2022

Postpartum Depression and COVID-19: A Special Emphasis on Military Women

Lacey R. Qui▪ones

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Lacey R. Quiñones, MSW Candidate

December 2022

The University of Texas at Arlington

Supervising Committee:

Dr. Regina Praetorius
Dr. December Maxwell
Dr. Phillip Schnarrs

Abstract

The purpose of this study is to explore the possible factors that contribute to postpartum depression in military women during the COVID-19 pandemic. The study had a total of 10 participants who were recruited by snowball and purposive sampling. The participants agreed to an interview with questions related to their overall experience of becoming a mother during a pandemic. The data collected showed two main themes emerged: environment and support. Of those, five subthemes appeared: policies and procedures and healthcare staff; in-person support, educational support, and mental health support, respectively. These findings point to potential shortcomings surrounding perinatal care for women. Recommendations to further support perinatal women include creating a safe birthing environment, allowing for autonomy, and providing support to the birthing person such as educational resources.

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Introduction

Military women have a unique experience unlike their civilian counterparts. In 2020, it was estimated that 21 million adults suffered from at least one major depressive episode in the United States (U.S.) (National Institute of Mental Health [NIMH], 2020). Centers for Disease Control and Prevention (CDC, 2020) suggest that 1 in 10 women reported symptoms of depression in 2020. With that, 1 in 8 women say they have experienced postpartum depression (PPD[1]) when asked by their doctor (CDC, 2020). Those that serve in our nation's armed forced are faced with additional stressors that can exacerbate depression. Yehia et al. (2013) claim that the conditions that military service women are exposed to can contribute to, and exacerbate stressors which negatively impact physiological, psychological, and social outcomes. They go on to say that this sub-group have a complex set of stressors, to include familial, personal, and professional and therefore are considered a vulnerable population (Yehia et al., 2013). In addition to struggles with military life and being a mother, the COVID-19 pandemic added an extra layer of challenges to an already difficult situation. The COVID-19 pandemic intensified the already preexisting stressors these women faced. One example of this was by severely limiting or completely removing the potential for in person due to travel bans globally.

Social science professionals take special interest in this area of study due to the significance it has on the mental health of women, and with PPD being a rising concern globally. The effects of PPD bleed over into other areas of life such as relationships, work productivity, and connection with the infant. The proposed study will further examine how the COVID-19

[1] PPD is defined as depression suffered by a mother following childbirth, typically arising from the combination of hormonal changes, psychological adjustment to motherhood, and fatigue.

pandemic affected military women. The importance of conducting research on this area is to determine what resources are needed to help prevent PPD overall, especially in unprecedented times such as a global pandemic.

Significance to Social Work

The importance this study will have on the Social Work profession is it will provide a better understanding of how to treat this specific population. Because these military women endure a lifestyle that is unmatched within the civilian population, they come with a special set of stressors. This will also allow for mental health practitioners to better gather resources to treat this population and to explore the significant contributors to PPD within the military population. This study can also be applied to other populations in unique situations with the goal to deliver the best possible therapy methods and provide truly patient centered care.

Review of the Literature

Pandemic and Mental Health

Historically, pandemics cause a lot of uncertainty and with that comes fear, anxiety, and depression. The fear of the unknown can raise the anxiety levels along with heightening the anxieties of those with pre-existing mental health conditions (Usher et al., 2020). There is a sense of hopelessness, grief, despair and even loss of purpose when such an event occurs (Usher et al., 2020). There is an isolating component to pandemics due to strict state and government restrictions to help reduce the spread of a virus; this often means physical isolation away from family and friends. A basic human need is the need for security, and in a pandemic, that is not guaranteed. One study conducted by Byrne et al. (2021) examined individuals both with and without a previous mental health diagnosis prior to the COVID-19 pandemic. The study suggested that there was an increase in mental health diagnoses in people who had no previous

history of a mental health condition. Another article by Javed et al. (2020) mentions that not only separation from family and friends but also loss of freedoms, boredom, and uncertainty can cause deterioration in one's mental health, both in children and adults.

