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Assessing Clinical Social Workers' Self-Efficacy Regarding Perinatal Mental Health Disorders

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Assessing Clinical Social Workers' Self-Efficacy Regarding Perinatal Mental Health Disorders

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ABSTRACT OF THE DISSERTATION

Assessing Clinical Social Workers' Self-Efficacy Regarding Perinatal Mental Health Disorders

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Directed by Dr. Sharon Lyter

This dissertation sought to explore social workers' perceived levels of knowledge, self-efficacy, and awareness of perinatal mental health. This study looked at how identifying as a parent, different social work licensures, and having additional training on perinatal mental health affect social workers knowledge, self-efficacy, and awareness responses. Utilizing a quantitative survey, this dissertation found having additional training on perinatal mental health to have a significant impact on social workers' knowledge, self-efficacy, and awareness.

Exploring social workers' knowledge, self-efficacy, and awareness of perinatal mental health allows for self-reflection of one's own ability to assist this vulnerable population. Continued research in this specialty area is needed to explore social work and the impact social work can have on perinatal mental health.

Keywords: Perinatal, Mental Health, Postpartum, Mood, Social Worker, Pregnancy

Author's Note

This author has chosen to use the term "woman/women" throughout this dissertation. This decision was based on current and past literature on the topic of perinatal mental health disorders. This decision was also guided by the theory cited within the dissertation.

Dedication

This dissertation is dedicated to all the mothers who so desperately want to be seen as more than just a mother. And to my daughter, one day you will see this was all for you.

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I want to thank my entire committee of Dr. Lyter, Dr. Sharma, and Dr. Kim for all of your time, experience, advice, feedback, and commitment. This has been a long process, but your help has made this all possible. A special thank you to my committee chair Dr Lyter, your constant support and encouragement helped me to believe in myself and my abilities.

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I would like to thank my husband for being with me through not one, not two, but three college degrees. You put our daughter to bed many nights while I stared at this screen. While I was busy, you were present, and for that, I cannot thank you enough.

To my daughter, thank you for your patience as Mommy worked. I'm sorry for the nights I couldn't put you to bed, but I am all yours now. I hope you grow up to know you can make a difference in this world.

To my DSW cohort, thank you for being the reassuring, supporting, and sanity restoring force that you were. I am lucky to know you all.

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Social Worker's Self-Efficacy Regarding Perinatal Mental Health

Chapter 1: Introduction

The names of Andrea Yates and Melanie Blocker-Stokes made national headlines for tragic reasons. Andrea Yates murdered her five children and Melanie Blocker-Stokes committed suicide. What did they both have in common? They were both experiencing severe maternal mental health crises. These women are only two of an ill-defined but critical number of women who have experienced such disorders and have succumbed to them in such tragic ways. While these women may represent the most extreme and severe cases, there is a spectrum of disorders and severities that affects too many mothers. The perinatal period encompases all women who are pregnant up until one year after they give birth. This includes women who experience miscarriage, still-birth, abortion, and adoption. All women in the perinatal period are vulnerable to any of these disorders (Uguz, 2016). Social workers are just one group of professionals that should have the means to help this vulnerable population.

The perinatal period is one accompanied by great change and transition. The term "matrescence" was coined by anthropologist Dana Louise Raphael in the 1970s and is used to describe the period of transition from independent, sole individual to mother. The transition involves the obvious physical changes that occur, but also includes the mental and emotional changes that occur from this transition. These changes have the potential to cause issues regarding the woman's mental health. Johnson et al. (2021) reported that women and providers identified maternal mental health care as an unmet need that caused unpredictable and broken screening, diagnosis, and in return, referrals for treatment. Early identification can be a positive

predictor of enhanced outcomes, including decreased symptoms of depression and an increase in response to treatment (Johnson et al., 2021).

Problem Statement

Social workers have many opportunities to interact with this population in ways that can help address this; however, their self-efficacy to do so is unclear. There are currently only eighteen states in the United States that have a perinatal psychiatric access program (Postpartum Support International, 2022). The first certification in perinatal mental health for mental health providers was not offered until 2018. The recentness of this training shows the infancy of the attention on this issue. PESI, a leading provider of mental health training and education, currently only offers six training opportunities on perinatal mental health disorders. The lack of available training results in a lack of available treatment specific to this population. Of the eighteen states with perinatal psychiatric access programs only three offer inpatient-level care programs (Postpartum Support International, 2022). Even if there were an appropriate number of perinatal training programs available, there is still a need for educated and competent providers to render these services.

The field of social work is ever advancing and growing, taking on a more prominent role within the workforce. While the idea that the current social work curriculum can prepare social workers to competently address all issues and concerns within the scope of social work practice is unrealistic, current social work education is not appropriately preparing social workers to address perinatal mental health concerns. With the current curriculum and the limited training available, there is not enough attention being given to perinatal mental health and because of this, individuals are not receiving appropriate care. Social workers and other mental health professionals lack awareness of these disorders and the unique circumstances surrounding them.

Statement of Purpose

Research into social workers' self-efficacy regarding perinatal mental health disorders will help to increase general awareness of perinatal mental health disorders. This research also aims to identify areas of educational need regarding perinatal mental health.

According to the United States Department of Labor Bureau of Labor Statistics (2022), there were 708,100 social workers working in the U.S. in 2021 with faster-than-average growth expected during the next decade. Specifically, 119,800 social workers working within the specialty of mental health with even faster than average growth expected (United States Department of Labor, 2022).

The Centers for Disease Control and Prevention (2022) reported 3,613,647 babies were born in 2020. Over one million women whose lives were forever changed. Change that could have been positive, negative, stressful, unwanted, difficult to adjust to, or a combination of it all. Women who identify their race as Black, Hispanic, or Alaskan/Native American had higher percentages of WIC support used, Medicaid-funded births, and late or no prenatal care (National Vital Statistics Report, 2022). Sidebottom et al. (2020) found that women who utilized government-provided healthcare and women who identified as a minority were less likely to be screened than women who utilized private insurance and women who identified as Caucasian. Wisner et al. (2013) also found that women who identified as African American, single, using government health insurance, or of lower educational status were more likely to screen positive on a postpartum depression scale. This is notably concerning when literature has found that women of minority backgrounds and those that fall within the low-income status are at elevated risk of developing postpartum depression (Abrams & Curran, 2007). Populations that are at

greater risk of developing a perinatal mental health disorder have a lower chance of being screened for them based on the literature above.

Women experiencing one or multiple perinatal or postpartum conditions may have limited interaction with individuals able to diagnose such conditions as they are often home recovering from childbirth or restricted due to having small children at home. Some women may only have contact with their obstetrician-gynecologist during their six-week appointment and their child's pediatrician during regular infant well-visits. Screening for postpartum depression is routinely completed at the hospital at the time of birth and, in some cases, pediatricians also screen mothers during their child's well visits. This is only a screening for one perinatal mental health concern and these screenings vary and are far from universal. Pediatricians are not required to screen mothers for mental health concerns and very few offer this despite being a recommendation by the American Pediatric Association (Earls, 2010). This method is also flawed when the mother is not the individual taking the child to well-visit appointments.

The concern surrounding these issues has only grown with the COVID-19 pandemic. Isolation protocols and general safety precautions regarding having a newborn or young child at home have increased isolation and decreased available support for women in these situations. COVID-19 has limited support and created additional fear, anxiety, and depression for new mothers and mothers with young children making an already difficult experience worse (Osborne et al., 2021).

Despite the setbacks and struggles brought about by the COVID-19 pandemic, there has been a silver lining. This pandemic opened the door for telehealth services. Lombardi et al. (2022) found that over 92% of social workers utilized a form of telehealth to provide services and reported the majority desired telehealth services to continue beyond the pandemic. Osborne

et al. (2021) found that during this time period, it may be difficult for women to leave their homes with newborns or small children. Many lack childcare and having the option to receive services via phone or computer could allow more women to receive services than pre-pandemic (Osborne et al., 2021). The pandemic reduced a barrier that so many mothers face when trying to care for themselves while caring for a baby.

Social workers follow the code of ethics set forth by the National Association of Social Workers (2017) which ensures social workers practice in a way that promotes human rights and works to improve services, resources, and opportunities for the clients they serve. Deichen Hansen (2022) stated "social workers can contribute in a variety of ways to developing interventions designed to address perinatal health care quality and accessibility while simultaneously addressing upstream factors that influence health outcomes" (p. 107). The Council on Social Work Education (2017) estimated there being 850,000 individuals employed in the U.S. as social workers in 2015. They estimated 350,000 licensed social workers were employed in 2015 (Council on Social Work Education, 2017). Licensed social workers are permitted to diagnose and treat perinatal mental health disorders and represent a large number of practicing therapists in the United States.

Advancing the rights of this vulnerable population has been gaining momentum over the last ten years, specifically the past five. A large portion of current literature stems from the field of nursing with the field of social work lacking. Despite a small portion of the literature coming from the field of social work, social workers are often in the position to identify, diagnose, and treat perinatal mental health disorders. Clinical social workers are trained to address mental health disorders; which should include the ones that present during the perinatal time period.

Research Questions

Based on the information above, the following research questions were developed.

- Q1: How do social workers perceive their current self-efficacy regarding diagnosing and treating perinatal mental health disorders?
- Q2: What is the relationship between additional training (outside the BSW and MSW curriculum) and clinical social workers' self-efficacy regarding perinatal mental health?
- Q3: What do social workers identify as their source, or sources, of their knowledge on perinatal mental health?
- Q4: Do social workers with independent licenses (vs associate licenses) indicate higher levels of perceived knowledge, awareness, and self-efficacy?
- Q5: Do social workers who identify themselves as parents, versus those who do not, indicate higher levels of perceived knowledge, awareness, and self-efficacy?

Overview of Research Design

The methodology utilized in this dissertation is a quantitative survey. An electronic survey was developed using Microsoft Forms. Twenty questions were developed to assess clinical social workers' self-efficacy regarding perinatal mental health disorders. Questions regarding the social work curriculum and additional training on the subject were also included. These questions were included to determine where social workers obtain their knowledge of perinatal mental health disorders.

Rationale and Significance

This study presents an opportunity to assess how clinical social workers treat and understand perinatal mental health disorders. This research will provide insight into if social workers, through current education, are given the opportunity to gain high levels of self-efficacy or if additional training is needed. The results of this study could provide a rationale for an

increase in perinatal mental health topics within the social work curriculum. This study will help to increase awareness of the topic and help social workers assess their own self-efficacy through self-awareness and reflection, perhaps encouraging social workers to seek out their own education on the topic in order to provide component services.

Role of the Researcher

This researcher was the sole developer of the survey utilized in this dissertation. This researcher developed all survey implementation materials. This researcher utilized a second party to engage with all potential survey participants, leaving this researcher with no contact with any participants of the survey.

This researcher is a licensed clinical social worker and a mother. Study participants have the potential to be colleagues or associates of this researcher. Being a mother also connects this researcher with the vulnerable population where the self-efficacy of clinical social workers is being called into question.

Definitions of Key Terminology

Perinatal

Referring to the time period of pregnancy to one year postpartum (Garcia & Yim, 2017).

Perinatal mood and anxiety disorders

Referring to the timeframe of pregnancy to one year postpartum (*Perinatal Mood and Anxiety Disorders - Center for Women's Mood Disorders*, 2019).

Chapter 2: Literature Review

Literature regarding the subject of social work and perinatal mental health is not plentiful. Of the limited research available, even fewer are from a social work perspective. Much of the literature on these topics comes from the fields of nursing, obstetrics, and psychiatry. Of the literature reviewed, there is little cohesiveness. Terminology is different from article to article. Statistics have dramatic ranges and differ from article to article. Laws and legislation vary from country to country. Within the U.S. these regulations vary from state to state and even hospital to hospital. These variations pose difficulties in data and research generalizability. A large portion of data comes from countries other than the U.S. This poses an issue for generalizability given the vast difference between each country's laws and legislation regarding the perinatal period and motherhood in general.

A Boolean search of Kutztown University's database library of the terms “social work readiness” and “perinatal” and the terms “social work preparedness” and “perinatal” yielded no directly related responses. McCloskey and Ragudaran (2018) also found little to no research reviewing the preparedness of social workers when working with perinatal mental health. Keefe et al. (2016) found that the current body of literature surrounding this topic lacked generalizability to oppressed groups and came from disciplines such as nursing and psychiatry. A Boolean search of “social work” and “perinatal mental health” was used to gather a deeper research pool to review and assess. Database searches were not limited to these specific search terms.

In a recent study, Taylor et al. (2019) identified key feelings women have when working with social workers in a child welfare capacity. While this article is not based on a clinical setting or experience, important information was identified through this research. Taylor et al. (2019)

found that women felt social workers would judge them as unfit mothers, focus only on the safety and risk of the child and not their mental health concerns, felt social work intervention intensified the pressure on their mental health and that they felt like they were set up to fail. This study recognized that although research may be on certain topics, the population of women in the perinatal period presents a unique research opportunity and may yield different results when compared to other populations or women during different time periods of their lives (Taylor et al., 2019). It also identifies key concerns and barriers women have when seeking help during this time period and possible misconceptions about different capacities and roles that social workers hold when working with this population. These identified feelings are tremendous barriers for women experiencing these mental health conditions to seek out help.

Polmanteer et al. (2017) surveyed 261 social workers in 2014 and found that only 43% reported learning about postpartum depression during some form of college education (BSW, MSW, BA, or BS). Given this, it is even less likely that these students would have learned about the other mental health disorders affecting individuals in the perinatal period. Social workers were found to be the preferred treatment providers when it comes to addressing the prominent maternal mental health issue of postpartum depression (Polmanteer et al., 2017). Despite this, the Council for Social Work Education does not have a specific requirement for perinatal mental health education required at a bachelor's or master's level.

McCloskey and Ragudaran (2018) developed a curriculum and implemented a maternal mental health class where they found increased test scores from a pre-and post-test survey. This survey was based on scoring individuals' knowledge of maternal mental health topics, showing that including this issue in the social work curriculum increased students' knowledge (McCloskey & Ragudaran, 2018). While limited by the small sample size, this study addresses

the gap in social work education regarding this topic and the positive impact addressing this gap could have for this vulnerable population.

In recent research by Puspitasari et al. (2021), perinatal providers, 40 of whom identified themselves as social workers, were surveyed on their training on the topic of perinatal mood and anxiety management. Almost 35% of the surveyed providers reported never having training on perinatal mood and anxiety management and provider comfort levels treating perinatal mood and anxiety disorders were almost 6% reporting not comfortable at all and almost 40% reporting somewhat comfortable (Puspitasari et al., 2021). Key barriers identified by the providers survived were lack of education and consistency in screening tools, nursing support staff lacking training needed to provide screening, and staff not consistently providing screening to individuals (Puspitasari et al., 2021). Higgins et al. (2017) surveyed 186 nurses and also found these nurses to lack knowledge and skills regarding a broader range of perinatal mental health disorders outside of postpartum depression.

Disorders and Concerns

Postpartum depression is a perinatal mental health concern that is widely known, discussed, screened for, and treated. However, this terminology limits individuals to only learning about, screening for, and talking about one of the many mental health disorders that can affect women during their perinatal experience. Martin (2012) found the terminology to be inappropriately used as general terminology for the larger category of mental health disorders. Even federal legislation such as the Affordable Care Act only utilizes the term postpartum depression. Much of the current literature only focuses on postpartum depression and only a small fraction has touched on other perinatal mental health disorders or the topic as a whole.

