/app on this researcher's mac book pro laptop. Quick Time audio is an in-built software/app on this researcher's mac book pro laptop. The cell phone was used to talk to participants about participating in the study and scheduled for the interview

Data Collection Procedure. This researcher conducted open-ended unstructured in-depth interviews with women in the African diaspora who experienced pregnancy and childbirth outside their cultural locations. This researcher offered to conduct a onetime interview with each

participant through face-to face, zoom or skype meetings, and participants chose to be interviewed via zoom due to COVID-19 pandemic restrictions. These interviews were recorded to ensure a high-quality and also to ensure that mothers' responses are well captured. Zoom and Quick Time audio interviewing tools were used to record interviews. These two tools were used as a backup plan, and they have been proven to have a high and good quality sound and capture voices well during recording process. During the zoom interview participants were encouraged to turn off their notifications or manually put their phones in "do not disturb" mode to avoid encountering any distractions (such as incoming calls or text messages for participants who might be zooming from their cellphones). Participants who do not know to turn off notification were guided on how to manage do so on their phone. Participants who did not want to use video or camera during the zoom interview were asked and encouraged to put video/camara off and were provided with guidelines on how to do so. During the period of time waiting for IRB to approval this dissertation proposal, prerecruitment for baseline assessment was conducted to gain access to the participants. Prerecruitment assessment adequately prepares this researcher to gain a successful entry and maximize the participants' recruitment, retention, and interview (Mario et al., 2017). The prerecruitment include gaining access to seeds (talking to leaders of women's organizations/associations or anybody) known to this researcher to introduce self (for familiarity purposes). This prerecruitment took place from September 2020 through October 2020.

Ethical Consideration

International Review Board (IRB) sanctions researchers to conduct a research study in a manner that would minimize potential harm to research participants (Collaborative Institution Training Initiatives [CITI], 2020). Researchers are responsible for ensuring that participants were well informed about their rights and protected (Bloomberg &Volpe, 2019). Following the

dissertation proposal defense, his researcher applied for IRB approval to conduct this study and gained approval on November 17, 2021. During the data collection, the researcher ensured that all IRB guidelines, procedures, and standards were adhered to and maintained. In other words, this researcher ensured maximum protection of participants— adhering to all ethical issues relating to the participants of this study, including maintaining confidentiality, anonymity, and informed consent regulations. Below describes how this researcher adhered to all ethical issues throughout data collection and analysis.

Protection Against Risks

Discussing this topic may lead to emotional/psychological distresses as it may bring unpleasant memories or unresolved issues. In adhering to participants protection against these risks, this researcher provided below crisis helpline information on maternal mental health issues to participants and also encouraged them to seek help if needed:

- Emergency hotline: Call 911:

- Postpartum Support International crisis hotline: Telephone number to call (1-800-944-4773); text a message (503-894-9453).

- Participants were referred to their individual state's local counseling/therapy resources.

- Participants were encouraged to consult with their primary care doctor if they do not feel comfortable reaching out to any of the resources provided.

Participants were clearly informed about the details of this study, which includes the purpose of the study, participants' right of voluntary participation, and participants' right to withdrew at any time they feel uncomfortable continuing without penalty. They were offered an opportunity to stop or withdraw from participating in the interview should any of the psychological/emotional distresses arise. This researcher encouraged participants to seek help

(counseling/therapy or medical attention) should the need arise. No information was withheld from the participants. Additionally, to ensure that the participants are well informed about their rights and the content of the consent form, they were verbally explained the contents of consent form in a level the participants clearly understand it. This explanation was provided to the participants after they have read the consent letter/form.

Confidentiality

Fouka & Mantzorou (2011) defined confidentiality as allowing participants to freely share and withhold as much information as they wish to the person they choose. Participants were interviewed via zoom in their chosen environment, which encouraged them to feel comfortable sharing their phenomenological sensitive lived experience. Interview records were immediately stored in this researcher's private protected password laptop and transcribed. All data files, documents, and contact information would be kept secure at least three years before destroying them per federal regulations. This researcher explained to participants were explained where confidentiality might be breached or violated. For example, the researcher explained to participants that if they disclose self-harm thoughts or thoughts of harming their baby or others, confidentiality would be profaned. This researcher also encouraged participants to call the crisis hotline or 911 if they feel any emotional distressed. This researcher let the participant know that the researcher is a mandated reporter and would assist in making calls and help participants get help should any issues occur during the interview.

Anonymity

As described by Fouka & Mantzorou (2011), "anonymity is protected when the subject's identity cannot be linked with personal responses" (p. 3). Protecting the anonymity of participants of this study is of paramount importance. This researcher ensured that none of the

participants' identities were revealed to guarantee adherence to this ethical consideration. This researcher scored the private information collected from the participants (such as demographic and other sensitive information) on the researcher's password-protected laptop. Each participant was assigned a code name in place of their name so that no one other than this researcher identifies them. The audio/video records of the interviews were also secured in this researcher's password-protected computer accessed only by this researcher.

Informed consent

This researcher created written informed consent, which detailed the purpose of this study, participants' right of voluntary participation, right to withdraw at any time they feel uncomfortable continuing with the interview, and how researcher would protect participants' rights and identities. This informed consent provided information about the potential benefits of this study. Before proceeding to interview the participants, the researcher went over this informed consent with the participants. Participants consent to participate in the interview and provided verbal signature to each section of the consent form. See Appendix for the copy of this informed consent.

Potential Benefits

There are no direct benefits to participating in this study, and this researcher also informed the participants about this. The researcher also explained how this study's findings or outcomes would be used to develop knowledge in this area and inform culturally appropriate programming for this population. The participants were also informed that the study would help create awareness and contribute to promoting maternal mental health policy, especially related to women of the African diaspora or immigrants. Sharing information on this sensitive topic may uncover unresolved issues that may need to be addressed by a mental health professional. In this

regard, participants were provided appropriate referral resources as needed and were encouraged participants to utilize them.

Reflexivity/Positionality Statement

In a phenomenological study, the need for a researcher to bracket self out of the study is emphasized as vital. The researcher's experiences impact the research results interpretations (Alvermann, O'Brien, & Dillion, 1996; Creswell & Poth 2018; Patton, 1999). Creswell and Poth (2018) stress that a researcher bracketing self out of the study by discussing the researcher's personal experiences with the phenomenon to be studied not only take the researcher completely out of the study but would help the researcher identify some of the personal experiences with the phenomenon. A researcher bracketing self out of the study allowed the researcher to focus on the experiences of the participants to be studied (Creswell & Poth, 2018). In this light, there is the need for a researcher to communicate openly about their personal experiences, trainings, perspective, prior knowledge they bring into the study; connection with the study site, access to the participants, and research funding (Alvemann, O'Brien & Dillion, 1999). Putting this into perspective, it is then ideal for this researcher to provide researcher's experience and role as relates to this phenomenon. This decision allowed this researcher's audience to learn little about the researcher's experiences and judge for themselves whether this researcher focuses solely on the research participants' experience in description without bringing myself into the picture (Creswell & Poth 2018). Refer to researcher's credibility statement on the trustworthiness section below.

My research interest is on maternal mental health, women and children, program development and evaluation. Being an Igbo-Nigerian, I was born and raised in Eastern Nigeria of Sub-Saharan Africa. I was equally trained and professed as a Catholic Sister (Nun) and as well as

an African diaspora living in the United States. I obtained my master's degree in social work and now doctoral degree in the same discipline. I am licensed in the State of Texas as a LMSW; I received certificate training in maternal mental health with Postpartum Support International; and currently practice as a social worker in the maternal and child arena. For over 20 years, I have worked in a healthcare setting and other social services settings that seek to provide services to women and their children who faced persistent social, economic, mental health, and medical problems. Currently, I am working in a medical hospital in the mother and baby units, thus dealing with mothers who have a history of perinatal mood and anxiety disorders or who are at risk of developing maternal mental health issues as a result of pregnancy or childbirth. My role as social worker is to educate mothers on perinatal mood and anxiety disorders (perinatal mood and anxiety disorders), identify signs and symptoms; recognize some risk/protective factors; and connect mothers to the appropriate community resources when there is a need.

Being an African diaspora researcher provides an insider perspective into some of the terms or concepts my participants may use to communicate during the interviews. I also believe that the knowledge and experiences gained through education, practice, and coming from a culture that holds a similar belief system on mental health issues helped me conduct this research effectively. This researcher understands that personal bias and the similarity of coming from the participants' cultural location may affect my views, conceptualization, and interpretations of the results. However, my responsibility is to ensure biases are diligently minimized. I embraced my own perspective and hope my unique perspective helped me see the interview data through new lenses.

Trustworthiness

Assessing for trustworthiness in qualitative research is imperative as it helps measure the validity and reliability of qualitative research (Bloomberg &Volpe, 2019; Durdella, 2019). Bloomberg and Volpe (2019) suggest that a qualitative researcher should be aware of potential biases present throughout the research design, methodology, and study analysis to ensure trustworthiness. Qualitative researchers use credibility, dependability, confirmability, and transferable criteria to evaluate trustworthiness in the research method (Bloomberg &Volpe, 2019; Durdella, 2019; Patton, 1999). "Credibility refers to whether the participants' perceptions match up with the research's portrayal of them" (Bloomberg &Volpe, 2019). In the light of this, the credibility criterion was used to assess for internal validity, and the following research strategies were utilized to enhance it: journaling/reflexivity; and member check (Bloomberg &Volpe, 2019; Durdella, 2019; Creswell & Poth 2018; Padgett, 2017; Patton, 1999). To enhance this study's internal validity, this researcher also used reflexivity/positionality statement, journaling, purposeful sampling, and detailed information (in-depth interview) strategies to achieve internal validity (Bloomberg &Volpe, 2019; Durdella, 2019). To ensure credibility and reliability, this researcher employed a member check by summarizing and paraphrasing participants' responses to them. This procedure employed allowed the participants to verify for accuracy and agreed that this researcher captured the essence of participants' thoughts and responses.

Data Analysis Process

Data analysis in grounded theory studies is a process that involves organizing data, data transcription, coding, interpretation, development, and identification of thematic patterns through coding and data interpretation (Bloomberg &Volpe, 2019; Chun-Tie et al., 2019; Durdella,

2019). A concurrent data generation/collection and analysis is the hallmark of ground theory approaches (Chun-Tie et al., 2019). The data analysis process grounded theory starts long before data collection in the field and continues after data analysis (Bloomberg &Volpe, 2019; Durdella, 2019). This process allows a researcher to work within a set of parameters that guide the researcher on gathering and interpreting information outside the field (Durdella, 2019).

This researcher utilized grounded theory and phenomenology methods of coding and analyzing data and began with detailed analysis and worked up to broader categories (Creswell & Poth 2018). During this data coding and analysis process, this researcher employed a three-stage or phase iterative data analysis process—preliminary, thematic, and interpretation as suggested by Durdella (2019). This researcher followed these three analytical processes, allowing the researcher to recognize and maintain a specific discrete set of analytical tasks and outcomes required when utilizing grounded theory research traditions: preliminary, thematic and interpretative data analysis (Bloomberg &Volpe, 2019; Durdella, 2019).

The preliminary Data Analysis Phase

In this phase and prior to initiating data collection, this researcher conducted a literature review to help the researcher familiarize self with the theoretical perspectives that shape the phenomenon on the participants' lived experiences on maternal mental health disorders during and after pregnancy. Concepts were formulated from the previous theoretical and empirical literature and research questions were formulated. This researcher also formulated and reviewed research questions and interview guide questions during data collection to help the researcher prepare self for the interviews and pre-data analysis. NVivo 12 software was utilized to manage and organize data—converted via transcription and storage for easier data management and analysis. In this phase, this researcher recorded, stored, transcribed, and organized interview

data. Zoom was used to transcribe interviews and these interview data were cleaned before data storage, coding, and management. The researcher, in this phase, also identified concepts, developed codes, and wrote field notes (such as, jotting and writing memos) during data collection, analysis, and interpretations. These steps helped this researcher to achieve phenomenological data reduction (Durdella, 2019). In formulating concepts, this researcher conducted NVivo query (such as, word frequency, text search, word tree), which helped the researcher identify the important words and quotes used by women in the African diaspora to describe their experiences. This researcher also assessed for outstanding issues for further data collection analysis in this phase (Durdella, 2019).

The Thematic Data Analysis Phase

In both grounded theory and phenomenology research traditions, the thematic data analysis stage occurs during and after a qualitative researcher leaves the field (completed interviews) and has completed the preliminary process (Durdell, 2019). It involves the process of segmenting, categorizing/coding, and linking data together to identify emerging themes (Chun-Tie et al., 2019; Durdell, 2019). This researcher employed three basic coding types (open, axial, and selective coding) during the coding process to achieve the goal of this phase. (Brod, Tesler & Christensen, 2009; Chun-Tie et al., 2019; Durdella, 2019; Miles, Huberman, & Saldana, 2014). These coding types are explored in detail below. Table 3 depicts a portion of the codebook displaying some of the themes that developed from the data coding. See Appendix for the full codebook that depicts these themes, concepts, categories, and patterns.

Open Coding. Open coding allowed this researcher to capture women's lived experiences on perinatal mood and anxiety issues, create categories and patterns, and organized them around thematic stories (Durdella, 2019; Miles, Huberman, & Saldana, 2014). Employing

the open coding method, this researcher conducted word frequency and text search queries,

which helped identify words the women used to describe their lived experiences during their

perinatal periods. See below the diagrams depicting these words women used to describe their

lived experiences and word tree for one those words. See below word cloud diagram displaying

the words women used to describe their lived experiences during their perinatal periods.

Diagram 5

Diagrams depicting the word cloud of most used and occurring words the women used to

describe their lived experienced during their perinatal periods; and word tree of one of their

words.

After exploring the words that women in the African diaspora used to describe their lived

experiences about perinatal issues, the researcher started coding word by word and line by line

while applying a descriptive and *in vivo* approach of coding (Rubbin and Rubbin, 2011) to create

nodes or themes. Coding word by word and line by line, the researcher used the exact words

women used to describe their lived experiences. For instance, the women used words such

as *"overwhelmed"* and *"crazy"* when describing the challenges, they experienced when they were

trying to manage their baby care. While utilizing the descriptive approach of coding, the

researcher also used one-word phrases to capture meaning in the lines, sentences, and

paragraphs. For example, the researcher used "*sleep deprivation"* to capture references regarding

the participants' difficulties in getting enough sleep during perinatal periods due to baby care: "I remember spending a whole night, not because of the baby, I couldn't even sleep" (WAD07, 2021). This researcher also used *"contradictory expectation"* to capture women's descriptions of pre-conceived expectations that motherhood would be full of *joy, happiness, excitement*, but on the contrary, it was experienced and described as something that turned out to be *stressful, sad, scary, overwhelming, and crazy*.

Additionally, during this process, the *initial coding* was employed. The researcher used the phrase *"Knowledge about resources"* to condense an expression made by some women regarding their knowledge about community resources during their perinatal periods and their ability to utilize these resources. This phrase also highlights some of the terms women used to emphasize the need for women to be aware of the community resources available to perinatal mothers to increase adaptation to the adversity of motherhood.