Military and Mental Health

A study conducted by Sampson et al. (2021) found that there were a few predictors of new onset of depression among the military population prior to COVID-19 including paygrade and deployment location. Another study by Gaderman et al. (2012) found that prevalence of depression was highest among females who were young (aged 17-25), enlisted, unmarried and have only a high school education. A study published in 2021 found that 57.2% of veterans registered with Veteran Affairs (VA) were found to have been diagnosed with at least one mental health disorder, with depression being 45% of the diagnoses within that sample population (Orak et al., 2021). Depression has been among the most reported mental health diagnoses for military members (Orak et al., 2021). It is no surprise that this same study also found that those who deployed to a combat zone had a higher rate of depression, along with higher rates among enlisted personnel (Orak et al., 2021). Orak et al. (2021) state that circumstances such as stressful conditions, role strain and disruptions in pre-existing relationships and social networks all contribute to the potential for depressive symptoms to emerge.

Motherhood and Mental Health

There is ongoing debate regarding whether the child-bearing years, including the postpartum period, are a time of increased risk for mental health problems in women (Holton et al., 2010). While there have been comparisons between the mental health of those who are mothers and those who are childless, there have been no consistent findings. A study done in 2005 in Australia found that of the 569 women aged 30 to 34, the rates of mental health

conditions in mothers, including those who had given birth in the preceding year, were no higher than in women without children (Holton et al., 2010). The study went on to show that mothers had a subjectively higher life satisfaction than their counterparts (Holton et al., 2010). These data imply that being a mother is linked with enhanced mental health for women and challenges the view that the child-bearing years are a period of diminished psychological well-being for women (Holton et al., 2010). Currently, there is no known literature on how motherhood in the military affects mental health.

Methods

Study Design

The study that was conducted as a descriptive, qualitative study which helps to develop and provide additional knowledge on a previously researched topic. The researcher set out to explore experiences of military women who became mothers during the COVID-19 pandemic with an emphasis on increased risk factors for postpartum depression.

Sampling

This study used snowball and purposive sampling. In this study, the researcher defined women as individuals with a uterus, capable of carrying and birthing an infant. The participants in this study had all given live births. The researcher chose to study those who had live births due to the complex grief that ensues after having a stillborn baby. To recruit, the researcher posted a message on the Facebook page "The Army Mom Life" stating that she was a member of the military and asked for qualified participants who meet the criteria stated previously to send a message to her. The researcher also relied on those who saw the post to reach out to individuals they knew who also qualify, which is where snowball sampling came into play. The participants

had to have given birth between March 2020 and March 2022. For the sake of the study, participants all had to have been on Active-Duty status at the time of delivery.

Data Collection and Instruments

The data were collected using qualitative research methods in the form of semi-structured interviews (Maxwell, forthcoming) (appendix A). A strength the instrument demonstrates is thought provoking questions specific enough to gather the data needed, along with clear and concise wording. This method was best suited for the study, as it allows the narrative to be expressed without constraints or limitations. It is possible to get some of the same results with a Likert-scale survey, however, interviews allow for a narrative approach incorporating open ended questions that grant more insight for experiences to be shared.

Procedures

Once the researcher contacted the potential study participant, she then asked them a few preliminary questions to ensure they met the criteria. If criteria were met, a date and time for the interview was scheduled. The researcher had the participants send their phone number, as it was a phoned interview, along with their email to send a written informed consent (Appendix B). Once the date and time had been established, the researcher called the participant and before they continued, the researcher verbally informed them that the interview would be recorded with a recording device. She then informed the participants that they had the option to withdraw from the interview at any given time for any reason. At this point, the researcher informed the interviewees that the recorder was being turned on and proceeded with the interview. She then read the limits of confidentiality statement and receive a verbal "yes" that they agreed to the study and understood their rights. Once the interview was completed, the researcher then stated that the recording was complete and stated the intent with the recording. Their information on the

recording remained anonymous, and the recording was uploaded and transcribed. The recording was then deleted from the recording device.