The Diagnostic and Statistical Manual 5th edition (DSM5) identifies the specifier of "with peripartum onset" and utilizes the term peripartum vs the term perinatal as used in other literature to describe the same period of time (American Psychiatric Association, 2013). This specifier is included in the diagnosis criteria for bipolar I, bipolar II, major depressive disorder, and persistent depressive disorder (American Psychiatric Association, 2013). The specifier is not included in the criteria for anxiety disorders. Brief psychotic disorder has a slightly different specifier of "with postpartum onset" to indicate postpartum psychosis; however, that direct term is not used in the DSM5 (American Psychiatric Association, 2013). Most terminology used in the literature for maternal mental health diagnoses is not DSM5 diagnoses that can be used for insurance coverage of treatment.

While Cox and Holden (2003) report that postpartum depression is not "fundamentally different from depression occurring at other times" (p.2). Cox and Holden (2003) do however identify indicators of postpartum depression that would not be applicable during other periods such as fear that professionals will be overly critical of the individual's ability to mother and being overly concerned with the new child's health. Cox and Holden (2003) defend the need for a postpartum-specific depression scale by saying current scales are "unlikely to be useful" (p.15) and instead have "serious limitations for use with pregnant and postpartum women" (p.15).

Current and past literature varies on the terminology used to describe mental health disorders that occur during the perinatal period. The perinatal period is defined as pregnancy up to 12 months post-birth (Beck, 2004). Prenatal, postnatal, postpartum, antenatal, and perinatal are all descriptors used to describe this same frame of time or portions of the same timeframe.

Perinatal/Postpartum Depression

The American Psychiatric Association estimates one in seven mothers experiences postpartum depression (2020). Of those experiencing postpartum depression, it was found in a primary care setting almost 75% were not seeking treatment for their depression (Smith & Lincoln, 2011). The DSM5 reported that almost 50% of postnatal depressive episodes begin during the prenatal period (American Psychiatric Association, 2013). It is also important to recognize the term "postpartum blues or baby blues" which is used to describe the low mood and mild changes in mood directly after birth and up to approximately one week following birth that can occur in up to 84% of postpartum experiences (Buttner et al., 2011). Psychological stress was linked to an increased risk of developing depression during the perinatal period (Beck et al., 2020).

Postpartum depression was indicated to be the number one cause of maternal deaths within the first year after a woman has given birth (Maxwell et al., 2018). Earls (2010) found perinatal depression to be the greatest underdiagnosed complication within the area of obstetrics. Earls (2010) also reports the rates of perinatal depression being dramatically higher for low-income mothers, and low-income mothers within the adolescent age range. Collins (2021) conducted semi-structured interviews with six mothers, the results of this study identified potential symptoms of perinatal depression that were inconsistent with current DSM-5 diagnostic criteria.

Perinatal Anxiety

Fairbrother et al. (2016) found that perinatal anxiety can affect more than 15% of women during the perinatal experience. Keefe et al. (2016) found that 66% of women who experienced perinatal depression also experienced perinatal anxiety. Even the DSM5 reports that individuals

who experience major depressive episodes in the perinatal period often experienced severe anxiety including panic attacks (American Psychiatric Association, 2013).

Beck (2021) found perinatal panic disorder to have a prevalence rate between .5% and 2.9%. In addition to the symptoms of panic disorder, Beck (2021) identified three additional symptoms specific to panic disorder during the perinatal period which included " hysterical crying, odd or painful feelings in the head, and distorted sense of time" (p.369). Beck (2021) describes implications for clinical practice but fails to mention social workers or any mental health providers, instead only making implications for nurses/psychiatric nurses. These implications include psychoeducation on coping skills, developing an aftercare plan, and suggesting journaling exercises to help women figure out their panic attacks (Beck, 2021).

Post-traumatic Stress Disorder/Traumatic Birth

The concept of traumatic birth is a newer concept that has been gaining attention and research over the last five to ten years. Koster et al. (2019) estimated that up to 30% of births can be considered traumatic and in return puts that mother at a higher risk of developing post-traumatic stress disorder as a result of that trauma. Beck et al. (2020) found a range of prevalence rates from 23 to 45%. Beck (2004) points out that trauma "lies in the eye of the beholder" therefore there is no universal standard of what makes a birth experience traumatic. Vignato et al. (2017) discuss the phenomenon of perinatal post-traumatic stress disorder as potentially separate and distinct from post-traumatic stress disorder occurring outside of the perinatal period. Hynan (2020) discussed how having a newborn in the neonatal intensive care unit (NICU) has the potential to be a traumatizing experience for the parents.

Grekin and O'Hara (2014) found prevalence rates from 1% to 30% for postpartum post-traumatic stress disorder, but indicated that prevalence rates increased dramatically for

women deemed “at-risk”. Despite growing research interest in this phenomenon, Koster et al. (2019) highlighted a lack of direction or recommendations for maternity care professionals, this included perinatal social workers, to address this growing concern.

A growing amount of research is being done on traumatic birth. A large portion is focused on provider interaction being a cause of negative or traumatic birth experiences. Hollander et al. (2017) found that negative provider interactions, loss of control, and a lack of support were other reasons women felt their birth experience was negative or traumatic. Negative interactions with providers included violations of the individual's consent, feeling their choices were not being respected, feeling as though the information was not appropriately given, and decisions not adequately explained (Hollander et al., 2017). An overall theme is that women felt that their experience would have been different if they had better communication and increased support (Hollander et al., 2017).

While the process of pregnancy and birth are largely medical, the role of social workers is ill defined. At the core of social work is advocacy. Some of the concerns identified by Hollander et al. (2017) can be addressed by social workers providing advocacy for this vulnerable population. Both support and communication can be addressed by a social worker through advocacy on behalf of the individual and increasing an individual's awareness of their rights during the experience of pregnancy and birth. Many postpartum women are not yet aware that what they experienced during the birth of their child was traumatic prior to their next contact with their obstetrician (Hollander et al., 2017). Having additional support during this crucial time period may assist individuals in identifying symptoms and concerns earlier. This could help individuals know when to ask for help and when they should seek support from their providers.

Postpartum Psychosis

Işık (2018) found that "Women experience 22 times more psychotic or mania episodes in the postpartum period than in any other periods of their lives" (p.1) and have a reported prevalence rate of prevalence of 0.1-0.2%. Approximately 20% of postpartum deaths can be attributed to suicide (Wisner et al., 2013).

Perinatal Mood and Anxiety Disorders

Perinatal mood and anxiety disorders (PMADs) is a newer term that encompasses all mood and anxiety disorders affecting women during the perinatal period. The term perinatal is used to describe the time frame of pregnancy and the 12 months following birth (Beck et al., 2020). While the terminology is advancing, it is important to note, clinically these are not DSM5 diagnoses and do not have diagnosis codes that can be used to justify health insurance coverage or reimbursement. Recent research has begun to expand our knowledge and awareness of pregnancy, birth-related, and postpartum mental health risks and concerns, however, much more needs to be done to gain a greater understanding and increase awareness of these issues.

Pregnancy Loss

While perinatal mental health disorders can occur for a multitude of reasons, situational events such as a miscarriage or stillbirth come with an increased risk for negative psychological effects. It is no argument that a miscarriage is a cause of mental stress. Białek and Malmur (2020) eloquently describe it as "loss of pregnancy… is in most cases a sudden and unexpected surprise, without the possibility of control, and for which one cannot prepare". The physical pain of miscarriage is accompanied by emotional pain and can create distrust in one's reproductive capabilities along with the ability and right to be a parent (Białek & Malmur, 2020). This can lead to a range of negative emotions including guilt and anger, and cast a shadow of anxiety and fear on future pregnancy endeavors (Białek & Malmur, 2020).

The Mayo Clinic estimates that 10-20 percent of pregnancies result in a miscarriage (2021). A miscarriage that happens at or after week 20 is considered a stillbirth and can happen in approximately 1 in every 100 pregnancies or about 24,000 babies per year (Center for Disease Control and Prevention, 2020). That means about 24,000 women experience the trauma of pregnancy loss each year.

As if the experience of pregnancy loss was not distressing enough, Chojenta et al. (2014) reviewed and identified continued or future complications that can occur after a pregnancy loss. When a woman experiences a pregnancy loss and then later becomes pregnant, increased levels of sadness, excessive worry, and low mood were found to occur (Chojenta et al., 2014). While these effects were found during the pregnancy, the experience of a prior pregnancy loss did not indicate an increase in these experiences during the postpartum period (Chojenta et al., 2014).

Beck et al. (2020) found that roughly 50% of women experienced depressive symptoms after experiencing a pregnancy loss. Women who have experienced a miscarriage consistently scored higher on depressive scales than pregnant women and women in the community within the two months following the miscarriage (Beck et al., 2020). Sleep disturbance is a common symptom of mental health disorders; almost 30% of women who experienced a miscarriage utilized sleeping pills, which is approximately three times greater than women who did not report having a miscarriage (Beck et al., 2020).

Séjourné et al. (2010) shed light on the general feelings of dissatisfaction surrounding the available psychological support for women after their miscarriage experience. One area of support participants of the study identified as needing improvement was the level of support they received from the medical professionals involved in their care just prior to, during, and immediately following their pregnancy loss (Séjourné et al, 2010). Each individual's experiences

are unique and different; support cannot be one size fits all. This uniqueness of experience requires providers and professionals to listen to each of their patients with care in order to assist these women with getting the support they need. Providing individualized care and support during this time may hope to address the fact that few women actively seek support (Séjourné et al., 2010).

Pregnancy Wantedness

Pregnancy wantedness also has an effect on perinatal mental health. When mothers wanted a pregnancy more than the father wanted the pregnancy, women were at increased risk and rates of pre and postpartum depression, PTSD, conflict within the relationship, and decreases in partner support during the perinatal period (Atzl et al., 2020). This study identifies a specific area practitioners can use to spot women at heightened risk based on these factors. From this, practitioners can implement prevention, provide education, or recommend treatment.

Unwanted or unintended pregnancies have other implications for mental health in addition to those identified above. Rackin and Brasher (2016) found that women who experienced unintended pregnancies were more likely to develop depression than women who had intended or planned pregnancies. Risk factors for unintended pregnancies include unmarried status, ages 15-24, increased poverty levels, decreased education levels, and identifying as Black or Hispanic (Finer & Henshaw, 2006). Maiocchi and Bernardi (2012) expressed concerns that adolescent unwanted pregnancies may indicate abuse or neglect within the home and reported women who had multiple pregnancy terminations were found to have increased rates of violence involved in their lives.

Finer and Henshaw (2016) reviewed birth data for 2001, there were 6,400,000 pregnancies, of those pregnancies 49% were unintentional. Of the 49% of unintended

pregnancies, 44% resulted in birth, 42% resulted in abortion, and 14% in pregnancy loss (Finer & Henshaw, 2006). These numbers are substantial and the consequences to one's mental health are evident.

Adjustment

Pregnancy and motherhood are often described as a transformation. Some women adjust to this transformation easily, while others have more difficulty adjusting. Few discuss the difficult aspects of adjusting to motherhood. Attention is focused on things like lack of sleep, but few talk about lack of identity. It is common to feel lost during this adjustment. A mother's needs and priorities are shifting and now must include another human being's needs. While the struggle to maintain an individual identity is ever present throughout motherhood, some parts of the individual identity are lost entirely. The loss of these aspects of identity can require a period of mourning. Babetin (2020) points out that society does not typically acknowledge the need for such a mourning period. Babetin (2020) states women are just "expected to be grateful for a baby with good health and an underpaid maternity leave from work to adjust" (p. 414).

Additional stressors to the adjustment to motherhood can often be financial. Unpaid maternity leave forces low-income mothers to return to work sooner than preferred, making the adjustment more difficult as their time to adjust and bond with their child has been cut short. Forsyth (2018) discussed that despite having the FMLA (Family and Medical Leave Act) which provided unpaid leave for childbirth, less than 60% of women meet the criteria to receive these (minimal) benefits.

Screening/Awareness

Postpartum depression, postpartum anxiety, perinatal mood and anxiety disorders, post-traumatic stress disorder, traumatic birth, grief associated with perinatal loss, and postnatal

psychosis are some of the most common terms used to describe mental health disorders occurring during the perinatal time frame. Awareness is a concern as only one of these conditions is routinely discussed in perinatal settings. Common screening practices only screen for postpartum depression and screening is not universal. While there are screening tools for generalized disorders like generalized anxiety and major depressive disorder, Davies et al. (2021) point out how these screening tools may include questions that are inappropriate or inapplicable to the experience of motherhood and "low scores may not reflect the absence of symptoms" (p.957). Postpartum anxiety can be screened for using the Postpartum Specific Anxiety Scale (PSAS) and a shortened form (PSAS-RSF). While the tool exists, it is not routinely used. There are no requirements to screen for postpartum anxiety or any other perinatal disorder like there are for postpartum depression.

Kendig et al. (2017) point out that although some states mandate screening, screening alone does not improve the outcomes of women experiencing these conditions. Kendig et al. (2017) continue by encouraging increased assessments, monitoring, and interventions. Even if primary care providers were screening women, Keefe et al. (2016) identify the continued issue of providers not being prepared to screen and treat for these conditions and the tendency of providers to dismiss symptoms as just a part of pregnancy and motherhood. Earls (2010) recommends that when licensed clinical social workers are part of the interdisciplinary team, positive screeners should be directed to said social worker for additional screening, diagnosis, and follow-up. Provider preparedness is not only in question for social workers, but providers in general.

Legislation

In the U.S., the only federal legislation regarding perinatal mental health falls within the Patient Protection and Affordable Care Act (2010) which mandates coverage of depression screenings for women during the perinatal period. Postpartum depression is a perinatal mental health concern that is widely known, discussed, educated on, screened for, and treated. However, this terminology is quickly becoming outdated and limits past research, excluding other perinatal mood and anxiety disorders and depression that occurs during pregnancy. Even the Patient Protection and Affordable Care Act only utilizes the term postpartum depression. Within the Patient Protection and Affordable Care Act (2010) calls for increased research and funding to do so were identified, but only the term postpartum depression is used indicating that other maternal mental health disorders may be excluded from such research.

While the US Preventive Services Task Force recommends universal screening of perinatal women for depression it is only a recommendation and not enforceable (Siu, 2016). Each state can determine its own legislation on this subject. Rhodes and Segre (2013) identified only three states that had mandates for both screening and education regarding postpartum depression. Five different states were identified as having mandates for education, which is typically given in the form of a brochure or pamphlet, and four additional states have mandates for awareness campaigns (Rhodes & Segre, 2013). Keep in mind this only addresses postpartum depression and no other perinatal mental health concerns.

Impact

When attempting to find the societal costs of postpartum anxiety, Ko and Haight (2020) found that the majority of literature on this only focused on postpartum depression. Luca et al. (2020) estimated the total cost of PMADs for children born in 2017 and for the next five years of their lives to be 14 billion dollars. An individual mother and child accounted for over 31

thousand dollars and mothers accounted for 65% of that number (Luca et al. 2020). McKee et al. (2020) found not only increases in the prevalence of PMADs between the years of 2006 and 2015, but individuals who experienced PMADs and serious mental illnesses experienced higher utilization of healthcare and their deliveries were more expensive than women without PMADs.

The effects of PMADs are not just felt by the individuals experiencing them. The children and families of these mothers also experience negative effects. During pregnancy and the time following birth, mothers are supposed to be building attachment with their fetus and baby. PMADs can affect a mother's ability to form secure attachments with her baby and in return affects the baby's (Alhusen et al., 2012; Erickson et al., 2019). Della Vedova (2014) found perinatal depression and anxiety are linked with maternal perception of elevated temperament difficulty of children and stressed the importance of intervening early in order to help encourage and support positive mother-child relationships.

