JACK N. AVERITT COLLEGE of GRADUATE STUDIES GEORGIA SOUTHERN UNIVERSITY

Georgia Southern University

Digital Commons@Georgia Southern

Electronic Theses and Dissertations

Jack N. Averitt College of Graduate Studies

Spring 2023

“My OB/GYN Has The Worst Bedside Manner...” A Qualitative Analysis of Patient-Provider Communication And Mental Health Outcomes of Women In Rural Georgia

Tobi F. Oloyede

Follow this and additional works at: https://digitalcommons.georgiasouthern.edu/etd

Part of the Anthropology Commons, Communication Commons, Rural Sociology Commons, and the Women's Health Commons

Recommended Citation

Oloyede, Tobi F., "“My OB/GYN Has The Worst Bedside Manner...” A Qualitative Analysis of Patient-Provider Communication And Mental Health Outcomes of Women In Rural Georgia" (2023). *Electronic Theses and Dissertations*. 2543.
https://digitalcommons.georgiasouthern.edu/etd/2543

This thesis (open access) is brought to you for free and open access by the Jack N. Averitt College of Graduate Studies at Digital Commons@Georgia Southern. It has been accepted for inclusion in Electronic Theses and Dissertations by an authorized administrator of Digital Commons@Georgia Southern. For more information, please contact digitalcommons@georgiasouthern.edu.

“MY OB/GYN HAS THE WORST BEDSIDE MANNER…” A QUALITATIVE ANALYSIS OF PATIENT-PROVIDER COMMUNICATION AND MENTAL HEALTH OUTCOMES OF WOMEN IN RURAL GEORGIA

by

TOBI OLOYEDE

(Under the Direction of Heidi Altman)

ABSTRACT

Despite technological advances in medicine and public health innovations, maternal mortality in the United States remains significantly higher than in other developed countries. Specifically, Georgia ranks as the second worst place to give birth in the country. Maternal mental health (MMH) conditions are common, manageable complications that can happen at any point during pregnancy, childbirth, or in the first year following delivery, with one in five women affected. Unfortunately, 75% of women who experience MMH symptoms are left untreated.

This study focuses on patient-provider communication through the birthing experiences of women who have been pregnant in Georgia to examine how their experiences of maternity care impact their mental health. This was a qualitative phenomenological study that relied on the Person-Centered Maternity Care (PCMC) and the Communicative Care Perspective as theories to construct the study and interpret the data. To analyze the lived experiences of participants, survey questionnaires and semi-structured in-depth interviews were conducted with thirteen women. The findings are presented using two emergent themes: (I) the indirect effects of communication on maternal mental health and (II) poor communication. The first emergent theme was divided into two subthemes: (a) postpartum depression and (b) postpartum anxiety. The second emergent theme was divided into two subthemes (a) bedside manner and (b)

hear/listen. The confluence of these themes informs maternal mental health outcomes, which is the study's primary focus.

INDEX WORDS: Maternal mental health, Communication, Postpartum depression, Postpartum anxiety, Georgia, Medical anthropology, Public health, Communicative care, Person-centered maternity care.

“MY OB/GYN HAS THE WORST BEDSIDE MANNER…” A QUALITATIVE ANALYSIS OF PATIENT-PROVIDER COMMUNICATION AND MENTAL HEALTH OUTCOMES OF WOMEN IN RURAL GEORGIA

by

TOBI OLOYEDE

B.A., Ekiti State University, 2016

MALS., East Tennessee State University, 2020

M.A.S.S., Georgia Southern University, 2023

A Thesis Submitted to the Graduate Faculty of Georgia Southern University in Partial Fulfillment of the Requirements for the Degree

MASTER OF ARTS in SOCIAL SCIENCES

COLLEGE OF BEHAVIORAL AND SOCIAL SCIENCES

© 2023

TOBI OLOYEDE

All Rights Reserved

“MY OB/GYN HAS THE WORST BEDSIDE MANNER…” A QUALITATIVE ANALYSIS OF PATIENT-PROVIDER COMMUNICATION AND MENTAL HEALTH OUTCOMES OF WOMEN IN RURAL GEORGIA

by

TOBI OLOYEDE

Major Professor:	Heidi Altman
Committee:	April Schueths
	Marieke Van Willigen
	Nandi Marshall

Electronic Version Approved:
May 2023

DEDICATION

This study is dedicated to my family for their wholehearted support and to the women who were interviewed. It is also dedicated to all the women in my life whose collective efforts were instrumental in getting me this far, and to all the men whose counsel have shaped my decisions.

ACKNOWLEDGMENTS

I would like to acknowledge my family for their unwavering support and confidence during the rigors of graduate school.

To Dr. Altman, thank you for creating a stimulating and enabling research environment that allowed me to grow and learn, and being involved in the Georgia Moms' Project. Thank you for believing in me and for always going above and beyond for me.

To the rest of my committee, Dr. Schueths, Dr. Van Willigen, and Dr. Marshall, I am grateful for your contributions and support beyond this research to my graduate study journey.

My gratitude goes to the MASS program for granting me graduate assistantships throughout and to all my friends, classmates, and everyone who supported me on this journey, thank you.

Above all, I am thankful to God for giving me understanding, insight, and strength.

TABLE OF CONTENTS

Page
ACKNOWLEDGMENTS……………………………………………………………..….. 3
LIST OF TABLES………………………………………………………………………. 5
LIST OF FIGURES……………………………………………………………………... 6
CHAPTER
1 INTRODUCTION……………………………………………………………………7
2 LITERATURE REVIEW…………………………………………….……………..….12
The Prevalence of Maternal Mortality in Georgia……………………………… 12
Social Determinants of Health and Maternal Mortality………………………… 12
Maternal Mental Health ………………………………………………………16
Postpartum Depression (PPD) and Postpartum Anxiety………………………...19
Theoretical Frameworks ……………………………………………………….. 21
Person-centered Maternity Care ………………………………………………. 21
Communicative Care Perspective ………… ………………………………… 24
3 METHODS……………………………………………………………………………30
Researcher's Positionality ……………………………………………………30
Research Design ……………………………………………………………… 30
Study Participants and Setting … …………………………………………….... 31
Data Collection ………………… ………………………………………….. 32
Data Analysis… ………………………………………………………………. 33

4 FINDINGS………………………………………………………………… …. 34
The Indirect Effects of Communication on Maternal Mental Health …. ….…. 34
Postpartum Depression……………………………………………………… 34
Postpartum Anxiety ……………………………………………………….37
Poor Communication…………………………………………………………39
Bedside Manner.………………………………………………………… 40
Hear/Listen……………………………………………………………...…43
5 DISCUSSION & CONCLUSION …………………………………………………...47
Limitations and Future Research ………………………………………………50

REFERENCES…………………………………………………………………52

APPENDIX: INTERVIEW QUESTIONS ………… …………………………………62

LIST OF TABLES

Page

Table 1: Constructs and Definitions of Person-centered Care 22
Table 2: Demographic Characteristics of Participants 31
Table 3: Occurrences of Poor Provider Communication 46

LIST OF FIGURES

Page

Figure 1: Leading Causes of Pregnancy-related Deaths in Georgia, 2018-2020……………….12

CHAPTER 1

INTRODUCTION

According to a recent report by the United Nations (UN) agencies (2023), the global effort to reduce maternal mortality has stagnated in recent years, with certain regions, such as Northern America and Europe, retrogressing since 2015. It is estimated that in 2020, there were 287,000 cases of maternal deaths globally, down from 309,000 in 2016. In 2020, 223 maternal deaths per 100,000 live births represented one pregnancy- or childbirth-related mortality every two minutes (UN, 2023). This means that the U.N.'s 2030 goal of reducing maternal mortality globally to 70 per 100,000 live births is falling behind.

Rather than falling below the maternal mortality rates (MMR) of other developed countries, the United States continues to exceed them. Gunja et al. (2022) affirmed that "in 2020, the maternal mortality rate in the U.S. was 24 deaths per 100,000 live births — more than three times the rate in most other high-income countries. In the Netherlands, almost no women died from maternal complications" (para.2). The current change in the MMR narrative is partly due to the adjustment in maternal death surveillance and its reporting. Joseph et al. affirmed that "studies carried out before 2003 showed that identification of maternal deaths based solely on death certificate information resulted in substantial numbers of missed maternal deaths" (2021, p.764). Hence, the National Center for Health Statistics revised death certificates by introducing a pregnancy checkbox in 2003. This led to a significant increase in the number of reported maternal deaths.

According to the Centers for Disease Control and Prevention (CDC), maternal mortality includes two categories: pregnancy-related and pregnancy-associated. The Pregnancy Mortality Surveillance System (PMSS)- a system that monitors pregnancy-related mortality and identifies

risk factors- defines pregnancy-related death as "the death of a woman while pregnant or within 1 year of the end of pregnancy from any cause related to or aggravated by the pregnancy" (CDC Division of Reproductive Health, PMSS 2022). Pregnancy-associated mortality is referred to as death from any condition or illness while pregnant or within one year after the end of the pregnancy, not caused or exacerbated by the pregnancy itself (Tikkanen et al., 2020). Data from Maternal Mortality Review Committees (MMRCs) in 36 US states including Georgia, 2017-2019 show that of the 1,018 pregnancy-related deaths:

> approximately 21.6% of deaths occurred during pregnancy, 13.2% occurred on the day of delivery, 12% occurred 1 to 6 day postpartum, 23.3% occurred from 7 to 42 days postpartum, and 30% occurred in the late postpartum period (43–365 days postpartum) (Trost et al., 2022).

This documents that more than half (65.3%) of the deaths take place after the day of delivery.

The phenomenon of maternal mortality in the United States calls for urgent intervention as the data from the MMRCs between 2017-2019 reflect that "among the 1,018 pregnancy-related deaths, a preventability determination was made for 996 deaths. Among these, 839 (84%) were determined to be preventable" (Trost et al., 2022). Also of concern is the fact that of the 1,018 pregnancy-related mortality, 82 (or 8.4%) were due to suicide, making it the leading cause of maternal mortality in the US (Trost et al., 2022).

In 2020, there were 55.3 deaths per 100,000 live births among non-Hispanic Black women, which was 2.9 times the rate among non-Hispanic White women (Hoyert, 2022). The rates for non-Hispanic Black women increased from 2019 to 2020. It is noteworthy that the data from the MMRCs between 2017-2019 maintain that:

> Cardiac and coronary conditions were the leading underlying cause of pregnancy-related deaths among non-Hispanic Black persons; mental health conditions were the leading underlying cause of death among Hispanic and non-Hispanic White persons; and hemorrhage was the leading underlying cause of death among non-Hispanic Asian persons (Trost et al., 2022, p.2).

Thus, the data revealed that there were differences in the leading underlying causes of pregnancy-related deaths among different racial and ethnic groups in the United States.

The maternal mortality rate in Georgia ranks among the highest in the country and in its most recent report, the Georgia Maternal Mortality Review Committee (GAMMRC) found that 68.9 per 100,000 live births were pregnancy-associated deaths and 25.1 per 100,000 live births were pregnancy-related deaths from 2015-2017. In 2018-2020, the GAMMRC found that of the leading causes of the pregnancy-related deaths, mental health conditions is the second highest after hemorrhage (Georgia Department of Health (DPH), n.d.). In Georgia, women who live in rural areas are more negatively affected than women who live in urban areas due to hospital closures in rural areas, limited access to health care providers, geographic location of obstetrics care, and social-economic factors and demographic factors like race, age, educational level, and marital status (United Health Foundation, n.d.; Delima et al., 2020; Armstrong-Mensah et al., 2021).