Protection of Human Subjects

The study was approved by the University of Texas at Arlington's Institutional Review Board. The researcher aimed to protect the participants' personal information as much as possible. While the consent forms had identifying information, the recorded data were de-identified and were not linked to the consent forms. This allows for the subjects to speak freely and not fear retribution from the U.S. Armed Forces or their Chain of Command. When mentioning direct quotes from participants, a pseudonym was given. The participants had the right to stop the interview at any time they chose for any reason.

Data Analysis

Once the interviews were concluded, recordings were transcribed using Otter.ai. I then read and re-read each transcript to ensure readability and clarity of the words. As I read, I took notes (open coding) to then compare codes across interviews to identify themes, or thematic analysis (axial coding). In an effort to increase rigor at this stage in the analysis, I used member checking to validate themes. Member checking is considered the highest form of triangulation for verifying the data (Patton, 1999). I was able to send each participant a draft of the themes to ensure what was said accurately represented their experience. The few individuals who did respond agreed that the results were accurate and all encompassing.

Researcher Positionality

I am a full-time, stay-at-home mom and a full time Graduate student who is a member of the Army Reserves (AR). While I am a member of the AR, I chose to look at Active-Duty members as they have a different experience than AR. I have spent 13 years in the military and

became a mother during the COVID-19 pandemic. I have the fortunate opportunity to have two thesis committee members who are also mothers; one who experienced post-partum depression and one who did not.

Findings

The researcher was able to interview and collect data from 10 participants. Of the 10 participants, six identified as Caucasian, two identified as African American, one as Hispanic and one identified as Puerto Rican, Italian and Chinese. The participants consisted of nine Army individuals and one from the Air Force—all on Active Duty at the time of delivery. None of the participants expressed being formally diagnosed with postpartum depression, but some stated that they experienced symptoms related to postpartum depression. This study did not account for the rank/grade of the individual giving birth nor age and how those variables may have affected their birthing experience.

Two main themes emerged along with five subthemes. The two main themes include environment and support and the five subthemes are policies and procedures, healthcare staff, in-person support, educational support, and mental health support. Although there are a lot of overlaps among the participant responses, there are also unique outliers that are important to note.

Environment

Policies and procedures.

A majority of the participants expressed the negativity they felt in their birthing environment. This includes the overall procedures and requirements for birthing, as well as the interactions mothers had with the health care staff. While not all were as affected by the

pandemic restrictions for labor and delivery, it was clearly a shift from how women have previously expected to deliver their babies.

Across the interviews, participants echoed that they felt "scared" throughout their delivery, with one participant, *Sarah*, stating:

> Scared. I remember especially going in for my c-section. You know, everyone was wearing masks. I was wearing a mask the whole time I was laboring. And I just remember looking at my husband and crying because I was so terrified.

Karen had this to say: "Lonely, very lonely. Just isolated, honestly," in referring to the delivery room and her experience while at the hospital.

Healthcare staff.

Within the birthing environment, some mothers expressed having negative experiences with the healthcare staff. One mom, *Beth*, mentioned this: "There were some providers who definitely made the experience not as welcoming as it should have been, especially as a pregnant person or a pregnant woman." She was not the only mother to comment on the healthcare staff within her birthing environment, either. Her sentiment was reiterated with a few others, *Lola* and *Susan*, stating the following respectively: "I asked if I could squat the baby out and they said they didn't do that there" and "I felt like they, they pulled her out. They weren't letting her come out naturally."

Alternatively, some participants expressed positive experiences with their healthcare staff. *Melissa* had this to say: "The staff was kind and professional and respectful," and *Heather* added, "It made me feel safe. The doctors, they actually, like, talked me through everything with the COVID thing going on." One respondent, *Tonya*, appeared to be very pragmatic about her

delivery, stating, “Yeah, I mean, for it to be a little bit more hands on with the nurses. But I think because of COVID, that was just their protocol.”

Support

In person support.

There was an overwhelming consensus from the interviewed participants about the lack of support they experienced throughout their pregnancy, delivery, or postpartum. Many participants lived far from their families, and the pandemic shut down many of the in-person educational classes that women, particularly first-time mothers, have historically relied on. This increased the difficulty of the pregnancy to postpartum experience across the board.