Theoretical Framework

Matricentric Feminism

Andrea O'Reilly coined the term "matricentric feminism" in her book *Matricentric Feminism: Theory, Activism, Practice* (2021). The concept of matricentric feminism is to identify a subgroup of women who are not quite explained through traditional feminism theory, mothers. Matri- represents matriarch, or a female head of a family. Matricentric feminism is a "mother-focused feminism" (O'Reilly, 2021, p.42). O'Reilly emphasizes that this is not a replacement for feminism, but a subcategory. Green (2019) describes it as a combination of a person's feminism and their mothering/parenting. You can be a woman and not be a mother, being a mother is a separate experience in itself and includes experiences and issues specific to the experience of motherhood.

O’Reilly describes motherhood as a socially constructed concept that is largely influenced by current patriarchal views that combine motherhood and womanhood together (2021). Feminism itself attempts to delink the two concepts of being female and being a mother. Holmes (2019) uses the terms “optional” and “nonessential” to describe being a mother in today's society. Matricentric feminism is a theory that validates women’s experiences as mothers to be seen for more than just their biological duty, right, or ability. O’Reilly states “any understanding of mothers’ lives is incomplete without a consideration of how becoming and being a mother shape a woman's sense of self and how she sees the world " (O'Reilly, 2021, p.41). This includes all ways an individual may become a mother, including but not limited to, birth, adoption, surrogacy, and fostering.

At the beginning of this dissertation there is a note regarding the gendered terminology used within this dissertation. By using the terms mother and woman/women, this writer acknowledges that they are essential to providing a distinction between the two. Using non-gendered terminology such as “individual” provides no such distinction and thus no differentiation between them. By using gendered terms, as current literature has, it acknowledges the current oppression and uniqueness of these groups and validates their differences.

Within O’Reilly’s (2021) text, she highlights an essay by Stephanie Wilkinson where she conducted a word association among her colleagues to compare their associations with civil rights versus mothers’ rights. The word associations for mothers’ rights were disappointing, limited to concepts such as maternity leave and childcare (O’Reilly, 2021). This in itself identifies a lack of deep thought given to this subject by others not directly involved. Being a mother is part of who you are as an individual; however, it does not have to consume your entire identity to the point that you no longer know who you are without it.

Feminism addresses workplace discrimination based on gender, matricentric feminism addresses workplace discrimination based on being or related to motherhood. O'Reilly (2021) describes this concept as a "maternal wall" (p. 42). Employers who fear maternity leave and frequent call outs due to child-related concerns may avoid hiring women whom they believe are in their prime child-bearing years or an individual that has been identified as having young children at home. Once a woman gets married, she is bombarded with the question of when are you going to have a child, once that happens, the next question becomes when will you stop working. The focus shifts away from the individual and their hopes, dreams, and goals to simply having and caring for children. Babetin (2020) describes becoming a mother as a "transformation from woman to mother" (p. 410). The term implies you stop being the first to become the second. This theory argues that while it is a transformation, it should not require losing yourself as a woman to become a mother.

Patriarchal views of parenting approve of women ceasing work in order to care for children and then perhaps once they have fulfilled this duty they may return to the workforce once their children are no longer in need of them. If someone wants to have a career while they have children they are often viewed as selfish, unless they are a male in which they are applauded for providing for their families. There tends to be a very large double standard when it comes to expected contributions to parenting. Father figures are applauded for having an active role, which is the expectation that mother figures always have an active and primary parent role.

This theory seeks to challenge patriarchal methods and perceptions of parenting. It encourages women to seek identity outside of motherhood. It seeks to disassemble the belief system that mothers have to be perfect and any misstep as a mother should be accompanied by immense amounts of guilt, shame, and judgment. Giving birth is generally perceived as a

positive life event for women. One might struggle to understand how a positive life event brings depression. Moustafa et al. (2019) explain that despite being a positive event (if it was), birth is a major transition that can bring about anxiety and stress which affects the mother more than the father. Looking at mental health disorders from this perspective supports the concept that perinatal mental health issues are unique from their non-perinatal counterparts. While there are many similarities between being a woman and a mother both are also unique from each other and require their own attention. The theory supports the concept that the two identities can be independent of one another.

Postpartum Depression Theory

Theorist Cheryl Tatano Beck developed the postpartum depression theory through her extensive research on perinatal mental health disorders. Dr. Beck has done a considerable amount of research on the phenomenon of postpartum depression and perinatal disorders. Dr. Beck's theory identifies 22 key concepts of postpartum depression. Identifying and defining postpartum mood disorders is the very first concept. Dr. Beck skillfully defines postpartum depression and other postpartum disorders discussed in this paper (Themes, 2017). This theory provides a cohesive definition and distinction to these disorders, something that has been lacking in literature, but still lacks inclusion in the prenatal period.

Despite her experiences and research coming from a nursing perspective, Dr. Beck's research is of great value to the social work profession. Dr. Beck has been researching issues regarding obstetrics and motherhood since 1972 and her contributions make her an expert in this area. In 1993 she published her theory on postpartum depression titled, *Teetering on the Edge.* From this research, Dr. Beck identified four stages of postpartum depression which were 1. Encountering terror, 2. Dying of self, 3. Trying to survive, and 4. Regaining control (Beck,

1993). Postpartum depression (and other maternal mental health disorders) serve as the terror, the consequences of those disorders cause the death of oneself, working through and getting help for the disorder is struggling to survive, and finally regaining control is the consequence of getting help (Lasiuk & Ferguson, 2005).

Beck's theory is described by Lasiuk and Ferguson (2005) as a mid-range theory, meaning it is more specific than a grand theory, but broader than a single-domain theory. One that emphasizes the importance and value of the experiences of the individual.

Beck identifies 11 general themes of postpartum depression which are also themes within other perinatal mental health disorders. These themes are:

> "1. Unbearable loneliness 2. Contemplation of death provides a glimmer of hope 3. Obsessive thoughts about being a bad mother 4. Haunting fear that "normalcy" is irretrievable 5. Life is empty of all previous interests and goals 6. Suffocating guilt over thoughts of harming their infants 7. Mental fogginess 8. Envisioning self as a robot, just going through the motions 9. Feeling on the edge of insanity due to uncontrollable anxiety 10. Loss of control of emotions 11. Overwhelming feelings of insecurity and the need to be mothered" (Lasiuk & Ferguson, 2005, p. 132).

These 11 themes are undeniably overwhelming. The idea that motherhood is a magical experience can worsen these feelings when women do not have that magical experience and make the assumption that it is somehow their fault. Shedding light on these experiences, which are more common than one might think, can help individuals understand that motherhood has its magical moments, but the entire experience is unique and profound.

Self-efficacy Theory

Developed in the 1970's by psychologist Albert Bandura, self-efficacy is based upon the concept that our own awareness and beliefs of our abilities or skills can determine our success. This theory is applied to social workers' self-efficacy regarding working with, including but not limited to diagnosing and clinically treating, perinatal mental health concerns. Self-efficacy is a part of the larger theory of social cognitive theory. In this case, the specific skill/skills are those related to the identification, diagnosis, treatment and overall awareness of perinatal mental health disorder. Bandura believed that if an individual felt strongly in their ability to do something, that would influence their success (Bandura, 1997).

Gaps in the Literature

Current social work literature has a major concentration on postpartum depression. It currently lacks attention on all other perinatal mental health disorders and the inclusion of the entire perinatal period. Howard and Khalifeh (2020) also felt that the entirety of the perinatal mental health spectrum lacked research as well as the effectiveness of current treatment and suggestions for improved treatment.

While there is a wealth of research that still needs to be completed, the interest of this research is regarding assessing social workers' knowledge, self-efficacy, and awareness of perinatal mental health disorders. By assessing social workers' self-efficacy working with individuals with mental health disorders who are in their perinatal period, gaps in social work education can be firmly identified and addressed. The outcomes will allow social workers to advocate for social work course offerings on this subject. By providing increased educational content on this subject social workers can increase their preparedness and provide more competent services to this population. In addition to social worker preparedness, providing courses that address this content will help to broaden social work education in general.

At the individual level, it is hoped that individual social workers may evaluate their own levels of preparedness and address any gaps in their own learning independently. If gaps are found, social workers can make conscious choices to address these gaps through independent education and research on the topics addressed here. Social workers may not be in positions where they only serve this specific population, but there is a high likelihood that social workers will interact with this population during their careers. As research regarding this population shows, these disorders are often missed and unreported. Having more professionals aware of these disorders at a greater level of awareness may help to address issues of misdiagnoses, underreporting, and individuals not seeking help.

By assessing self-efficacy, this research also aims to increase awareness of perinatal mental health issues beyond postpartum depression. By shedding light on other perinatal mental health conditions, social workers can not only increase their awareness, but join in the research and advocacy regarding these critical issues in women's health and wellness.

Conclusion

Our current society's view on pregnancy and motherhood is largely patriarchal still. While the feminist movements are making progress, there is still a long road ahead for matricentric feminism. Societal pressure to be perfect mothers, lack of personal identity, and the overwhelming pressure knowing you are responsible for another human being is a lot for an individual to take on. Couple that with poor support, inadequate coping skills, and unrealistic expectations and it becomes the perfect environment in which mental health disorders thrive.

Having a child or choosing to be a mother should not expose women to increased discrimination or bias. Women should not have to choose between being a good mother, and being whatever type of person they want to be. Mothers should not have to give up their careers

to have children, especially when fathers are not subjected to the same parental pressures. No one asks a father if they plan to quit their job to stay home and raise children, yet it's a common expectation of mothers. Addressing the way our society talks about mothers is essential. Being a mother should not be a barrier to a successful career, and the decision to pursue such a career should not be an open invitation for others to judge your quality as a parent. Mothers should feel safe reaching out for help when facing a perinatal mental health disorder and social workers should have the tools and resources to adequately help.

Fear of judgment by any provider should not be a barrier for women and or mothers to seek help during this vulnerable time in their lives. By ensuring social workers have a competent understanding of these issues, they are more able to provide competent, judgment-free, and empathetic assistance and services. Being a mother does not mean you must endure without complaint all of the concerns that can arise as mentioned throughout this paper. Perinatal mental health concerns are not a “rite of passage” into motherhood or a consequence of a woman's decision to have a child.

If you take all the psychological symptoms and negative experiences that can occur during pregnancy, birth, and postpartum and look at them without the influence of the baby, there would be no argument of mental distress and the need for help. Sleep abnormalities, struggles to maintain basic hygiene, decreased mood, fatigue, hopelessness, fear of failure, and more are all commonly associated with moderate to severe mental health concerns. However, when you add a new baby to that mixture, those symptoms are masked by the shadow of the baby and are too often overlooked, missed, or dismissed.

Current literature is paving the way for a greater depth of knowledge in this area. Interest in this topic is growing, however, there is still much more that needs to be researched. There are

many gaps surrounding the current body of literature. There was virtually no literature addressing social workers' self-efficacy regarding the perinatal mental health topic. Current literature on social work and perinatal mental health education is severely lacking and needs increased attention. Prevalence rates vary dramatically and these disorders are underdiagnosed and undertreated. Addressing why still needs more research. More research is needed to identify barriers to women seeking treatment for perinatal mental health issues so barriers can be addressed.

The literature also lacks a greater understanding of the needs of mothers during the perinatal time period. It would also be beneficial to gain a greater understanding of the effects of societal pressures on mothers. While this population is not new by any means, some of the areas of concern addressed here are relatively new. A large portion of literature is produced from professions other than social work, leaving the role of social workers needing definition. Despite being mental health specialists and these disorders being of a mental health nature, current literature does not have social workers playing a large role.

When we ask the question, how do currently licensed and licensed clinical social workers perceive their self-efficacy in regard to addressing perinatal mental health disorders? We are attempting to ensure women experiencing these concerns receive appropriate and specialized care. Mothers have a mountain of concerns they face daily in addition to the concerns addressed in this paper. Society tries to make women feel as though their mountains are overdramatized molehills. That in some way, women "sign up" for these concerns when they become a mother or simply by being born as a woman in a patriarchal society. Here is a vulnerable population in need of help. This research aims to assess the perceived knowledge and competence level of social workers to provide that help. Bringing awareness to this issue also helps to prevent further

traumatizing or harming women by providing poor quality care or further promoting harmful beliefs about motherhood and perinatal mental health disorders.

Chapter 3: Methodology

Introduction

Due to the ever-rising topic of perinatal mental health, questions of social workers' self-efficacy level to address these issues also begins to rise. It is important that social workers are knowledgeable and competent when addressing perinatal mental health concerns, or have an awareness of a lack of knowledge and competence and thus the need to refer out to a clinician who is better trained to work with these concerns. Social work has many specialties and it is unrealistic for a person to specialize in all mental health concerns for every population, however, social workers should be practicing self-awareness and reflection. In doing so social workers would acknowledge shortfalls in their competence and knowledge causing the desire to be trained or educated to address said shortfall or identify referral resources to refer individuals to appropriate providers.

This study will specifically focus on exploring clinical social workers' self-efficacy surrounding perinatal mental health concerns. To be more specific, it will look at clinical social worker's knowledge and awareness regarding the subject and self-efficacy in diagnosing and treating perinatal mental health disorders. Using a quantitative method, social workers' knowledge, awareness, and self-efficacy to address perinatal mental health disorders will be examined. Since there is little research already completed on this subject, this will be an exploratory study aimed at lessening the gap of knowledge surrounding social work and perinatal mental health. This survey was created due to there not being a measurement instrument known to this researcher that measures social workers' perceived levels of knowledge, awareness, and self-efficacy.

Gist & Mitchell (1992) define self-efficacy as "a person's estimate of his or her capacity to orchestrate performance on a specific task" (p.183). In this case, those specific tasks would include the identification, treatment, and general awareness level of perinatal mental health disorders and the resources available. Bandura (1982) discusses the relationship between levels of self-efficacy and levels of performance achievements, finding that higher levels of reported self-efficacy lead to higher levels of performance achievement.

Variables

This study sets out to measure the following variables.

1. Social workers perceived level of knowledge on perinatal mental health disorders.
2. Social workers perceived self-efficacy in clinically addressing perinatal mental health disorders.
3. Social workers awareness of perinatal mental health disorders and resources available.

Rationale for Research Design

A quantitative survey methodology was chosen for this study due to the efficiency of a quantitative survey and the ability to examine relationships between variables. By only asking participants simple dichotomous, multiple choice, and Likert scale questions, it is hoped that the response rate will be higher than that of a more cumbersome qualitative survey design. Utilizing a web-based survey ensured the survey would be able to reach a large number of potential participants with a smaller financial cost than utilizing a mailed survey. Based on the guidance of Ruel et al. (2015) questions were developed using a single construct question design, used clear and simple language, avoided abbreviations, and closed-ended question formatting. As advised by Greasley (2007), all questions were developed to be closed questions and avoid double questions. Relevant answer options were determined through testing questions with colleagues

and peers to review answers and determine answer options that are relevant to all or most of the population being surveyed.

Purpose

The objective and purpose of this research is to assess how social workers currently perceive their self-efficacy, knowledge, and awareness levels related to identifying, treating, and general awareness of perinatal mental health. By addressing this question, potential gaps in social work education and training can be identified and progress can commence on addressing these gaps. This research could lead to the development and implementation of perinatal mental health courses, training, and curriculum that would better prepare social workers for assisting this vulnerable population. At a very minimum, this research hopes to increase awareness of these disorders and encourage professionals and individuals to advocate for more education regarding these disorders. The results of this research could identify a need for specialized training to justly serve this population, and increase general awareness of perinatal mental health.