Existing research has explored and is currently exploring social determinants of health and causes of maternal mortality in rural Georgia. Armstrong-Mensah et al. found “five key social determinants associated with high maternal mortality rates in Georgia - geographic location of obstetric services, access to health care providers, socioeconomic status, racism, and discrimination” (2021, p.278). This shows that a combination of factors drives the high maternal

mortality rate in Georgia. In addition to limited access to care, other factors such as distance, transportation, social supportive organizations, and poor patient-provider communication are risk factors for rural women in Georgia (Georgia House Budget & Research Office, 2019; Armstrong-Mensah et al., 2021).

This study is an offshoot of the Georgia Mom's Project, led by Dr. Heidi Altman, a research initiative that collects narratives and lived experiences of maternity care and maternal health. The goal of the project is to understand the unique challenges faced by pregnant and postpartum women in Georgia, particularly those living in rural areas or with limited access to healthcare. The research involves collecting data through surveys, and interviews, and working with community partners. To find a solution to the maternal mortality crisis in Georgia, common themes and experiences are identified.

My study examines the lived experiences of women in rural Georgia with a focus on patient-provider communication and mental health. Within this research, the Communicative Care Perspective (CCP) and Person-Centered Care theoretical framework were used to explore the ways in which our study participants report communicating with providers. As a therapeutic alliance, communication is a basic aspect of clinical expertise that if performed efficiently and competently, can build provider-patient trust and result in quality healthcare (Chichirez & Purcărea, 2018; Ratna, 2019). In addition, Wang et al. (2021) found that communication remains an issue in maternal health, and they reemphasize that compassionate and consistent communication can improve patients' feelings of agency, manage trauma, and increase satisfaction. As a bidirectional process between provider and patient, a lack of effective communication could serve as a barrier to women's access to quality care and satisfaction. Hence, this study's research question is **"How do women who report poor patient-provider**

communication experience its impact on their mental health?" This research investigates the issue of maternal morbidity from the stories of the women who experience maternity care in rural Georgia and how their negative experiences with providers result in diminished agency and satisfaction.

As a rationale for this study, apart from existing literature and statistics, my personal and intellectual interest triggered my involvement in the study of maternal mortality. In a chapter entitled *When Personal Experience, Family History, and Research Subjects Intersect,* Wendy Sharer, a feminist scholar states, "I can encourage new scholars to find topics via their lived experiences because those experiences help us to recognize what is significant, even if we are not able to articulate a rational, 'neutral' reason for that significance" (2008, p.54). I have had people close to me die during childbirth and my mother's experience was a near-miss during my birth. For me, maternal health issues have been a frightening phenomenon with emotional impacts. As a global issue, maternal health concerns embody a challenging phase of women's lives and continue to raise my curiosity. I am interested in this study, not only because of my personal experiences and intellectual interests but also because the experiences and voices of these women need to be heard.

CHAPTER 2

LITERATURE REVIEW

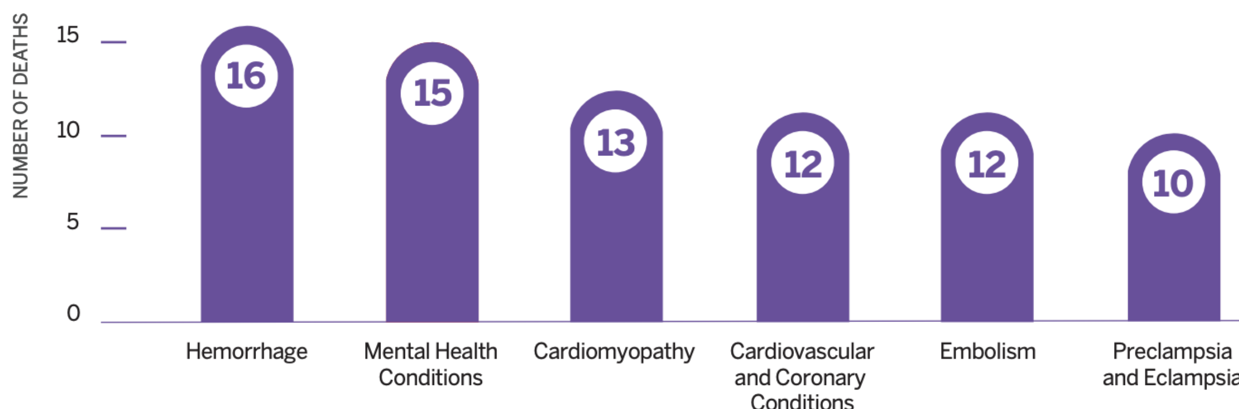
In this chapter, I will focus on the prevalence of maternal mortality in Georgia, the social determinants of maternal mortality, and care and communication. For the understanding of patient-provider care and communication, I draw insights from scholarly works in medical and linguistic anthropology and public health.

The Prevalence of Maternal Mortality in Georgia

According to Amnesty International, Georgia had the highest maternal mortality rate in the United States in 2010 and depending on the year, it is either the worst or the second worst after Louisiana. In 2018, Georgia had a maternal mortality rate of 46.2 deaths per 100,000 live births, compared to the national average of 17.4 deaths per 100,000 live births (DPH, n.d.). This means that Georgia had a maternal mortality rate that was 2.7 times higher than the national average. Between 2018 and 2020, there were 48.6 per 100,000 live births pregnancy-related deaths among non-Hispanic Black women and 22.7 per 100,000 live births pregnancy-related deaths among non-Hispanic White women (DPH, n.d.). Thus, non-Hispanic Black women were more likely than non-Hispanic White women to die from pregnancy-related deaths. Pregnancy-related causes of death include cardiomyopathy, cardiovascular/coronary disease, hemorrhage, embolism, preeclampsia, and eclampsia while pregnancy-related deaths include homicide, motor vehicle accidents, and drug toxicity (Armstrong-Mensah et al., 2021). Understanding the right cause of pregnant women's death is vital to avert preventable deaths through effective health care programs, solutions, and adequate policies.

Figure 1

Leading Causes of Pregnancy-related Deaths in Georgia, 2018-2020



Note. Georgia 2018-2020 Maternal Mortality obtained from Georgia Department of Health. Mental health conditions are the second leading cause of pregnancy-related deaths in Georgia. Although statistics show that non-Hispanic Black women are more likely than non-Hispanic White women to die of pregnancy-related deaths in Georgia, national statistics show that White are more likely to die from mental health conditions (DPH, n.d.; Trost et al., 2022). There is limited data available on the specific question of whether White or Black women are more likely to experience maternal mental health issues in the state of Georgia.

Race, marital status, educational level, and age of women have all been linked to high maternal mortality in Georgia (World Population Review, 2022; DPH, 2015; DPH, 2011). The increased rates of maternal mortality in Georgia is alarming and it indicates the need for improved support services and maternal healthcare. Although the rates are different for each ethnic group, it is important to explain how factors that can be referred to as social determinants play a role in how Georgia women are affected.

Social Determinants of Health and Maternal Mortality

Social Determinants of Health (SDOH) are factors that affect health outcomes. According to the CDC, SDOH are "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life" (2022). According to

Healthy People 2030, the social determinants of health are defined as “the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks” (ODPHP, n.d.). These conditions pose a variety of risks and repercussions on the quality of life, health, and functioning. One of the goals of Healthy People 2030- a framework developed by the Office of Disease Prevention and Health Promotion, is addressing SDOH.

Many of the factors influencing maternal health and mortality are directly related to a mother's socioeconomic and demographic circumstances. Because different contexts influence the outcomes of health care, social variables such as economic status, language/literacy skills, access to health and geographic location of obstetrics services, physical environment, and social and community contexts are required to be studied to provide quality care. For instance, Georgia's maternal mortality rate may be affected by systemic racism and discrimination. Research has shown that racial bias and discrimination can contribute to inequities in access to quality healthcare and other resources needed for optimal maternal health outcomes as Black women in Georgia have a higher maternal death rate than white women (DPH, n.d.; Armstrong-Mensah et al., 2021).

The closure of hospital labor and delivery services in rural areas of Georgia—places with a population of 35,000 or less (Georgia State Office of Rural Health 2008)— has led to a shortage of obstetric care providers in these areas (Armstrong-Mensah et al., 2021). This shortage has resulted in pregnant women traveling long distances to access maternity care, which can lead to complications and poor health outcomes, particularly for low-income women who may not have access to transportation. The research question "How do women who report poor patient-provider communication experience its impact on their mental health?" is connected to

this issue as it explores how the inaccessibility of obstetric care providers leads to poor communication between patients and providers therefore affecting patients' mental health. Women who must travel to receive maternity care and have trouble communicating with their doctors may be more likely to have anxiety or depression because of the stress and uncertainty of their situation. Also, women who are low-income and lack access to transportation may be more likely to have poor mental health due to the logistical and extra financial stress.

In rural Georgia counties, there is an uneven population to physician ratio that shows that there is an OB/GYN shortage. According to the Georgia Board of Health Care Workforce (n.d.), the rate of OB/GYN physicians in Georgia is 232 per 100,000 residents. In rural Georgia, Oglethorpe, and Madison counties, for example, have a population of 15,054 and 29,650 respectively, yet they have no practicing OB/GYNs. As a result of this shortage, patient-provider communication can significantly affect mental health outcomes for women in rural Georgia, particularly in terms of prenatal care and childbirth experiences which can contribute to mistrust and lower health outcomes (Miteniece et al., 2018). This may result in limited prenatal appointment frequency and duration, which can hinder effective communication. For example, if a patient does not feel heard or understood by their provider, they may be less inclined to follow treatment recommendations or get adequate care. The lack of access to prenatal care and hospital delivery services can lead to stress, anxiety, and depression during pregnancy, and poor communication with healthcare providers can result in feelings of neglect or mistreatment, which can further exacerbate mental health issues. Altogether, the closure of labor and delivery units and the shortage of providers in rural Georgia has had significant consequences for women's mental health, emphasizing the importance of ensuring adequate access to obstetric care and improving patient-provider communication in these areas.

Overall, the relationship between patient-provider communication and maternal health outcomes in rural Georgia is complex, but effective communication is critical to ensuring that women receive the care they need to maintain good mental health outcomes. By addressing communication barriers and promoting education and awareness, providers can help reduce health disparities and improve outcomes for rural women with low SES.

Maternal Mental Health

Maternal mental health (MMH) conditions are common, manageable complications that can happen at any point during pregnancy, childbirth, or in the first year following delivery, and one in five women are affected in the United States (800,000 women per year) (Maternal Mental Health Alliance (MMHLA), 2021). MMH conditions span emotional distress such as anxiety, depression, post-traumatic stress disorder (PTSD), bipolar disorder in the peripartum, obsessive compulsive disorder, substance use disorder, and rarely psychosis (Fawcett et al., 2019; ACOG 2019). The impacts of untreated MMH conditions not only negatively affect the mother, but also the child, family, and society. Perinatal mood and anxiety disorders (PMADs) are some of the most prevalent mental health issues women of reproductive age experience (Fawcett et al., 2019). The intersection between maternal mental health and the social determinants of health creates a direct impact on one another as both are interdependent. For instance, you cannot anticipate an improvement in an individual's physical health if the mental health does not improve, or vice versa. The significance of maternal mental health and social determinants of health (SDOH) cannot be overstated, as various social factors such as poverty, healthcare accessibility, and education can potentially impact a mother's mental well-being. Conversely, poor maternal mental health can make it harder for people to access health care and/or work, and to care for themselves and their children.