Due to the military lifestyle, eight out of the ten participants were living in a different state than family. Only two of the mothers had family within comfortable driving distance. Although this was not an anticipated part of the study, it is worth mentioning for future studies. *Susan*, who is not a first-time mom and has experienced postpartum life without family present previously, said, "I've never really had that family support for any of my kids. It's always just kind of been me and my husband." *Lola* echoed that sentiment and followed up with a comment on how supportive her gym friends were:

> You know what it's like to be alone that, like, you don't have that comfort that someone telling you, everything's gonna be okay. Everything's gonna be okay. We got this, you know, you don't have that support. Yet. It's very important. It seems so little. But it is so important...Their [gym friends] support has been unwavering.

Educational support.

There was also a severe lack of access to educational classes, materials, and lactation consultants due to the pandemic. When asked specifically about birthing classes and preparing

for a baby, *Sarah* said this about the hospital she delivered at: “BAMC [Brook Army Medical Center] shut those down. They shut down their breastfeeding classes too,” Another respondent, *Karen*, explained that her birthing classes “were all canceled because of the pandemic.” *Katrina,* a first-time mom, had this to say about her experience: “There was never anything about like, going into labor and what to expect or things like exercises that could help you for pregnancy or for labor, like nothing was tailored to labor.” Another first-time mom, *Tonya* who had twins, explained the lack of medical support she had available: “There was a lactation consultant that was available, but they weren’t very helpful. And I wasn't really able to get a whole lot of colostrum out. And they just kept saying, Oh, the boys will be fine.” This left her feeling “nervous and anxious” about her boys getting enough food.

Some participants had given birth before and expressed their confidence in being able to deliver their child since they had already done so in the past. It was the first-time moms without experience who felt pressure to learn from somewhere. When asked how they prepared for a baby, the three first-time mothers noted respectively, “A lot of YouTube videos,” “We did watch a lot of YouTube,” and even “I had to resort to Google™ [search engine] and YouTube to figure out what to do.”

Mental health support.

Many of the moms commented on the lack of mental health care available to them, particularly postpartum. Mental health support was something that a few of the moms wanted and did not receive. One mom, *Beth,* actively sought mental health care during her postpartum, and had her concerns discounted. "I advocated for myself, truthfully, and honestly, and had providers kind of brushed it off and be like, Oh, well, it might just be your hormones still." Another postpartum mom, *Susan,* stated: "My six-week checkup, I never was asked how I felt.”

One mom, *Lola*, mentioned that she was not even aware of postpartum depression symptoms. “Postpartum depression definitely is something that I wasn't really aware of.” One of the participants was hopeful for the future of mental health care for postpartum moms. *Katrina* had this to say: “Healthcare is changing and a way of looking at mental health. But I think that there still needs to be some work.”

Discussion

This portion is dedicated to discussing the factors that influence military women who develop postpartum depression. We will be reviewing the results of the study described and making a determination if these results coincide with previous studies. This will also serve to explore the limitations and what recommendations can be made, along with implications for social work practice.

The participants expressed having a mostly negative experience in their birthing environment, with a few exceptions. A study done by Ayerle et al. (2018) mentions how imperative it is for staff to offer more choices to the birthing person for self-determination during labor and birth. Further, they mention that birthing individuals expect continuity of care, control, and choices, as these lead to more positive outcomes for birth and mental health postpartum (Ayerle et al., 2018). Another study concluded that the birth environment, when perceived as secure and protected, enables the release of endogenous neurohormones in birthing women including oxytocin. This chemical released in the body mediates labor contractions, reduces stress and pain levels, helps to promote positive emotions, and facilitates adaptation and maternal bonding with their infant (Goldkuhl et al., 2022). These findings further support the outcomes in this study by recognizing that a positive birth environment leads to positive outcomes and a negative or unsafe birthing environment can lead to more negative outcomes.

Another study further points to safety within the birthing environment. Aune and colleagues (2015) state that being in a safe environment includes stability in everyday life, close relationships with family and friends, and is considered an essential component of perinatal care. A recommendation comes from a study done by Mgawadere et al. (2019) presenting the idea that a "good relationship" with the healthcare staff, or rapport building with the birthing team, is a necessary component to make the environment a positive one for the birthing person.