Research Questions

The following research questions were developed for the purpose of this survey and dissertation.

- Q1: How do social workers perceive their current self-efficacy regarding diagnosing and treating perinatal mental health disorders?
- Q2: Do social workers who identify themselves as parents, versus those who do not, indicate higher levels of perceived knowledge, awareness, and self-efficacy?
- Q3: What is the relationship between additional training (outside the BSW and MSW curriculum) and clinical social workers' self-efficacy regarding perinatal mental health?

- Q4: Do social workers with independent licenses (vs associate licenses) indicate higher levels of perceived knowledge, awareness, and self-efficacy?

The following hypotheses coincide with the questions above.

- H1: Social workers are more likely to have a low level of perceived self-efficacy in diagnosing and treating perinatal mental health concerns.
- H2: Social workers who identify themselves as a parent will have higher levels of perceived self-efficacy, knowledge, and awareness.
- H3: Social workers who identify having training outside of their BSW and MSW education will have higher levels of perceived self-efficacy, knowledge, and awareness.
- H4: Social workers who indicate having an independent clinical license, as opposed to an associate license, will have higher levels of perceived self-efficacy, knowledge, and awareness.

Survey

A 21-item survey (Appendix A) was developed to assess social workers perceived level of knowledge, awareness, and self-efficacy regarding different aspects of perinatal mental health. Prior to the development of the survey, many different current measurement and assessment tools were reviewed. The Mental Health Literacy Scale (MHLS) (O'Connor & Casey, 2015), the Postpartum Depression Literacy Scale (PoDLiS) (Mirsalimi et al., 2020), and the Mental Health Awareness and Advocacy Assessment tool (MHAA-AT) (Fauth et al., 2021) were identified and used to guide the survey questions development. The MHLS identified 7 attributes of mental health literacy to which questions were developed to assess each attribute (O'Connor & Casey, 2015). The PoDLiS utilizes an adapted version of the seven attributes from the MHLS (Mirsalimi et al., 2020). The MHAA-AT utilized three domains from which all questions can be

derived from and set out to measure an individual's self-efficacy regarding mental health and mental health awareness. These attributes and domains were adapted and modified to fit the survey needs and the survey population of social workers working in a clinical capacity.

Based on the literature above, three domains namely, knowledge, self-efficacy, and awareness have been developed.

Operationalization

Knowledge is operationalized by asking questions assessing perceived knowledge levels and questions assessing where the knowledge derives from. Questions 6, 7, 17, and 18 fall within the social workers' knowledge of perinatal mental health disorders domain. These questions include those assessing where social workers feel they obtained their knowledge on perinatal mental health from, questions asking respondents to rate their perceived knowledge level on perinatal mental health disorders, and questions aimed at assessing respondents knowledge on perinatal information. Questions 8, 9, 10, and 16 also fall within the knowledge domain, however, these questions measure where knowledge derives from and are not measures of perceived levels of knowledge.

Self-efficacy is operationalized by asking questions that allow the respondents to rate their self-efficacy level on a scale. Questions 11, 12, 19, and 20 fall within the self-efficacy to identify and treat perinatal mental health disorders domain. This includes questions asking respondents to determine their level of self-efficacy in regard to diagnosis and treating perinatal mental health disorders and their comfort level treating those disorders clinically.

Awareness is operationalized by asking questions aimed at assessing respondents' level of awareness on the subject of perinatal mental health. Questions 13, 14, and 15 fall within the awareness of perinatal mental health disorders and resources domain. This includes questions

regarding the respondents awareness of current terminology, experience working with the perinatal population, and awareness of resources for this population.

Questions 18, 19, and 20 all utilize a Likert scale for the responses with the options of very poor, poor, fair, good, and very good. Questions 18, 19, and 20 are broken down into 7 different perinatal mental health concerns including perinatal depression, perinatal anxiety and panic, traumatic birth, perinatal post-traumatic stress disorder, perinatal obsessive compulsive disorder and impacts of perinatal mental health on infants and children. The survey is self-administered and self-paced. The survey is estimated to take an average of 15-25 minutes. While adequate instructions are given for each section of questions, the questions were designed to be easy to read and complete with little to no instruction needed.

One expert, who identified as being a certified perinatal mental health specialist currently practicing clinically in the specialty field, felt the questions measured the intended variables and the survey utilized understandable language. In regard to question 10, asking if respondents have additional training on perinatal mental health, an expert with a certification in perinatal mental health suggested adding an option that allows respondents to indicate they received additional training both on their own and from their job. Previously the question allotted two responses for yes, allowing respondents to choose yes, from their job or yes, on their own. This question was updated with the feedback from this expert. Question 15, which was previously written as “Are you aware of any resources in your practicing area for women experiencing perinatal mental health issues?”, an expert indicated that the utilization of the gendered term “women” may be better improved and provide better inclusion through the use of a non-gendered term such as “person” or “individual”. This survey question was amended to include this feedback.

The survey was conducted online via Microsoft Forms. The responses were made anonymously and the respondents' email or any other identifying information was not tracked or retained.

Research Population, Sample, and Data Sources

The target population for this study is social workers who work in a clinical capacity. For the feasibility of this dissertation, a sampling frame were the members of the PA chapter of the National Association of Social Workers (NASW). The NASW defines clinical social work as "a specialty practice area of social work which focuses on the assessment, diagnosis, treatment, and prevention of mental illness, emotional, and other behavioral disturbances" (National Association of Social Work, n.d.). While social work has many specialties and areas of focus, this study aims to look at social workers who work in a clinical capacity. Within the invitation email, the wording "clinical social workers" was used and a list of possible social work licensure was included to assist potential respondents in identifying their eligibility. Questions three assessed for clinical work, to ensure all respondents were involved in clinical work at the time of the survey.

Study participants were invited to participate in the research study through the use of the NASW Pennsylvania chapter's email blast list. This is a list of all members' email addresses and is used to advertise approved subjects and materials. In order to obtain access to this resource, this researcher was required to submit an application which included the survey and all IRB approval letters. This researcher's application was approved by the director of the PA chapter. The survey blast cost this researcher $200 to conduct. While there is no way to refine what members receive the email, screener questions are included in the survey, and eligibility requirements are included in the recruitment email.

The survey is anonymous and at no time did the primary investigator have access to the email addresses that the survey was sent to or of those who completed the survey. There are no personally identifying questions included in the survey. Once a respondent completed the survey, their results were logged within Microsoft Form and participants did not need to take any further action after clicking submit. This survey has been approved by the Kutztown University Institutional Review Board and has been given the approval #01082022.

Data Collection

An "email blast" offered by the National Association of Social Workers, the Pennsylvania chapter, allowed this researcher to send out a link to the survey to all NASW-PA members. A total of 3,486 emails were sent out. Utilizing the non-probability convenience sampling method, an email containing the recruitment message and a link to the survey was sent out to 3,486 emails. In an effort to increase the number of responses, the survey was also promoted on the NASW online forum. The survey invitation was sent out via this online forum inviting Pennsylvania members to participate in the survey.

The email blast containing the survey developed for this dissertation was delivered on December 23rd, 2022, via the PA-NASW email blast. There was no set end date provided in the recruitment email. As stated above, this researcher did not have access to participant information including any demographic information or their email addresses. The following information was provided by the NASW-PA regarding the data collected from the email blast. The survey invitation was emailed to 3,486 emails, 1,873 individuals opened the email, 77 individuals clicked the link provided in the invitation, and 126 emails were returned due to invalid email addresses. Of the 77 individuals that opened the survey, 42 completed and submitted the survey. The difference can be attributed to individuals who exited the survey without submitting, and

individuals who were prompted to exit due to not meeting survey participation requirements. An additional 10 responses were collected via promotion of the survey on the NASW online forum. The NASW online forum is only accessible via NASW membership and the post was directed toward Pennsylvania members. After reviewing responses for adherence to the eligibility criteria, 40 responses were left that met all eligibility criteria.

Pilot Test

After the evaluation of the survey by a group of experts, changes based on their feedback were made. A pilot test of the survey was conducted in November 2022. The pilot survey sample was made up of a group of thirteen clinical social workers that more closely resembled the target population and had greater diversity in their education, experience, and training.

Validity and Reliability

The survey was presented to a group of six experts in perinatal mental health, all of whom were clinical social workers. The experts all have specific experience working with perinatal mental health. Two experts hold PhDs and have conducted research regarding perinatal health. The remaining four experts all hold perinatal mental health certificates from Postpartum Support International and currently practice clinically within this specialty. These six experts have an average of 16 years of experience in perinatal mental health. One expert is the recipient of the National Association of Perinatal Social Work's award for excellence in perinatal social work. While these individuals would be eligible participants for the survey, they were sought out for their expertise in the subject area of perinatal mental health.

The individuals' responses showed their high level of experience, education, and training in this area. The responses of these individuals will likely not represent the results of the data as not all social workers will have this level of experience, training, or education on the subject. All

six experts were provided the survey and were permitted to respond to all questions and then were given space for feedback as well as a list with the variables the survey was intended to measure. Each was given the following sample feedback questions to help generate feedback and response.

1. Do you feel the questions measured the intended variables?
2. What would you identify as the survey's strengths?
3. What would you identify as the survey's weaknesses?
4. What changes, corrections, and or additions would you suggest be made?

A collective summary of the feedback provided led to changing two gendered responses to be more inclusive. Two grammatical errors were corrected. Feedback was given regarding a suggested question be added on the impact of perinatal mental health disorders on infants and children which resulted in one additional question being added to the survey. The overall feedback reported the questions were easily read and highly understandable. The experts felt the questions appropriately measured the variables indicated in the list provided to them.

Face validity was established by a group of experts. The experts' feedback clearly indicated the survey was relevant to what it is intended to measure, appropriate for the population it seeks to survey, and serves the purpose intended by the researcher. Suggested changes based on the feedback of the experts were made in order to strengthen the survey and ensure the survey measures the identified variables. Based on a checklist provided by Ruel et al. (2015) (p.95) the assessment of the survey by the group of experts was also able to establish content validity. The experts' responses determined all parts of the survey are necessary, relevant, and representative and felt this was an adequate measure as indicated in the checklist.

A reliability test through SPSS was run on the survey data. Reliability was established on the three domains of knowledge, self-efficacy, and awareness. The Cronbach's Alpha score ranges from 0 to 1, the closer to one, the greater the reliability. The knowledge domain within this survey has a Cronbach's Alpha score of .815. This score makes the reliability of the knowledge domain questionable. The self-efficacy domain has a Cronbach's Alpha score of .86. This score makes the reliability of the self-efficacy domain good and acceptable. The awareness domain has a Cronbach's Alpha score of .49. This score makes the reliability of the awareness domain poor or unacceptable. It is important to note that the awareness domain is only made up of three multiple choice questions, making it a poor fit for this reliability test. Both the knowledge and self-efficacy domains are made up of both categorical and Likert scale questions to measure the domains.

Given the small sample size, the result's significance is questionable. Despite having two domains with a higher Cronbach's Alpha score, the small sample size should be taken into consideration when reviewing the reliability of the survey.

Table 1

Cronbach's Alpha Scores

Domain	Number of Items	Cronbach's Alpha	%
Knowledge	10	.815	82%
Self-efficacy	10	.859	86%
Awareness	3	.488	49%

Data Analysis

Data has been analyzed utilizing IBM SPSS software and presented in tables with a written analysis of the data gathered by the survey. The descriptive and bi-variate analysis were

used. Level of social work license, parental identification, and level of training were all analyzed through descriptive statistics.

Survey data was first reviewed for entries that did not meet eligibility requirements. Despite adequate instructions at each section of the survey, the data needed to be cleaned of entries that did not meet the eligibility requirements such as social work license and clinical work environment.

Limitations

This survey has been developed with the guidance of Fowler's (2013) *Survey Research Methods.* This survey is subject to social desirability bias as it calls for social workers to utilize self-reflection and potentially identify professional weaknesses. There is potential for individuals to see certain responses as "socially undesirable". This survey will rely on the honest answers provided by the respondents; however, it is not immune to individuals who may respond less than honestly for the desire of providing "better" or more desirable responses or the desire to not admit perceived fault.

This survey is only being presented to Pennsylvania social workers as the cost of advertising the survey via an email blast in multiple states would be too great, thus limiting the survey results' generalizability and creating an undercoverage of the sample population. The survey was also limited by the researcher's sampling methods budget. This research was unable to provide incentives for survey participation which could have potentially increased the sample size of the survey.

The survey method of using a list frame poses limitations as email lists are not always kept up to date. Members of the organization have to maintain and update their email addresses as needed, but some may fail to do so. This may cause undercoverage of the target population.

However, Groves et al. (2011) find membership organization list frames, like the one utilized in this survey, are a “near-perfect frame” (p.85).

Chapter 4: Findings

Survey Data Set

The data was exported from Microsoft Forms to an Excel worksheet. From Excel, the data was then transferred to IBM SPSS, a statistical software. Questions 1 through 5 are nominal or categorical questions aimed at gathering demographic and exclusionary information from the participants. Questions 6 through 17 are nominal questions based on understanding participants' awareness and knowledge of perinatal mental health disorders. Questions 18 through 20 are scale questions that are based on understanding participants' knowledge level and self-efficacy regarding diagnosing and treating perinatal mental health disorders.

Descriptive Statistics

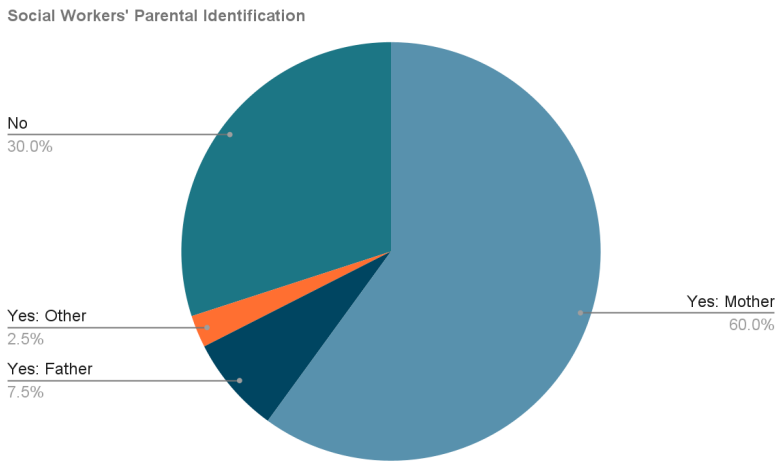
Description of Participants

There were 52 submitted surveys and of the 52 respondents, all 52 identified themselves as professional social workers, meaning each participant has obtained either a bachelor's or master's degree in social work. Based on the responses to question number two, one participant's responses had to be excluded as they indicated they did not possess a clinical license of any capacity, leaving 51 responses. Based on the responses to question three, 7 participants' responses were excluded from the survey results as they indicated the participant did not have a job role that was primarily clinical. Based on the responses to question four, 4 participants' responses were excluded as they indicated they did not work in a clinical mental health setting. While there are directions prompting respondents to exit the survey if their answers to questions one, two, three, and four do not meet eligibility, some respondents continued to respond and their responses were excluded from the survey results. After all exclusions, 40 responses (N=40) met all criteria for inclusion.

Of the 40 responses, 28 (70%) identified themselves as parents. This broke down to 24 (60%) who identified themselves as mothers, 3 (7.5%) identified as fathers, and 1 (2.5%) identified as "other". This left 12 (30%) who did not identify as parents. Being a parent was not part of the eligibility criteria; however, this dissertation will look at the responses of those who identified as parents and those who identified as not a parent.