Axial Coding. Axial coding allowed the researchers to relate categories to their subcategories (Brod, Tesler & Christensen, 2009; Chun-Tie et al., 2019; Durdella, 2019). In utilizing axial coding, this researcher conducted concept map analysis utilizing NVivo 12 software to relate categories/overarching themes that emerged within the concept/constructs. See diagram six depicting a concept and its category/themes and subthemes formulated through axial coding.

Diagram 6

Diagram depicting axial coding.
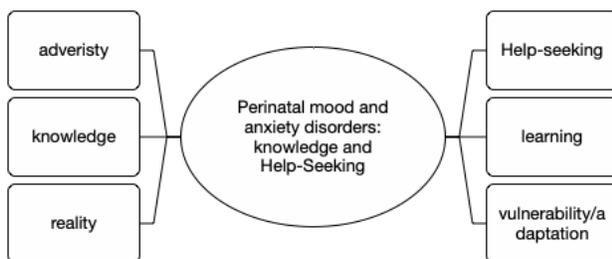
Selective Coding. This researcher also conducted a selective coding analysis. Selective coding was employed to allow all categories to unify around an overarching core concept (Brod, Tesler & Christensen, 2009; Chun-Tie et al., 2019). During and after data collection, this researcher used concepts to develop categories that segmented data into meaningful "bits," elaborated concepts, used and linked categories that shared similar characteristics and described patterns (Bloomberg &Volpe, 2019; Durdella, 2019; Miles, Huberman, & Saldana, 2014). Diagram 7 below depicts selective coding analysis.

Diagram 7

Diagram depicting concepts/constructs that explain the perinatal mood and anxiety disorders among women in the African diaspora formulated through axial coding.
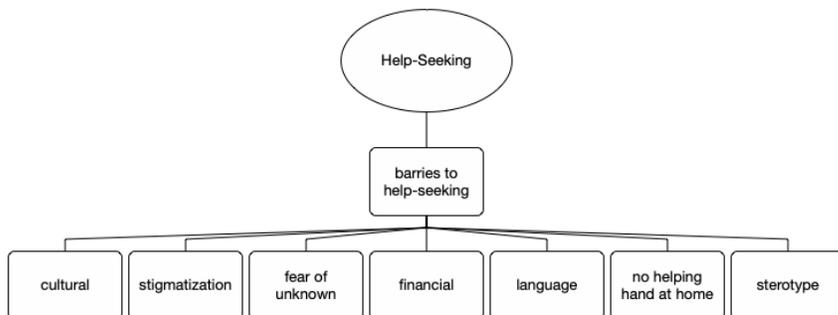
Interpretation of Data Analysis Phase

In this phase, the researcher ensured that concepts, code, and networks were developed and analyzed as necessary. In this process, this researcher was involved in describing and examining patterns, themes, regularities, contrasts, paradoxes, irregularities in the data and move from parts to the whole (Durdella, 2019). This researcher was also involved in formulating and drawing conclusions about emerging themes by retrieving coded data and grouping coded sets into combinations to explore relationships; and applied results of data analysis to research context through conceptual/theoretical framework and empirical lenses (Bloomberg &Volpe, 2019; Durdella, 2019). See diagram 8 depicting the relationships between concepts and categories (themes and subthemes).

Diagram 8

Diagram depicting the relationships between concepts and categories
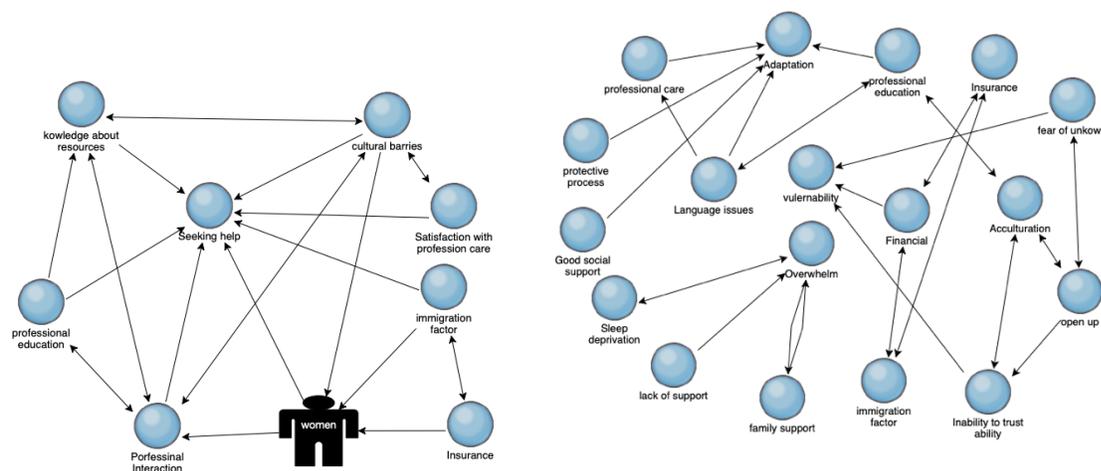
Demographic Data. This study sought to collect information on participants' demographic profiles, which allowed this researcher to understand the study participants much better. As it relates to this study, the following demographic information/profile was collected

from the participants during the interview: country of origin in Africa; level of education; employment status; length of residence in the United States, number of children and their age; and any history of perinatal mood and anxiety disorders. The participants' code represents women in the African diaspora (WAD). Refer to the table section the table that depicts the demographic data collected from the participants.

Chapter Conclusion

This chapter provided the in-depth methodology section, the method, design, data collection, and procedures to select, recruit and interview participants. This chapter also discussed the data analysis procedure. Adhering to all the methodology section requirements following concepts, categories, themes, and subthemes were obtained*: Help-seeking behavior* (4 overarching themes with 30 codes); *knowledge* (6 codes); *learning* (5 codes/themes); *reality* (2 overarching themes with 16 codes); *vulnerability/adaptability* (3 overarching themes with 20 codes). The categories/overarching themes that emerged include: symptoms, accepting help, barriers to help-seeking, intervention, personal interpretation to help-seeking, personal interaction with professional, sought help, prior knowledge about symptoms, knowledge about resource/system, interpretation of information, interpretation of experience, interpretation of interaction, motherhood expectation, belief system, cultural interpretation on cause and treatment of mental health issues, personal interpretation of causes of mental health issues, adaptation/protective factor, protective process, and vulnerability/risk factor. One hundred and thirty-one (115) codes emerged within the data. The themes and subthemes that emerged provide the avenue to answer the research questions, which center on understanding the knowledge women in the African diaspora possess about perinatal mood and anxiety disorders. These codes also helped conceptualize the interpretations women in the African diaspora hold about help-

seeking in the United States. See below the diagram that depicts the concepts and themes that

helped in answering these questions. Also, see Appendix for the table depicting these concepts,

categories/themes, and subthemes.

Diagram 9

Diagram depicting the concepts and categories/overarching themes.
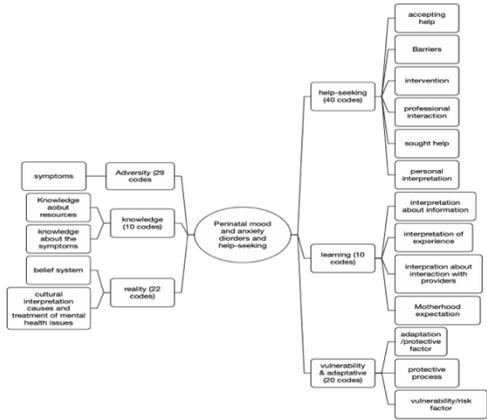
Chapter 4: Finding and Presentation of Themes

This chapter covers the data analysis findings and presents the emerging concepts, categories, themes, and subthemes. These themes were appropriately supported with participants' interview responses.

Findings

Three research questions were developed to conceptualize women's knowledge of perinatal maternal mental health issues and help-seeking behaviors among women in the African diaspora during perinatal periods. Each of the three research questions covered different topic areas.

Research Question 1 (RQ1)

The first question this research study asked was "what knowledge about perinatal mood and anxiety disorders do the women in the African diaspora possess, and what are their interpretations about a mother's vulnerabilities/adaptation to perinatal mood and anxiety disorders during the perinatal period? This research question seeks to understand (1) women in the African diaspora's knowledge about mood and anxiety symptoms and their interpretations about factors that increase vulnerability/adaptations during perinatal periods. *Adversity (borrowed from resiliency theorists)* and *knowledge (borrowed from constructivists)* formulated during preliminary interview data analysis helped answer this research question. *Adversity* concept is described as perinatal mood, and anxiety symptoms participants encountered during their perinatal periods, and *knowledge* is described as women's knowledge about the perinatal symptoms and their interpretation about vulnerability/adaptation factors to perinatal mood and anxiety disorders.

The data analysis results pertaining to this research question revealed that participants have knowledge about the symptoms of perinatal mood and anxiety disorders as they used terms that describe mood and anxiety to describe their experiences. The results also revealed that women's interpretation of vulnerability/adaptative to perinatal mood and anxiety mostly revolved around hormone changes, social support, not being prepared for motherhood, history of perinatal symptoms, and women abusing substances (drugs). It highlighted strong family support as a factor that increases adaptive power mothers during perinatal periods. It also shows that having strong family support increase adaptive power to function effectively during perinatal periods. The themes and subthemes that emerged from the concept, adversity, and knowledge were highlighted and discussed below:

Presentation of Emerging Themes for Adversity/ Knowledge (RQ1)

Symptom (terms participants used to described perinatal issues). The participants used several discrete terms and phrases to describe the mood and anxiety symptoms they felt or experienced during their perinatal periods. These include the feeling of anxiety, feeling of blame, feeling crazy, feeling like crying, depressed, feelings of dying, fear, frustration, guilt, helplessness, isolation, lack of desire to do stuff, miserable, moody, nervous, not able to care for the baby, overwhelmed, sadness, scared, sleep deprivation, stress, tiredness, worry, and unease. The themes of overwhelmed, sleep deprivation, frustration, worry, crying recured throughout the coding process. Taken these words, terms, or phrases together suggest participants knowledge about perinatal mood and anxiety disorders, The following responses from the women indicate they have knowledge about perinatal mood and anxiety symptoms: "I was overwhelmed. I was tired… lack of sleeping and overwhelmed with things" (38-year-old mother from Ivory Coast mother); "I felt overwhelmed; "I felt overwhelmed especially with breastfeeding" (32-yearold

mother from Ivory Coast); "for me, I was out here by myself"(32-yearold mother from Ivory Coast); "it's just been for me it's been like uneasy; "I wasn't really talking, I was just in my little area" (32-year old mother from Ivory Coast); you feel like to do things and it's not getting done, you feel like this is a lot and nothing is working out for you" (39-year old mother from Ghana); "I experience feeling so sad, looking at my husband like an enemy that put me to a punishment" (38-years old mother from Nigeria). Some women exact words for symptoms of mood and such as feeling of depression and anxiety: "it's not easy at all, I was so depressed, so frustrated, I was so depressed" (31-years old mother from Nigeria); it didn't go to the point that I wanted to kill myself… I was just down, just depressed" (22-year-old mother from Ivory Coast); "at first, I thought it was because of my condition at that moment that I was feeling depressed" (32-yearold mother from Ivory Coast).

Knowledge about symptoms. Several themes emerged from this overarching them. These include living in denial, lack of primary education, no prior history of perinatal mood and anxiety disorders, prior knowledge, and screening. 'Living in denial' identifies where women appear not to accept that perinatal problems affect many mothers after childbirth, notwithstanding cultural backgrounds. It also highlights areas where participants believed they experienced postpartum depression symptoms and justified why they experienced them. A woman shared, "we kind of being in denial, that takes all kind of any attention to it away" (WAD02). A woman said, "well, that does not mean that I have any mental issue or I'm mentally depressed" (WAD09). Another woman also said, "when that person has no helping hand, it is not seen as a mental depression" (WAD11).

Some women denied having prior knowledge about perinatal mood and anxiety disorders before relocating to the United States and their first pregnancy, when asked to describe their

knowledge about it. Three of the women said, "well, I've never heard about it to start with" (WAD10); "I only experienced motherhood here in America, before that, I didn't even hear it; I've never known that such a thing was really real till when I got here" (WAD07); "I `don't know much about it honestly...I don't think I have enough knowledge (WAD05). While some women denied having prior knowledge about perinatal mood and anxiety disorders, others admitted and shared their knowledge about perinatal symptoms. A woman noted, when asked to describe if she has any prior knowledge about perinatal symptoms, "I would say, yes. It may not actually be the term postpartum depression, but I have seen new moms being anxious about their kids" (WAD11). Although she denied any history of perinatal symptoms, this same woman shared her observation among women who experienced the symptoms: "women always disturbed when something little happens to their baby, they're always worked up. Postpartum depression is nothing but anxiety over something that has to do with your child, and if it lingers, it could become another problem for that person" (WAD11).

This researcher used in-the-moment questions to clarify if women received education on perinatal mood and anxiety symptoms and screening during and after perinatal periods. A woman responded, "no, I don't… I don't remember having that discussion with anybody" (WAD05). Many women admitted that they received such education; however, this was after they delivered their baby. A woman said, "yes, they did talk about the postpartum depression, they did talk about it" (WAD12). While many of the women shared that they received education on the symptoms of postpartum depression, some of them said that they did not remember if they completed the Postpartum Depression Scale (PDS) screening. One of the women shared when asked if they received education about perinatal mood and anxiety symptoms, what to expect, and how to manage them:

Yes, I do. I receive the training on what postpartum depression means. My doctor told me I'm going to experience these because 90 percent of new moms' experience that your lifestyle change. Woke up in the night and I don't do things you want to do but according to your baby's big schedule (WAD09).

Although professionals provide education on postpartum depression, some women commented that there is much information to decode and retrieve when women go home with their baby. A woman shared, "Some of the things that you have in the hospital they don't sink in until you…" (WAD08). Another woman said, "yes, I have heard that before. I heard it, but I didn't carry with me, I will put it that way. I was like, "okay maybe it may happen but … It's not going to happen to me" (WAD03).

Prior history of a perinatal mood and anxiety disorder was one of the subthemes that emerged from the overarching theme, "knowledge about symptoms." Few women admitted that they experienced perinatal symptoms. However, they said that they experienced such symptoms only after their postpartum delivery depression:

Yes, it happened, and I think even 10 days, especially 10 days after I gave birth, before my mom came, I caught myself crying for no reason. There was no justification, there was nothing. I just don't know. Maybe, it was just so many of emotion. I was so excited and happy for this baby that we've been wanting for so long but at the same time, I felt overwhelmed. I felt overwhelmed especially with breastfeeding (WAD05).

However, all the women expressed that they felt overwhelmed during and after postpartum period:

COVID-19 started, and we were all in quarantine. We couldn't go out anymore, that's when I started to feel a little depressed because being in the house all day with the

hormones and all of that, it started to affect my feelings, that's when I started to be mood

(WAD12).

Another woman said,

Yes, it wasn't documented, but I felt it big time for the first one, my nine-year old one,

because at that time I was a single mother and I had just moved to the United States, and I

was alone with the baby (WAD07).