This study used qualitative interviews to corroborate findings from other mental health studies. The data show a number of different variables which can contribute to a service member being clinically diagnosed with postpartum depression. One study done by O'Boyle et al. (2005) mentions that active-duty women have a higher rate of depression and suicidal ideation compared to their civilian counterparts. These findings support the idea that the birthing women in my study felt that there was a lack of mental health support. Rychnovsky (2007) also mentions that the symptoms of fatigue affect both the mother and child by causing prolonged exhaustion in the mother, and that it negatively affects all aspects of work and life.

With evidence-based practices and preventative resources, military women have the potential to have a happier and more balanced postpartum experience while transitioning back into military responsibilities. Some of the studies discuss solutions to the lack of mental health resources available to military women. Nicholson et al. (2020) indicated that it is key to have a more preventative approach to postpartum depression. It is encouraged to discuss postpartum depression with moms, educate them not only on what symptoms to look for but also the resources available to them. This will raise awareness of postpartum depression symptoms, enabling women to feel more confident and comfortable in seeking help as they advocate for their own mental health care.

Limitations

One of the biggest limitations of this study was its small sample size. The collected data is beneficial for future research and studies, there was not enough data to make a generalized assumption about the overall military population. The military make-up of the participants is not varied enough to determine if military branch causes a difference in delivery, as nine were Army and one was Air Force. Another limitation of the study is the race/ethnicity of the participants. There was not enough diversity within the participants to confidently say one group of individuals had a much different experience than the other, and we therefore cannot infer so. Lastly, the researcher was not able to conduct the interviews in person due to the COVID-19 pandemic, leading to a lack of ability to pick up on non-verbal cues and participant body language to add depth to the participant responses.

Social Work Practice

The research shows the importance of mental health care in the military and educating women on the symptoms of postpartum depression. As investigated in this study, there are many factors that can increase the severity of postpartum depression that military women experience. The mental health professionals who have an understanding of these factors will have better knowledge on what interventions would be most beneficial. With the expertise of social workers and other mental health professionals, symptoms of postpartum depression can be lowered with the help of preventative strategies. The military is already currently working to increase mental health support by embedding mental health clinicians within each major command; this is a great step toward combating the military's mental health crisis and providing support for its service members.

Conclusion

This study aimed to explore what factors impact the severity of postpartum depression in military service women who became mothers during the COVID-19 pandemic. The themes that this study found to be most relevant and taxing to the service members were the negative birthing environment and the lack of supports. From the findings of this study and of other studies like it, it can be inferred that these are important factors to keep in mind when researching women in the military. Through the use of studies like these, mental health professionals can attune their social work practice to better attune their social work practice to better serve the military population with a more preventative methodology.

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Appendix A

Interview Questionnaire

1. Will you please share your birth story with me?

Possible prompts: Is this different than you had planned? Did you have a birth plan?

Possible prompts: What about preparation for the baby? Did you plan on a baby shower (did you get to have one?) Did you have a chance to get all the things you needed?

Possible prompts: What about family to be there after the birth?

2. Will you share with me some concerns or worries you may have, if any, about having an infant right now?

3. Can you share with me how the environment of your birth made you feel? What would you change about the birthing environment?

Possible prompt: Was there anyone present from your family or close circle at the birth? If not, how did that make you feel? If so, how did that make you feel?

Possible prompt: How did/do you navigate transportation to/from hospital and your appointments?

4. Can you tell me how you feel about becoming a mother right now?

Possible prompt: Will you share with me the ways you feel equipped to be a mother right now? Any ways you don't feel equipped?

Possible prompt: Are any of these concerns related to the pandemic? Would they be there without being in quarantine?

Possible prompt: Do you breastfeed? If so, how is that going for you?

5. Can you tell me how you feel about the baby right now?

Possible prompt: Can you elaborate on that?

6. Will you share with me the supports you have right now in caring for the infant, yourself, and your family? What are you doing to get social support? Spiritual support?

7. Can you tell me about getting to your prenatal appointments and the hospital?

Possible prompt: How was public transportation if used?