Figure 1

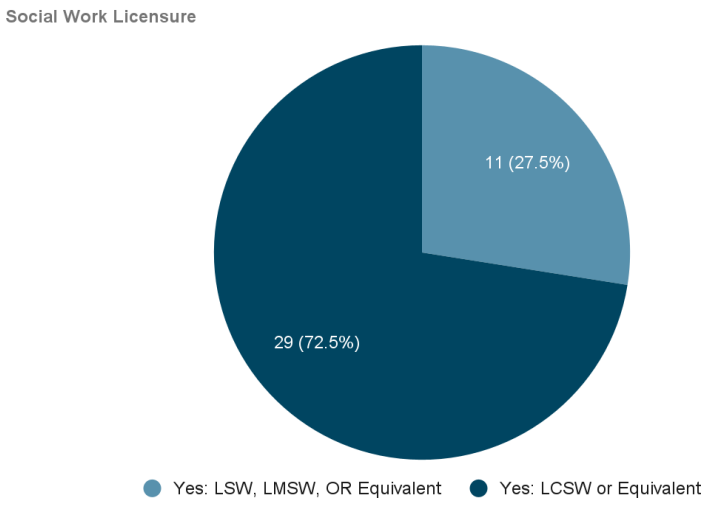
Survey Respondents' Parental Identification



In order to be eligible to participate in this survey, participants must hold a current social work license that allows for clinical social work. Participants were asked to identify one of two different levels of licenses, independent or associate. All participants indicated they held some form of social work license, which included 11 (27.5%) licensed social workers or equivalent to an associate license and 29 (72.5%) licensed clinical social workers or equivalent to an independent license.

Figure 2

Survey Respondents Social Work License



Participants were also asked about training on perinatal mental health disorders outside of the BSW and MSW curriculum. The goal of this question is to attempt to identify where participants obtained their knowledge on perinatal mental health disorders. Participants had four options to choose from including three options for yes and one option for no. The results of this question are displayed in table 3.

Knowledge

The survey produced adequate data within the three domains. Frequency tests were run to determine frequencies of responses for each variable. Participants were asked if they remembered any perinatal mental health content being included in their BSW or MSW education. This question is intended to provide insight into where social workers obtain their knowledge base on perinatal mental health disorders from. Question 8 regarding the BSW

education content resulted in the following responses: Yes (1), No (13), I do not recall (6), and I do not have a BSW (20). Question 9 regarding the MSW education content resulted in the following responses: Yes (3), No (27), and I do not recall (10). It is important to note, a BSW is not required to obtain a MSW or social work licensure, however, a MSW is required for clinical social work licensure. This explains the need to include "I do not have a BSW" to the response list, but there is no corresponding response for the MSW question. When asked if participants thought their social work education prepared them to clinically treat perinatal mental health disorders, 85% answered no.

Table 2

Perinatal Mental Health Topics Within Social Work Education

		BSW		MSW	
Question	Response	N	%	N	%
Do you recall content on perinatal mental health topics being included in your BSW or MSW education?	Yes	1	2.5%	3	7.5%
	No	13	32.5%	27	67.5%
	I Do not Recall	6	15%	10	25%
	I do not have a BSW	20	50%	N/A	N/A
	Total	40	100%	40	100%

Table 3 summarizes participant's responses when asked if they had any training on perinatal mental health disorders. This question is intended to provide insight into where social workers obtain their knowledge base from. Question 10 yielded the following data: Yes: I received training through my job (4), Yes: I sought additional training on my own (10), Yes: I received additional training through my job and on my own (5), and No (21).

Table 3

Social Worker's Perinatal Mental Health Training

Question	Response	N	%
Do you have any additional training on the topic of perinatal mental health?	Yes: I received additional training through my job.	4	10%
	Yes: I sought additional training on my own.	10	25%
	Yes: I received additional training through my job and on my own.	5	12.5%
	No	21	52.5%
Total		40	100%

Participants were asked if they could identify and describe all perinatal mental health disorders (Q6). Over half the participants (N=23, 57.5%) indicated they could identify some, but not all perinatal mental health disorders. Only 12.5% (N=5) indicated they could identify and describe all the perinatal mental health disorders. This left 27.5% (N=11) who indicated they could not identify and describe all perinatal mental health disorders. This question had one "no response" (2.5%).

Question 7 asked participants to identify the correct perinatal time-frame. As defined earlier in this dissertation, the correct answer is: pregnancy to 1 year postpartum, which 50% (N=20) of participants answered correctly. Participants were asked if they thought their social work education prepared them to clinically treat perinatal mental health disorders (Q16) and 85% (N=34) responded with no. Participants were asked if they felt mental health disorders that present during the perinatal period differed from mental health disorders that present during any other period in an individual's life (Q17) and 92.5% (N=37) indicated yes, while only 5% (N=2) indicated no with 2.5% (N=1) providing no response.

Question 18 is a Likert scale question with 7 parts. The 7 parts are for 7 different perinatal mental health concerns to be assessed on the Likert scale. The Likert scale includes five

response options ranging from very poor to very good. The question assesses participants' perceived knowledge levels on the 7 perinatal mental health concerns. Table 4 displays the results from question 18 and each disorder assessed.

As indicated in Table 4 below, there were a total of 280 responses made over the 7 Likert scale questions assessing knowledge. The most frequently reported knowledge level was “fair”, accounting for almost 30% of all the responses. The responses “good” and “very good” only accounted for a combined 27% of the total number of responses. The responses “poor” accounted for 27% and “very poor” accounted for 15% of the total number of responses. The least frequently reported knowledge level was “very good” (6%).

Table 4

Participants Perceived Knowledge Levels

	Very Poor	Poor	Fair	Good	Very Good	No Response
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Perinatal Depression	4 (10%)	5 (12.5%)	16 (40)	10 (25%)	5 (12.5%)	0
Perinatal Anxiety and Panic	4 (10%)	10 (25%)	10 (25%)	12 (30%)	4 (10%)	0
Traumatic Birth	4 (10%)	10 (25%)	9 (22.5%)	13 (32.5)	2 (5%)	2 (5%)
Perinatal Post-Traumatic Stress Disorder	6 (15%)	11 (28%)	12 (30%)	9 (22%)	1 (2.5%)	1 (2.5%)
Perinatal Obsessive Compulsive	7 (17.5%)	18 (45%)	9 (22.5%)	4 (10%)	1 (2.5%)	1 (2.5%)
Perinatal Bipolar and Postpartum Mania	11 (27.5%)	15 (37.5%)	10 (25%)	3 (7.5%)	1 (2.5%)	0
Impacts on Infants and Children	6 (15%)	6 (15%)	15 (37.5%)	9 (22.5%)	3 (7.5%)	1 (2.5%)

Self-Efficacy

Self-Efficacy is measured by 10 questions (Q 11, 12, 19, & 20). Question 20 within this domain is broken into 7 parts for the 7 different perinatal mental health concerns being assessed. Questions 11 and 12 are dichotomous categorical questions with yes or no response options. Questions 19 and 20 are measured using a Likert scale that provides the participants with five response options ranging from very poor to very good.

Question 11 asked participants if they were comfortable treating individuals clinically for perinatal mental health concerns. The majority of participants (N=21, 52.5%) indicated they were not comfortable. Question 12 asked participants if they were comfortable treating individuals clinically whose primary complaint is or is related to complicated grief caused by perinatal loss. The majority of participants (N=22, 55%) indicated they were not comfortable. Question 19 asked participants to rate their perceived self-efficacy level regarding clinically treating clients who identify their presenting problem to be or is related to pregnancy loss. The Likert scale responses revealed 12 (30%) respondents answered poor, 12 (30%) answered fair, 11 (27.5%) answered good, and 5 (12.5%) answered very good. There were 0 responses for the response option "very poor".

Table 5

Social Worker's Comfort Clinically Treating Perinatal Mental Health Concerns (N=40)

Questions	Response	N	%
Do you feel comfortable treating clients in a clinical setting whose primary complaint is or is related to a perinatal mental health concern?	Yes	19	47.5%
	No	21	52.5%
Do you feel comfortable treating clients in a clinical setting whose primary complaint is or is related to complicated grief after a perinatal loss?	Yes	18	45%
	No	22	55%

Table 6 displays the Likert scale responses for questions 20 and the 7 perinatal mental health disorders assessed. There were a total of 280 responses made over the 7 different disorders. The most frequently reported self-efficacy level was "fair" (31%). The least frequently reported self-efficacy level was "very poor" (6%). As indicated by the table, 36% of participants felt their self-efficacy level regarding the identified perinatal mental health concerns was "very

poor" or "poor". Participants indicated self-efficacy levels of "good" or "very good" 30% of the time. Overall, more participants indicated their self-efficacy level to be "very poor" or "poor" than "very good" or "good". This question had the highest number of "no response", possibly indicating respondent fatigue by this point in the survey. This was the final question of the survey.

Table 6

Participants Perceived Self-Efficacy Levels Regarding Diagnosing Perinatal Mental Health Disorders

	Very Poor	Poor	Fair	Good	Very Good	No Response
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Perinatal Depression	0	11 (27.5%)	12 (30%)	11 (27.5%)	6 (15%)	0
Perinatal Anxiety and Panic	0	11 (27.5%)	13 (32.5%)	9 (22.5%)	6 (15%)	1 (2.5%)
Perinatal Bipolar and Postpartum Mania	6 (15%)	13 (32.5%)	14 (35%)	6 (15%)	0	1 (2.5%)
Traumatic Birth	2 (5%)	9 (22.5%)	11 (27.5%)	14 (35%)	2 (5%)	2 (5%)
Perinatal Post-Traumatic Stress Disorder	2 (5%)	12 (30%)	12 (30%)	11 (27.5%)	2 (5%)	1 (2.5%)
Impacts on Infants and Children	2 (5%)	13 (32.5%)	14 (35%)	7 (17.5%)	3 (7.5%)	1 (2.5%)
Perinatal Obsessive Compulsive	4 (10%)	15 (37.5%)	11 (27.5%)	5 (12.5%)	2 (5%)	3 (7.5%)
Total= 280	16 (6%)	84 (30%)	87 (31%)	63 (23%)	21(7%)	9 (3%)

Table 7

Participants Perceived Self-Efficacy Level Regarding Clinically Addressing Pregnancy Loss

	Very Poor	Poor	Fair	Good	Very Good	No Response
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Pregnancy Loss	0	12 (30%)	12 (30%)	11 (27.5%)	5 (12.5%)	0
Total= 40 (100%)						

Awareness

Awareness was measured with three questions, each being a multiple choice question. Questions were developed to assess whether participants have prior experience working with the population of individuals experiencing perinatal mental health concerns, if they have heard of the term "perinatal mood and anxiety disorders", and if they have any resources for individuals experiencing perinatal mental health disorders. As indicated in table 8, along with the frequencies for all three questions, over 70% of participants have experience working with individuals experiencing perinatal mental health disorders. Only 52.5% of participants had heard of the term perinatal mood and anxiety disorders outside of the survey.

Table 8

Social Worker's Perinatal Mental Health Awareness

Question	Response	N	%
Have you ever worked (in a clinical capacity) with a client/patient who was experiencing a perinatal mental health disorder?	Yes	29	72.5%
	No	11	27.5%
Outside of this survey, have you ever heard or seen the term "perinatal mood and anxiety disorders"?	Yes	21	52.5%
	No	19	47.5%
Are you aware of any resources in your practicing area for individuals experiencing perinatal mental health issues?	Yes	22	55%
	No	17	42.5%
	No Response	1	2.5%

Hypothesis Testing

In order to test the four hypotheses of this study, a combination of frequency testing and crosstab analysis with Chi-Square tests were conducted. In order to evaluate the relationship between parental identification, licensure level, and training level, and knowledge, self-efficacy, and awareness, crosstab with Chi-Square tests were conducted through SPSS. In order to be

considered significant, the p-value needs to be less than or equal to .05, indicating a 95% confidence interval. All statistically significant associations are at a 5% significance level.

Hypothesis One

Hypothesis one states: the majority of social workers will, on average, score below fair regarding their self-efficacy in diagnosing and treating perinatal mental health concerns. Table six displays the self-efficacy score percentages and shows a total of 36% of respondents reported scores below fair, while 61% reported scores of fair or higher (3% no response). This causes us to reject the hypothesis and accept the null hypothesis that the majority of social workers will score fair or above regarding their self-efficacy in diagnosing and treating perinatal mental health concerns.

Hypothesis Two

Hypothesis Two states: social workers who identify themselves as a parent will have higher levels of perceived self-efficacy, knowledge, and awareness. Appendix C includes the crosstab and Chi-Square tables for all significant tests within the independent variable parental identification. A crosstab analysis with chi-square was run to assess the relationship between parental identification and self-efficacy, knowledge, and awareness. The results are as follows.

The crosstab analysis indicated 68% of respondents who could identify and describe all perinatal mental health disorders identified as a parent and 32% of respondents did not. The Chi-Square test indicated that there is no significant association between identifying as a parent and being able to identify and describe all perinatal mental health disorders,

$x^2\ (1,\ N\ =\ 39)\ =.088,\ p$=.767.

The crosstab analysis indicated 80% of respondents who could correctly identify the perinatal timeframe identified as a parent and 20% of respondents did not. The Chi-Square test

indicated that there is no significant association between identifying as a parent and being able to identify and describe all perinatal mental health disorders, $x^2\ (1,\ N\ =\ 39)\ =\ 1.905$, p=.168.

The crosstab analysis indicated 70% of respondents who felt perinatal mental health disorders were different than disorders at any other time identified as a parent and 30% of respondents did not. The Chi-Square test indicated that there is no significant association between identifying as a parent and being able to identify and describe all perinatal mental health disorders, $x^2\ (1,\ N\ =\ 39)\ =.366$, p=.545.

The crosstab analysis indicated 67% of respondents who had knowledge levels of fair or above in regard to perinatal depression identified as a parent and 32% of respondents did not. The Chi-Square test indicated that there is no significant association between identifying as a parent and knowledge of perinatal depression, $x^2\ (1,\ N\ =\ 40)\ =.335$, p=.563.

The crosstab analysis indicated 65% of respondents who had knowledge levels of fair or above in regard to perinatal anxiety and panic identified as a parent and 35% of respondents did not. The Chi-Square test indicated that there is no significant association between identifying as a parent and knowledge of perinatal anxiety and panic, $x^2\ (1,\ N\ =\ 40)\ =.754$, p=.385.

The crosstab analysis indicated 63% of respondents who had knowledge levels of fair or above in regard to traumatic birth identified as a parent and 37% of respondents did not. The Chi-Square test indicated that there is no significant association between identifying as a parent and knowledge of traumatic birth, $x^2\ (1,\ N\ =\ 38)\ =.1.057$, p=.304.

The crosstab analysis indicated 68% of respondents who had knowledge levels of fair or above in regard to perinatal PTSD identified as a parent and 32% of respondents did not. The

Chi-Square test indicated that there is no significant association between identifying as a parent and knowledge of perinatal PTSD, $x^2\ (1,\ N\ =\ 39)\ =.325$, p=.568.

The crosstab analysis indicated 64% of respondents who had knowledge levels of fair or above in regard to perinatal OCD identified as a parent and 46% of respondents did not. The Chi-Square test indicated that there is no significant association between identifying as a parent and knowledge of perinatal OCD, $x^2\ (1,\ N\ =\ 39)\ =.608$, p=.435.