Over 65% of rural counties lack psychiatrists and over 60% of Americans reside in areas with a shortage of mental health providers (Morales et al., 2020; RHIB 2021). This scarcity contributes to the existing health disparities among rural and urban women. MMH issues are compounded by the factors associated with rural healthcare in Georgia.

As a result, primary care physicians frequently fill the void and provide mental health services while dealing with their own challenges, such as a lack of time with patients or inadequate financial reimbursement. Apart from the shortage of mental health providers, the lack of social support and stigmatization that rural women experience leaves an indelible mark on their mental health, and "research suggests that individuals living in rural areas are less likely than residents of urban areas to seek professional help for psychological distress for several reasons including stigma (both public and self-directed) and limited mental health literacy" (Morales et al., 2020, p.4565). In the postpartum period, stigma serves as a barrier to seeking help, but a decrease in the perception of stigma and an increase in health literacy can improve women's health (Jones 2022). By implication, adequate patient-provider communication impacts the perception of satisfaction and health.

In Georgia, it is estimated that Black women are more likely to experience pregnancy-related morbidity and mortality, while nationally, White women are more likely to experience maternal mental health issues (DPH, n.d.; Trost et al., 2022). Compared to other racial and ethnic groups, White women may be more likely to have postpartum depression and anxiety. However, research on maternal mental health outcomes is complex, and access to care and other social determinants of health can affect outcomes. There is limited data available on the specific question of whether White or Black women are more likely to experience maternal mental health issues in the state of Georgia. However, there is evidence to suggest that maternal mental health

issues are a significant concern for all women in the state, regardless of race. Potentially, cultural differences in seeking MMH care may be the reason for disparity in data between Black and White women. Black women are not only less likely to seek help because of their experiences of social injustices which make them see themselves as resilient, but also the stigmatization around seeking help. (Richards, 2021; Bodnar-Deren et al., 2017). For example, Black women experiencing postpartum depression are less likely to use medication or seek care not only because of the stigma, but also because of prior negative experiences (Richards, 2021).

It is important to note that Trost et al. (2022) study analyzed data from 2017-2019 which were before the COVID-19 pandemic. As a result of the COVID-19 pandemic, it is estimated that MMH conditions including PMAD rates have increased three-four times for Black mothers compared to White mothers nationally. (Avalos et al., 2022; Feinberg et al., 2022; Lebel et al., 2020). The disparity may be due to several pandemic-related stressors that disproportionately affect racial and ethnic minority groups, such as higher rates of unemployment, financial insecurity, and exposure to COVID-19 (Avalos et al., 2022). Thus, there remains an increased number of untreated Black mothers experiencing PMADs. Within the context of maternal mortality, maternal mental health issues such as PMADs that are left undiagnosed or untreated result in higher mortality rates (Lebel et al., 2020). In a recent study by Floyd James et al. (2023), “In the United States (US), 29–44% of Black women experience postpartum depressive symptoms (PDS)” (p.1). They argue that regardless of the increased percentage, the reasons for the disparity are diverse.

With the COVID-19 pandemic, more women suffering from PMADs die by suicide or not seeking help (Raiff, et al. 2022; Susser et al., 2021). The primary cause of pregnancy-associated deaths is currently maternal mortality resulting from suicide. This phenomenon is

observed to occur during the postpartum period in 83% of cases, while 17% of cases occur during pregnancy. The prevalence of suicide as a cause of maternal mortality is often attributed to underlying mental health conditions such as depression and anxiety, which are commonly associated with suicide. (Martin, 2021; Spencer 2022). To indicate the seriousness of MMH in Georgia, in 2022, lawmakers signed a resolution naming May 4 a "Maternal Mental Health Day" (Oak, 2022). This was an important step to educate and bring visibility to MMH.

In a bid to help women in need of MMH treatment, the Barkin Index of Maternal Functioning (BIMF) is used across sectors; academic, clinical, industry, and communities as a global measure of functioning (Barkin et al., 2010). BIMF is a 20-item self-report measure of maternal functioning that captures mothers' experiences and perceptions in the postpartum period since maternal mortality due to suicide is now the leading cause of pregnancy-associated deaths (Martin, 2021; Spencer 2022). It's critically important that the Barkin Index evaluates women's feelings during the postpartum period as it marks a pivotal time for both mother and child. By using the BIMF, researchers and healthcare providers can identify where mothers may be having difficulty and help them get better by giving them targeted support and interventions.

The menace of maternal health is multifaceted and needs to be handled at different levels. While there is no evidence to suggest that White women are more likely to experience MMH issues specifically in Georgia, there are disparities in maternal health outcomes by race and ethnicity nationwide. These disparities suggest that addressing maternal mental health issues requires a comprehensive approach that addresses the social determinants of health. For this study, postpartum depression and postpartum anxiety are the two types of MMH to be discussed.

Postpartum Depression (PPD) and Postpartum Anxiety

According to the CDC, postpartum depression is a form of "depression that occurs after having a baby. Feelings of postpartum depression are more intense and last longer than those of "baby blues," a term used to describe the worry, sadness, and tiredness many women experience after having a baby" (2022). Previous depression, anxiety, and mood disorders are major risk factors for postpartum depression, but the symptoms of postpartum depression include sadness, pessimism, anger, crying more, difficulty sleeping, feeling distant from the baby, and concern about hurting the infant (America's Health Rankings, n.d.). PPD has three main effects:

> (a) maternal effects, including physical health, relationship, mental well-being, and risky behaviors; (b) infant effects, including physical health, sleep, anthropometry, and language, emotional, social, behavioral development motor, and cognitive; and (c) mother-child relationships, including breastfeeding, bonding, and the maternal role (Lima, 2021).

Many studies have explored the diagnosis, prevalence, cause, and treatment of postpartum depression, but less have examined postpartum anxiety disorders. Ali (2018) affirms that anxiety disorders are more prevalent in postpartum women than in the general population, with incidence estimates ranging from 6.1% to 27.9% within the first six months postpartum. The symptoms of postpartum anxiety include worries, guilt, feeling overwhelmed, and feelings of dissociation (Ali, 2018). Comorbidity between depression and anxiety, in which many symptoms are shared, is an additional factor that complicates matters (Ali, 2018; Wardrop & Popadiuk, 2013).

PPD and postpartum anxiety are linked as 25%–50% of women with pre-existing anxiety disorders develop PPD two months following childbirth and two-thirds of postpartum depressed women have anxiety disorders (Nakić Radoš et al., 2018). Poor adherence to medical care, poor

nutrition (inadequate or excessive gestational weight gain), loss of financial resources, smoking and substance misuse, and their associated hazards are associated with maternal anxiety and depression (Kendig et al., 2017).

Naturally, labor and delivery is a stressful process but the addition of poor provider communicative skills adds more stress on the mother. It is usual to be worried about how to care for one's child, but weakening women more with poor communication is enough to increase their worry and uncertainty about being good mothers, leading to increased stress levels.

Theoretical Frameworks

To examine the narratives of women who have been pregnant in Georgia, I have identified theories cardinal to the interpretive aspects of this study. I use the person-centered maternity care and communicative care theoretical perspectives to construct the study and interpret the data.

Person-Centered Maternity Care

Afulani et al. (2018) define PCMC as a form of perinatal care that is respectful of and sensitive to women's preferences, values, and needs. This means ensuring that their needs, values, and preferences direct all clinical choices before, during, and after childbirth. The PCMC includes patient-provider communication, system and provider responsiveness, patient engagement, and interpersonal treatments. The World Health Organization's (WHO) recommendation for quality maternity care includes a positive childbirth experience (Afulani et al., 2018). With the high rate of maternal mortality in the US and in Georgia specifically, I am using the PCMC to interpret the data since it is a framework for conducting patient care and it focuses on respect, consent, privacy, and communication among others. Thus, we can interpret the experiences of the women against this framework.

PCMC is an offshoot of Person-Centered Care (PCC). The Center for Medicare and Medicaid defines PCC as "integrated health care services delivered in a setting and manner that is responsive to the individual and their goals, values, and preferences, in a system that empowers patients and providers to make effective care plans together" (n.d.). For patients, PCC means their ability to make informed decisions regarding their care and well-being on the one hand while for providers, on the other hand, it means collaborating with patients and other providers to provide the best care. The domains of PCC and PCMC are not mutually exclusive. The domains include dignity, autonomy, privacy/confidentiality, communication, social support, supportive care, trust, and health facility environment (Sudhinaraset et al., 2018).

TABLE 1
Constructs and Definitions of Person-centered Care

Construct	Definition
Dignity	Dignity refers to the ability of women to receive care in a respectful and caring setting. It captures the typologies of physical and verbal abuse from the literature on the mistreatment of women during labor and delivery, as well as less subtle acts during patient-provider encounters that make women, and their families feel disrespected.
Autonomy	Autonomy implies that providers of health services respect women's views of what is appropriate and support women, her family, and companion of choice to make informed choices. This includes providing consented care. An example of a measure for autonomy is whether women feel involved in decision-making about their care and whether their permission is sought before treatments.
Privacy/Confidentiality	This relates to privacy in the environment in which care is provided, and the concept of privileged communication and confidentiality of medical records. An example is whether women feel others who are not involved in their care could hear information about their care or could see them during physical examinations or during labor and delivery without physical examinations.
Communication	This domain refers to providers clearly explaining to women and family the nature of their condition, details of treatment, and available treatment options. An example is whether providers clearly explain to women their conditions and the purpose of treatments, any side effects of treatments, and whether women understand explanations.
Social support	This domain reflects the extent to which women have access to their companion of choice when receiving care. It also includes their right to receive food and other consumables from a family when deemed appropriate. An example is whether family and friends are allowed to stay with them during care.
Supportive care	This refers to providers providing care in a timely, compassionate and caring manner, as well as integration of care in a way that is responsive to patient needs. It also captures abandonment or denial of care, protection from harm and unnecessary procedures, and patient safety. It includes women's perceptions of how providers respond to them when they need more help.
Trust	This captures how women assess their care with providers. Here, measures include whether women feel providers tell them the truth about their care, their health, their child, their situation, and whether they have confidence in the competence of their providers.
Health facility environment	This captures the quality of the facility and providing a fully enabled environment, including the commodities and equipment, but also referral system, communication and transportation, maternal and neonatal health team that can cover the full continuum of care, environment where staff are respected and valued and that is clean, and the extent to which a health facility offers a welcoming and pleasant environment. Examples include clean surroundings and enough space in waiting rooms and wards.

Note. The table was adopted from Sudhinaraset (2018, p.4).

Communication between pregnant people and their providers during the prenatal and delivery phase has a significant impact on their utilization of services and satisfaction. Sudhinaraset et al. posit that:

> Continuous support during labor and delivery from partners and providers, including companions of choice, is associated with shorter labor, better coping with pain, decreased incidence of operative birth, increased incidence of spontaneous vaginal delivery, increased maternal satisfaction, less anxiety, and increased rates of breastfeeding initiation (2018, p.3).

They argue that continuous support from providers can help the mother feel more calm and in control, reducing anxiety levels.