8. Is there anything you wish would have gone differently during the birth of your child, if so, will you share with me? How is the current situation changed the painting you had in your mind about this time in your life?

9. What is getting you through this? Where do you find hope? What was your biggest fear through all of this?

10. (For those who experienced IPV): To what extent has the Corona Virus (COVID-19) affected your experience of domestic violence and your ability to access transportation?

Probe: Has your partner used the Corona Virus (COVID-19) as reason to keep you from accessing transportation to leave the house?

Probe: Has your partner used the Coronavirus (COVID-19) as a reason to keep you from your perinatal appointments?
Probe: How have you overcome these challenges?

Appendix B

Informed Consent

TITLE OF RESEARCH PROJECT
Pandemic Parenting: Becoming a Mother During a Pandemic

RESEARCH TEAM
December Maxwell, PhD, MSW, School of Social Work, december.r.maxwell@gmail.com
Regina Praetorius, PhD, LMSW-AP, School of Social Work, rtpraetorius@uta.edu
Craig Keaton, MSW, School of Social Work, craig.keaton@uta.edu
Sarah Herrera, MSW, School of Social Work, sarah.hererra@uta.edu
Amanda Six, BSW, School of Social Work, amanda.six@mavs.uta.edu
Komal Alam, College of Nursing and Health Innovation, Komal.alam@mavs.uta.edu

IMPORTANT INFORMATION ABOUT THIS RESEARCH PROJECT
The research team above is conducting a research study about the experiences of becoming a mother during the current COVID-19 pandemic. The purpose of this research is to understand how the pandemic affected pregnancy, perinatal care, birthing and birthing environment, and maternal mental health. This study is to help us better understand how mothers can be supported during extreme circumstances to best support maternal mental health. You can choose to participate in this research study if you are over the age of 18 and are either pregnant or have given birth during the recent COIVD-19 pandemic, and are able and willing to participate in a phone or Microsoft Teams interview about your experience.

You might want to participate in this study if you want to contribute your perspective to a scientific study involving becoming a mother and would like the chance to talk about your experiences with the hope to shape future perinatal policy. Also, you might want to participate in this study if you are comfortable sharing your perspective with one or more researchers via phone or Microsoft Teams and having it recorded. Additionally, you will be asked questions about domestic violence, so you may want to participate only if you can do so in a private place. However, you might not want to participate in this study if you are uncomfortable sharing your experiences with people you don't know, you are not comfortable with being recorded, or you do not have time to participate in a 30-60 minute interview.

This study has been reviewed and approved by an Institutional Review Board (IRB). An IRB is an ethics committee that reviews research with the goal of protecting the rights and welfare of human research subjects. Your most important right as a human subject is informed consent. You should take your time to consider the information provided by this form and the research team and ask questions about anything you do not fully understand before making your decision about participating.

TIME COMMITMENT
Participation in this study will last between 30-60 minutes for the initial interview. You will also be asked to be available for one follow-up interview a month after initial interview, for questions either by phone or by email. Follow-up questions may take an additional 30 minutes. You do not have to participate in the follow-up to participate in the initial interview.

RESEARCH PROCEDURES

If you decide to participate in this research study, this is the list of activities that we will ask you to perform as a part of the research:

1. Read through this informed consent and talk with the research team to make sure that any questions you may have are answered; then make your choice about whether to participate.
2. If you agree to participate, you will be asked to fill out a basic demographic form with questions on it prior to the interview.
3. You will then be asked a series of questions regarding any stories you have regarding pregnancy, birthing, or new motherhood during the pandemic. You may be asked about supports and barriers you have experienced during and after your pregnancy.
4. Your interview will be audio recorded using a handheld encrypted digital recorder or video recorded using Microsoft Teams, depending on your preference. After the interview, the recording will be transcribed, which means they will be typed exactly as they were recorded, word-for-word, by either a member of the research team or a professional transcription service. Any names you use will be changed or redacted from the transcription.
5. A month after your initial interview, you may be contacted with some questions to ensure that you agree with the findings of the study. This follow-up will be done via phone or email and with your willingness.

POSSIBLE BENEFITS

The possible benefits from this study include contributing to knowledge about how to best support mothers who are pregnant or give birth during extreme situations such as natural disasters and pandemics.