The crosstab analysis indicated 50% of respondents who had knowledge levels of fair or above in regard to perinatal bipolar and mania identified as a parent and 50% of respondents did not. The Chi-Square test indicated that there is a significant association between identifying as a parent and knowledge of perinatal bipolar and mania, $x^2\ (1,\ N\ =\ 40)\ =\ 4.103$, p=.043.

The crosstab analysis indicated 67% of respondents who had knowledge levels of fair or above in regard to the impacts on infants and children identified as a parent and 33% of respondents did not. The Chi-Square test indicated that there is no significant association between identifying as a parent and knowledge of the impacts on infants and children, $x^2\ (1,\ N\ =\ 39)\ =.271$, p=.603.

The Chi-Square test only produced one significant p-value for one survey item out of ten that measured knowledge. This leads us to reject the hypothesis and accept the null hypothesis that there is no significant association between identification as a parent and awareness level.

The crosstab analysis indicated that 67% of respondents who felt comfortable treating perinatal mental health identified as a parent and 33% did not. The Chi-Square test indicated that there is no significant association between identifying as a parent and being comfortable treating individuals with perinatal mental health concerns, $x^2\ (1,\ N\ =\ 40)\ =.234$, p=.629.

The crosstab analysis indicated 68% of respondents who felt comfortable treating concerns related to perinatal loss identified as a parent and 32% did not. The Chi-Square test indicated that there is no significant association between having additional training and being comfortable treating individuals with perinatal mental health concerns, $x^2\ (1,\ N\ =\ 40)\ =.077$, p=.781.

The crosstab analysis indicated 64% of respondents who had self-efficacy levels of fair or above in regard to diagnosing concerns related to perinatal loss identified as a parent and 36% did not. The Chi-Square test indicated that there is no significant association between having additional training and higher self-efficacy regarding diagnosing perinatal loss, $x^2\ (1,\ N\ =\ 40)\ =\ 1.451$, p=.228.

The crosstab analysis indicated 69% of respondents who had self-efficacy levels of fair or above in regard to diagnosing perinatal depression identified as a parent and 31% did not. The Chi-Square test indicated that there is no significant association between having additional training and higher self-efficacy regarding diagnosing perinatal depression, $x^2\ (1,\ N\ =\ 40)\ =.054$, p=.817.

The crosstab analysis indicated 68% of respondents who had self-efficacy levels of fair or above in regard to diagnosing perinatal anxiety and panic identified as a parent and 32% did not. The Chi-Square test indicated that there is no significant association between having additional training and higher self-efficacy regarding diagnosing perinatal anxiety and panic, $x^2\ (1,\ N\ =\ 39)\ =.088$, p=.767.

The crosstab analysis indicated 65% of respondents who had self-efficacy levels of fair or above in regard to diagnosing perinatal bipolar and mania identified as a parent and 35% did not. The Chi-Square test indicated that there is no significant association between having additional

training and higher self-efficacy regarding diagnosing perinatal bipolar and mania, $x^2\ (1,\ N\ =\ 39)\ =.345$, p=.557.

The crosstab analysis indicated 67% of respondents who had self-efficacy levels of fair or above in regard to diagnosing traumatic birth identified as a parent and 33% did not. The Chi-Square test indicated that there is no significant association between having additional training and higher self-efficacy regarding diagnosing traumatic birth, $x^2\ (1,\ N\ =\ 39)\ =.133$, p=.715.

The crosstab analysis indicated 64% of respondents who had self-efficacy levels of fair or above in regard to diagnosing perinatal PTSD identified as a parent and 36% did not. The Chi-Square test indicated that there is no significant association between having additional training and higher self-efficacy regarding diagnosing perinatal PTSD, $x^2\ (1,\ N\ =\ 39)\ =.895$, p=.344.

The crosstab analysis indicated 67% of respondents who had self-efficacy levels of fair or above in regard to diagnosing the impacts on infants and children identified as a parent and 33% did not. The Chi-Square test indicated that there is no significant association between having additional training and higher self-efficacy regarding diagnosing the impacts on infants and children, $x^2\ (1,\ N\ =\ 39)\ =.193$, p=.661.

The crosstab analysis indicated 67% of respondents who had self-efficacy levels of fair or above in regard to diagnosing perinatal OCD identified as a parent and 33% did not. The Chi-Square test indicated that there is no significant association between having additional training and higher self-efficacy regarding diagnosing perinatal OCD, $x^2\ (1,\ N\ =\ 37)\ =.218$, p=.641.

The Chi-Square test did not produce any significant *p*-values when comparing parental identification and self-efficacy scores. This leads us to reject the hypothesis and accept the null hypothesis that there is no significant association between identification as a parent and self-efficacy scores.

The crosstab analysis indicated 65% of respondents who had experience working with the perinatal population identified as parents and 35% of respondents did not. The Chi-Square test indicated that there is no significant association between identifying as a parent and having experience with the perinatal population, $x^2\ (1,\ N\ =\ 40)\ =\ 1.009$, p=.315.

The crosstab analysis indicated 67% of respondents who had heard the term "perinatal mood and anxiety disorders" prior to the survey identified as a parent and 33% of respondents did not. The Chi-Square test indicated that there is no significant association between identifying as a parent and having heard the term "perinatal mood and anxiety disorders" prior to this survey, $x^2\ (1,\ N\ =\ 40)\ =.234$, p=.629.

The crosstab analysis indicated 68% of respondents who were aware of resources for perinatal mental health identified as a parent and 32% of respondents did not. The Chi-Square test indicated that there is no significant association between identifying as a parent and being aware of resources, $x^2\ (1,\ N\ =\ 39)\ =.026$, p=.872.

The Chi-Square test produced no significant *p*-values for the three survey items that measure awareness. This leads us to reject the hypothesis and accept the null hypothesis that there is no significant association between identification as a parent and awareness level.

Overall, parental identification only produced one significant *p*-value within all three areas of knowledge, self-efficacy, and awareness. This leads us to reject the hypothesis that there would be a significant difference between respondents who identified as a parent and those who

did not within those three areas. In return, we can accept the null hypothesis that there is no difference or association between the responses of parents and those who are not parents.

Hypothesis Three

Hypothesis Three states: social workers who identify having training outside of their BSW and MSW education will have higher levels of perceived self-efficacy, knowledge, and awareness. Appendix D includes crosstab and Chi-Square tables for all significant tests within this independent variable.

The crosstab analysis indicated that 76% of respondents who felt comfortable treating perinatal mental health reported training on perinatal mental health outside of their BSW or MSW and 24% did not report additional training. The Chi-Square test indicated that there is a significant association between having additional training and being comfortable treating individuals with perinatal mental health concerns, $x^2\ (1,\ N\ =\ 40)\ =\ 14.593$, p<.001.

The crosstab analysis indicated 68% of respondents who felt comfortable treating concerns related to perinatal loss reported having training on perinatal mental health outside of their BSW or MSW and 32% did not report additional training. The Chi-Square test indicated that there is a significant association between having additional training and being comfortable treating individuals with perinatal mental health concerns, $x^2\ (1,\ N\ =\ 40)\ =\ 8.386$, p=.004.

The crosstab analysis indicated 61% of respondents who had self-efficacy levels of fair or above in regard to diagnosing concerns related to perinatal loss reported having training on perinatal mental health outside of their BSW or MSW and 39% did not report additional training. The Chi-Square test indicated that there is a significant association between having additional training and higher self-efficacy regarding perinatal loss, $x^2\ (1,\ N\ =\ 40)\ =\ 6.535$, p=.011.

The crosstab analysis indicated 65% of respondents who had self-efficacy levels of fair or above in regard to diagnosing perinatal depression reported having training on perinatal mental health outside of their BSW or MSW and 35% did not report additional training. The Chi-Square test indicated that there is a significant association between having additional training and reporting higher levels of self-efficacy regarding perinatal depression, $x^2\ (1,\ N\ =\ 40)\ =\ 13.727$, p<.001.

The crosstab analysis indicated 64% of respondents who had self-efficacy levels of fair or above in regard to diagnosing perinatal anxiety and panic reported having training on perinatal mental health outside of their BSW or MSW and 36% did not report additional training. The Chi-Square test indicated that there is a significant association between having additional training and reporting higher levels of self-efficacy regarding perinatal anxiety and panic, $x^2\ (1,\ N\ =\ 39)\ =\ 13.133$, p<.001.

The crosstab analysis indicated 70% of respondents who had self-efficacy levels of fair or above in regard to diagnosing perinatal bipolar and mania reported having training on perinatal mental health outside of their BSW or MSW and 30% did not report additional training. The Chi-Square test indicated that there is a significant association between having additional training and reporting higher levels of self-efficacy regarding perinatal bipolar and mania, $x^2\ (1,\ N\ =\ 39)\ =\ 9.393$, p=.002.

The crosstab analysis indicated 63% of respondents who had self-efficacy levels of fair or above in regard to diagnosing perinatal traumatic birth reported having training on perinatal mental health outside of their BSW or MSW and 37% did not report additional training. The Chi-Square test indicated that there is a significant association between having additional

training and reporting higher levels of self-efficacy regarding perinatal traumatic birth, $x^2\ (1,\ N\ =\ 38)\ =\ 9.098$, p=.003.

The crosstab analysis indicated 64% of respondents who had self-efficacy levels of fair or above in regard to diagnosing perinatal PTSD reported having training on perinatal mental health outside of their BSW or MSW and 36% did not report additional training. The Chi-Square test indicated that there is a significant association between having additional training and reporting higher levels of self-efficacy regarding perinatal PTSD, $x^2\ (1,\ N\ =\ 39)\ =\ 8.925$, p=.003.

The crosstab analysis indicated 54% of respondents who had self-efficacy levels of fair or above in regard to diagnosing impacts on infants and children reported having training on perinatal mental health outside of their BSW or MSW and 46% did not report additional training. The Chi-Square test indicated that there is no significant association between having additional training and reporting higher levels of self-efficacy regarding impacts on infants and children, $x^2\ (1,\ N\ =\ 39)\ =\ 1.612$, p=.204.

The crosstab analysis indicated 54% of respondents who had self-efficacy levels of fair or above in regard to diagnosing perinatal OCD reported having training on perinatal mental health outside of their BSW or MSW and 46% did not report additional training. The Chi-Square test indicated that there is a significant association between having additional training and reporting higher levels of self-efficacy regarding perinatal OCD, $x^2\ (1,\ N\ =\ 37)\ =\ 6.060$, p=.014.

The crosstab and Chi-Square analyses produced significant results for all but one survey item. This leads us to accept the hypothesis and reject the null hypothesis, concluding that there is a significant association between respondents who reported having training on perinatal mental health outside of their BSW or MSW and their self-efficacy scores within this survey.

The crosstab analysis indicated 61% of respondents who could identify and describe all perinatal mental health disorders reported having training on perinatal mental health outside of their BSW or MSW and 39% of respondents who did not have training. The Chi-Square test indicated that there is a significant association between if respondents could identify and describe all perinatal mental health disorders and having additional training, $x^2\ (1,\ N\ =\ 39)\ =\ 8.469$, p=.004.

The crosstab analysis indicated 55% of respondents who could correctly identify the perinatal timeframe reported having training on perinatal mental health outside of their BSW or MSW and 45% of respondents who did not have training. The Chi-Square test indicated that there is no significant association between if respondents could identify and describe all perinatal mental health disorders and having additional training, $x^2\ (1,\ N\ =\ 40)\ =.902$, p=.342.

The crosstab analysis indicated 49% of respondents who felt perinatal mental health disorders are different than mental health disorders that present during any other period in an individual's life reported having training on perinatal mental health outside of their BSW or MSW and 51% of respondents who did not have training. The Chi-Square test indicated that there is no significant association between if respondents felt perinatal disorders are different and having additional training, $x^2\ (1,\ N\ =\ 39)\ =.001$, p=.970.

The crosstab analysis indicated 61% of respondents who had knowledge levels of fair or above in regard to perinatal depression reported having training on perinatal mental health outside of their BSW or MSW and 39% did not report additional training. The Chi-Square test indicated that there is a significant association between having additional training and higher knowledge of perinatal depression, $x^2\ (1,\ N\ =\ 40)\ =\ 10.507$, p=.001.

The crosstab analysis indicated 69% of respondents who had knowledge levels of fair or above in regard to perinatal anxiety and panic reported having training on perinatal mental health outside of their BSW or MSW and 31% did not report additional training. The Chi-Square test indicated that there is a significant association between having additional training and higher knowledge of perinatal anxiety and panic, $x^2\ (1,\ N\ =\ 40)\ =\ 14.067$, p<.001.

The crosstab analysis indicated 67% of respondents who had knowledge levels of fair or above in regard to traumatic birth reported having training on perinatal mental health outside of their BSW or MSW and 33% did not report additional training. The Chi-Square test indicated that there is a significant association between having additional training and higher knowledge of traumatic birth, $x^2\ (1,\ N\ =\ 38)\ =\ 7.238$, p=.007.

The crosstab analysis indicated 77% of respondents who had knowledge levels of fair or above in regard to perinatal PTSD reported having training on perinatal mental health outside of their BSW or MSW and 23% did not report additional training. The Chi-Square test indicated that there is a significant association between having additional training and higher knowledge of perinatal PTSD, $x^2\ (1,\ N\ =\ 39)\ =\ 19.666$, p<.001.

The crosstab analysis indicated 79% of respondents who had knowledge levels of fair or above in regard to perinatal OCD reported having training on perinatal mental health outside of their BSW or MSW and 21% did not report additional training. The Chi-Square test indicated that there is a significant association between having additional training and higher knowledge of perinatal OCD, $x^2\ (1,\ N\ =\ 39)\ =\ 9.235$, p=.002.

The crosstab analysis indicated 71% of respondents who had knowledge levels of fair or above in regard to perinatal bipolar reported having training on perinatal mental health outside of their BSW or MSW and 29% did not report additional training. The Chi-Square test indicated

that there is a significant association between having additional training and higher knowledge of perinatal bipolar, $x^2\ (1,\ N\ =\ 40)\ =\ 4.945$, p=.026.

The crosstab analysis indicated 59% of respondents who had knowledge levels of fair or above in regard to the impacts on infants and children reported having training on perinatal mental health outside of their BSW or MSW and 41% did not report additional training. The Chi-Square test indicated that there is a significant association between having additional training and higher knowledge of the impacts on infants and children, $x^2\ (1,\ N\ =\ 39)\ =\ 3.903$, p=.048.

Out of the 10 questions used to measure knowledge, only 2 did not produce a significant relationship between level of training and knowledge. A significant association was found with 8 survey items. This leads us to accept the hypothesis that social workers who indicate having additional training will have higher levels of perceived knowledge.

The crosstab analysis indicated 66% of respondents who had experience working with the perinatal population reported having training on perinatal mental health outside of their BSW or MSW and 35% of respondents who did not have training. The Chi-Square test indicated that there is a significant association between having additional training and having experience with the perinatal population, $x^2\ (1,\ N\ =\ 40)\ =\ 13.727$, p<.001.

The crosstab analysis indicated 62% of respondents who had heard the term “perinatal mood and anxiety disorders” prior to the survey reported having training on perinatal mental health outside of their BSW or MSW and 38% of respondents who did not have training. The Chi-Square test indicated that there is no significant association between having additional training and having hear the term “perinatal mood and anxiety disorders” prior to this survey, $x^2\ (1,\ N\ =\ 40)\ =\ 3.679$, p=.055.