In their study to investigate barriers to accessing maternal care in Georgia, Miteniece et al. (2018) found that poor patient-provider communication was a significant problem. The study participants expressed concerns regarding inadequate communication in terms of approachability and comprehensibility of their healthcare providers. Research shows that poor patient-provider communication causes care delays for pregnant women in Georgia and this also leads to a late or missed diagnosis that can be detrimental to the pregnancy (Meyer et al., 2016; Prather et al., 2018; Shahin et al., 2020). While these authors measured factors that influence the increased rate MMR, I did an analysis of the narratives of women via interview, who have given birth in Georgia. Their works highlight the value of patient-provider interaction in fostering patient autonomy and trust, both of which are crucial components of quality care. Trust is based on both communication and perceptions of supportive treatment, whereas autonomy relates to the patient's capacity to make decisions regarding their medical care. These two areas serve as a

foundation for universal standards for medical practice and are based on human rights. While there may be cultural disparities in care expectations, it is critical to adopt culturally relevant approaches that protect patients' basic human rights. This implies that healthcare providers should be trained to communicate effectively with their patients, taking cultural differences and individual patient needs into account, to ensure that all patients receive quality care that respects their autonomy and builds trust between them and their providers.

Communicative Care Perspective

The Communicative Care Perspective (CCP) seeks to address the problematic patient-provider relationship in Western medicine. This relationship has been studied extensively by social scientists who have identified poor communication and patient dissatisfaction and patient noncompliance as key issues (Lazarus, 1988). For over four decades, medical anthropologists have sought to understand the patient-provider relationship. Thus, Lazarus (1988) posits that:

> What happens and what fails to happen when doctors and patients interact must be documented empirically, but it is also essential that we go beyond these data to place information about the doctor-patient relationship in a theoretical context. In this way we can learn why the relationship is so fraught with problems and how it might be improved (p.34).

This shows that it is crucial to monitor interactions between doctors and patients, particularly pregnant women, and their providers, to better understand why communication breakdowns occur and how to enhance these relationships. To understand why doctors and patients do not communicate properly, we need to put evidence in a theoretical perspective.

Ethnographic attention is now being drawn to certain care practices as opposed to the meaning-making, reflexive accounts dominant in previous studies, establishing a clear distinction

between signifying and enacting care. Simply put, ethnographic studies of care practices are shifting their focus from understanding how individuals make sense of their experiences (meaning-making, reflexive accounts) to analyzing the actual practices and behaviors involved in caring (enacting care). The distinction between signifying and enacting care suggests that there is a difference between simply talking about caring and actually engaging in caring behaviors. Signifying care involves the use of language and symbols to express care, whereas enacting care involves physically doing things that demonstrate care, such as providing physical assistance, emotional support, or practical help. Therefore, the focus of current studies is on observing and analyzing the concrete practices of caring rather than solely on the discursive or reflective aspects of care. Quality patient-provider communication not only breeds care but also implies meaningful care (Arnold, 2020). This suggests that effective communication between patients and healthcare providers is crucial not only for delivering proper care but also for conveying a sense of meaningful care. Quality patient-provider communication involves active listening, clear explanations, empathy, and shared decision-making. When patients feel heard and understood by their healthcare providers, they are more likely to trust and comply with the treatment plan. Effective communication also fosters a sense of partnership between the patient and provider, which can enhance the patient's sense of being cared for in a meaningful way. Therefore, this statement emphasizes the importance of not only providing competent medical care but also communicating with patients in a way that acknowledges their concerns, respects their autonomy, and supports their overall well-being just as the PCMC posits.

Arnold (2020) maintains that practicing communicative care is a social action that allows inclusion. The inclusion of patients in important decision-making is essential. Effective communication is crucial for shared decision-making and patient-centered care while interacting

with and providing for patients. Communication is key to ensuring that patients and family caregivers may take an active role in their care and make informed decisions throughout a patient's involvement with the health care system, including diagnosis, treatment, and phases of other care settings, such as the home. However, there is a chance for harm if these communication encounters are subpar or missing entirely. Alio et al., (2022) study found that women who described negative experiences mentioned a lack of knowledge regarding what to expect and a lack of information. They conclude that "woman-provider communication was the most important factor influencing the maternal experience … Observational studies outside of the perinatal period suggest that clinicians often use medical terminology, miss affective cues, and signs that the patient is no longer following, and block opportunities for patients to address their concerns" (p. 757). These communication defects can result in adverse consequences.

Embodied communication facilitates the expression of care (Black 2018). Embodied communication refers to the nonverbal ways in which individuals communicate with each other, including facial expressions, body language, touch, and other physical cues. It involves using one's body to convey emotions, attitudes, and intentions, in addition to the words spoken or written. In the context of care, embodied communication can be an important way to express and receive care. For example, a caregiver's gentle touch, tone of voice, or facial expressions can communicate empathy, compassion, and concern to the person receiving care, even if they don't explicitly state these feelings. In all, embodied communication suggests that by using nonverbal cues to express care, healthcare providers can create a deeper and more meaningful connection with those they are caring for. An essential prerequisite for intersubjectivity is the perception of another entity as a feeling and thinking subject like oneself (Black 2018). This explains that

when care providers see their patients (people) as people who have agency and autonomy, they can build a collaborative relationship during the care period.

A prevalent top-down language ideology that transpires from provider to patient is the objectification of the patient's sick body which reduces the patient's autonomy and agency during care routines (Black 2018). Providers may be unaware of patients' distinct ways of constructing conversations, the style of communication, participant roles, or the diagnostic process, which can lead to misdiagnosis, and exclusion from care (Harvey 2013; Guzman 2014). This shows that health care delivery itself can present a bastion of communication problems especially when providers and patients have different cultural backgrounds. For instance, the data obtained from the Georgia Board of Health Care Workforce (GBHCW) 2019-2020 physician renewal survey show that most Obstetricians/Gynecologists in rural Georgia are White males (78.57%), and they fall between the ages of 50-64 (GBHCW n.d.). Arnold and Black (2020) theorize that there is a link between care and communication and as such, language is used to enact, facilitate, and signify care.

Patient-provider communication is a contributing factor to mothers' experiences of perinatal care as it impacts whether they experience a positive or negative outcome. To address the inequities in maternal health, particularly pregnancy outcomes, improving patient-provider communication during the perinatal period informs research, practice, and interventions. Different communication contexts can be associated with individual well-being (Segrin, 2014). Owing to the fact that communication is a social skill that allows people to appropriately interact with one another, the lack thereof from one end can impact the other. Street et al., (2009) explain that:

> While talk itself can be therapeutic (e.g., lessening the patient's anxiety, providing comfort), more often clinician–patient communication influences health outcomes via a more indirect route. Proximal outcomes of the interaction include patient understanding, trust, and clinician–patient agreement. These affect intermediate outcomes (e.g., increased adherence, better self-care skills) which, in turn, affect health and well-being (p.295).

This suggests that patient-provider communication can reduce mental health outcomes such as reducing anxiety and improving overall well-being.

Effective communication between healthcare providers and mothers is critical for managing maternal mental health concerns. Kountanis et al. (2020) found that good communication between healthcare providers and mothers was associated with lower levels of MMH during the postpartum period. In his study on "Communication and Well-being*,"* Segrin (2005) affirm that:

> Interpersonal communication problems have also been implicated in a host of psychological disorders… Throughout life, people develop a sense of self-identity, self-esteem and feelings of competence based in large part on how they are treated by others. When communication from other people… is hostile, belittling, peculiar, or otherwise enacted with malfeasance, the psychological toll on the recipient can be dramatic (p.548).

This explains how dysfunctional communication can affect an individual psychologically. The implication for patient-provider communication is that effective communication can be crucial in promoting patients' mental health and wellbeing. Providers must be aware of the impact of

communication patterns on their patients and strive to foster positive, supportive, and empathetic communication.

In summary, poor patient-provider communication can affect a patient's mental health. There is a growing body of research showing that communication between doctors and patients plays an important role in patient outcomes, including mental health. Patients who feel that their providers listen to them, explain things clearly, and involve them in their care are more likely to report positive mental health outcomes, such as decreased mental health issues and improved quality of life.

CHAPTER 3

METHODS

Researcher's Positionality

I am the primary investigator for this research. I did not collect the data myself as I am relying on data from the Georgia Mom's Project. As a graduate assistant, I am involved in the process of coding the data. I am an international student from Nigeria. I have had close experiences with maternal near misses, maternal mortality, and health inequality in Nigeria, as it did take a toll on me, and this has prompted my interest in understanding maternal health care. Although I have an insider perspective on the phenomenon under study, the location under study is unique, and the interpretation of data depends solely on participants' narratives. Thus, this work serves as a deep form of learning for me as I learn not from my personal experiences, but from the participants.

Research Design

I take a critical ethnographic stance that includes an advocacy perspective as a response to serve individuals marginalized because of gender, class, and race by systems of power and authority (Creswell & Poth, 2018). In this study, I focused on understanding the lived experiences of women who have been pregnant in Georgia and the experiences they had with their providers. Particularly, I delve into patient-provider communication and how it influences the mental health outcomes of these women. As a phenomenological method, I relied on their lived experiences, leaving out my personal interpretations as the aim was to see how poor communication affected them and how it affected their mental health.

Study Participants and Setting

Table 2

Demographic Characteristics of Participants

Identifier	Pseudonym	Age	Race	Highest Education	Occupation	Place of Child(ren) Birth
15554	Kim	33	White	PhD., M.D., J.D.	Attorney	Georgia
27935	Anna	23	Black	High school diploma	PCA	Georgia
26326	Jessie	44	White	Masters	Analyst	Georgia
10769	Helena	33	White	Masters	Stay at home mom	Georgia
24203	Courtney	35	White	Bachelors	Behavior Specialist	Georgia
46165	Alaina	37	Black	PhD., M.D., J.D.	Associate Professor	Georgia
59878	Kate	35	White	Masters	Advisement Coordinator	Georgia
30527	Dana	34	White	Masters	Teacher	Georgia
56093	Megan	37	White	PhD., M.D., J.D.	Assistant Professor	Georgia
75207	Alex	32	White	Bachelors	Stay at home mom	Georgia
18194	Sam	42	Black	Masters	College Administrator	Georgia
28861	Regina	24	White	Bachelors	Self Employed	Georgia
34420	Nelly	39	Black	Masters	Therapist	Georgia

The study relies on data from the Georgia Moms Project (GMP), a pilot project led by Dr. Heidi Altman. The first set of data collected by the GMP includes a total of forty-two women participating in the survey and thirty-eight women were interviewed. For my study, only 13

participants' narratives that showed the co-occurrence of poor communication and mental health outcomes were analyzed and interpreted to answer the research question. The inclusion criteria included women who are at least 18 years of age, have had an experience with prenatal, labor/delivery, and postnatal care in the state of Georgia within the past ten years, and are more than one year postpartum. The average participant was 34.1 years of age and they identified as Blacks/African Americans (4) and Whites (9). Their educational level ranged from a High School diploma (1), bachelor's degree (3), and master's degree (6) to a Ph.D./M.D./J.D. (3).