POSSIBLE RISKS/DISCOMFORTS

This research study is not expected to pose any additional risks beyond what you would normally experience in your regular everyday life. Participation does include some discussion of experiences with domestic violence and if at any time you do not feel comfortable answering any questions, you may say “skip.” Also, if you do experience any discomfort, please inform the research team. There is list of resources for psychological and therapeutic support at the bottom of this form as well.

COMPENSATION

There is no compensation being given for this study.

ALTERNATIVE OPTIONS

There are no alternative options offered for this study.

CONFIDENTIALITY

The research team is committed to protecting your rights and privacy as a research subject. All paper and electronic data collected from this study will be stored in a secure location on the

UTA campus and/or a secure UTA server for at least three (3) years after the end of this research. The recording of your interview will be immediately destroyed after transcription.

The results of this study may be published and/or presented without naming you as a participant. The data collected about you for this study may be used for future research studies that are not described in this consent form. If that occurs, an IRB would first evaluate the use of any information that is identifiable to you, and confidentiality protection would be maintained.

While absolute confidentiality cannot be guaranteed, the research team will make every effort to protect the confidentiality of your records as described here and to the extent permitted by law. In addition to the research team, the following entities may have access to your records, but only on a need-to-know basis: the U.S. Department of Health and Human Services and the FDA (federal regulating agencies), the reviewing IRB, and sponsors of the study.

Under certain situations, we may break confidentiality. If during the study we learn about child or elder abuse or neglect, we will report this information to the appropriate authorities including the police and/or child protection agencies.

CONTACT FOR QUESTIONS

Questions about this research study or reports regarding an injury or other problem may be directed to December Maxwell at december.r.maxwell@gmail.com or Regina Praetorius at rpraetorius@uta.edu . Any questions you may have about your rights as a research subject or complaints about the research may be directed to the Office of Research Administration; Regulatory Services at 817-272-3723 or regulatoryservices@uta.edu.

CONSENT

By signing this form, you are confirming that you understand the study's purpose, procedures, potential risks, and your rights as a research subject. By agreeing to participate, you are not waiving any of your legal rights. You can refuse to participate or discontinue participation at any time, with no penalty or loss of benefits that you would ordinarily have. Please sign below if you are at least 18 years of age and voluntarily agree to participate in this study.

As a representative of this study, I have explained the purpose, the procedures, the benefits, and the risks that are involved in the research study:

_____

SIGNATURE OF RESEARCHER **DATE/TIME**

Did the subject give their consent to participate in this study? YES
NO

We have provided the following resources in the instance that following participation you may need additional support:

Crisis Textline: Free 24/7 crisis support with a live trained crisis counselor. Text HOME to 741741 to connect with a crisis counselor.

SAMHSA National Helpline: SAMHSA's National Helpline is a free, confidential, 24/7, 365-day-a-year treatment referral and information service (in English and Spanish) for individuals and families facing mental and/or substance use disorders. 1-800-622-HELP

Postpartum Support International: An international helpline to find resources for postpartum depression support. Call PSI helpline at: 1-800-944-4773 #1 for English, #2 for Spanish, or TEXT for English: 503-894-9453 or for Spanish: 971-420-0294

National Postpartum Depression Warmline: 1-800-273-8255

National Sexual Assault Hotline/RAINN: Call 800-656-HOPE (4673) to be connected with a trained staff member from a sexual assault service provider in your area. When you call 800-656-HOPE (4673), you'll be routed to a local RAINN affiliate organization based on the first six digits of your phone number. Cell phone callers have the option to enter the ZIP code of their current location to more accurately locate the nearest sexual assault service provider.

National Domestic Violence Helpline: At the National Domestic Violence Hotline, highly trained expert advocates are available 24/7 to talk confidentially with anyone in the United States who is experiencing domestic violence, seeking resources or information, or questioning unhealthy aspects of their relationship. Advocates are available 24/7 at 1-800-799-SAFE (7233) in more than 200 languages. All calls are free and confidential.

National Suicide Prevention Lifeline: 1-800-273-TALK