The crosstab analysis indicated 59% of respondents who were aware of resources for perinatal mental health reported having training on perinatal mental health outside of their BSW or MSW and 41% of respondents who did not have training. The Chi-Square test indicated that there is no significant association between having additional training and being aware of resources, $x^2\ (1,\ N\ =\ 40)\ =\ 3.679$, p=.055.

The Chi-Square test only produced a significant p-value for one survey item out of three that measure awareness. This leads us to reject the hypothesis and accept the null hypothesis that there is no significant difference between respondents who identify themselves as parents versus those who do not in regard to their awareness level.

Overall, having additional training on perinatal mental health produced significant associations within the areas of knowledge and self-efficacy. This leads us to partially accept the hypothesis in regard to the portions related to knowledge and self-efficacy and reject the portion related to awareness. For awareness, we can accept the null hypothesis that there is no association between having additional training on perinatal mental health and awareness levels.

Hypothesis Four

Hypothesis four states: social workers who indicate an independent clinical license, as opposed to an associate license, will have higher levels of perceived self-efficacy, knowledge, and awareness.

The crosstab analysis indicated that 91% of respondents who felt comfortable treating perinatal mental health concerns identified as independently licensed social workers and 9% identified as associate licensed social workers. The Chi-Square test indicated that there is a significant association between licensure level and being comfortable treating individuals with perinatal mental health concerns, $x^2\ (1,\ N\ =\ 40)\ =\ 7.166$, p=.007.

The crosstab analysis indicated 73% of respondents who felt comfortable treating concerns related to perinatal loss identified as independently licensed social workers and 27% identified as associate licensed social workers. The Chi-Square test indicated that there is no significant association between licensure level and being comfortable treating individuals with perinatal mental health concerns, $x^2\ (1,\ N\ =\ 40)\ =\ 2.129$, p=.145.

The crosstab analysis indicated 79% of respondents who had self-efficacy levels of fair or above in regard to diagnosing concerns related to perinatal loss identified as independently licensed social workers and 21% identified as associate licensed social workers. The Chi-Square test indicated that there is no significant association between licensure level and higher self-efficacy regarding diagnosing perinatal loss, $x^2\ (1,\ N\ =\ 40)\ =\ 1.726$, p=.189.

The crosstab analysis indicated 79% of respondents who had self-efficacy levels of fair or above in regard to diagnosing perinatal depression identified as independently licensed social workers and 21% identified as associate licensed social workers. The Chi-Square test indicated that there is no significant association between licensure level and higher self-efficacy regarding perinatal depression, $x^2\ (1,\ N\ =\ 40)\ =\ 2.453$, p=.117.

The crosstab analysis indicated 82% of respondents who had self-efficacy levels of fair or above in regard to diagnosing perinatal anxiety and panic identified as independently licensed social workers and 18% identified as associate licensed social workers. The Chi-Square test indicated that there is no significant association between licensure and higher self-efficacy regarding perinatal anxiety and panic, $x^2\ (1,\ N\ =\ 39)\ =\ 3.155$, p=.076.

The crosstab analysis indicated 85% of respondents who had self-efficacy levels of fair or above in regard to diagnosing perinatal bipolar and mania identified as independently licensed social workers and 15% identified as associate licensed social workers. The Chi-Square test

indicated that there is no significant association between having additional training and higher self-efficacy regarding perinatal bipolar and mania, $x^2\ (1,\ N\ =\ 39)\ =\ 2.438$, *p*=.118.

The crosstab analysis indicated 80% of respondents who had self-efficacy levels of fair or above in regard to diagnosing perinatal PTSD identified as independently licensed social workers and 20% identified as associate licensed social workers. The Chi-Square test indicated that there is no significant association between having additional training and higher self-efficacy regarding perinatal PTSD, $x^2\ (1,\ N\ =\ 39)\ =\ 1.162$, *p*=.281.

The crosstab analysis indicated 82% of respondents who had self-efficacy levels of fair or above in regard to diagnosing traumatic birth identified as independently licensed social workers and 18% identified as associate licensed social workers. The Chi-Square test indicated that there is no significant association between having additional training and higher self-efficacy regarding traumatic birth, $x^2\ (1,\ N\ =\ 38)\ =\ 1.377$, *p*=.241.

The crosstab analysis indicated 79% of respondents who had self-efficacy levels of fair or above in regard to diagnosing impacts on infants and children identified as independently licensed social workers and 21% identified as associate licensed social workers. The Chi-Square test indicated that there is no significant association between having additional training and higher self-efficacy regarding impacts on infants and children, $x^2\ (1,\ N\ =\ 39)\ =.756$, *p*=.384.

The crosstab analysis indicated 78% of respondents who had self-efficacy levels of fair or above in regard to diagnosing perinatal OCD identified as independently licensed social workers and 22% identified as associate licensed social workers. The Chi-Square test indicated that there is no significant association between having additional training and higher self-efficacy regarding perinatal OCD, $x^2\ (1,\ N\ =\ 37)\ =.410$, *p*=.522.

The Chi-Square test produced one significant *p*-value for the ten survey items that measure self-efficacy. This leads us to reject the hypothesis and accept the null hypothesis that there is no significant association between licensure level and self-efficacy levels.

The crosstab analysis indicated 83% of respondents who had experience working with the perinatal population have an independent social work license and 17% have an associate license. The Chi-Square test indicated that there is a significant association between licensure level and having experience with the perinatal population, $x^2\ (1,\ N\ =\ 40)\ =\ 5.566$, *p*=.018.

The crosstab analysis indicated 91% of respondents who had heard the term "perinatal mood and anxiety disorders" prior to the survey have an independent social work license and 9% have an associate license. The Chi-Square test indicated that there is a significant association between licensure level and having heard the term "perinatal mood and anxiety disorders" prior to this survey, $x^2\ (1,\ N\ =\ 40)\ =\ 7.166$, *p*=.007.

The crosstab analysis indicated 77% of respondents who were aware of resources for perinatal mental health have an independent social work license and 23% have an associate social work license. The Chi-Square test indicated that there is no significant association between licensure level and being aware of resources, $x^2\ (1,\ N\ =\ 39)\ =.748$, *p*=.387.

The Chi-Square test only produced a significant *p*-value for one survey item out of three that measure awareness. This leads us to reject the hypothesis and accept the null hypothesis that there is no significant difference between respondents who identified having an independent license versus those who identified an associate license in regard to their awareness level.

The crosstab analysis indicated 79% of respondents who could identify and describe all perinatal mental health disorders have independent social work licenses and 21% of respondents have associate social work licenses. The Chi-Square test indicated that there is no significant

association between licensure level and being able to identify and describe all perinatal mental health disorders, $x^2\ (1,\ N\ =\ 39)\ =.924,\ p$=.336.

The crosstab analysis indicated 80% of respondents who could correctly identify the perinatal timeframe have independent social work licenses and 20% have associate licenses. The Chi-Square test indicated that there is no significant association between licensure level and being able to identify the perinatal timeframe, $x^2\ (1,\ N\ =\ 40)\ =\ 1.129,\ p$=.288.

The crosstab analysis indicated 73% of respondents who felt perinatal mental health disorders were different from disorders at any other time have independent social work licenses and 27% have associate social work licenses. The Chi-Square test indicated that there is no significant association between licensure level and believing perinatal mental health disorders are different, $x^2\ (1,\ N\ =\ 39)\ =.495,\ p$=.482.

The crosstab analysis indicated 84% of respondents who had knowledge levels of fair or above in regard to perinatal depression have independent social work licenses and 16% have associate social work licenses. The Chi-Square test indicated that there is no significant association between licensure level and knowledge of perinatal depression, $x^2\ (1,\ N\ =\ 40)\ =\ 8.935,\ p$=.003.

The crosstab analysis indicated 85% of respondents who had knowledge levels of fair or above in regard to perinatal anxiety and panic have independent social work licenses and 15% have associate licenses. The Chi-Square test indicated that there is no significant association between licensure level and knowledge of perinatal anxiety and panic, $x^2\ (1,\ N\ =\ 40)\ =\ 5.469, p$=.019.

The crosstab analysis indicated 79% of respondents who had knowledge levels of fair or above in regard to traumatic birth have independent social work licenses and 21% have associate

licenses. The Chi-Square test indicated that there is no significant association between licensure level and knowledge of traumatic birth, $x^2\ (1,\ N\ =\ 38)\ =\ 1.010$, p=.315.

The crosstab analysis indicated 77% of respondents who had knowledge levels of fair or above in regard to perinatal PTSD have independent social work licenses and 23% have associate licenses. The Chi-Square test indicated that there is no significant association between licensure level and knowledge of perinatal PTSD, $x^2\ (1,\ N\ =\ 39)\ =.748$, p=.387.

The crosstab analysis indicated 79% of respondents who had knowledge levels of fair or above in regard to perinatal OCD have independent social work licenses and 21% have associate licenses. The Chi-Square test indicated that there is no significant association between licensure level and knowledge of perinatal OCD, $x^2\ (1,\ N\ =\ 39)\ =.495$, p=.482.

The crosstab analysis indicated 86% of respondents who had knowledge levels of fair or above in regard to perinatal bipolar and mania have independent social work licenses and 14% have associate licenses. The Chi-Square test indicated that there is no significant association between licensure level and knowledge of perinatal bipolar and mania,

$x^2\ (1,\ N\ =\ 40)\ =\ 1.886$, p=.170

The crosstab analysis indicated 82% of respondents who had knowledge levels of fair or above in regard to impacts on infants and children have independent social work licenses and 18% have associate licenses. The Chi-Square test indicated that there is no significant association between licensure level and knowledge of impacts on infants and children,

$x^2\ (1,\ N\ =\ 39)\ =\ 2.335$, p=.127.

The Chi-Square test only produced two significant p-values for two survey items out of ten that measure knowledge. This leads us to reject the hypothesis and accept the null hypothesis that there is no significant association between licensure level and knowledge.

Overall, the three areas of knowledge, self-efficacy, and awareness did not produce enough significant results to accept the hypothesis that social workers who have independent licensure would have higher levels of knowledge, self-efficacy, and awareness. Instead, we shall accept the null hypothesis that there is no relationship or association between licensure level and knowledge, self-efficacy, or awareness.

Chapter 5: Discussion and Synthesis

Introduction

This chapter will discuss the results of the survey and the connection to current literature. The objectives of the dissertation will be reviewed and evaluated along with the purpose of the dissertation. The limitations of this dissertation study will also be discussed within this chapter.

Discussion

The purpose of this study is to assess how clinical social workers perceive their self-efficacy, knowledge, and awareness regarding their ability to diagnose and treat perinatal mental health disorders. The study was aimed at assessing social workers' level of knowledge on perinatal mental health and where they identify the source of that knowledge to be. The study was also aimed at assessing social workers' self-efficacy to diagnose and treat perinatal mental health concerns. The study also looked at how aware social workers were of perinatal mental health disorders.

While the literature on this subject is still progressing, there is little research on how social workers perceive their self-efficacy to diagnose and treat perinatal mental health disorders. There is also limited literature on social workers' perceived knowledge and awareness levels on the subject. The majority of literature on perinatal mental health derives from the medical field, specifically nursing, and obstetrics.

Education

When asked if participants felt their social work education prepared them to clinically treat perinatal mental health disorders, an alarming 85% said no. Only 6 individuals out of 40 felt their social work education had prepared them to treat perinatal mental health disorders. While it may be unrealistic to include every single clinical specialty in the social work curriculum, there

is a need for social work education to better prepare individuals to provide services to this vulnerable population. Currently the Council for Social Work Education does not have a specific requirement for perinatal mental health education required at a bachelor's or master's level providing an opportunity for social workers to advocate for this to change.

McCloskey and Ragudaran (2018) developed a perinatal mental health education course that was implemented as an elective option for MSW students. Students who participated in the study found the material to be important and assisted in increasing their learning and competence. This corresponds with the results of this study. Specialized education on the topic of perinatal mental health was significantly related to higher scores of knowledge, awareness, and self-efficacy. Most respondents of this survey did not receive their specialized education through BSW or MSW curriculum, but rather training that was provided by their jobs and/or they sought training on their own. The study conducted by McCloskey and Ragudaran (2018) and this current study would support the addition of specialized perinatal mental health education to the social work curriculum as a way of increasing social workers' knowledge, awareness, and self-efficacy in working with perinatal mental health concerns.

Polmanteer et al. (2017) found that 43% of social workers reported learning about postpartum depression during some form of college education. This was not the case in this survey. Only one social worker remembered perinatal mental health topics being taught in their BSW education, and three remembered the content being covered in their MSW education. Despite this, six social workers felt their BSW and/or MSW education prepared them for working with this population. While postpartum depression has the highest awareness and the most literature on it, based on the results of this study, it is unlikely that 43% of social workers would report learning about perinatal disorders outside of postpartum depression.

While Higgins et al. 's (2017) study involved nurses, not social workers, the findings are congruent with this study's in that nurses who had specific education on perinatal mental health had significantly higher levels of knowledge and confidence than nurses that did not.

Postpartum Depression Theory

Postpartum depression theory emphasizes the individual's experience as a key component to understanding mental health during the perinatal period. This study was unable to find a significant relationship between being a parent and a social worker's knowledge, awareness, or self-efficacy related to perinatal mental health. This allows us to consider and explore the idea that being a parent is not enough of a shared experience to create a significant relationship. Future studies may choose to examine one level closer and explore a potential relationship between social workers who identify as a parent who has experienced directly or indirectly a perinatal mental health disorder.

Dr. Beck's theory on postpartum depression has been described as a way for providers to "enter the mindset" of an individual experiencing postpartum depression (Marsh, p. 53, 2013). This supports the study's findings that social workers who indicated they had obtained additional training on the topic of perinatal mental health scored significantly higher on almost all questions assessing knowledge, awareness, and self-efficacy.

Matricentric Feminism

Matricentric feminism highlights the importance of viewing issues concerning mothers distinctly from the same or similar issues concerning women outside of the perinatal period. The study found that 73% of respondents had experience with the perinatal population, but only 53% were aware of the term "perinatal mood and anxiety disorders" before the survey and only 55% were aware of resources for perinatal mental health concerns. It can safely be assumed that all

the respondents (being social workers who work in a clinical capacity) have experience working with mental health disorders and have corresponding resources. When it comes to mental health disorders directly related to mothers, there is a lot of room for social workers to increase their knowledge, awareness, and self-efficacy. Together, matricentric feminism and postpartum depression theory call for social workers to look at these disorders from a mother's perspective. While each mother's experience is different they share the common experience and themes of motherhood.

Policy

As discussed in the literature review of this dissertation, policy on this subject focuses on the primary diagnosis of perinatal depression. Recently proposed legislation has begun to utilize the terminology “maternal mental health”, which helps to advance legislation through inclusive terminology. Federal and state legislation is advancing and adapting because of the increased research being done in this area. The results of this study provide grounds for policy to develop on perinatal mental health training. Social workers with limited knowledge, self-efficacy, and awareness are working with this population, potentially retraumatizing mothers who are in need of help. There is a great need for policies to be developed that ensure clinically appropriate treatment and services are provided to this population.

In regard to screening, there is a need for a federal policy on how, when, and who conducts perinatal mental health screenings. Far too many women are not being screened for perinatal mental health disorders. Policies that support more appropriate and effective screening would also aid in exploring more accurate prevalence rates for these disorders. The findings of Puspitasari et al. (2021) research also found lack of training on screening and inconsistency in

providing screening to be a real issue in providing quality care and ensuring identification of perinatal mental health disorders.

Currently in the U.S. there is no federally mandated paid leave for mothers during pregnancy or childbirth. This is a huge area for policy to change in order to support this population. Social workers can advocate for policies that provide financial support for mothers during the perinatal period.