Data Collection

The study relies on the GMP, and it is approved by Georgia Southern Institutional Review Board (IRB) as protocol H19465. Participants were recruited through the offices of healthcare providers who practice at the Curtis V. Cooper clinics in Savannah, Georgia. The Clinics provided space for the in-person recruiting of participants. In addition, postcards were given to women with information about how to schedule appointments for the interview. Women who were interested in participating emailed the confidential email address (GAMomsProject@gmail.com) on the postcard to be included in the study if they were unable to register during a face-to-face recruitment period. Social media was also used to recruit prospective participants from Dr. Altman's social network. A website, Facebook page, and Twitter account for the project were created and shared among social networks in the region. The confidential email address (GAMomsProject@gmail.com) was provided for participants to contact the Primary Investigator Dr. Heidi Altman to volunteer to be interviewed.

The surveys were filled online and semi-structured in-depth interviews (in person and online) with open-ended questions ranging from 45-120 minutes and were audio-recorded with digital audio recording equipment. The audio files were uploaded to Otter.ai for transcription.

The files were also stored in a backup Google Drive folder. The transcripts were then uploaded into NVIVO 12 and Atlas.ti coding software. Random identification numbers were assigned to all participants by the survey software before the interview to ensure the anonymity of the participants.

Data Analysis

The first step of data analysis was done in NVIVO 12 following a codebook of themes. The PI and I moved the data to Atlas.ti for better collaboration. In Atlas.ti, we developed both descriptive and narrative codes/themes that emerged for participants' narratives. Different themes with strong structural regularities were moved together as subthemes under the two emergent themes for this study. Braun and Clarke refer to themes as something that "captures something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set" (2006:10). To specifically answer the research question, a co-occurrence table was used in Atlas.ti to generate responses from participants who experienced communication issues and mental health issues. In this research, the four themes were bedside manner, hear/listen, postpartum depression, and postpartum anxiety which were divided under two emergent themes.

The PI and I both coded themes to present intercoder reliability which is "to see whether the constructs being investigated are shared—whether multiple coders reckon that the same constructs apply to the same chunks of text" (Bernard 2017, p.477). This signifies agreeability in terms of codes/themes.

CHAPTER 4

FINDINGS

Predicated on the purpose of this study, the findings are presented using two emergent themes: (I) the indirect effects of communication on maternal mental health and (II) poor communication. The first emergent theme was divided into two subthemes: (a) postpartum depression, and (b) postpartum anxiety. The second emergent theme was divided into two subthemes (a) bedside manner and (b) hear/listen. The confluence of these themes informs maternal mental health outcomes, which is the study's primary focus.

The Indirect Effects of Communication on Maternal Mental Health

The main purpose of this study as stated earlier is to analyze the narrative of women who have been pregnant in Georgia to find out how their communication experiences with their providers result in adverse mental health experiences. To affirm this, the women interviewed for this study were those with cooccurrences of both poor communication and mental health experiences. Thus, the themes below are from the narratives of the women explored under the themes above.

Postpartum Depression

In this study, seven participants who experienced poor communication from their providers also narrated their postpartum depression. Kim’s experience with her provider was one that lacked a sense of being cared for. She further explained that she experienced postpartum depression and felt overwhelmed in the postpartum phase. Fear of not being a good mother is a symptom of postpartum depression and Kim mentioned, “I was constantly afraid that he was going to choke and die.” 81:0 ¶ 167 in 15554tx.docx.

Another participant, Jessie experienced lack of inclusion in decision making regarding her choices and whom her provider did not listen to when she complained about hemorrhaging mentioned that she had thoughts of death and difficulty bonding with her baby. She stated:

> I don't understand why postpartum depression isn't just labeled PTSD, because that's what it is. I remember thinking like war couldn't be worse than what I just went through. And I was not alright. I really was not alright. … I wasn't happy. I wasn't sad. And I was not angry. I was not present … which made me like super depressed and suicidal. I had a hard time nursing that baby kind of had a hard time nursing the baby. 87:104 ¶ 289 in 26326tx.docx.

For Alaina, her lack of inclusion in decision making and no sense of being cared for which are constructs of the CCP had an impact on her mental health. She expressed:

> I had some postpartum depression, self-diagnosed but I didn't talk to the doctor about it. I think I was too embarrassed. But it was really bad. Like, I was supposed to be working on my dissertation. I would tell everyone I was but for six months, I didn't do anything. Yeah, I would drop him off at my mom's house and come home, sit on the couch, watch TV, and just soak and then pick him up when it was five and act like everything was fine. And I didn't think until I got out of it that I realized, oh, I probably should talk to somebody. 96:106 ¶ 319 in 46165tx.docx

Alaina spoke of some symptoms of postpartum depression such as shame and diminished ability to concentrate particularly on her dissertation.

Another participant, Kate, had a poor communication experience with her provider regarding trouble with breastfeeding but the provider gave an insensitive response which made her start crying and upset. After the incident, she experienced postpartum depression and had to

call her OB’s office to speak with someone but was scheduled without asking the needed questions about her screening. As a person with a background in mental health who had been a therapist, she experienced both insensitive care and communication. Kate explained that:

> there was no further screening like, It wasn't like, how desperate are you? Like, are you gonna throw your baby out the window tonight? Or is it like you're kind of just needing, and I just remember being shocked at that and being like, there was no further questioning. And my appointment was three or four days later, which was fine for me, but might be too late for some people. 101:55 ¶ 407 in 59878tx.docx

Regina had a good rapport with her obstetrician, but it was her anesthesiologist who was nonchalant about her panic attacks and referred to her as being dramatic. She narrated that she ended up with both depression and anxiety. In her words:

> I still have postpartum PTSD from all of the trauma from the operating room and everything like that from the C section. Yeah, from, from the whole delivery experience… I also had really bad postpartum depression and anxiety… I definitely still had the depression, anxiety, I, it was all heightened by everything that was going on. That's what I really struggled with. 116:4 ¶ 227 in 46165tx.docx.

Helena’s case was a little different as she had treated depression before delivery and she went into the delivery anxious, but the height for her was when her provider broke her water without telling her. While her postpartum depression played out more by feeling sad and having nightmares, Courtney’s was not having any interest in the baby. Courtney stated, “I decided that the baby and I weren't going to bond” 84:191 ¶ 276 in 24203tx.docx.

Postpartum depression is a serious mental condition such that different factors and several symptoms contribute to it. As seen from the narratives of these seven women, postpartum

depression plays out in different forms, but a common factor is poor patient-provider communication. As an outlier, one of the women had experienced depression which had been treated, but her experience with a provider left her sad and anxious. In their study, Ghaedrahmati et al., (2017) found that in addition to biological factors, social factors play a significant role in making people prone to postpartum depression. Thus, poor provider communication skills influence women's mental health. Longitudinal studies have indicated that challenges in social communication might cause mental health issues and influence their trajectories (Dall et al., 2022).

Postpartum Anxiety

Another emergent subtheme for this study is postpartum anxiety. Anxiety disorders in new mothers are frequently overlooked because it is widely assumed that all new mothers are overly anxious (Sebastian, 2016). Of the participants who experienced poor provider communication, four explained their experiences with postpartum anxiety.

Regina's communication experience with her provider was one of verbal abuse and disrespect. She narrated how overly worried she was after the delivery. Her constant worry or dread of something terrible happening is a symptom of postpartum anxiety. After going into an emergency C-section that she was not prepared for, there was an issue with keeping her baby's heart rate stable. She stated, "I was in the room crying. It was a lot of anxiety, not knowing what was going on" 116:7 ¶ 197 in 28861tx.docx

Another participant, Kim also mentioned that she had panic attacks, was always anxious, and had thoughts about something bad happening to her baby. She stated:

> I would be anxious about him, him breathing, or if he was alive in the car, I would not be able to drive or go anywhere, unless I had that passed me and could hear him crying, and I knew he was breathing. 81:8 ¶ 295 in 15554tx.docx

Kim further explained:

> After he was delivered, I asked to do skin on skin because I'd read about the benefits for the skin on skin. And they denied that and said I couldn't do it. Because he was having trouble breathing. They wrapped him up in a blanket and took him off to the nursery. And I told my husband, I said, Follow them. So, he went with the baby. And then after my husband left, it was just me and the doctor, and one nurse and I was crying because I was upset about my baby, right. And the doctor told me, I need to dry it up. I just had a baby. This was a happy time. And he was sewing me up at the time because I'd had a fourth-degree tear… And a nurse had come in and was like, what's wrong? And he was sitting right there. And so I wasn't able to express what just happened. Because I was fearful of him. 81:148 ¶ 138 in 15554tx.docx.

In addition to Kim's racing thoughts about terrible scenarios, anger, fear, and crying can also be symptoms of postpartum anxiety after experiencing poor communication with her provider.

Anna, whose anesthesiologist did not listen when she complained about her epidural not being right and also wanted a c-section because the baby's heart rate was dropping, spoke about being sleepless and worried after he was born. She stated, "I'm worried about me failing as a mother" 89:76 ¶ 505 in 27935tx.docx.

Sam experienced poor communication as she was not listened to,, mentioned that she was worried and sad after the birth of her baby. She stated, "I was really sad. I questioned. Just the whole notion of having another baby" 115:7 ¶ 177 in 18194tx.docx. She was worried about the

baby because she noticed something was wrong but was not taken seriously and it happened that the child was not okay and could not take breastmilk.

As seen in the participants' narratives, these women's narratives affirm the lack of supportive care, active listening, dignity (disrespect), and no sense of being cared for among other constructs of the PCMC and CCP. All of which precipitate or indirectly result in their postpartum mental outcomes. It can be noted that poor patient-provider communication can increase anxiety and isolation. If the patient cannot express their concerns or receive adequate support from their healthcare provider, their anxiety may worsen and result in more serious mental health issues.

Poor Communication

Patient-provider communication is the combination of all forms of exchange of information between a patient and a healthcare provider. According to the American College of Obstetricians and Gynecologists (ACOG), "Physicians' ability to effectively and compassionately communicate information is key to a successful patient–physician relationship… Patient outcomes depend on successful communication." (2014, p.389). This affirms that compassion is a key aspect of communication in healthcare as providers who show kindness, empathy, and understanding when interacting with patients make their patients feel heard and supported. Good patient-provider interactions start with communication, and it builds trust, rapport, and comprehension. Hence, poor patient-provider communication can have negative consequences on health outcomes.

Poor patient-provider was an emergent theme that several of our participants narrated and was a characteristic of their birthing experiences. After analyzing the data, two clustered themes emerged: bedside manner and hear/listen.

Bedside Manner

One significant shared experience of the women was encountering providers who lacked effective communication skills while they were on admission for delivery or during their prenatal visits. Seven of the participants expressed that they encountered a provider who lacked bedside communication manner as they narrated their experiences. Alaina, a 37-year-old Black woman explains her interaction with her obstetrician:

> My OB has the worst bedside manner on the planet. He's horrible to the extent that I almost considered switching when I had my second child, but the only reason I didn't was because my thought was, I didn't want anything to go wrong. …he was horrible as far as his attitude. But that also changed after I had the baby. When he found out my father was a physician. He treated me completely differently. 96:36 ¶ 107 in 46165tx.docx

The above suggests that there is no sense of being cared for as enacting care is a construct of the CCP. Alaina further explained that she had an unpleasant experience with her nurse as the nurse mistakenly took off her stitches before the completion of the two weeks that her doctor had recommended while she just endured the pain. She states that "she's starting to take them out. And it's really painful, I'm like crying, tears falling, and she gets the one staple, she can't get out. And she's yanking and I'm like, Oh my gosh, oh my gosh, and yanking." 96:65 ¶ 183 in 46165tx.docx. In relation to communication, this experience shows that there was no form of inclusion in decision making which also flouts the constructs of the CCP, else she would not have had to endure the pain or would have told the nurse about her doctor's prescription.