Other women also shared, "yes I did… sometimes unhappy, distress, sometimes not

wanting to talk to anybody" (WAD09). Among women who admitted a history of postpartum

depression, one of these women disclosed, "first one week at work I feel like I'm dying"

(WAD10). A woman shared, "those symptoms of depression and it didn't go to the point that I

wanted to kill myself with something like this, as they say" (WAD12).

Vulnerability/adaptation. This theme was also borrowed from resiliency theorists.

Several codes or subthemes surfaced from this overarching theme and helped answer the second

topic area of the first research question—women's interpretation of vulnerability and adaptation

to perinatal mood and anxiety disorders. "Vulnerability" factor was described as risk factors and

psychological processes that decrease women in the African diaspora's ability to function

effectively during perinatal mood and anxiety disorders. "Adaptation" factor was described as

factors that mitigate, increase women's adaptive power to function effectively amid adversity of

motherhood, or factors that reduce women's chances of developing perinatal mood and anxiety

symptoms. The data analysis result indicated that participant's interpretation about perinatal

mood and anxiety disorders vulnerability was lack of family support and hormone changes.

These women's quotes support these findings: "It's just lack support. I think it's just a support

system. If you don't have a good support system" (37-year old woman from Nigeria); "I'm the

only one here, being pregnant, that's really, really very challenging (40-year old women from Nigeria); ..some people have their moms handy here, helping them out, while some people are just doing it on their own, somebody like me"; "…the burden of not having the paper, the burden of not be able to work, the burden of learning everything all together" (38-year-old woman from Ivory Coast); "… 99%. 99% of postpartum depression is people that doesn't have help. Now, my mom is here, my husband is here and that's why I told you that my own is just as smooth as A, B, C" (40-year-old woman from Nigeria). Factors such as lack of social support and hormone changes were protuberant in the interview data, while substance abuse and not being prepared for motherhood were not particularly prominent. Only one participant highlighted substance abuse as a vulnerability factor, and so do another participant for "not being prepared for motherhood**."**

Adaptation factor. This theme borrowed from resiliency theory also helped answer the women's interpretation of vulnerability/adaptation to perinatal mood and anxiety disorders. The several subthemes or codes developed from this overarching theme. A strong social support system was highlighted as a factor that increased women's adaptative power during their perinatal periods. These include the support they received from their family members and friends and other social support systems. The theme "Strong social support" was common among participants' interview responses. Women's interpretation of solid social support as an adaptative factor highlighted parental (mother or mother figure in particular) and spousal supports as their adaptation sources. This narrative conversation between the participant and her mother during her postpartum periods captures and supports this finding on a strong social support system as an adaptative factor:

"I'm now your house girl." I said, "I understand." It was hard for me to take her [mother] as my house girl, but she told me plain. I have to pump my milk and just keep it up on the

table or in the fridge where she can see... I can't tell you how much I started feeling

relaxed. I could get quality sleep. People always wonder how I recovered fast after

pregnancy. It's not my doing, it's, I have a good support system" (37-year-old women

from Nigeria).

Protective process. This theme also emerged and helped provide an answer to the first

research question. The protective process was borrowed from the resilience theory concept and

was described as personal/psychological characteristics or traits that define individual resilience

power. This protective process includes a person's views or ideology about a problem, how to

handle it, innate ability, or capacity to handle any existential problems or adversity. Participants

used different words to describe their interpretation of vulnerability/adaptative factors in relation

to the protective process. The participants' responses include the ability to face responsibilities,

accept the fact about pregnancy, balancing life, going back to self (self-reflection), ability to trust

one's capability, life course, ability to multitask, and self-satisfaction (with one's body and

satisfied with the care received from providers or family members). As one participant puts it,

when asked about their interpretations of vulnerability/adaptation during their perinatal periods,

"you cannot live in this country, and if you do not know how to multitask, it doesn't matter where

you're coming from, if you do not know how to multitask…" (34-year-old women from Nigeria).

A woman reflected and shared that accepting the facts about pregnancy comes with many

challenges. However, accepting and facing the responsibilities of motherhood decreases her risk

of perinatal mood and anxiety symptoms:

I had to accept the fact that I was pregnant, accept the fact that my life was going to

change with school, the work, and the baby… I just started to let's say, talk myself, I will

say, and then started to reason myself into like getting better, and then that's when I

started to go back to my old self (" (22-year-old woman from Ivory Coast).

The participants discussed that trusting in one's ability to face a life course (challenges or

difficulties that adversity of motherhood brings) increases women's adaptation. One woman's

statement captures this:

You have to learn to maybe trust yourself a bit and know that you can do it. In the

beginning, it's not obvious because you don't have experience, you never had a child, so

you want to listen to people, but it become a lot of information and that can also create

constant type of anxiety and stress for no reason (32-year-old woman from Ivory Coast).

Knowledge (emerged themes for RQ1)

Research Question 2 (RQ2)

Another question this study asked was, "how do the contextual experiences of women in

the African diaspora impact their personal interpretations of vulnerabilities/adaptations to

perinatal mood and anxiety disorders during perinatal periods? This second research question

centers on understanding how living in the United States with different cultural influences and

impacts the participant's interpretations of vulnerabilities/adaptations to perinatal mood and

anxiety disorders during perinatal periods. R*eality* and *learning as a concept (*borrowed from

constructive theorists) were coded into categories to help answer this question

The *reality* concept was described as women's personal and cultural beliefs and

interpretations of perinatal mood and anxiety vulnerability/adaptive factors. Two overarching

themes/categories were coded into these concepts to help provide a theory that explained this

question. These categories include belief systems (cultural) and personal interpretations of the

causes and treatment of perinatal disorders. The *learning* category is described as the meaning

and interpretations about the new information women gained from interacting with their new cultural environments in the United States— the belief system surrounding mental health issues, treatment, and management in the United States.

The data analysis regarding this research question revealed that participants' views on the causes and treatment of mental health appeared to have shifted from what they believed when they were in their country. This finding suggests that the influence of women's current location's cultural and social activities has impacted their interpretation of the causes and treatment of mental health issues and management, particularly perinatal mental health. Many participants shared that mental health issues were viewed as physical (enemies) and supernatural (curs and repercussion) cause-related in their country, and people who were identified with these illnesses received ill-treatment. For example, a 38-year-old woman from Ivory Coast, when asked their cultural interpretation about the mental health issues, causes and treatment, said,

"for us, it's just a curse... it's mostly the consequences of your actions[;] usually, good people don't just become one day depressed or have mental illness issues", it's a little bit of a shame, so usually, people don't talk about it."

Another 32-year- old woman from Ivory Coast also said,

"I think in Côte d'Ivoire, I think the mental illness for me growing up, you probably would think it's a curse or maybe the person did some type of substance abuse or things of that nature" (38-year-old women from Ivory Coast). Some participants from Nigeria also said, "they say is village people cause it to you (37-year-old women from Nigeria); "in our place, some people, they believe that anybody mad maybe it is somebody that did it to them" (39-year-old women from Nigeria).

The finding also revealed that having this mentality about mental health issues limits women from disclosing any perinatal symptoms during perinatal periods, and these attitudes impacted their level of help-seeking for fear not to be considered a "weak mother." One of the participants shared her conversations with her sister regarding his history of perinatal mood and anxiety symptoms:

> ... back home, I have my sisters because I came from a family of girls... were having babies, and I've never ever noticed that they had postpartum depression till when I started having mine, especially with the second pregnancy. One day I was talking to one of my siblings back home, and she was saying, "Oh yes, I felt the same way." I'm like, "You did?" She's like, "Yes." I'm like, "No, I've never seen it." When she has a baby, I was home with her." She said, She was feeling it and I was shocked. I'm like, wow. I was thinking because I was away from home, I had no help and I was stressing with my situation, that's when she said, "It doesn't matter." I was like, "Why you didn't say anything about it?" She's like because nobody talks about it, she didn't want to feel ashamed. She didn't want people to know that maybe she's not a good mother (38-year-old woman from Ivory Coast).

This study also found that as participants socialize in a culture with a better interpretation of mental health issues and treatment, their perceptions about perinatal mental health issues changed. In other words, they believe that living in the United States had changed their level of thinking about mental illness, particularly perinatal mood and anxiety symptoms and management. This participant reflected, "if I have a chance to go back to my previous experience, I will do things differently (32-year-old woman from Ivory Coast).

Presentation of Emerging Themes for Reality/Learning (RQ2)

The below paragraphs provide detailed explanations of themes that emerged from reality/*learning* concepts that demonstrate the findings of this second research question. These emerging themes helped to formulate a theory.

Belief system. This theme explicitly describes some of the women's views as to how their African cultures view the causes and treatment of mental health issues and their attitudes towards persons with mental health issues. The subthemes that emerge from the overarching theme include curse, enemies, harsh treatment, idea, illness treatment, neglect of persons with mental health need, no cultural understanding about mental illness, taboo, and witchcraft. See Appendix for the table describing concepts, categories, and subthemes. The codes such as taboo, enemies, and witchcraft gained many responses from the interviews. Women shared that people from their cultural location believe a mental illness results from enemies and witchcraft. The following statements capture such beliefs: "whenever you see somebody that is going through a mental health issue, you would see them saying, "Oh, it's this person that did diabolic stuff" (38-year-old women from Nigeria). Many women discuss their cultural views on perinatal issues; "I think in Côte d'Ivoire, I think the mental illness for me growing up, you probably would think it's a curse or maybe the person did some type of substance abuse or things of that nature (38-year-old women from Ivory Coast).

Cultural interpretation. This overarching theme describes women in the African diaspora's report on the beliefs or interpretations that they hold regarding perinatal issues, interventions' options, and attitudes towards women who face such adversity. The codes (themes) that develop from cultural interpretation include cultural expectation, cultural identity, culture versus personal interpretation, ignoring the symptom, just being pregnant, no knowledge

about the cultural view on causes of mental illnesses, and not take it seriously stigmatization for

mental illness. Women have cultural knowledge about how the people of their cultural location

perceive and interpret causes and intervention of mental health issues, except two women who

denied that they know. This statement captures this denial, "honestly, I never heard about that

back there; in my area, in my family, nobody had those kinds of issues, so I never really heard

that" (22-year-old woman from Ivory Coast). Cultural expectation as a subtheme also draws

many codes. All women believe that people from their African culture lay certain expectations

on motherhood. They share that these expectations can sometimes create or exacerbate perinatal

symptoms:

> Yes, or maybe, especially we got this from Africa, you have two girls, and you are here
>
> in the United States, or you have three girls and you're looking for a boy. You are
>
> pregnant, hoping that this one was going to be a boy. When the time to do the lab comes,
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> to check the sex of the baby, you find out it's a girl, some mothers will not be-- some of
>
> them will not be happy because they want a male child, that they already have a female
>
> child (31-year-old women from Nigeria).

Women also described cultural expectations regarding helping women by family

members (usually by her mother, sister) and friends during perinatal periods. They explained that

family members are expected to help women during perinatal periods, especially during the

postpartum period:

> It is actually not a problem in Africa. I don't know if it is a problem here. It's actually a
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> good thing where mothers are expected to go out there and help out their children, who
>
> they perceive might be needing help. It's a good thing. It's what people are waiting for,
>
> it's our culture, it's African culture and precisely Nigerian culture. People are actually

looking forward to a situation like that. In that way, the young mom will have enough time to rest and be able to take care of the newborn baby (34-year-old women from Nigeria).

The women interpreting from the African cultural views concluded that the inability to fulfill these cultural expectations might increase the women's vulnerability to perinatal mood or anxiety symptoms. Women stress that in the African culture, a woman experiencing any issues during perinatal periods is a "cry for help" and not a mental issue.

The way we perceive it is we look at it from the angle that, this person probably needs somebody to help her take care of a lot of things. That is why you see a lot of people having their mothers around them when they have their kids…to help out in taking care of the baby…, so that the mom or the new mom can have enough time to rest. What is actually causing the postpartum depression, is the inability of the new mom to get enough rest, and once you don't have enough rest, it sends a signal to your system that something is really happening..., if not carefully handled, the person could be seen as somebody that has lost it. No, it is usually not that way, but because we are from a place where we believe that a new mother should have somebody around her to guide her (38-year-old women from Nigeria).

Another subtheme that draws lots of codes is cultural versus women's interpretations about perinatal mood and anxiety. Some women hold a different interpretation of motherhood's adversity from what the people from their culture interpret about perinatal mood anxiety symptoms. Likewise, some women hold similar interpretations. One of the women holds a similar interpretation when she says, "for us, it's just a curse... it's mostly the consequences of your actions. Usually, good people don't just become one day depressed or have mental illness

issues" ("(38-year-old woman from Ivory Coast). A woman said, "in my own understanding, I cannot define postpartum mental health as being mentally depression, but I can say it happens at to 70 percent of mothers, especially in new ones" (34-year-old women from Nigeria). Some women denied that mental health issues defined it as a life course that women have encountered: "women are born to be pregnant…and how well you handle your pregnancy determines your strength as a woman" (40-year-old women from Nigeria).

Personal interpretation of perinatal disorders. The overarching theme examines women's self-interpretation about the cause and treatment of mental illness and perinatal mood and anxiety disorders. The subthemes that emerged from this theme include comparison, personal definition, definition issues, and questions about reality. In referencing African cultural ways of interpreting the causes of mental health issues, especially maternal mental health needs, the code for comparison emerged. To make their point, women made many comparisons between Africa and America, their first and second pregnancies. In describing differences between how Africans handle women with perinatal symptoms and how Americans do, a woman stated:

> …in America, from my own understanding, when someone says that she or he is depressed, as kind of he's frustrated and depressed, they pay good attention. They will take it serious because they will know the results if they didn't take it seriously. That person can do some kind of-- maybe go to suicide and start shooting on the street. Here in America, once they hear depressed and frustrated, they take it seriously. But back home, when you're telling, "Oh, I'm frustrated, I'm so depressed, I'm that," they will look at you as if, what on earth is this person talking about? (31-year-old women from Nigeria).

Another woman comparing Africa versus America on the quality-of-care women received when they delivered their babies said: I guess back home, they'll have more helping hand. When the women give birth back home, you know how people come, start helping, washing baby clothes, let the mother rest and the mother would take a nap" (38-year-old women from Nigeria). Women who have more than one pregnancy also compared their first and second pregnancies: "of course, with my first pregnancy, I don't know what I was doing, but I was always getting tired" (34-year-old women from Nigeria). Another woman shared, "well, during the pregnancy, my second and third pregnancy, I was okay, but for the first one…I was new, even when I go to the doctor, everything he's saying, I just say, yes, yes, if I understand or not" (38-year-old woman from Ivory Coast).