Another participant, Alex, a 32-year-old White woman narrates her dreadful experience with her provider:

> I was very much in labor when I got there. I was nine centimeters dilated when I got to the hospital and good. I was planning on having an epidural. They said nope, too late. And I literally started just bawling my eyes out, I was terrified. And so, we, you know, things go very, very quickly, very active labor. And I start pushing and this doctor, and I, he literally yells at me and he says, No, no, no, you're doing it all wrong and I think I apologized to him at this point. Yeah, it was bad. So, I apologized to him at this point. 107:6 ¶ 11 in 75207tx.docx

Alex went on to explain that after her son was delivered, her doctor did not allow her to carry her son but left the baby in a corner and her mom yelled at him. As he walked out of the door, the doctor cursed at them saying “go to hell.” 107:6 ¶ 11 in 75207tx.docx. She stated that after a few minutes, the doctor came in and started throwing things on the counter as he told them to go to hell a second time and told the nurses to F* off. Not only was Alex’ experience lacking inclusion in decision making, it was also disrespectful. As a construct of the PCMC, dignity refers to treating patients with respect without undermining their decisions.

Jessie, a 44-year-old White woman, explained her experience with a provider who sat beside her, monitoring her but never spoke to her or give her a better explanation for not allowing her to leave. She stated:

> There was a man sitting beside me who did not talk for two hours… I think he was like a nurse or something. But I mean, he just maybe was like the anesthesiology nurse or whatever. But he was like, every now and then I'd be like, can I just go? And he would say, your toes have to move, so I'm just forcing, trying to get these toes to move.

This clearly shows that there was a lack of communication and inclusion. Communication as a construct of the PCMC explains that providers clearly explain to the women their condition.

Regina, a 24-year-old White woman emphasized that she had the best obstetrician, but her anesthesiologist lacked effective bedside manner. She stated, “I was like having a panic attack and then the anesthesiologist was yelling at me… He was telling my doctor, because I was like, panicking. But after that, I was just being dramatic.” 116:11 ¶ 233 in 28861tx.docx. This is another example of disrespect through verbal abuse.

Kim, a 33-year-old White woman also noted that of the two doctors that attended to her, one was very good as he would sit and listen to her but the other was the opposite. She mentioned, “the other doctor that I had, he was also the one that just had, like, no bedside manner, at all, would rush me through my appointments and things like that.” 81:75 ¶ 49 in 15554tx.docx. Her experience also shows that she had no sense of being cared for by the second doctor who rushed her through her appointments.

Another participant whose experience lacked inclusion in decision making was Helena, a 33-year-old white woman. She explained that her obstetrician put her on progesterone which she knew nothing about, and broke her water without her consent. She narrated:

> she goes uh decision made; it’s broken on its own…. she didn't tell me what she was going to do. She asked me now, on the flip side, earlier in that delivery, she said, you know, your cervix is way back there. I'm going to try and pull it forward for you and she just like, and I screamed, and you know, like, so, you know, they're not saints there, they do it too without asking. 80:100 ¶ 427 in 10769tx.docx.
>
> For Courtney, a 35-year-old White woman, it was the way her anesthesiologist just overlooked her stance that the epidural was not in the right position in her back. She explained that he just told her that she was only being nervous but only redid it when her

mother and obstetrician intervened. Courtney's experience was one of disrespect and lacked communication.

The narratives of these Alaina, Alex, Jessie, Regina, Kim, Helena, and Courtney manifest the kind of poor bedside communication experiences that occur between patients and their providers. In relation to the PCMC and CCP, the experiences of these women were fraught with disrespect, communication, and care.

Hear/Listen

One significant aspect of patient-provider communication is active listening. The lack of active listening to patients can result in unintentional harm and misdiagnosis of patients (Jahromi, et. al., 2016). Five participants explained different instances where their providers did not listen to them when they either had questions or felt something was wrong with them or their babies. Jessie went on to explain her hemorrhage experience:

> I just felt like I was going to die, and I kept telling them, you know, in that state of impending doom or whatever, like I knew something was wrong. And after the third day in the hospital, when I could barely stand, I convinced one of the women, one of the nurses to check my hemoglobin and it was like six. And so, then I got a transfusion. 87:130 ¶ 253 in 26326tx.docx.

Jessie knew something was not right in her body, but no one listened to her. It took three days for someone to be convinced and to listen to her. This could have cost her life as she further pointed out, "…them not even noticing it I mean like had I been sent home I would have died, had I not heard about something like that had happened to a woman and had gotten big in the news that year." 87:332 ¶ 596 in 26326tx.docx.

Another participant with a similar experience was Anna, a 23-year-old Black woman. She expressed that:

> They were not, they weren't listening to me. I know how my body was feeling. When I told the anesthesiologist that he didn't do the epidural right. He was Like no I did, and I was like No, you didn't. I still feel contractions, like I'm numb on one side of my body and not the other, you know, showing you that I can't pick this leg up, but I can pick this one up. But they wouldn't listen to that. When it was getting later in the day, I'm telling them that. They told me that his heart rate was dropping. Okay, give me a C-section. But they wouldn't listen. No, no, we going to wait now. 89:148 ¶ 569 in 27935tx.docx.

It cannot be overstated that Jessie and Anna’s experiences lacked some constructs of this study’s theoretical frameworks such as communication (active listening), respect and inclusion in decision making. All of which could have resulted in death if not for her persistence.

Kim mentioned that whenever she brought up her concerns during her appointments or called her doctor’s office, they would only tell her it was normal and nothing more. She acknowledged that although her concerns may be normal to them, she wanted to be heard and given better explanations. Kate, a 35-year-old White woman also shared that her provider did not listen to her when she complained about having trouble breastfeeding. She recounted:

> I had been telling her like, I've been having trouble breastfeeding, I like started crying because I was really upset. She's like, well just stop. And I just remember being like, that's not what I needed to hear at that moment. I guess in that really sensitive state, I just need support. It's fine for you to tell me to stop eventually if that's what it needs but I think the delivery was horrible. 101:132 ¶ 399 in 59878tx.docx.

Another instance of her provider not actively listening to her was when she called the obstetrician's office to tell them she needed medications for depression but was only scheduled for an appointment without further questioning. For Kate, it was as if it did not matter why she called in, but scheduling was more important. She wanted to feel supported after telling them she needed medication for depression which is a serious mental health issue. Kim and Kate's experiences lacked a sense of being cared for and poor communication skills by their providers.

Both Sam, a 42-year-old Black woman, and Dana, a 34-year-old White woman mentioned that they were not listened to during their birthing experiences. When asked about her labor and delivery, Sam stated, "I don't think anybody listened to me when I say something's not right." 115:3 ¶ 141 in 18194tx.docx. Dana also mentioned that she knew something wasn't right in her body as she found blood in her urine until it became worse during her visit to the pediatrician and was rushed to the hospital. "I knew that something wasn't right. But nobody would listen to me," she said. 90:467 ¶ 303 in 30527tx.docx.

Nelly, a 39-year-old Black woman, recounted her experience with her providers, stating that the provider already knew that she did not want to know the gender of her babies. Unfortunately, after taking the harmony test, her provider told her the genders of her twins without minding her decision. She explained that "he kind of just brushed it off, he was like there are more important things to worry about; whether or not your kids are healthy and what type of twins they are. He just really downplayed the whole thing." 92:22 ¶ 335 in 34420tx.docx. This is an example of disrespectful care which also lacks inclusion in decision making. Additionally, autonomy as a construct of the PCMC which explains that women's values and choices be respected was flouted.

In *the importance of physician listening from the patients' perspective,* Jagosh et. al. concludes that “listening can determine the outcome of matters of urgency, it can reduce stress, increase joint decision making, and instill patient confidence … Listening can also foster a deeper connection between physician and patient” (2011, p.373). Physician communication is a crucial skill in medical practice that shows the provider’s authenticity of intention.

TABLE 3
Occurrences of Poor Provider Communication

Theoretical Constructs in the Women’s Experiences	**Number of Occurrences**
Sense of being cared for	4
Inclusion in decision making	7
Dignity (Disrespect)	5
Communication	6
Autonomy	1

Note. This table shows the instances in which women experienced poor patient-provider communication that violated the constructs of both PCMC and CCP and the number of times they occurred.

CHAPTER 5

DISCUSSION & CONCLUSION

This study aimed to analyze an underexplored area of maternal health by examining the narratives of women who experienced poor communication with their providers and its (in)direct effects on the postpartum mental health. Thus, answering the research question, "How do women who report poor patient-provider communication experience its impact on their mental health?" This study showed that there is a co-occurrence of poor communication and adverse mental health outcomes among pregnant women in Georgia.

The literature on the prevalence of maternal mortality in Georgia discusses how different factors have worsened and helped rank the state as the worst place for pregnant women (Manton 2019; Armstrong-Mensah et al., 2021). Although the existing literature on the prevalence of maternal mortality and maternal mental health in Georgia show that Black women are more affected, this study did not have an equal representation of races. In addition, maternal mental health is an important issue in Georgia, as it is in other states. In a study on the perinatal health of women in Georgia, 71% of women experienced at least one mental health difficulty after pregnancy, compared to 32% before pregnancy (Hernandez et al., 2022). Maternal mental health issues are prevalent among new moms and, if left untreated, can have severe implications for both the mother and child. As seen in the findings, postpartum depression and postpartum anxiety are significant mental health outcomes.

It is noteworthy that there is a dearth of research on how communication affects maternal mental health as respectful and appropriate communication can help patients feel more in control, deal with trauma, and be happier (Wang et al., 2021). Since communication is bi-

directional between the provider and the patient, a lack of it could make it harder for women to receive quality care.

Effective communication is a shared process between patients and their providers. The delivery of care is jeopardized if either the patient or the provider does not understand the information conveyed or a person's phenomenal will is overlooked and diminished (Ratna, 2019). To facilitate a therapeutic alliance through communication between patients and providers, openness, kindness, and attention manifested by providers boost patients' satisfaction (Chichirez & Purcărea, 2018).

Interpersonal communication issues have also been linked to a variety of mental conditions (Segrin, 2001). Depression, anxiety, loneliness, substance addiction, among others have been linked to poor interpersonal communication patterns. Segrin (2005) posits that "in some cases, the communication problems appear to precipitate the disorder, in others they affect the course of the disorder" (p.548). Just as in the case of the participants above, the ineffective communication that occurred with their providers in some ways affects how they feel about themselves and their babies. Also, some of the participants who had treated either anxiety and depression before the communication experience spoke about having to deal with these mental issues again. Thus, poor patient-provider communication can precipitate or indirectly affect the course of the mental issue. People's self-esteem, self-identity, and competence are largely shaped by how others regard them. The psychological impact of unfriendly, denigrating, or malicious words from others, can have a significant psychological impact.

As retrieved from the findings, the communication issues discussed under the themes; bedside manner and hear/listen played significant roles in the course of the participants' mental health outcomes; postpartum depression and postpartum anxiety. The use of the person-centered

maternity care and communicative care theoretical perspectives to interpret the data provided insights into understanding participants' experiences. Both theoretical perspectives emphasize empathizing, active listening, understanding patients' needs, and involving the patient in decision-making processes which were lacking in the findings. Person-centered maternity care and communicative care emphasize the importance of patient-provider communication in maternal health outcomes (Sudhinaraset et al., 2018; Black, 2018). According to the findings, poor patient-provider communication can harm pregnant women's mental health. These theoretical approaches can assist healthcare providers improve communication and patient-centered care. Hence, they can improve maternal health care and outcomes.