Interpretation of information. This category describes the women's interpretations of the information they received during their perinatal care. The different subthemes that emerged from this overarching theme include conflicting information, hidden information, problem with terms interpretation, professional education, and too much information to grasp. The subtheme that draws many codes is 'professional education.' This subtheme defines or describes the information that women receive during the perinatal education from their professionals or providers about mood and anxiety symptoms and help-seeking needs. Women acknowledge that they receive education from providers during their perinatal periods: "In the class, they taught you how to in the night if your baby is moving, kicking, how you are going to sleep, the position you are going to sleep" (31-year-old women from Nigeria); "Yes I do. I receive the training on what postpartum depression means" (38-year-old women from Nigeria). However, some women shared that the pieces of information received were too much for them to grasp:

too many information so you become really…you tend to panic for every bit because now there are so many things, you don't know what to do, and people are trying also to tell you, "You should be doing this, you shouldn't be doing this." At one point you are like, "Which is which? Which one am I supposed to do and not to do?" (31-year-old women from Nigeria).

For some women, the professional education and the information they got from the cultural/traditional personnel regarding how they should care for themselves and their babies after delivery conflicted and overwhelmed them. In sharing her experience on the conflicting information, a woman gave this example,

> "She [referring to her mom] is like "The baby is thirsty. Give him water. That will help him." Here they tell me, "No don't give," so I'm debating within myself, "What should I do? Should I trust my mom or should I trust the doctor?" The doctor went to school for that and my mom, she has experience" (38-year-old woman from Ivory Coast).

In discussing her learning experience during perinatal periods, one woman interpreted that some women from her culture withheld information about their pregnancy and childbirth for fear of not being perceived as a 'bad mother.' A 38-year-old woman from Ivory Coast shared a conversation between herself and her sister that capture this learning:

One day I was talking to one of my siblings back home, and she was saying, "oh yes, I felt the same way." I'm like, "you did?" She's like, "yes." I'm like, "No, I've never seen it." When she has a baby, I was home with her. I'm like, "you had everybody, you were sleeping. We were cooking for you." She said, "No, it doesn't matter." She was feeling it and I was shocked… I was thinking because I was away from home, I had no help and I

was stressing with my situation, that's when she said, "It doesn't matter." I was like, "Why you didn't say anything about it?" She's like because nobody talks about it, she didn't want to feel ashamed. She didn't want people to know that maybe she's not a good mother.

Interpretation of experience. This overarching theme describes how women interpreted their experiences during perinatal periods. Several codes emerged from this theme, and these include breastfeeding issue, experience with different pregnancies, learning on the job, punishment, scariness, single mother versus married mother, indescribable, experienced and worsening symptoms. Women described their experiences with pregnancy, childbirth, and baby care as including painful breastfeeding, scariness, and worsening mood and anxiety symptoms. Of these experiences, breastfeeding draws much coding from most of the women's interviews. The women discussed their experiences with the breastfeeding challenges, especially with their first baby. Some describe the challenges they encountered during breastfeeding experience as, "so sore and so painful (31-year-old women from Nigeria); "I felt overwhelmed especially with breastfeeding" (38-year-old woman from Ivory Coast); "my milk did not come. …I was sad… don't know what I'm doing… until I had to call my lactation specialist" (37-year-old women from Nigeria); "It was scary. It was very, very, very scary" (38-year-old woman from Ivory Coast). Women learned that the challenges they encountered during their first pregnancy lessened with their second pregnancy: "some pregnancies are different, the way my baby do me is not the way the second one" (38-year-old women from Nigeria). Some women discussed that the new information they learned about the value of breastfeeding a baby was menaced by the difficulties they experienced trying to breastfeed their baby:

I wanted to go 100% breastfeeding. I did not want to add any type of formula, nothing to

my child nutrition, but after 10 days and two weeks, I was like, "I don't think I can do it."

I don't think I can do that 100% breastfeeding. It was painful. I was not producing enough

milk. It was stressful. I wasn't sure I was feeding the baby right, and I just burst into tears.

I decided, "You know what, maybe I have to make some changes when it comes to

feeding the kid"(32-year-old woman from Ivory Coast).

For some women, the information they learned from the professionals about the value of

breastfeeding their baby encouraged them to continue breastfeeding even amid the difficulties.

These statements highlight these women's expression of how the new information learned about

breastfeeding helps them overcome their breastfeeding challenges:

my milk did not come… until I had to call my lactation specialist…she said "no, no, no,

you just have to just keep trying, keep nursing…you have to supplement," things like

that. I continued to do what I was doing, and milk just started coming (37-year-old

women from Nigeria).

They started telling me about breast pump…their orientation, everything helps me a lot.

It's different in term of breastfeeding. They encourage you more to breastfeed…the help

worth it, though. It really worth it (38-year-old women from Nigeria).

Interpretation of interaction with providers. This theme is described as women's

interpretation of their encounters with the providers or professionals. The emergent subthemes

include country of opportunity and issues with providers. Women, from their learning, view the

United States as a country of opportunity when it comes to pregnancy and childbirth as there are

available resources and understanding providers to help women manage their issues related to

pregnancy and childbirth. A woman stated:

"believe you me, this is a country of opportunities. Even if you don't understand English, you can enroll in something that will help you. The internet is there, TV is there, a lot of technologies that are out there that can help you. I'm sure the phone can also do that. You can put in a code (34-year-old women from Nigeria).

Motherhood expectation. This overarching theme identifies the interpretations mothers hold about what it means to be a mother. Several codes developed from this theme. These include contradictory experiences, excitement, finding happiness and comfort, happiness and joy, and expecting to be pregnant. Although a woman believes that she expected motherhood to be very demanding, she shared that her first pregnancy was exciting throughout perinatal periods, when she shared, "my first child, it's all excited..., I didn't have any issue… it was really very smooth and nice (39-year-old women from Nigeria). Other women admitted that before pregnancy, they thought that motherhood will be an excitement and joy and will find happiness and comfort, but on the contrary, it turned out to be demanding and challenging. These women's narratives best capture these women's discussions on their expectations of motherhood: "before my pregnancy, I'm so happy, so excited to be a mother…when I took in, I was so happy. I'm so frustrated, so depressed (31-year-old women from Nigeria); "expectation of motherhood is too much…I think it is an easy job, but expectation of motherhood is indescribable, and that is one that leads to mental depression in so many people…for me an expectation for motherhood is a challenge" (38-year-old women from Nigeria).

Research Question 3 (RQ3)

The third and final research question asked, "what are the lived experiences of women in the African diaspora about help-seeking during perinatal and postnatal periods? This question focuses on understanding two areas related to this research topic. These include self-recognition

and interpretation of help-seeking and barriers to help-seeking and personal experience with barriers. Three concepts were integrated to answer this research question: help-seeking *behavior* (developed from literature review and interview data during preliminary analysis) and *knowledge* and *learning* (borrowed from constructivists). These concepts helped inform the theory that best explains women in the African diaspora lived experience of perinatal issues and help-seeking behaviors. *The help-seeking behavior* concept was described as women's desires and willingness to seek help during their perinatal periods and the barriers they encountered in the process of seeking help. *Knowledge* concept was defined as women's knowledge about mental health treatment and available resources. *Learning* category (some themes that emerged from this concept helped to answer this third research question) is described women's interoperations about their interactions with the healthcare providers/professionals, the new meaning they hold about motherhood, and expectations.

The results from the emerging themes and subthemes from data analysis indicated that participants recognized the need for help-seeking during the perinatal period and sought help medical advice from their doctors and nurses during perinatal periods but depend primarily on their family and friend support and to navigate for community resources. In this study, it was found that, though most of the women have knowledge of perinatal resources, they gained this knowledge from their friends and barely utilized them during postpartum periods. The following statements from the participants support these findings: "I moved out because I went to my parents so they could help with the baby" (22-year-old woman from Ivory Coast). Another woman admits that she sought help when she answers: "yes… if I have any issue, like I'm having muscle crump…my baby is not doing as I wanted it to be… I'm having a fever, or I'm having swollen...I can't eat, I will call my doctor (39-year-old women from Nigeria).

Additionally, the finding revealed that the participants have resources that help receive quality care during their perinatal periods; however, they experienced barriers that discouraged them from continuing help-seeking after they delivered their baby. One of the themes that gained many responses from participants' interviews was "struggle to define the best practice" for themselves and their babies. This statement best supports these findings:

> they don't incorporate your culture into the teaching so, at the end of the day when you come home, you're home with your culture. It makes you vulnerable because now you are debating between two cultures and sometime even within yourself or with your husband or partner. They will tell you, for instance, "Don't do this to the baby," and you'll say, my mom used to do it and it was fine and the baby had no problem," and here, it's wrong and so on (38-year-old women from Nigeria).

The emerging themes and subthemes helped answered this research question were detailed and discussed below.

Presentation of Themes of Help-Seeking, Knowledge & Learning (RQ3)

Themes and subthemes were developed during coding analysis process to help answer research question 3.

Sought help. This overarching theme describes women's ability to seek help during their perinatal periods. The subthemes that emerged from the overarching theme, "sought for help," include women's ability to 'seek help' and 'reach out for help,' and have no problem seeking help (ability to utilize available help from the support system). Women acknowledge the importance of help-seeking during perinatal periods and suggest women's need to seek help at these periods. A woman described her ability to seek help during her perinatal periods this way. In describing the need for help-seeking, 31-year-old women from Nigeria suggested that women should:

Also talk to your doctor, your health care provider. That one is a very good help. Talk to your nurse. A nurse is not only giving you injection, your medication, or all that. Nurses can also share their own experience if you have a good relationship with your nurses, who will tell you how to about.

Knowledge about resources. This overarching theme emerged from the construct of "Knowledge" with subthemes that developed from it. This theme is described as women's knowledge about available resources and accessibility and how the American system operates in terms of resource accessibility. The subthemes include knowledge about resources, knowledge about the system, and are discussed as women's knowledge about the location of the resources, how to navigate themes (e.g., transportation access, how to drive to the locations for those who have the means of driving, etc.). While many women shared knowing about resources availability, some shared that they lacked knowledge of how and where to access maternal resources, especially during their first pregnancy: "I think in my own case, maybe the lack of information, resources, and also culture…I even didn't know that they have translators till I went to nursing schools myself... I remember this doctor never offered me any translator" (22-year-old woman from Ivory Coast).

Barriers to Help-Seeking. This overarching theme explores some of the factors that can negatively impact women's ability to seek help during perinatal periods. These factors include being ashamed, cultural barriers, stigmatization, fear of the unknown, financial, insurance, lack of trust, language issues, no helping hand at home, and stereotypes. Among these subthemes, no helping hand at home, language issues, fear of the unknown, lack of trust, experience with stigmatization, financial, and insurance and culture barriers gained many codes. See Appendix for the codebooks depicting the description of these themes and subthemes. The women

maintained that not having a 'helping hand' at home, especially when the baby's father is not involved, and other relatives (mom or sister) are not present at home to assist women with baby care. A woman states, "there's nothing as good as a woman being pregnant with your husband around you…I really got a lot of help from him" (40-year-old women from Nigeria).

The women identified financial constraints and insurance as one of the major factors that discourage seeking help. Some women in explaining financial and insurance as factors said: "yes, I think it's the financial part of it, the burden of not having the paper, the burden of not be able to work, the burden of learning everything all together" (38-year-old woman from Ivory Coast); "I know that challenge is the issue of insurance, too, because if you're going to do if you do that, you have to pay extra money for that" (40-year-old women from Nigeria); and "I know that challenge also is the issue of insurance, too, because if you're going to do that, you have to pay extra money for that... I'm not going to get it... because that will make me pay more bills" (37-year-old women from Nigeria). A woman in defining financial constraint said, "another factor is if you don't have, like some people don't have insurance when they first come to the United States because they don't have the job or maybe the job they are doing, don't give them insurance and maybe their spouses don't have insurance" (40-year-old women from Nigeria).

Language issue also draws several codes as one of the significant barriers to help-seeking during perinatal periods. Although language issue is highlighted to limit some women in the African diaspora from seeking help, most women denied it as an issue: "I think, yes, language barrier can still cause them not to share what they wanted" (39-year-old women from Nigeria). They stressed that accents could prevent effective communication between women and their providers, even with women speaking English: A 37-year-old women from Nigeria stated, "here in America, depends on the kind of doctor she has, maybe there are some doctors who can be so

harsh because of your accent." A woman advised that language should not be an issue because providers provide language services to individuals who do not speak English in the hospital:

> Language shouldn't be a barrier to accessing what the government has put in place for everybody. The only thing I would advise people is, even if you don't understand English, even if you don't speak English, there has to be someone that either speaks or understands English. If you're going to the government to access a service, for instance, you have to go with somebody who understands what they are saying. There has to be an interpreter, somebody who will understand or listen to them, get what they're saying, and then be able to communicate to you. It shouldn't be a problem (34-year-old women from Nigeria).

Fear of the unknown and lack of trust also gained many women's responses as barriers to help-seeking. For "fear of the unknown," women discussed how fear limited them from seeking and accepting help from both family members and professionals.

> You don't even trust even your husband or your mom to take care of your baby because you think that when someone else does it, that person might not take care of that baby and something might happen to that baby (32-year-old woman from Ivory Coast).

Women describe lack of trust as the inability to trust family members assisting them with caring for the baby and also providers: "you haven't built the trust with people, so you don't feel comfortable to open up" (38-year-old woman from Ivory Coast). Some women talked about a situation where they found it difficult to trust:

> even when I was going to the doctor for my visit, I was literally scared to leave my kids with my mom… you keep asking yourself, "Oh, does she then change his diaper?...You know that she will do it, but you keep asking yourself, is she going to do it… do it right?

I know my baby don't like this. Is she going to know that he don't like this? (22-year-old woman from Ivory Coast)

So, I don't want to open up, even when I'm going through a lot, even when he asked me, "Oh, do you need any kind of help?" "No, sir. I'm fine." "Are you okay?" Yes, I'm very okay." "Do you have a car seat?" While at that time, I didn't even have a car seat, I told him yes, because I'm thinking, "Okay, if I tell him I don't have a car seat, they might say that I won't be able to care for my baby." These are stupid things that come into our minds that don't make sense. When you think about it, it really doesn't make sense (38-year-old woman from Ivory Coast).

Personal interpretation of barrier to help-seeking. This overarching theme is described as the women's understanding of barriers to help-seeking and examining their views about different factors that limit women in the diaspora from seeking help. Many codes or subthemes were developed from this overarching theme. These include issues with acculturation, an experienced helper, personal reality consciousness, do not need help, husband is not always present at home, negative experience, open up, reaching out to mom, restriction of information, and satisfaction, shying way from accepting help, socialization, turning help offer off, uncomfortable seeking help. See the codebook in the Appendix for the definition or description of each code. Women shared about their difficulty in opening up for help when they delivered their baby:

Even when we go and then they ask us like the postpartum depression, we lie in the answers. "Did your mood change?" I will put no, but while I'm putting the no, I know that within myself, I'm like, "I won't let these white people think-- or write in my paper that I'm depressed (38-year-old woman from Ivory Coast).

Among other themes, many women interpreted "open up for help" as the adaptive power to the adversity of perinatal mood and anxiety disorders and believe that these factors increase women's knowledge about symptoms and resources and enlarge the possibilities of people reaching out to offer help to women. "Open up" is described as the ability to accept the reality of the perinatal issue/symptoms, and also being able to be open to receiving help— feeling free to communicate ones' needs or symptoms without fear or feeling ashamed. To adapt successfully during the perinatal period, women believe that women's ability to open up will increase their adaptive power. This statement captures well these women's beliefs:

I think for adapt; they have to be able to open themselves up. It's two different cultures. I would say, African culture is more like, I would say, vocal. It's more like oral. You don't really open up as Africans, everybody is just on their own little place (38-year-old woman from Ivory Coast).

Women discussed the need for a woman to 'open up' in communicating their needs or problems during perinatal periods as this widening their networks for resources and help. They believe that women received quality care for themselves and not only from families but from friends and professionals/providers as well when they suggested:

I think it's important to always seek help. Don't always try to figure it out yourself because by talking, you might realize that other people have been through the same situation…but you can never know until you open up and you talk about it. Don't assume that people are seeing you, so they might think that "Oh, that's what she's going through. Let's help her" (38-year-old woman from Ivory Coast).

Speak up. Ask people that's been through that. Ask people that have a baby, how did they take care of their own problems when they're pregnant, after pregnancy. Speak up, ask questions (31-year-old women from Nigeria).

Intervention. This overarching theme examines some of the women's suggestions and how help-seeking can be enhanced among women in the African diaspora. Women discussed their views about measures that can improve women's ability to seek help during the perinatal periods. During this discussion, the following codes or themes emerged: available translation services, culturally appropriate programs, education, faith, longing for home-like assistance, and spiritual intervention. To them, faith becomes of paramount importance as many women shared how their faith in God encouraged them to effectively manage the adversities of perinatal mood and anxiety issues during and after pregnancy and help them recognize the need for help-seeking, especially trusting the 'higher power.'

I was praying Virgin Mary to come and help me because she also had a baby. Maybe she experienced it or not, but what I know, she's a mother, so she understands me better. I think it was mostly my faith that made me be resilient and believing that the future is bright" (34-year-old woman from Ivory Coast).

…my feelings about motherhood is that you cannot survive motherhood if, you can survive it, but it's very tough to survive without support. You need support from your family, friends, your husband, from God, in fact from anybody around you" (38-year-old women from Nigeria).

Professional interaction. This overarching theme describes the impact of women's interaction with professionals or healthcare providers during help-seeking behaviors of women in the African diaspora. Several subthemes or codes developed from this overarching theme. These

include intercultural competency, professionals' frustrations, professional care, receiving care from similar cultural locations, and satisfaction with professional care. See the Appendix for the descriptions of each of these subthemes. The women discussed their interaction experiences with providers about the care they received during their perinatal periods. Although two women shared their frustrations during the help-seeking process, most women shared that their interpersonal relationship with providers was good—they received quality care and good attention from their providers, especially when they were in the hospital. When asked to share their experience with their providers during the helping process, one of the women states, "100% sure they treat me good. They treat me very well, even before I took in when I was taking my treatments in the hospital" (31-year-old women from Nigeria). I got good care from the doctors and the nurses, and that's good" (40-year-old women from Nigeria). However, one woman interpreted the providers' ability to interact well with women as fear not to lose a job: "Like I said, they do not want to lose their job. I delivered in a big hospital where it's very difficult for people to get a job... everybody was up and doing, making sure you get the right" (34-year-old women from Nigeria). Other women believe that interacting well with a provider depends on the provider's personality and the situation at hand:

> At one point, one of the nurses tagged me a difficult patient [laughs] because I was
> asking questions and talking back…that one came and said, "oh, I already heard your
> story. Why are you difficult? You're not difficult." She was checking me. Again, she's
> immigrant, so it depends on who we're dealing with at a particular time" (40-year-old
> women from Nigeria).
> …that was that one time, the nurse frustration. She was really frustrated that everything
> was not going as planned, according to her, maybe, but to me, I could not help. I was just

in pain and that's for me after, because at the moment you don't think of all that. After I had some thinking I was like, no, that was not normal. She was not supposed to be talking to me this way, she was not supposed to be getting frustrated at me because I had done nothing" (32-year-old woman from Ivory Coast).

Receiving care from professionals who are from women's cultural locations attracted discussions. Many subthemes were coded from most of the women interviews. Women discussed the importance of having a professional/provider from women's similar cultural locations during perinatal periods. They believe that having such professional care improves communication and reduces the language barriers to help-seeking that may arise among women experiencing language issues. A woman says, "those women will probably be comfortable with somebody that let's say come from their country" (22-year-old woman from Ivory Coast). In discussing the importance of reaching out to women at their various homes, especially during the postpartum period, a woman shared that having a professional who has similar cultural knowledge will improve and encourage women's help-seeking behaviors. This statement explains such this the belief:

> I say that is very important. After you have the baby, all follow ups, it's very important…. If somebody is coming to your home that's a greater advantage for you…in that you can be able to express yourself and you can get the help you need as soon as possible" (39-year-old women from Ghana).

Another woman shared a different view by disclosing that while it would be more beneficial to have a provider follow up with her, it does not matter whether the provider has shared similar cultural values with her:

…well, it's not bad. It depends on individual. Some would prefer, oh, I will like a doctor

that is from my country to attend to me because he or she understand me. In my own

case, whether African, whether America, as far as we are on the same page, that's it. You

can go from there" (32-year-old woman from Ivory Coast).

Satisfaction with care received from the professionals is also one of the emerging

subthemes from the overarching theme, 'professional interaction. This subtheme examines how

satisfied women are with the care they received from their providers or professionals during

perinatal help-seeking processes. Women expressed that they were satisfied with the help or care

they received from their providers:

For me, I think I got pretty decent hospital, pretty decent care. I think the quality of the

care, that was very good. I think how people are treated back home; I think here we're

doing really good. We get a lot of help (32-year-old woman from Ivory Coast).

However, some who share difficulties they encounter during their help-seeking believe

that service could have been better, had it been they understood the system well at their first

pregnancy. A 32-year-old woman from Ivory Coast believes, "think it's just knowledge about

the country, the culture. I understand it better. I know it better. I know that they are not there just

to judge me or just to report me, but all they want to do is to help me."

Chapter 4 Conclusion

This chapter contains result of the data analysis, shows how concepts, categories, themes,

and subthemes were generated from the data that was collected from 13 women who took part in

this research study, and demonstrate consistency of data analysis with phenomenological and

grounded theory methodology. Consistent with the grounded theory method of analysis,

categories, themes and subthemes were generated through an application of open, selective, and

axial coding and thematic/content analysis, with the major categories/concepts to include

adversity, help-seeking behavior, knowledge, learning, reality, vulnerability/adaptability. These

categories and themes connected analysis back to resiliency and constructive theories and

research questions. The generated codes indicated that women responded to this research on

mood and anxiety disorders and had shared their lived experiences and interpretations about their

knowledge and help-seeking during the perinatal periods. These generative concepts, categories,

overarching themes and along with subthemes that emerged from data were discussed and

supported with the women's quotes from the recorded and transcribed interviews. It can be

observed that there was a predominance of citations from the women. These indicated how some

of the women were more open to narrate their lived experience meaningfully.

     As noted above, several subthemes emerged from the data. However, this researcher was

unable to tease out or delineate these subthemes from each because it was difficult to do so as

each woman's lived experience or life course was unique and diverse. For instance, it can be

noticed that on the subtheme, "husband not being present or supportive" (under the overarching

theme "personal interpretation of help-seeking) gained one (1) code. This indicated that while

other women shared that their spouse was their great source of help when their mother was not

present to help with baby care, the experience was different for this woman. During coding

process, this researcher observed that there were trends of similarity in the women's responses,

expressions, and interpretations across all the women which cannot be described without the

women's unique cultural context, life circumstances, or different life course experience.

     Chapter 5 will highlight and discuss the findings of this research study and how they

connect to previous literature and theories. It will also discuss some of the implications of this

study and will provide some recommendations that can be put in place to improve women's

knowledge about perinatal mental health issues and encourage their desire to seek help so as to function effectively during their perinatal periods. Chapter 5 will also provide a conclusion detailing the whole summary on each of this dissertation chapter.

Chapter 5: Discussion of Findings and Implications

This chapter covers this dissertation study's discussion of results/findings, implications, recommendations, and conclusion. This study explored the perinatal mood and anxiety disorders among women in the African diaspora, thus focusing on understanding these diaspora women's knowledge and lived experience on help-seeking during the perinatal periods. Three research questions this researcher developed helped to achieve the purpose of this study, which are the women's knowledge about mental health struggles and help-seeking during and after pregnancy; their cultural belief about mental illness and perinatal mood and anxiety disorders; and their personal experience with seeking and receiving help during pregnancy and after childbirth in the United States of America. In general, this chapter summarizes the findings of this study and the contributions this researcher made to help improve the lives of women in the African diaspora and their babies.

The first section of this chapter highlights this study's findings and discusses how these findings connect to previous literature. The second section discusses the two theories (resiliency and constructive) utilized in this study and how they relate to the results of this study. The theories' constructs help provide a better conceptualization around women in the African diaspora's knowledge and help-seeking behaviors regarding mood and anxiety issues during perinatal periods. The final section of this chapter deepens the implications of these research findings and provides recommendations on the constructive strategies that can be put in place to help improve maternal and child mental health measures among women in the African diaspora living in the United States. This section also offers a new theory that this researcher thinks best explains help-seeking among women in the African diaspora during perinatal periods.

Discussion of the Research Findings and Previous Study

Conceptualizing women in the African diaspora's lived experiences on knowledge and help-seeking behaviors about perinatal mood and anxiety disorders, this researcher developed three research questions covering these specific areas:

- Knowledge about perinatal symptoms,

- cultural belief on perinatal issue and care

- self-interpretation about vulnerability and adaptation,

- self-recognition and interpretation of help-seeking,

- personal experience with help-seeking and barriers encountered during the help-seeking process.

The findings of each of these research questions and centralized areas are detailed and discussed below with the previous literature. The diagram below depicts this dissertation research topic, research questions and centralized areas.

Diagram 9

Diagram depicting research questions and topic areas.
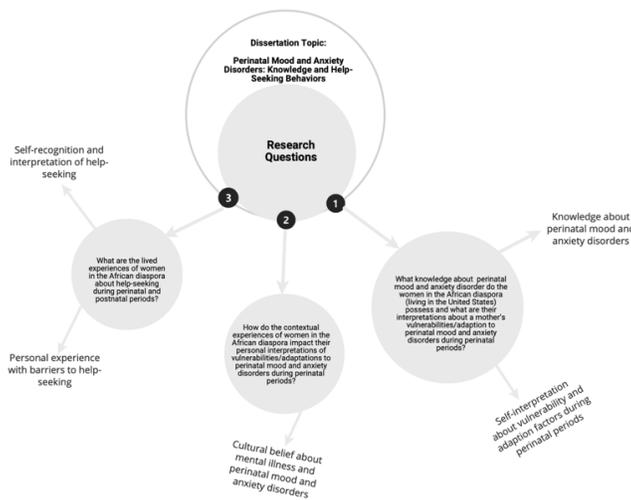
Research Question 1

This study answered the first research question, which intends to understand "what knowledge about perinatal mood and anxiety disorders do the women in the African diaspora possess, and what are their interpretations about a mother's vulnerabilities/adaptation to perinatal mood and anxiety disorders during the perinatal period? This research question explored women in the African diaspora's *knowledge* and *self-interpretation* of mood and anxiety symptoms, vulnerability, and adaptation factors to perinatal mood and anxiety disorders.

Knowledge and interpretation of Symptoms of Mood and Anxiety disorders. From the results of this study, it is clear that women in the African diaspora have at least a fundamental knowledge of mental health issues or challenges that ensue during pregnancy. The women's descriptions of their own lived experiences and other women's experiences during perinatal periods significantly show that they have knowledge about the perinatal symptoms. A good example of this description would be women who shared that some women during perinatal periods, especially at their postpartum period, encounter some adversities (challenges) or symptoms such as a feeling of blame, craziness, crying, depression, feelings of dying, fear, frustration, guilt, helplessness, isolation, lack of desire to do stuff, miserable, moody, nervous, not able to care for the baby, overwhelmed, sadness, scared, sleep deprivation, stress, tiredness, worry and uneasy. These descriptions confirmed the symptoms of mood and anxiety disorders during and after pregnancy as described by Postpartum Support International (PSI, 2019). Previous studies also support that some immigrant women experience the above-started symptoms during the perinatal periods, particularly during the postpartum period (Beniot et al., 2007; Garner et al., 2014; 2010; Guy et al., 2014; Nnaka, 2018).

Another promising finding of this study concerning this research question was that, although women used these phrases that denote mood and anxiety symptoms to describe their lived experiences of motherhood, they did not define or interpret them as mental health disorders or issues. Many of the women, on the contrary, delineated and construed women experiencing mood and anxiety issues during perinatal periods as needing help from people, especially the family members. One of these women's statements, "cry for help" (31-year-old woman from Ivory Nigeria), can be used to qualify or capture the general meaning of the other women's responses. This finding confirmed what previous literature stipulated on the concept definition and meaning interpretation. For instance, literature underlined that woman in the African diaspora's description of the reality of perinatal mood and anxiety symptoms are tightened around their cultural definition and personal interpretation of mental health issues (Brau, 2020; Ertmer & Newby, 1993; Fisher & Mawr, 2015; Kim, 2001). Constructivists address human development's social and cultural aspects and see both individual and community meaning interpretation as collaborative (Franklin, 1995). In other words, the individual's interpretation of a problem is shaped by how the society to which the individual belongs defines that problem. Thus, their appraisals are subject to society's definition of this phenomenon, and the knowledge they live by as is constructed around the phenomenon in question (Exploratorium, 2019). Constructivists view learning as something that intimately associates with people's connection with other human beings. Alternatively, women who took part in this study interpreted perinatal issues as an everyday experience that comes with "being pregnant," which signifies a woman's '*cry for help'* during perinatal periods, particularly during the postpartum period.

On this research question, this study's result revealed that women currently have basic knowledge about perinatal mood and anxiety disorder as most women denied having prior

knowledge of the symptoms before migrating to the United States and before their first pregnancy. This lack of prior knowledge about perinatal issues led to the speculation that they were ignorant about the mood and anxiety symptoms they experienced during their first pregnancy. For instance, women who have second pregnancies shared that they were unaware of what was going on with them during their first pregnancy. They admitted that their second pregnancy experience was positively different as compared to their first one. Like one of the women accentuated, "if I had to go back again, I will do things differently" (38-year-old woman from Ivory Coast). Previous studies backed this finding as their findings unveil that the women having prior knowledge of perinatal mood and anxiety issues will not only help them to understand the symptoms to expect but also encourages them to seek help during perinatal periods (Guy, 2014; Nnaka, 2018; Row & Harman, 2014).