Therefore, the findings recommend that healthcare providers make effective communication with their pregnant patients a priority. This can be done through training and education programs that emphasize the importance of actively listening with empathy to understand patients' needs, and to include patients in decision-making processes. Implementing person-centered maternity care and communicative care can help improve the way patients and providers talk to each other, which can lead to better health outcomes for mothers.

Additionally, it is important that providers adopt a method that values and respects diversity not only by improving curriculum for medical students, but also training in the area of cultural humility and cultural competence. Cultural humility refers to the practice of adopting an interpersonal approach that is focused on the other person's cultural identity (Shankar et al., 2021). This emphasizes the recognition of the patient as the primary authority on their own health and it prioritizes the patient's own perspective on their health. In this scenario the patient is prioritized in the process of making shared decisions just as the PCMC and CCP affirm. Cultural competence refers to the continuous effort made by healthcare providers to develop the

ability to proficiently work within the cultural framework of their patients (Khumoetsile Daphney et al., 2023). Culturally competent healthcare providers can build trust, enhance communication, and tailor care to patients' cultural and individual needs, improving patient outcomes.

Limitations and Future Research

For this study, a few limitations exist. First, the existing literature emphasizes racial differences in the effect of adverse maternal mental health outcomes of people of color. Thus, people of color are at the detriment of experiencing adverse health outcomes because as racial discrimination and low socioeconomic status. Only 13 participant narratives were analyzed from the GMP data. With the study participants, only 4 of 13 were people of color and all participants had similar experiences. Secondly, this study sought out to focus on rural women as seen in the literature review, but participants were from both rural and metropolitan areas in Georgia. Lastly, as a study using pilot data, subsequent data may show the direct effect of poor patient-provider communication on maternal mental health outcomes, but this study affirms there is a correlation. Thus, studies conducted mainly among rural women and an equal number of women with different racial status may provide different results. However, these limitations do not undermine the contributions of the study.

For future research, this study could be a prototype for other studies to analyze the communication gap as the findings highlight the need for further investigation. Regina, Courtney, and Anna reported negative experiences with their anesthesiologist, thus, future research might focus on the type of provider. Future studies could examine which communication strategies improve maternal mental health and person-centered maternity care and communicative care theoretical perspectives could be studied to improve provider-patient

communication in clinical settings. Additionally, future studies could examine how cultural and linguistic barriers affect patient-provider communication and maternal mental health. Understand how these issues affect communication and how to handle them.

In conclusion, this study sheds light on the effects of poor patient-provider communication on pregnant women's postpartum mental health in Georgia. The findings indicate a correlation between poor communication and negative mental health outcomes, including postpartum depression and anxiety. Given the importance of respectful and appropriate communication for patient satisfaction and improved health outcomes, it is disturbing that there is a dearth of research on how communication impacts maternal mental health.

REFERENCES

Ali E. (2018). Women's experiences with postpartum anxiety disorders: a narrative literature review. *International journal of women's health, 10*, 237–249. https://doi.org/10.2147/IJWH.S158621

American College of Obstetricians and Gynecologists. (2014). Committee Opinion No. 587: Effective patient-physician communication. *Obstetrics and Gynecology*, 123(2), 389–393. https://doi.org/10.1097/01.aog.0000443279.14017.12

Afulani, P. A., Sayi, T. S., & Montagu, D. (2018). Predictors of person-centered maternity care: The role of socioeconomic status, empowerment, and facility type. *BMC Health Services Research*, *18*(1), 1–16.

Alio, A. P., Dillion, T., Hartman, S., Johnson, T., Turner, S., Bullock, S., & Dozier, A. (2022). A Community Collaborative for the Exploration of Local Factors Affecting Black Mothers' Experiences with Perinatal Care. Maternal and child health journal, 26(4), 751–760. https://doi.org/10.1007/s10995-022-03422-5

Amnesty International. (2011, May 7). *Deadly Delivery: The Maternal Health Care Crisis in the USA: One Year Update, Spring 2011*. Author New York. https://www.amnestyusa.org/reports/deadly-delivery-the-maternal-health-care-crisis-inthe-usa/

Armstrong-Mensah, E., Dada, D., Bowers, A., Muhammad, A., & Nnoli, C. (2021). Geographic, Health Care Access, Racial Discrimination, and Socioeconomic Determinants of Maternal Mortality in Georgia, United States. *International Journal of Maternal and Child Health and AIDS*, *10*(2), 278.

Arnold, L. (2021). Communication as Care across Borders: Forging and Co-Opting Relationships of Obligation in Transnational Salvadoran Families. *American Anthropologist*, *123*(1), 137–149.

Arnold, L., & Black, S. P. (2020). How Communicative Approaches Enrich the Study of Care. In *Medical Anthropology* (Vol. 39, Issue 7, pp. 573–581). Taylor & Francis.

Avalos, L. A., Nance, N., Zhu, Y., Croen, L. A., Young-Wolff, K. C., Zerbo, O., Hedderson, M. M., Ferrara, A., Ames, J. L., & Badon, S. E. (2022). Contributions of covid-19 pandemic-related stressors to racial and ethnic disparities in mental health during pregnancy. *Frontiers in Psychiatry*, *13*. https://doi.org/10.3389/fpsyt.2022.837659

Barkin, J. L., Wisner, K. L. I., Bromberger, J. T., Beach, S. R., Terry, M. A., & Wisniewski, S. R. (2010). *Development of the Barkin Index of Maternal Functioning. Copyright: Mary Ann Liebert, Inc.*

Bernard, H. R. (2017). *Research methods in anthropology: Qualitative and quantitative approaches*. Rowman & Littlefield.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Bodnar-Deren, S., Benn, E. K., Balbierz, A., & Howell, E. A. (2017). Stigma and postpartum depression treatment acceptability among black and white women in the first six-months postpartum. *Maternal and Child Health Journal*, *21*(7), 1457–1468. https://doi.org/10.1007/s10995-017-2263-6

Centers for Disease Control and Prevention. (2022, April 29). *Depression during and after pregnancy*. Centers for Disease Control and Prevention. Retrieved February 10, 2023, from https://www.cdc.gov/reproductivehealth/features/maternal-depression/index.html

Centers for Medicare & Medicaid Services. (n.d.). *Person-centered care*. Innovation Center. Retrieved September 17, 2022, from https://innovation.cms.gov/key-concepts/person-centered-care

Chichirez, C. M., & Purcărea, V. L. (2018). Interpersonal communication in healthcare. *Journal of Medicine and Life*, *11*(2), 119.

Creswell, & Poth, C. N. (2018*). Qualitative inquiry & research design: choosing among five approaches* (Fourth edition.). SAGE.

Dall, M., Fellinger, J., & Holzinger, D. (2022). The link between Social Communication and Mental Health from childhood to young adulthood: A systematic review. *Frontiers in Psychiatry, 13,* 1–18. https://doi.org/10.3389/fpsyt.2022.944815

DPH Georgia. (2015, June). *Georgia Maternal Mortality 2012 Case Review*. Georgia Department of Public Health. https://dph. georgia.gov/maternal-mortality

Fawcett, E. J., Fairbrother, N., Cox, M. L., White, I. R., & Fawcett, J. M. (2019). The prevalence of anxiety disorders during pregnancy and the postpartum period: A multivariate Bayesian meta-analysis. *The Journal of Clinical Psychiatry*, *80*(4), 1181.

Floyd James, K., Smith, B. E., Robinson, M. N., Thomas Tobin, C. S., Bulles, K. F., & Barkin, J. L. (2023). Factors associated with postpartum maternal functioning in black women: A secondary analysis. *Journal of Clinical Medicine*, *12*(2), 647. https://doi.org/10.3390/jcm12020647

Georgia Board of Health Care Workforce. (n.d.-a). *Health Care Workforce Data*. Georgia Board of Health Care Workforce. Retrieved September 10, 2022, from https://healthcareworkforce.georgia.gov/health-care-workforce-data

Georgia Board of Health Care Workforce. (n.d.-b). *Metrics for the State of Georgia*. https://dch.georgia.gov/documents/georgiarural-county-map.

Georgia House Budget & Research Office. (2019). *House of Representatives Study Committee on Maternal*

Mortality. https://www.house.ga.gov/Documents/CommitteeDocuments/2019/MaternalMortality/HR_589_Final_Report.pdf

Georgia State Office of Rural Health. (2008). *Georgia's Rural Counties*. Georgia Department of Community Health. . https://dch.georgia.gov/documents/georgiarural-county-map.

Ghaedrahmati, M., Kazemi, A., Kheirabadi, G., Ebrahimi, A., & Bahrami, M. (2017). Postpartum depression risk factors: A narrative review. Journal of education and health promotion, 6, 60. https://doi.org/10.4103/jehp.jehp_9_16

Gunja, M. Z., Gumas, E. D., & Williams II, R. D. (2022, December 1). *The U.S. maternal mortality crisis continues to worsen: An international comparison.* The Commonwealth Fund. Retrieved February 25, 2023, from https://www.commonwealthfund.org/blog/2022/us-maternal-mortality-crisis-continues-worsen-international-comparison#:~:text=In%202020%2C%20the%20maternal%20mortality,exceptionally%20high%20for%20Black%20women.

Guzmán, J. R. (2014). The Epistemics of Symptom Experience and Symptom Accounts in Mapuche Healing and Pediatric Primary Care in Southern Chile. *Journal of Linguistic Anthropology*, *24*(3), 249–276.

Gynecologists, A. C. of O. and. (2018). ACOG Committee Opinion No. 757: Screening for perinatal depression. *Obstet Gynecol*, *132*(5), e208–e212.

Harvey, T. S. (2013). *Wellness beyond words: Maya compositions of speech and silence in medical care*. UNM Press.

Hernandez, N. (2022). Addressing maternal mental health among black perinatal women in Atlanta, Georgia: A CBPR approach. *Journal of the Georgia Public Health Association*, *8*(3). https://doi.org/10.20429/jgpha.2022.080314

Hoyert, D. L. (2022). Maternal mortality rates in the United States, 2020. *Centers for Disease Control and Prevention*. https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2020/maternal-mortality-rates-2020.htm

Jahromi, V. K., Tabatabaee, S. S., Abdar, Z. E., & Rajabi, M. (2016). Active listening: The key of successful communication in hospital managers. Electronic physician, 8(3), 2123–2128. https://doi.org/10.19082/2123

Jagosh, J., Donald Boudreau, J., Steinert, Y., Macdonald, M. E., & Ingram, L. (2011). The importance of physician listening from the patients' perspective: enhancing diagnosis, healing, and the doctor-patient relationship. Patient education and counseling, 85(3), 369–374. https://doi.org/10.1016/j.pec.2011.01.028

Jones, A. (2022). Postpartum Help-Seeking: The Role of Stigma and Mental Health Literacy. *Maternal and Child Health Journal*, *26*(5), 1030–1037.

Joseph, K. S., Boutin, A., Lisonkova, S., Muraca, G. M., Razaz, N., John, S., Mehrabadi, A., Sabr, Y., Ananth, C. V., & Schisterman, E. (2021). Maternal mortality in the United States: Recent trends, current status, and future considerations. *Obstetrics and Gynecology*, *137*(5), 763.