Knowledge and Interpretation about Vulnerability and Adaptation. Another finding of this study associated with this research question was that, though women have knowledge about risk and protective factors regarding mood and anxiety disorders during the perinatal mood, they also have different views about specific factors that increase the women's adaptive power. **Vulnerability.** Women in sharing their lived experience on vulnerability factors highlighted the following factors that increase women's vulnerability to perinatal mood and anxiety disorders: biological change, drug use, heredity, history of perinatal or mental health issues, and lack of support. These stated themes were reported as factors associated with perinatal mood and anxiety issues in the studies conducted by Beniot et al. (2007) and Gardner et al. (2014), who sampled women in the African diasporas. From these above-outlined themes, lack of support had gained several codes or responses from all the women who participated in this study. In this study, women interpreted that not having any consistent caregivers

(particularly their mother or sister) to assist them with baby care exacerbates the feeling of being overwhelmed, resulting in increased stress levels, preventing them from functioning adequately, and alongside, women can encounter mood or anxiety issues.

In contrast with other previous studies that sampled women in the African diaspora regarding perinatal mood and anxiety symptoms, this study's findings pointed to drug use as one of the factors that increase women's vulnerability to perinatal mental health issues (Beniot et al., 2007; Gardner et al., 2014). In the previous studies, drug use did not emerge as a vulnerability factor to perinatal mood and anxiety among women in the African diaspora (Beniot et al., 2007; Gardner et al., 2014). Suggesting that, though drug issues may contribute or increase women's vulnerability to mood and anxiety disorders, it may not be the significant vulnerability factor when interpreting the problem from the African cultural contextual perspective. As seen in the women's narratives (interviews) for this current study, only one woman highlighted drug use as a risk factor to mood and anxiety among women in the African diaspora when this woman was making a general statement on the contributing factor to mood and anxiety disorders.

Adaptation. Aligning with the previous studies, this study found that certain factors such as social support and proactive process (individual characteristics or traits) reduce women's vulnerability to mood and anxiety issues increase their adaptative power (Ganann et al., 2016; O'Mahony & Donnelly, 2010). Lack of support as a theme has an association between vulnerability and adaptation. To clarify, while it was found in this study that women highlighted lack of support (family member, in particular) as a factor that increases the vulnerability of women in the African diaspora to perinatal mood or anxiety, they also interpreted it as a mitigating factor that enhances women's adaptative power to manage the symptoms.

Some researchers argue that some mothers may have a sound support system, but they may not be satisfied with the care they received from their support persons (DeLauca & Lobel, 2014). This research finding, to some extent, is in disagreement with DeLauca and Lobel's (2014) finding as only one of the women accented, "you know men do not do much, but having your mother is a big relief" (34-year-old woman from Nigeria). This statement may sound that these women were dissatisfied with the support received from their spouse; it might be a way of emphasizing how vital it is for them to have their mother or sister assist them during the perinatal period, particularly postpartum period. On the other hand, viewing this statement from the African cultural perspective on gender roles may imply not that the women are not satisfied with the care they received from their spouse, but having their mother perform the role may make a big difference as they share similarities in their lived experience in childbearing and care. Also, their mother will center primarily on assisting with the baby care and other home chores, which traditionally men were not socialized to perform such a role, but to work and bring food home, especially during the perinatal period. Therefore, this study did not find enough evidence to conclude that women are not satisfied with the care they received from their support persons as most women in this study shared how helpful and grateful they were with the care and support they receive during perinatal periods. For example, one of the women applauded, "thankfully, my husband, my support, he works close by" (32-year-old woman from Ivory Coast). Another woman also stated, "…I went into a situation whereby I never had such experience, but with the support of my husband, trying to wake up at night to feed the baby…that was it was a big support from my husband" (38-year-old woman from Ivory Coast).

Another promising finding regarding factors that increase the adaptive power of women in the African diaspora during the perinatal period, which tied nicely with the previous study's

findings, is the protective process (Hooper, 2009, Luthar, Cicchetti & Becker, 2000). This study found that women in the African diaspora who possess certain psychological traits are more likely to adapt effectively and experience less perinatal mood and anxiety symptoms than their counterparts. Luthar, Cicchetti and Becker (2000), in their study, found that individuals who possess problem-solving ability, social competency, and have positive beliefs about their problems adapt effectively to the adversity of motherhood. Likewise, this study found that women's problem-solving ability (ability to multitask, accept their life course and trust their capabilities help themselves) function effectively in the adversity of motherhood.

Women in this study defined and described this protective process as the ability to face responsibilities, accept the fact of being pregnant, balance life, trust in their capability, multitask, and others. For example, when the women were asked to describe what adaptation means to them, some of the women stated: "you should be ready to face the challenge, ready to wake up and be ready to respond to any family or child responsibilities that come at any time" (31-year-old woman from Nigeria); "you have to learn to trust yourself maybe there a bit and know that you can do it "(WAD05); "I had to accept the fact that I was pregnant, accept the fact that my life was going to change with school, the work, and the baby" (WAD12); "just like you said, adaptation, when you look behind or when you are convinced that you have no helping hands, you have to get up and do things for yourself" (WAD11); "it was a self-motivation, I would say because it didn't come from anybody. I started to talk myself into things, and then I started to get better and started to live my life again" (WAD02).

Research Question 2

The second research question that this study answered is: "how do the contextual experiences of women in the African diaspora impact their personal interpretations of

vulnerabilities/adaptations to perinatal mood and anxiety disorders during perinatal periods? The themes that emerged from the "*reality"* construct/concept after conducting thematic and qualitative content analysis best helped answer this research question. These themes include personal interpretation of mental health issues, cultural belief system on the causes of mental health illness, and cultural interpretation of perinatal mental health issues. Among the subthemes on the cultural belief system, the codes such as taboo, enemies, and witchcraft gained many responses from the interviews. See Appendix for the table describing concepts, categories, themes, and subthemes.

As related to this research question, the finding of this study reveals that interpretation of vulnerability and adaptation to perinatal mental health issues is associated with the cultural belief system. In other words, the beliefs women hold about perinatal issues through cultural socialization impact their worldview and their openness to help-seeking for perinatal care. This finding can be seen through the lens of social constructivism stipulation, which explains that how individuals create and interpret meaning is influenced by their societal norms and traditions (Brau, 2020; Ertmer & Newby, 1993; Fleck-Henderson, 1994). In sharing what most people from their cultural location believe about causes and treatment of mood and anxiety disorders, many of these women reported that it is common for their people to believe that any mental health issues are a taboo and a curse inflicted by witchcraft and enemies or evil and leads to ill-treatment and neglect of persons with mental health needs. While published data supported this finding (Callister, Beckstrand & Corbett, 2011; Garner et al., 2014; Mukherjee et al., 2018; Park et al., 2017), other studies contend that level of knowledge about perinatal issues, which can be gained through education and interaction within one's social environment improves literacy and

offers women the capacity to think differently and make a favorable decision about their health (Guy et al., 2014; Ratzan & Parker 2000).

A consensus was found when comparing this finding with published data (Bodnar-Deren, 2017; Prevatt & Desmarais, 2018). Although some of the women's current views on the causes of mental health appeared to have shifted from what they used to believe when they were in their country, some still hold that there is some truth that having a mental health issue is a curse. For example, a woman who reported a history of postpartum depression commented that, though she had perinatal symptoms, it does not mean "I mentally depressed" (38-year-old woman from Nigeria), but rather interpreted the symptoms experienced as being "inexperienced" and overwhelmed with the baby care. This woman stated, "So, in my own understanding I cannot define postpartum mental health as being mentally depression" (40-year-old woman from Nigeria). This statement may imply that she is, to some extent, still holding a similar belief system with her cultural location. The narrative rom another woman (from a different African cultural location) also supported this mentality when they commented, "in our culture, I don't know about here, but I know from where I come from, I would say that people look out for that in a woman, especially when that person has no helping hand. It is not seen as a mental depression" (34-year-old woman from Ivory Coast).

Some women admitted that coming to America has changed their perception of mental health issues, especially help-seeking. For instance, one of the women said if she has a chance to go back to previous experience, she "will do things differently" (38-year-old woman from Ivory Coast) because she was new in the United States and encountered "fear of unknown" where she faced inner struggle on whether to open up or lie about symptoms. She added that she acted that way for fear of not being ridiculed by co-women or judged by people because "back home it is a

taboo to said you have that type is a problem "(34-year-old woman from Ivory Coast), some women said, "some people, not all, kind of 65% back home will see it that you are not serious, you are weak, you are not a woman in life" (34-year-old woman from Ivory Coast).

Research Question 3

The final research question that this study explored is: "what are the lived experiences of women in the African diaspora about help-seeking during perinatal and postnatal periods? This research question aims to deepen understanding into women's lived experience of help-seeking during perinatal periods and covers areas such as self-recognition and interpretation of help-seeking, and personal experience with barriers to help-seeking. The purpose of exploring these question areas was to explore the women's interpretation of help-seeking and their personal experience during their help-seeking process and to understand any barriers they encountered during the help-seeking process and how they handled it. Six emergent overarching themes with subthemes helped answer this research question: barriers to help-seeking, cultural identity, intervention, personal interpretation of help-seeking, professional interaction, and sought help.

Self-recognition and interpretation of help-seeking. In exploring this research question area, this study found that notwithstanding factors such as cultural belief about mental illness, migration factor (acculturation issues), language issues, and other factors, women understood the importance of help-seeking during perinatal periods and sought help throughout those periods from their provider (OB/GYN and nurses), especially during the prenatal period. However, their interpretation of perinatal help-seeking in relation to accepting help (community resources) for perinatal care revolved around family and friends. This study found that women depended primarily on their family and friends for support to educate them about the available community resources, especially during their postpartum periods. However, some women are reluctant to

utilize these community resources because they believe they do not need them, and it will be a waste of resources to accept what they were not going to use. For instance, a woman stated, "they mentioned them all to me, but I, in my heart, I'm like, why waste that resource that can go to somebody else when I don't really need it?" (39-year-old woman from Ghana). This finding is in alignment with the results of the previous studies, which confirmed that during the perinatal period, immigrant women are more likely to depend on their social support system and prefer seeking help within their family system instead of getting help from professionals or providers (Bilzsta et al., 2010; Corrigan, Kwasky & Groh, 2015; Park et al., 2017; Templeton et al., 2003). A further novel finding of this study regarding women's interpretation of help-seeking, which the previous literature reviewed did not report, was demonstrated in two things. The first was their definition of perinatal mood and anxiety issues, and the second was their justification for rejecting help offered during perinatal periods. This study found that women do not define perinatal mood and anxiety issues as mental health or psychological issues, but they interpreted them as something with a biological and physical explanation. For the biological factor, women interpreted feelings they encountered during perinatal periods as normal as something that comes with motherhood (*just being pregnant*) and does not need any medical or psychological treatments such as medication or therapy. For example, this woman said,

> "I did not take any medication because I realize that my situation is not of mental
>
> problem but is because of the condition of this situation I find myself into and the doctor
>
> too said that it is normal for real moms not to be happy, sometimes they feel the
>
> depression because their lifestyle changes" (38-year-old woman from Nigeria).
>
> Also, the women who participated in this study described perinatal mood and anxiety

disorders as physical stress and feeling overwhelmed, and a woman's *"cry for help"* (need for an

experienced woman to help them manage the overwhelming responsibilities of baby care). With this interpretation, they shared that having a professional person assist with the baby care will help them get enough sleep, rest and improve physical and emotional well-being. While A previous study comparing Black and White perinatal women found that Black mothers were less likely to accept prescription medications and more likely to receive spiritual counseling (Bodnar-Deren et al., 2017), they did not provide any further explanation on why it is so.

In terms of interpretation of help-seeking, this study revealed an interesting finding on seeking professional help during the perinatal period. The result unveiled differences between this study's findings and the findings of the previous studies concerning women receiving care from professionals/providers who are not from the women's culture to visit them after being discharged from hospital. Other studies found that immigrant women will prefer to receive care from a professional/provider from their cultural location. On the contrary, this study found that while the women would like a culturally sensitive program to follow up with them after discharge from the hospital, they reported that they were satisfied with the services they received throughout their perinatal visits. They do not have any issues receiving care from professionals/providers who are not from their culture. This finding to some extent, disagrees with the result of the previous studies that found that perinatal immigrant women prefer not to seek help during perinatal periods due to unavoidable circumstances such as lack of insurance, language, and immigration issues (Bilszta et al., 2010; Daw, Benjamin & Sommers, 2019; Ganann et al., 2016).

Personal experience with barriers to help-seeking. This study explored women's personal experiences with barriers to help-seeking to answer research question number three. Different themes and subthemes emerged from the women's narrative/interviews. One of these

themes that is vital to highlight here is insurance. Though most women admitted that lack of insurance or not having good insurance could limit a woman from seeking help, they affirmed that insurance was not an issue for them as they have good insurance, which gave them the power to access qualitative care throughout the perinatal periods. This finding to some extent refutes the evidence provided by several studies that supported the belief that advanced issues such as lack of insurance, low coverage, or high premiums, were found to be barriers to help-seeking among immigrant women (Benoit et al., 2007; Bilszta et al., 2010; Daw, Benjamin & Sommers, 2019; Ganann et al., 2016). The study's demographic data indicates that most of the women who took part in this study have at least an associate degree, held a good job, or their partner held a good job that can afford them good insurance. Reasonably, this might reflect why the women reported that insurance was not an issue during their perinatal periods. In addition to this, there is a tendency that the previous researchers surveyed lower-income women or families who cannot afford good insurance because of financial constraints. This statement may explain the inconsistency between the finding of this study and the results of the previous literature.

Different themes and subthemes also emerged from the women's narratives/interviews on barriers to help-seeking, which also helped in answering research question number three. One of these themes that is vital to highlight here is insurance. Most women, however, reported another finding of this study. It has to do with women's experience with barriers to help-seeking in terms of their experience during interaction with professionals/providers during the help-seeking process. The two major areas that the women identified were "mom-baby care" and nutrition prescription/recommendation. For the "mom-baby care," many women shared their struggle with understanding the best practices or appropriate ways of caring for themselves and their baby during perinatal periods as the information they received from their providers on how to do so

disagreed with those they received from their mother/mother figure. Women disclosed that the providers/professionals do not incorporate African cultural frames in their perinatal teaching or education, which left them overwhelmed and confused. For instance, one of the women divulged:

> they don't incorporate your culture into the teaching so, at the end of the day when you come home, you're home with your culture. It makes you vulnerable because now you are debating between two cultures and sometime even within yourself or with your husband or partner. They will tell you, for instance, "Don't do this to the baby," and you'll say, my mom used to do it and it was fine and the baby had no problem," and here, it's wrong and so on (34-year-old woman from Ivory Coast).

Nutrition prescription/recommendation was a theme that emerged from many women's narratives/interviews, of which this researcher did not access any previous researchers that mentioned it in their studies. This study's finding revealed that women encountered issues during their prenatal and postpartum classes in understanding the appropriate food or diets to eat to promote their women's wellness. Many of the women described the experience they encountered during perinatal class/education. They shared that the professionals/providers only provided them with a list of foods or diets that are westernized/Americanized but failed to incorporate, include, or discuss some of the African foods that are good in balancing hormones or promoting good women's health. Some commented that some of the food they were prescribed were foods they do not eat. This example can be seen in the following statement made by these women. A 34-year-old woman from Ivory Coast 's report captures these women's experiences with food and nutrition.