Kendig, S., Keats, J. P., Hoffman, M. C., Kay, L. B., Miller, E. S., Moore Simas, T. A., Frieder, A., Hackley, B., Indman, P., Raines, C., Semenuk, K., Wisner, K. L., & Lemieux, L. A. (2017). Consensus bundle on Maternal Mental Health. Obstetrics & Gynecology, 129(3), 422–430. https://doi.org/10.1097/aog.0000000000001902

Khumoetsile Daphney, S., Tinda, R., Antoinette, D. P., & Petra, B. (2023). Experiences of midwives regarding provision of culturally competent care to women receiving maternal care in South Africa. *Midwifery, 116*. https://doi.org/10.1016/j.midw.2022.103527

Kountanis, J. A., Kirk, R., Handelzalts, J. E., Jester, J. M., Kirk, R., & Muzik, M. (2021). The associations of subjective appraisal of birth pain and provider-patient communication with postpartum-onset PTSD. *Archives of Women's Mental Health*, *25*(1), 171–180. https://doi.org/10.1007/s00737-021-01154-z

Lazarus, E. S. (1988). Theoretical considerations for the study of the doctor-patient relationship: Implications of a perinatal study. *Medical Anthropology Quarterly*, *2*(1), 34–58. https://doi.org/10.1525/maq.1988.2.1.02a00030

Lebel, C., MacKinnon, A., Bagshawe, M., Tomfohr-Madsen, L., & Giesbrecht, G. (2020). Elevated depression and anxiety symptoms among pregnant individuals during the COVID-19 pandemic. *Journal of Affective Disorders*, *277*, 5–13.

Lima, F. de. (2021). *Postpartum Depression*. Nova Science Publishers, Incorporated.

Manton, J. D. (2019, November 8). *Georgia's maternal mortality rate for women of color is a big problem*. Harris Lowry Manton. https://www.hlmlawfirm.com/blog/georgias-maternal-mortality-rate-for-women-of-color-is-a-big-problem/

Martin, H. (2021, October 4). *Preventing maternal suicide through screening: A sister's story. 2020 Mom*. 2020 Mom. https://www.2020mom.org/blog/2021/10/3/preventing-maternal-suicide-through-screening-a-sisters-story

Maternal health in Georgia. (2019). *Reproductive Rights*. https://reproductiverights.org/wp-content/uploads/2020/12/USPA-MHRI-GA-FS-Final-ForPrint-Pages.pdf

Maternal Mental Health Leadership Alliance. (2022). *Fact sheet: Maternal Mental Health and Substance Use Disorders Act of 2022 MMHLA*. https://www.mmhla.org/wp-content/uploads/2022/04/Into-the-Light-Fact-Sheet-3.31.22.pdf

Miteniece, E., Pavlova, M., Shengelia, L., Rechel, B., & Groot, W. (2018). Barriers to accessing adequate maternal care in Georgia: A qualitative study. *BMC Health Services Research*, *18*(1), 1–12.

Morales, D. A., Barksdale, C. L., & Beckel-Mitchener, A. C. (2020). A call to action to address rural mental health disparities. *Journal of Clinical and Translational Science*, *4*(5), 463–467.

Nakić Radoš, S., Tadinac, M., & Herman, R. (2018). Anxiety During Pregnancy and Postpartum: Course, Predictors and Comorbidity with Postpartum Depression. Acta clinica Croatica, 57(1), 39–51. https://doi.org/10.20471/acc.2017.56.04.05

Oak, M. (2022, May 4). Maternal Mental Health Day' established by Georgia lawmakers. *11Alive*. https://www.11alive.com/article/news/health/lawmakers-establish-maternal-mental-health-day/85-94b9b313-756a-4b08-9e70-62b7d9e85085

Prather, C., Fuller, T. R., Jeffries IV, W. L., Marshall, K. J., Howell, A. V., Belyue-Umole, A., & King, W. (2018). Racism, African American women, and their sexual and reproductive health: A review of historical and contemporary evidence and implications for health equity. *Health Equity*, *2*(1), 249–259. https://doi.org/doi:10.1089/heq.2017.0045

Raiff, E. M., D'Antonio, K. M., Mai, C., & Monk, C. (2022). Mental Health in Obstetric Patients and Providers During the COVID-19 Pandemic. *Clinical obstetrics and gynecology, 65*(1), 203–215. https://doi.org/10.1097/GRF.0000000000000668

Ratna, H. (2019). The importance of effective communication in healthcare practice. *Harvard Public Health Review*, *23*, 1–6.

Richards, E. (2021, September 23). *The state of mental health of Black Women: Clinical Considerations*. Psychiatric Times. Retrieved March 7, 2023, from

https://www.psychiatrictimes.com/view/the-state-of-mental-health-of-black-women-clinical-considerations

Sebastian, L. (2016). Overcoming Postpartum Depression and Anxiety (1st ed.). Addicus Books.

Segrin, C. (2014). Communication and personal well-being. *Encyclopedia of Quality of Life and Well-Being Research*, 1013–1017. https://doi.org/10.1007/978-94-007-0753-5_446

Segrin, C. (2005). Communication and the study of personal well-being. *Gazette (Leiden, Netherlands), 67*(6), 547–549. https://doi.org/10.1177/0016549205057549

Segrin, Chris (2001) Interpersonal Processes in Psychological Problems. Mahwah, NJ: Lawrence Erlbaum.

Shahin, Z., Hardwick, I. M., Jeffery, N., Jordan, J., & Mase, W. (2020). Maternal mortality among African American women in the state of Georgia, causes, policy, and ethical considerations. *Journal of Georgia Public Health Association*, *8*(1), 14.

Shankar, M., Williams, M., & McClintock, A. H. (2021). True Choice in Reproductive Care: Using Cultural Humility and Explanatory Models to Support Reproductive Justice in Primary Care. *Journal of general internal medicine*, *36*(5), 1395–1399. https://doi.org/10.1007/s11606-020-06245-8

Sharer, W. B. (2008). Traces of the familiar: Family archives as primary source material. In Gesa E. Kirsch and Liz Rohan (Eds.), *Beyond the archives: research as a lived process* (47–55). Carbondale: Southern Illinois University Press.

Spencer, B. (2022, May 4). *Perinatal mood and anxiety disorders: More common and life-threatening than you might think.* https://connectionswellnessgroup.com/perinatal-mood-and-anxiety-disorders-more-common-and-life-threatening-than-you-might-think/

Street, R. L., Jr, Makoul, G., Arora, N. K., & Epstein, R. M. (2009). How does communication heal? Pathways linking clinician-patient communication to health outcomes. *Patient education and counseling, 74*(3), 295–301. https://doi.org/10.1016/j.pec.2008.11.015

Sudhinaraset, M., Afulani, P., Diamond-Smith, N., Bhattacharyya, S., Donnay, F., & Montagu, D. (2017). Advancing a conceptual model to improve maternal health quality: The person-centered care framework for reproductive health equity. *Gates Open Research*, *1*.

Susser, L. C., Wilkins, V. M., & Sternberg, L. H. (2021). Perinatal Planning Guide: Mitigating Perinatal Mood and Anxiety Disorders During the COVID-19 Pandemic. *Primary Care Companion for CNS Disorders (2155-7772), 23*(5), e1–e6. https://doi.org/10.4088/PCC.21nr02953

Tikkanen, R., Gunja, M. Z., FitzGerald, M., & Zephyrin, L. (2020, November 18). *Maternal mortality and maternity care in the United States compared to 10 other developed countries*. The Commonwealth Fund. https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries

Trost, Susanna, Beauregard, Jennifer, Chandra, Gyan, Njie, Fanny, Berry, Jasmine, Harvey, Alyssa, & Goodman, David A. (2022, September 19). *Pregnancy-related deaths: Data from Maternal Mortality Review Committees in 36 US States, 2017–2019.* Centers for Disease Control and Prevention. https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/data-mmrc.html

United Health Foundation. (n.d.). *Explore maternal mortality in Georgia: 2021 Health of Women and Children Report.* America's Health Rankings. Retrieved August 21, 2022, from https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/maternal_mortality_b/state/GA

United Nations Agencies (2023). *Trends in maternal mortality 2000 to 2020*: estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division. Geneva: World Health Organization; 2023. License: CC BY-NC-SA 3.0 IGO. Retrieved February 25, 2023 from https://www.who.int/publications-detail-redirect/9789240068759

Wang, E., Glazer, K. B., Sofaer, S., Balbierz, A., & Howell, E. A. (2021). Racial and ethnic disparities in severe maternal morbidity: A qualitative study of women's experiences of peripartum care. *Women's Health Issues*, *31*(1), 75–81.

Wardrop, A., & Popadiuk, N. (2013). Women's experiences with postpartum anxiety: Expectations, relationships, and sociocultural influences. *The Qualitative Report, 18*(3), 1–24. https://doi.org/10.46743/2160-3715/2013.1564

World Population Review. (2022). *Maternal mortality rate by state 2022*. World Population Review. https://worldpopulationreview.com/state-rankings/maternal-mortality-rate-by-state

APPENDIX

INTERVIEW QUESTIONS

Georgia Mothers: Reflections on Their Health Care Journeys

- Tell me about how you viewed pregnancy and having children as you were growing up?
    - Did you have siblings?
    - Did your mom talk about her pregnancy(ies)?
- How did you know you were pregnant?
    - How did you feel about being pregnant at first?
- How far along were you when you began to see a health care provider about your pregnancy?
- How often did you see a healthcare provider during your pregnancy?
- How did your provider respond to your questions or to your concerns about your pregnancy?
- When did you first meet the healthcare provider who delivered your baby?
- Did you receive childbirth education?
    - If so, what did it consist of?
- What, if any, obstacles to obtaining health care (i.e., insurance, money issues, access to a local provider) did you experience while you were pregnant?
    - During your labor/delivery?
    - During the year after your baby was born?
- Do you feel like you received adequate care during your pregnancy?

- Why or why not?

• What, if any, personal difficulties (job loss or change, marital issues, residence change, etc.)did you experience during your pregnancy?

- During your labor/delivery
- During the year after your baby was born?

• What, if any, complicating physical conditions (diabetes, pre-eclampsia, hypertension, etc.) did you experience during your pregnancy?

- During your labor/delivery? (eclampsia, hemorrhaging, etc.)
- During the first year after your baby was born? (incision healing, blood pressure issues, etc.)

• What support did you have at home during your pregnancy?

- With you during labor and delivery?
- During the year after your baby was born?

• Did your healthcare provider encourage you to breastfeed?

- Did you breastfeed?
- If so, for how long?
- What obstacles did you face to breastfeeding
- If you did not, did you consider breastfeeding?
- What kept you from breastfeeding?

• Looking back what could have improved your healthcare experience (better insurance, different provider, more support, etc.) during pregnancy?

- during labor/delivery?

o During the year after your baby was born?

• What was the best part of your pregnancy experience?

• What was the most difficult part of your pregnancy experience?

• What did you worry about most or feel most anxious aboutwhen you were

pregnant?

o During labor/delivery?

o During the year after your baby was born?

• What did you feel most confident/strongest about when you were

pregnant?

o During labor/delivery?

o During the year after your baby was born?

• Did you feel like you were in control of your pregnancy?

o During Labor/delivery? T

o During the year after your baby was born?

In conclusion, is there anything that you would suggest or request to make pregnancy, childbirth and the postpartum period better for future Moms? How could Georgia do better?