> They don't truly understand the culture. I'm not being biased, but to a certain extent, it's really hard for them to get the stuff. For my pregnancy, I was diagnosed with gestational diabetes. The list of food that they gave me that I should eat are food that I don't even eat. [laughs] When I would come and I asked her, "Okay, what about so, so, and so food?" She says, "Go and Google." I'm like, what are you doing here?"

WAD05 commented:

> …the different way of treating after pregnancy, cultures are very different. Getting somebody from your culture, they understand some of the thing you are doing and here, they don't because for them, they feel like it's not necessarily. You don't have to do all this. For example, I know a common one, that we have to start tying the belly to kind of help with getting back the stomach to what it was before. Here, they want you to wait a little bit before you start putting so much pressure, because you just carried a baby. That would be some of the differences. It would help, it would be nice to have somebody from home….

Another important finding of this study that is common with other studies is about factors that discourage help-seeking behaviors during perinatal periods. These include shame, cultural barriers, stigmatization, stereotype, fear of the unknown, financial constraint, insurance, lack of trust, and language issue (for women who are from Francophone countries) (Bilzsta et al., 2010; Gardner et al., 2013; Park et al., 2017; Prevatt & Desmarais, 2018). Most women shared how some of these factors impacted them individually and discouraged them from seeking help.

Theoretical perspective and finding Interpretation

Resiliency and constructive theories were employed to provide a better conceptualization of perinatal mood and anxiety disorders among women in the African diaspora. Resiliency

theorists explain that certain factors (social/environmental, psychological, biological, and spiritual) put women at risk of perinatal mood and anxiety disorders. As stipulated by these theorists, these outlined factors as well serve as mitigating factors or moderating variables. Individual characteristics (such as self-capability, self-esteem, self-efficacy, etc.) increase women's innate tendency to adapt successfully even amid adversity of perinatal mood and anxiety disorders (Garmezy & Rutter, 1983; Hunter, 2012; Luthar, Cicchetti & Becker, 2000; Werner & Smith, 1992).The findings of this study support this assumption as the women who took part in this study highlighted the above mentioned factors to increase women's vulnerability to the risk of perinatal mood and anxiety issues. The women also stressed that the social/environmental and economic factors and psychological characteristics help them bounce back during their perinatal periods.

Another promising finding of this study regarding the resiliency theory is on the protective process. For example, the results of this study revealed that while having a suitable social support system and being economically stable is vital in helping women manage adversity of motherhood, their internal locus of control which sustained them throughout their perinatal periods, was the core of their survival (Luthar, Cicchetti & Becker, 2000; Masten & Obradovic, 2006). The themes that capture this interpretation as women defined and described this protective process are the ability to face responsibilities; trust oneself; accept the fact about being pregnant or motherhood; multitask; balance life; and face life changes. This woman's reflection effectively captures this protective process: "I feel like when you're not ready to take on that responsibility, it just takes you to this depressed mode, straight" (34-year-old woman from Ivory Coast).

Constructivism perspective played a considerable role in helping to unpack the meaning behind the women in the African diaspora help-seeking behaviors during perinatal periods. The social constructivists from which this dissertation borrowed their ideology assumes that meaning and the knowledge that people hold about their problems is revolved around the circus of their cultural and societal meaning or definition construction (Brau, 2020; Ertmer & Newby, 1993; Fishe & Mawr, 2015; Kim, 2001). The highlight of this theory's key concepts includes knowledge, learning, and reality, and this forms the categories of this research theme. One of the aspects that this dissertation explored that is peculiar to these constructive theoretical assumptions is women's knowledge and interpretation of perinatal mood and anxiety symptoms, help-seeking, and resource availability. In this study, the results interestingly show that some women lack knowledge about the perinatal mood and anxiety disorder before their pregnancy but then engaging in learning during perinatal periods (experiencing the adversity of motherhood) while resident in a different cultural location in which they gained new knowledge and interpretation about perinatal mood and anxiety issues and help-seeking. These findings align with the assumptions of the social constructivists, which specified that human beings experience and develop new knowledge through interaction between their experience and ideas acquired from their social environments (Brau, 2020; Ertmer & Newby, 1993; Fishe & Mawr, 2015).

Additionally, this study explained why women lack basic knowledge and still hold cultural beliefs about mental illness was because their people do not freely talk about the issue related to mental health issues, particularly as it relates to perinatal mental health. However, experiencing motherhood in a different cultural location (United States), their interpretation of perinatal mood and anxiety issues and help-seeking slightly shifted. With this new knowledge gained, women saw the need to encourage and advise other women on the need for the women to

open up to care and resources so as to manage their perinatal symptoms or demands effectively.

For example, the women acknowledged that they do not openly talk about perinatal mood and

anxiety in their culture because of how mental health issues are being perceived. As a result,

women do not comfortably seek psychological help (counseling/therapy or/and medication)

when they encounter any mood and anxiety issues as they interpret it as a "cry for physical help"

(need for someone to help with perinatal responsibilities that are overwhelming). For instance,

constructivist stipulation on social interaction supported this result which theorized that human

beings create and acquire knowledge through their interactions with their social environment

(Brau, 2020; Kim, 2001).

Implications for Social Work and Recommendations for Best Practices

Generally, this study's findings and the findings of the previous studies show that the rate

at which women encounter mood and anxiety disorders during their perinatal periods, especially

postpartum, is enormous, and there is no sign indicating that number is abating (Luthar, Cicchetti

& Becker, 2000). Although the participants of this study did not explicitly use the word

"depression" or "anxiety" to describe their experience during their perinatal periods, there is

evidence that the terms they used denote either depression or anxiety. For example, the women

used weakness, tiredness, lack of sleep, lack of energy to do things, overwhelmed, etc., to

describe their experience. All these words defined mood and anxiety symptoms (PSI, 2019;

WHO, 2019). This study found that participants have basic or fundamental knowledge about

mood and anxiety disorders. However, their behaviors towards help-seeking and knowledge

about community resources need to be enhanced. This study recommends a structured and

effective strategic plan to help curb the issue as the inability to provide a suitable intervention

plan may affect not only the psychological, physical, and spiritual well-being of the women but

also that of their newborns, family, and the community at larger (2020 Mom, 2019; NPA, 2018, PSI, 2019; WHO, 2019).

The population (African diaspora) that this study explored is crucial as it was highlighted in the literature as the fastest-growing culturally diverse group in the United States. The National Association of Social Workers (2021) embraces the diversity and dynamics of cultural groups, particularly vulnerable populations such as African diaspora women. To promote cultural awareness and social diversity, NASW sanctioned its members to "continuously seek knowledge and improve skills and ability to meet the need of people of diverse cultures and background" (n.p.). This statement directs social workers to endeavor to develop and promote cultural and ethnic diversity activities and demonstrate skills in the service provision. This study indicates that, regarding perinatal mood and anxiety issues and help-seeking, professionals, especially social workers, are yet to delve into African cultural-sensitive interventions. As reported by some of the women who participated in this study, the perinatal education/teaching they received lacked African culturally sensitive information, such as diet and nutrition appropriate for the perinatal women in African culture. For example, the perinatal information/resource package they received did not include options for any African foods or diets for perinatal mothers.

Additionally, with the growth rate of this diverse African population, this study recommends the need for social work professionals to develop, implement, monitor, and evaluate plans that are culturally specific in addressing women in African diasporas wellness or perinatal issues. Social worker core competency such as "engaging in practice-informed research and research-informed practice" (NASW, 2018) highlights the importance of social workers engaging and promoting activities for a diverse population. Social workers' cultivating these behaviors of identifying, evaluating, and selecting African cultural practice strategies will

encourage them to participate in research related to African maternal-child issues. Also, research-informed practice in this area will allow social workers to gain scientific knowledge that enables them to answer some critical and theoretical questions about African diaspora issues and provide best practices or evidence-based practice in African maternal and child areas.

Screening is of paramount importance in the assessment of perinatal mood and anxiety. It helps in the early detection of symptoms and identifying women's perinatal readiness in terms of resources. The results of this study revealed a "*lack of trust;*" and inability to open up during the screening and assessment process as an issue. Social workers from a range of cultural groups can provide adequate services to a woman in the African diaspora not only when a clear understanding of how their cultural belief system influences their interpretation of help-seeking behavior during perinatal periods. Therefore, advancing research exploring women in the African diaspora interpretation of help-seeking regarding perinatal mood and anxiety disorders is paramount to help create awareness, culturally sensitive screening, and policy advocacy. Also, research in this area will help social workers develop cultural knowledge of screening women in the African diaspora to help them be culturally skilled and suitable for assessing and screening them for perinatal mood and anxiety disorder appropriately.

Additionally, this study recommends a culturally sensitive screening tool and program. Understanding clinical intervention strategies about assessing women in the African diaspora cultural groups will encourage appropriate screening for perinatal symptoms for early detection. Therefore, this recommendation calls for more social workers at the micro, mezzo, and macro levels to engage in intervention research and program evaluation that can benefit women affected by maternal mental health issues. Their involvement will help create more awareness of mental health conditions and advocate for and assist with assessment and treatment. Social work

presence will have more avenues to educate policymakers on the needs of the Sub-Saharan African diaspora in the United States.

Notwithstanding the conceptualization that these resiliency and constructivist theories provided on understanding better the mood and anxiety disorders and women in the African diaspora help-seeking behaviors, this study revealed and proposed a theoretical model that can provide better understanding of perinatal mental health issues as relates to help-seeking and guideline on how social workers can effectively work with women in the African diaspora population. See below, the diagram and picture depicting this model. Grounded theory qualitative approach was utilized to help develop a "cultural competemility and professionalism model", which comprises three key concepts: interpersonal relationship, spiritual/faith, and cultural/social awareness. The term, "competemility" was borrowed from the Stubbe (2020) explanatory research study which stressed on the importance of infusing cultural humility into cultural knowledge to allow for the permeations of five components of cultural competences (awareness, knowledge, skill, desire, and encounter). Cultural competemility and professionalism model will allow social work professionals to develop a meaning relationship and interact professionally with their women in the African diaspora. This model comprises of three key concepts: interpersonal relationship, spiritual/faith, and cultural/social awareness.

The interpersonal relationship describes the interaction between professionals and women and how professionalism can be maintained during the help-seeking process to achieve a working relationship and effective intervention. In the National Association of Social Workers code of ethics, social workers are sanctioned to be culturally competent and humble (NASW, 2015). In other words, social workers should be aware of their deficient knowledge of other cultures and be humble to learn from the best way to help them during the helping process

(NASW, 2015). The cultural competemility and professionalism model will explore professional openness, awareness, and supportive interaction in meeting the women's needs in the context of their culture during their interpersonal relationships. This model provides better recommendations on how professionals, especially social workers, can effectively interact with women in the African diaspora to engage them in care and encourage them to be engaged and seek help.

During the thematic analysis of this study's data, different themes emerged concerning the need for women to be open in accepting care or help. However, many women in their narratives interpreted that the women lacked openness to care because some of the perinatal teaching or education they received lacked their cultural contents. An example of this can be seen in diet, food, or nutrition recommendations by the professionals during perinatal teaching. In this study, it was found that professionals do not incorporate in their perinatal teaching/education package diets or foods that are customary to the women and culturally suitable in managing perinatal symptoms. Therefore, this suggested model explores professionals' openness, which is defined as "possessing an attitude that is willing to explore new ideas...in the context of their teaching capacity" (Foronda, Baptiste & Reinholdt, 2015, p. 211), and will provide techniques that will help both the professionals and women in the African diaspora work effectively together. In the African diaspora's cultural context, this will apply to professionals, especially social workers, who will cultivate an attitude of willingness to explore new ideas from the women about their diet or foods they are used to and incorporate such into their perinatal teaching and education.

Another aspect of this model that helps explain women in the African diaspora and help-seeking during perinatal periods is spiritual/faith and cultural/social awareness. It is essential for

professionals working with this population to reflect on their own strengths, spiritual values, and beliefs to recognize the women's strengths and spiritual needs. Spirituality/faith was found in this study as women's core strength sustaining them during their perinatal periods. Most of the women in this study shared that their faith and trust in God helped them get through their motherhood adversity. Literature supports that in the African worldviews on illness and help-seeking, the totality of life entails more than just the physical or biological, but rather, it embraces the whole of a person's existence—health, social, economic, political, cultural, and spiritual wellbeing as well as those of the community and the entire cosmic order (Njoku, 2012; Onongha, 2015). Also, an essential dimension of the African worldview on illness and help-seeking is the belief that illness and health are connected to spirituality (Asare & Danquah, 2017; Njoku, 2012; Onongha, 2015). This African worldview also helps explain the next concept: cultural/social-cultural awareness in relation to developing interventions and services that are culturally and spiritually sensitive. The spiritual/cultural worldview on help-seeking justifies the need for professionals to be humble and self-aware of these values and beliefs and incorporate questions that will help them assess appropriately during the biopsychosocial assessment and intervention. Resilient Mom's Heart program (picture below) will incorporate cultural competemility and professionalism model.

Diagram 10

Diagrams depicting cultural competemility and professionalism model and Resilient Mom's Heart program
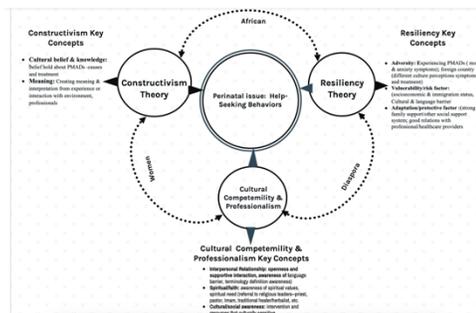
Limitations of the Study Design and Recommendations for Resolutions

Although generalization is not the goal or purpose of qualitative research relating to the population as the sample size of three to thirty-five is too small to make such a conclusion (Padgett, 2017), there is a need to interview more participants to gain their lived experience on this study phenomenon. In this case, utilizing a quantitative or mixed methods research study where more participants can be surveyed or interviewed allows for generalization on the population (Patton, 1999; Padgett, 2017; Gheondea-Eladi, 2014). Furthermore, due to circumstances beyond the researcher's control, this study interviewed women in the African diaspora from the same African location (West Africa). This calls for a research study that will include women from another part of the African continent—the include East, South, and others.

The intercoder agreement is one the process used to ensure credibility and trustworthiness in qualitative research and second coder strategy help achieve this goal (Creswell & Poth 2018). This researcher did not utilize a second coder to help code and evaluate data collected for the level of agreement during the coding process. Although not utilizing this process can be considered one of this study's imitations, Bloomberg and Volpe (2019) stipulate that the intercoder agreement process is not required in the dissertation study because one person or a researcher does the study. Another limitation of this research is the issue with self-bracketing. Trustworthiness (validity and reliability) is a core aspect of the phenomenological research study, and the researcher's ability to bracket personal experience to achieve trustworthiness (Bloomberg &Volpe, 2019; Creswell & Poth, 2018; Durdella, 2019; Padgett, 2017; Patton, 1999).

Nonetheless, the literature highlights that a researcher bracketing personal experience is difficult or impossible (Padgett, 2017). An author suggested that instead of a researcher

bracketing personal experience, the researcher should "strive to decide how and in what ways the researcher's personal understanding can be introduced into the study and usefully incorporated into analysis" (Bloomberg &Volpe, 2019, p.55). The researcher's reflexivity/positionality or credibility helped clarify any biases this researcher brings to this study. In other words, this researcher utilized self-bracketing as a tool to help recognize and address biases such as personal thoughts, beliefs/perceptions, and interpretations.

The sampling method, snowball-sampling, is considered the best sampling method to utilize when sampling a difficult-to-reach population (immigrants and others) (Creswell & Poth 2018; Fusch & Ness, 2015; Kichherr & Charles, 2018; Padgett, 2017). However, it can threaten research validity and reliability (Fusch & Ness, 2015; Kichherr & Charles, 2018). It may lead to a situation whereby a researcher has little control over the method or where the representativeness of the sample size is not assured or guaranteed (Durdella, 2019; Kichherr & Charles, 2018). In this light, there is a tendency that this researcher, using a snowball sampling method, may encounter a sample size reduction (fewer referrals than proposed); or a larger sample size or snowball sampling effect (more referrals or referral multiplication than this researcher can accommodate). Kichherr and Charles (2018) suggested different ways a researcher can resolve, maximize referrals, or deal with sample size reduction issues in qualitative research. These include but are not limited to prior personal/professional contacts of a researcher (beginning with asking well-situated people), sample seed diversity (beginning with seeds that are diverse as possible), and persistence to secure interviews (persevere-repeat contact) (Kichherr and Charles, 2018). This researcher adopted these recommendations.

Data saturation is another means that helped this researcher resolve the snowball sampling effect (more referrals or referrals multiplication) or referrals after data collection

(Creswell & Poth 2018; Fusch & Ness, 2015; Kichherr & Charles, 2018; Padgett, 2017). In other words, this researcher stopped sampling when reached data saturation and when the proposed number of participants is attained (Creswell & Poth 2018; Fusch & Ness, 2015; Kichherr & Charles, 2018; Padgett, 2017). This researcher also thanked and notified both the referred participants and recruitment seeds (group leaders) that the recruitment was closed and request their participation in any future research relates to this dissertation topic.

In addition, the limitation of this study is the inability to meet all the triangulation of methods. Qualitative research incorporating multiple data gathering methods is encouraged as it is a strategy used to develop a more complex understanding of the phenomenon in question (Bloomberg &Volpe,2019). For example, this researcher did not utilize investigator triangulation because this study is dissertation research which is done with one person—this researcher (Bloomberg &Volpe, 2019). However, other triangulation methods such as data sources triangulation or methodological triangulation allowed this researcher to address any rigor issues that may arise during data collection and analysis processes.

The delimitations that exist in this study include this researcher's inability to interview (a) women in the African diaspora who have children other than between 0-5 years old; and (b) those participants who only speak English. Women who have children between 6 years old and above may have encountered lived experiences that relate to the phenomenon of this research worth exploring. Africa is a multi-lingual continent, and it would be unreasonable to assume that every African diaspora woman living in the United States speaks and understands the English language. For example, there is a frequency that some newly immigrated women in the African diaspora who are from African French (francophone) colonial countries are in the progress of

learning to speak English once they are established in the United States. However, adding the English language as one of the criteria helped to address this issue.

Dissertation Conclusion

This dissertation, utilizing phenomenological and grounded qualitative research approaches, explored the lived experience of women in the African diaspora living in the United States on perinatal mood and anxiety disorders in relation to their knowledge and help-seeking behaviors. Systematic steps were undertaken to explore this dissertation topic. In chapter one, this researcher conducted a review of the literature to define and understand the magnitude, relevance and scope of this perinatal mood and anxiety disorders, not only among the women in the African diaspora but also in the world at large. Chapter one also reviewed related literature on the population to which this dissertation explored their lived experience—African diaspora, thus evaluating their culture and belief system to understand how they impact their help-seeking behaviors. This chapter concludes by examining the purpose for which this dissertation topic was chosen and why the study was to be conducted. Finally, this chapter also detailed the relevancy of this dissertation topic, especially its relevance to the social work profession.

Chapter two of this dissertation covers the literature review on this topic. Thus, exploring related studies conducted on perinatal mood and anxiety disorder and help-seeking, especially as it applied to women in the African diaspora. In this second chapter, this researcher reviewed and synthesized the findings of previous studies to understand the gap(s) that needs to be covered. The literature review results revealed the paucity of research on this topic and the participants, most noticeably absent is research conducted by the social workers in this topic and participants is missing. In Chapter three, the methodology section, this researcher outlined and detailed different research methods and discussed the two qualitative research approaches utilized to

design this dissertation study. This chapter also described the data collection process, which included the selection of participants, different procedures taken to answer this dissertation research questions, and protective measures taken to ensure that ethical considerations were maintained (minimizing the potential for harm throughout the research process)—ensuring that participants' rights of voluntary informed consent, confidentiality, and anonymity were maintained.

Chapter four provides systematic detail of the procedures taken to analyze and interpret the data results—the coding process and thematic and content analysis performed. This chapter explored and described the emerged concepts/categories and overarching themes and subthemes and supported them with appropriate quotes from the participants' narratives.

Finally, in chapter 5, the findings of this dissertation study were discussed, thus connecting them with the findings of the previous studies. This chapter also provided and assessed the implication of this research study, provided recommendations, and proposed a model that provides a better conceptualization of the perinatal mood and anxiety disorders among women in the African diaspora and their help-seeking behaviors.

Appendix

Table 2
Interview schedule

No.	Pseudo Name	Date/Time	Interview Type	Experienced Any Issues	Reschedule
1	WAD05	Saturday November 21, 2020/9:00am	Zoom	5ms late notified prior to the time	
2	WAD12	Saturday November 21, 2020/12noon	Zoom	No issue	
3	WAD07	Saturday November 21, 2020/2:00pm	zoom	Issue with video recording,	
4	WAD010	Saturday November 21, 2020/4:00pm	Zoom	Late, issues with audio recording	
5	WAD04	Sunday November 22, 2020/ 10: 00a.m	Zoom	No issue	
6	WADni1	Sunday November 22, 2021 @ 2:00pm	Zoom	No show	Attempted to reschedule but no success.
7	WAD08	Sunday November 22, 2021 @ 12:00m	Zoom	No issues	
8	WADni2	Sunday November 22,2020 @ 2:00pm	zoom	No show	Rescheduled and no show at the second time.
9	WAD01	Sunday November 22, 2020 at 3:00pm	zoom	No issues	
10	WAD02	Monday November 23, 2020 @ 5:00pm	zoom	No issue	
11	WAD03	Monday November 23, 2020/7:30 pm			
12	WADni3	Friday November 27, 2021 @ 4:00pm	zoom	Internet issues	Rescheduled for face to face when is not going to be home, but there was severe weather issue and schools were cancelled for kids
13	WAD09	Sunday November 28, 2021 @ 12;00pm	Zoom	No issues	
14	WAD06	Sunday Jan. 24, 2021 @ 4:00pm		No issue	Rescheduled
15	WAD11	Monday Jan. 25, 2021 at 8:20pm	Zoom	No issue	Rescheduled
16	WADni4	Wednesday Jan. 27, 2021, @ 5:30pm	Zoom	No show	Attempted to reschedule was not successful

Table for Codes\\Vulnerability/adaptation

Describe some risks, protective factors and process that influence women's ability fall vulnerable or adapt to adversity of perinatal mood and anxiety disorders.

Emerged Themes	Description	Files	References
Adaptation/Protective Factors	*Overarching themes describes women's interpretation of protective or adaptation factors during perinatal periods.*	*1*	*1*
Adaptation	Ability to function well in the midst of difficulties.	5	5
family support	Having family member (mother, or mother figure) being present to assist with care	9	15
Good social support	Having someone who will assume the responsibility of visiting and assisting with care, in absence of mother or parent	8	14
Good support system	Reported having support from baby daddy, family, and friend. Believe that this support helps her to accept the reality.	2	3
mother figure and friends	Someone to play a mother role for those do not have their mother here in U. S	9	17
Mother Help	Mother was source of help.	8	15
parental support	Receives parental support.	3	3
Protective Process	*Overarching themes describes psychological characteristics factors for adaptation*	*1*	*1*
ability to face responsibilities	This describes as an ability to face challenges	2	2
Accepting fact	It appeared that she experienced symptoms during pregnancy but interpret as something that comes with nature, (being pregnant), and signs and symptoms that has to do with pregnancy with every mom.	1	2
Balancing life	Ability to handle responsibilities and normal life	1	1
Going back to old self	This describes as self-reflection.	1	1
Inability to trust ability	Inability to trust self or Question about ability or competence to care for the baby.	1	1
lack of satisfaction	Not satisfied with her body, figure	1	1
life course	Describe here as change in responsibility	3	4
Multitask	Ability to do hand different responsibilities at the same time.	1	1
protective process	Personal characteristics that defined individual resilience power. These to include personality traits, views or ideology about handling with existential problems.	6	13
Vulnerabilities Factors	*Overarching themes that interpretation vulnerability factors*	*1*	*1*
Biological change	Hereditary/ history of mental illness runs int he family, hormonal changes	7	14

Drug issue	Substance use issues	3	3
hereditary	Both mom and sisters had history of perinatal mood and anxiety disorder.	1	1
History of mood (depression)	Experienced perinatal mood symptoms during or after pregnancy,	3	3
immigration factor	Immigration issues vulnerability factor	8	14
lack care	mental illness are not properly taken care of	1	1
lack of support		7	12
vulnerability	Factor that can put woman at risk of mood and anxiety disorders during and after pregnancy.	5	9

Table Codes\\Reality

Personal and cultural beliefs hold about perinatal mood and anxiety disorders and help-seeking

Emerged Themes	Description	Files	References
Belief system	***Overarching theme describes African cultural views on the causes and treatment of mental health issues.***	0	0
A curse	This subtheme describes as a view that mental health issues is a supernaturally or physical curse.	2	3
Enemies	Having a believe that the symptoms or mental illness issue is as result of what someone (an enemy) did to someone.	3	4
Harsh treatment	Professional's attitude of not being considerate during patient-providers relationship.	1	2
Ill treatment	Belief that those with mental lines are not treating well the way they should or neglect	2	2
No cultural understanding	Denied cultural awareness about how people from cultural location perceived cause and treatment of mental illnesses	3	3
Personal view on cause of mental illness	***This overarching how women personally view cause of mental illnesses.***	***0***	***0***
taboo	View as taboo to have mental illness	4	4
Witchcraft	View mental illness as caused by wicked people.	3	4
Cultural **Interpretation** on Perinatal mood & anxiety	Having cultural view causes and treatment of mental health issues. cultural interpretation on mental health issue, interventions options, and attitudes towards individuals with the illness/issue.	0	0
cultural expectation	things that are expected from mom as women, or culturally and socially constructed as women and family. e.g., having male vs female child.	4	8
Cultural knowledge about mental **illness**	This theme is described as cultural knowledge about causes and treatment of mental health issues, how people from cultural locations interpret mental health issues, and their interventions.	9	15

Name	Description	Files	References
Culture vs personal interpretation	This theme describes as women's definitions of what is normal and abnormal and how they interpreted their African way of doing things vs. American ways of doing things about pregnancy and childbirth.	8	19
Just being **pregnant**	This theme describes as experience that comes with being pregnant that every woman experienced.	1	1
No knowledge about culture view	This theme describes as women denied having any prior knowledge about how people from their cultural view causes and treatments of mental illness	4	5
stigmatization for MI	Mentally illness individual be stigmatization	3	5
Personal interpretation of MI Symptom	Self-interpretation about the cause and treatment mental illness or perinatal mood and anxiety disorders	4	5
Comparison	Comparing how people who mentally illness individuals are treated in African vs. Western world.	7	14
Definition issues	Different women described perinatal moods and anxiety disorders diffidently.	1	1
Ignore the **symptoms**	Women acknowledging do not pay attention to perinatal mood anxiety symptoms because they consider it as something normal.	1	2
No taken **seriously**	People not taking mom seriously when they complained about feeling of depression or anxiety	2	2
Personal definition	Describe different ways to which women conceptualize or interpret their perinatal mood and anxiety disorders.	3	7
question about reality	Confused about what is real, which measure is effective or better.	1	1

Table of Codes\\Learning
Describes as meaning interpretations women gained from their interaction with cultural and social environment, such as family members and friends, healthcare providers/professional

Name	Description	Files	References
Interpretation of Information Received	*Overarching themes covers issues related to women's interaction with professionals, education/trainings received and how women interpreted the information they gathered.*	0	0
conflicting information	Describes as lack of consensus between right and wrong way to care self and baby—conflicting information as relate to what professionals and mother recommendations (traditional way of caring for baby).	1	2
Hiding information	Withholding information as result of fear of unknown (e.g., Not to be considered as a bad mother, being stigmatized.	1	1

problem with terms interpretation (terminology issues)	Describes as women knowledge about what different perinatal items or things are called or what they mean. Assigning meanings.	1	2
professional education	Defined whether or not women received education from the professionals about perinatal mood and anxiety symptoms, retreatment.	10	21
Too much information to grasp	Having so much information related to baby care and resources, confusing information contracting to cultural normal information from mother.	2	4
Interpretation of Experience	***Overarching theme describing women's interpretation of their experiences during their perinatal periods.***	*0*	*0*
Breastfeeding issue	Difficult with breastfeeding.	3	5
difference in experience for help-seeking	Some women having less problem during perinatal periods than other women	2	4
different experience	Have different experience with different delivery	5	6
difficult at beginning of pregnancy	Due to not planned for the pregnancy, it was difficult at the beginning of the pregnancy	1	1
learning from the job	Describe as lack experience caring new baby and has to teach self and adapt based on what the day brings or demands from the baby.	1	1
punishment	Feeling be punished.	1	1
Scary	women described their experience scary.	1	1
single mother vs married	Compared single mother and married	1	1
undescribed	Inability for a woman to describe what was going on with her, how feeling and experience during perinatal periods.	1	2
Unexperienced	Describes difficult of being a first-time mom vs having a second child.	2	3
Worsen symptom during COVID	When accepted the reality of the pregnancy, she became find during pregnancy, but after pregnancy she started being moody and experience depression. Mom interpreted this as result of covid pandemic because they were in quarantine and was unable go out and involve in any social activities.	3	7
Interpretation of Interaction with Professionals	***Overarching theme describing women interactions with the healthcare professionals/providers.***	*0*	*0*
A Country of opportunities	understanding that U.S is a country to has resources for everyone, and people can access this if you want.	1	1
issue with provider (same culture)	Experience with a provider from the same cultural location during help-seeking	3	3
Motherhood Expectation		0	0
comfort	Began feeling happy when she moved back to her home	1	1

Contradictory expectation	Feeling of disappointment, expecting pregnancy to be thing of happiness and joy and it turns to be the opposite	2	3
Excitement	Happy and joyous being pregnant	1	1
Happiness	A moment of happiness ensued as result of finding peace with oneself.	4	6
Joy	Feeling being grateful for having a baby.	3	3
not expecting being pregnancy		2	2

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