Practice

Postpartum psychosis has the lowest prevalence rate of all the perinatal mental health disorders identified in chapter two. This study found that the connected disorders perinatal bipolar and mania had the lowest knowledge and self-efficacy out of all the disorders measured by the survey. Despite the low prevalence rate of postpartum psychosis, the risk of having a manic episode is dramatically increased during the perinatal period Işık (2018). Also considering that around 20% of postpartum deaths can be attributed to suicide (Wisner et al., 2013), the low knowledge and self-efficacy levels are alarming. The research identifies these disorders to be severe and potentially life-threatening, yet social workers within this study knew the least about them and had the lowest levels of self-efficacy when it came to diagnosing them.

Social workers across all levels of social work utilize best practices, evidence-based practices, and create plans to help the individuals they serve. However, all of these practices neglect to consider motherhood. When developing a treatment plan, how often do social workers consider the impact that being a mother will have on the clients treatment or their ability to engage in the planned treatment? Multiple different entities set out to define what treatment should look like, but none of these may look like what that particular client needs their treatment to be. Taylor et al.'s (2019) findings about women feeling that social workers would judge them

as being unfit mothers and focus only on the safety and risk of the child and not their mental health, emphasizes the need to repair the relationship between social workers and mothers. Taylor et al. (2019) found that women felt social workers would judge them as unfit mothers, focus only on the safety and risk of the child and not their mental health concerns Taylor et al. (2019) found that social work intervention actually intensified the pressure on mothers mental health and made them like they were set up to fail. Treatment that reinforces the idea that having not being able to care for their children due to their mental health makes them a "bad parent" only continues to traumatize that mother. The concept that being a parent somehow makes you able to manage your mental health better simply because you have children to care for is flawed and perpetuates feelings of worthlessness and inferiority.

Limitations

The small sample size of this survey is one of the survey's largest limitations. Such a small sample size limits the survey's generalizability to the overall population. Given a larger sample size, there is a potential to produce more significant results. The survey is also limited by the lack of literature surrounding social work and perinatal mental health disorders. Utilization of the NASW email blast excluded social workers who were not members of the NASW. The use of an online survey format excludes social workers who do not utilize or have access to a computer or internet service. As mentioned in earlier chapters, the survey itself is self-report which is subject to limitations of recall and social desirability bias.

This survey specifically looked at social workers working in clinical capacities. This was a specific delimitation designed for the purpose of the study to isolate a specific area of social work practice. This introduces an intentional systematic bias. The education level of a social worker who works in a clinical capacity is at a minimum of a master's degree, however, not all

social workers who have master's degrees decide to work in clinical capacities or gain clinical licensure. Inconsistency in terminology limits this study as licensure identification varies from state to state and can potentially be confusing for respondents.

The sampling method of this study also presents a limitation. The non-probability sampling method, convenience sampling, was utilized to assess the population of social workers within the state of Pennsylvania. The study would have benefitted from a random sampling method, however, this was not feasible given the time and budgetary restraints of the researcher. The sample also focused on only one state due to time and budgetary restraints. These limitations reduce the survey's generalizability to the population of social workers as a whole and even the more specific populations of social workers working in a clinical capacity.

Conclusion

While there is very limited literature on this particular subject, the results of this survey appear to be supported by the current literature. The research confirms that there is a need for more educational content on perinatal mental health be provided within BSW and MSW curriculum. It also confirms that having specialized education on this subject helps to make social workers more knowledgeable, have higher efficacy, and greater awareness.

Chapter 6: Conclusions and Implications

Out of the three independent variables, one stood out as having a significant impact on social workers' knowledge and self-efficacy of perinatal mental health disorders. Having additional training on perinatal mental health disorders showed significant associations with two out of the three areas of knowledge, self-efficacy, and awareness. Additional training did not produce a significant association with awareness scores. Parental identification and licensure level did not prove to be significant variables in association with knowledge, self-efficacy, and awareness.

Implications

Research

As discussed in the literature review section of this dissertation, there is very little literature on perinatal mental health concerns that come from a social work perspective. This study provides new insights into social work and perinatal mental health. It brings awareness to the lack of research being conducted on how social workers are interacting, treating, and advocating for this population. It is hoped that the results of this study provide a new and inspired perspective on this topic. It is hoped that this study will inspire others to reduce the gap in current social work literature on the topic of perinatal mental health.

Education

Adding content on perinatal mental health to social work education is one way we can help prepare social workers to address these issues. Acknowledging that perinatal mental health disorders are more than just the "with postpartum onset" specifier listed in the DSM. Feminist theory is a topic often covered in social work education, but matricentric feminism is not. This is

a potential opportunity for social work education to include portions of this specialty within current curricula. It is recommended that the specialty be given its own course, such as McCloskey and Ragudaran developed and analyzed in 2018.

Practice

The results of this survey hold many implications for social work practice. With over 70% of social workers reporting experience working with individuals experiencing perinatal mental health disorders, there is a need for social workers to be prepared to do so. Social workers who indicated they had additional training outside of their social work education had significantly higher levels of knowledge, awareness, and self-efficacy. Many specialties in social work offer educational concentrations, minors, and electives to help social workers bridge the gap between generalist practice and specialty practice areas of both BSW and MSW educational curricula.

An objective of this study was and is to increase awareness of perinatal mental health disorders. The results of this study should prompt and encourage social workers to engage in their own self-reflection and analysis of their own knowledge, self-efficacy, and awareness of the population and the indicated disorders. By identifying additional training as a key factor in competently addressing the conditions and concerns highlighted in this dissertation, social workers can choose to ensure competent practice by seeking out training. Agencies and practices can ensure competent services are being provided by training their clinical staff and ensuring clients with perinatal mental health concerns are treated by trained clinicians.

Reducing the stigma surrounding perinatal mental health is essential for allowing individuals to be able to seek help and share their stories without fear. Advocacy for women experiencing perinatal mental health is vital to improving the services provided to this

population. Advocacy can be done at every level of social work and can be used to empower women to advocate for themselves. Social workers should advocate for additional training resources so more social workers can become trained in perinatal mental health at all levels and not just the clinical level.

Furthering research and education on these subjects and perinatal mental health as a whole, we can hope to reduce and eventually eliminate the stigma that currently makes mothers feel ashamed and afraid to seek help.

Conclusion

Mothers are being seen more and more, seen for more than just the vessels that bring children into the world. Through literature, research, policy, education, and practice, the field of social work can help empower, support, and advance maternal mental health for all mothers. There is not a single social work competency that is not centered within this work.

References

Alhusen, J. L., Gross, D., Hayat, M. J., Rose, L., & Sharps, P. (2012). The role of mental health on Maternal‐Fetal attachment in Low‐Income women. *Journal of Obstetric, Gynecologic &Amp; Neonatal Nursing*, *41*(6), E71–E81. https://doi.org/10.1111/j.1552-6909.2012.01385.x

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders, 5th edition: DSM-5* (5th ed.). American Psychiatric Publishing.

American Psychiatric Association. (2020, October). *What is postpartum depression?* Psychiatry.Org. https://www.psychiatry.org/patients-families/postpartum-depression/what-is-postpartum-depression

Atzl, V. M., Narayan, A. J., Ballinger, A., Harris, W. W., & Lieberman, A. F. (2020). Maternal pregnancy wantedness and perceptions of paternal pregnancy wantedness: Associations with perinatal mental health and relationship dynamics. *Maternal and Child Health Journal*, *25*(3), 450–459. https://doi.org/10.1007/s10995-020-03084-1

Babetin, K. (2020). The birth of a mother: A psychological transformation. *Journal of Prenatal and Perinatal Psychology and Health*, *35*(5), 410–428.

Bandura, A. (1982). Self-efficacy mechanism in human agency. *American Psychologist*, *37*(2), 122–147. https://doi.org/10.1037/0003-066x.37.2.122

Bandura, A. (1997). *Self-Efficacy in changing societies*. Cambridge University Press.

Beck, C. T. (1993). Teetering on the Edge. *Nursing Research*, *42*(1), 42–48. https://doi.org/10.1097/00006199-199301000-00008

Beck, C. T. (2004). Birth trauma: In the eye of the beholder. *Nursing Research*, *53*(1), 28–35. https://doi.org/10.1097/00006199-200401000-00005

Beck, C. T. (2021). Postpartum onset of panic disorder: A metaphor analysis. *Archives of Psychiatric Nursing*, *35*(4), 369–374. https://doi.org/10.1016/j.apnu.2021.05.004

Beck, C. T., Biaggi, A., Bramante, A., Davis, W., Desai, P., Foss, S., Gemmill, A., Glangeaud-Freudenthal, N. M. C., Glatigny, E., Glover, V., Goutaudier, N., Gressier, F., Hall, S., Kingston, D., Lacaze De Cordova, I., McCue, K., Milgrom, J., Monk, C., Mughal, M. K., . . . Wischmann, T. (2020). *Handbook of perinatal clinical psychology: From theory to practice* (R. M. Quatraro & P. Grussu, Eds.; 1st ed.). Routledge.

Białek, K., & Malmur, M. (2020). Risk of post-traumatic stress disorder in women after miscarriage. *Medical Studies*, *36*(2), 134–141. https://doi.org/10.5114/ms.2020.96794

Buttner, M. M., O'Hara, M. W., & Watson, D. (2011). The structure of women's mood in the early postpartum. *Assessment*, *19*(2), 247–256. https://doi.org/10.1177/1073191111429388

Centers for Disease Control and prevention. (2020, August 13). *Pregnancy and infant loss | CDC*. Centers for Disease Control and Prevention. Retrieved March 8, 2022, from https://www.cdc.gov/ncbddd/stillbirth/features/pregnancy-infant-loss.html

Centers for Disease Control and Prevention. (2022). *FastStats*. Births and Natality. https://www.cdc.gov/nchs/fastats/births.htm

The Center for Disease Control and Prevention, (2022, March 1). *NVSS - birth data*. The Center for Disease Control. Retrieved March 8, 2022, from https://www.cdc.gov/nchs/nvss/births.htm

Chojenta, C., Harris, S., Reilly, N., Forder, P., Austin, M. P., & Loxton, D. (2014). History of pregnancy loss increases the risk of mental health problems in subsequent pregnancies but not in the postpartum. *PLoS ONE*, *9*(4), 1–7. https://doi.org/10.1371/journal.pone.0095038

Collins, S. (2021). An interpretative phenomenological analysis of mothers' negative experiences and emotions during early motherhood. *Counselling Psychology Review*, *36*(2), 35–44.

Council on Social Work Education. (2017). Profile of the social work workforce. In *www.Socialworkers.org*. The George Washington University Health Workforce Institute. https://www.socialworkers.org/LinkClick.aspx?fileticket=wCttjrHq0gE%3D&portalid=0

Davies, S. M., Christiansen, P., Harrold, J. A., Silverio, S. A., & Fallon, V. (2021). Creation and validation of the postpartum specific anxiety scale research Short-Form (PSAS-RSF). *Archives of Women's Mental Health*, *24*(6), 957–969. https://doi.org/10.1007/s00737-021-01114-7

Deichen Hansen, M. E. (2022). Reinvigorating social work's focus on perinatal health. *International Journal of Social Work Values and Ethics*, *19*(1), 102–120. https://doi.org/10.55521/10-019-111

Della Vedova, A. (2014). Maternal psychological state and infant's temperament at three months. *Journal of Reproductive and Infant Psychology*, *32*(5), 520–534. https://doi.org/10.1080/02646838.2014.947472

Earls, M. F. (2010). Incorporating recognition and management of perinatal and postpartum depression into pediatric practice. *Pediatrics*, *126*(5), 1032–1039. https://doi.org/10.1542/peds.2010-2348

Erickson, N., Julian, M., & Muzik, M. (2019). Perinatal depression, PTSD, and trauma: Impact on mother–infant attachment and interventions to mitigate the transmission of risk. *International Review of Psychiatry*, *31*(3), 245–263. https://doi.org/10.1080/09540261.2018.1563529

Fairbrother, N., Janssen, P., Antony, M. M., Tucker, E., & Young, A. H. (2016). Perinatal anxiety disorder prevalence and incidence. *Journal of Affective Disorders*, *200*, 148–155. https://doi.org/10.1016/j.jad.2015.12.082

Fauth, E. B., Aller, T. B., Novak, J. R., & Schwartz, S. (2021). Measuring mental health literacy: Development of the mental health awareness and advocacy assessment tool. *Journal of MultiDisciplinary Evaluation*, *17*(39), 15–31.

Finer, L. B., & Henshaw, S. K. (2006). Disparities in rates of unintended pregnancy in the United States, 1994 and 2001. *Perspectives on Sexual and Reproductive Health*, *38*(2), 90–96. https://doi.org/10.1363/3809006

Fowler, F. J. (2013). *Survey research methods* (Fifth). SAGE Publications, Inc.

Garcia, E. R., & Yim, I. S. (2017). A systematic review of concepts related to women's empowerment in the perinatal period and their associations with perinatal depressive symptoms and premature birth. *BMC Pregnancy and Childbirth*, *17*(S2). https://doi.org/10.1186/s12884-017-1495-1

Gist, M. E., & Mitchell, T. R. (1992). Self-Efficacy: A Theoretical Analysis of Its Determinants and Malleability. *Academy of Management Review*, *17*(2), 183–211. https://doi.org/10.5465/amr.1992.4279530

Greasley, P. (2007). *Quantitative Data Analysis Using Spss: An Introduction For Health And Social Sciences*. McGraw-Hill Education (UK).

Green, F. J. (2019). Practicing matricentric feminist mothering. *Journal of the Motherhood Initiative for Research & Community Involvement*, *10*(1 & 2), 83–99.

Grekin, R., & O'Hara, M. W. (2014). Prevalence and risk factors of postpartum posttraumatic stress disorder: A meta-analysis. *Clinical Psychology Review*, *34*(5), 389–401. https://doi.org/10.1016/j.cpr.2014.05.003

Groves, R. M., Fowler, F. J., Jr, Couper, M. P., Lepkowski, J. M., Singer, E., & Tourangeau, R. (2011). *Survey Methodology*. John Wiley & Sons.

Higgins, A., Downes, C., Carroll, M., Gill, A., & Monahan, M. (2017). There is more to perinatal mental health care than depression: Public health nurses reported engagement and competence in perinatal mental health care. *Journal of Clinical Nursing*, *27*(3–4). https://doi.org/10.1111/jocn.13986

Hollander, M. H., Van Hastenberg, E., Van Dillen, J., Van Pampus, M. G., De Miranda, E., & Stramrood, C. a. I. (2017). Preventing traumatic childbirth experiences: 2192 women's perceptions and views. *Archives of Women's Mental Health*, *20*(4), 515–523. https://doi.org/10.1007/s00737-017-0729-6

Holmes, A. (2019). The gift: Matricentric feminism, physiological mothering, and art Practice. *Journal of the Motherhood Initiative for Research & Community Involvement*, *10*(1/2), 219–232.

Howard, L. M., & Khalifeh, H. (2020). Perinatal mental health: a review of progress and challenges. *World Psychiatry*, *19*(3), 313–327. https://doi.org/10.1002/wps.20769

Hynan, M. T. (2020).. *Journal of Perinatology*, *40*(7), 985–986. https://doi.org/10.1038/s41372-020-0696-z

Işık, M. (2018). Postpartum psychosis. *Eastern Journal of Medicine*, *23*(1), 60–63. https://doi.org/10.5505/ejm.2018.62207

Johnson, A., Stevenson, E., Moeller, L., & McMillian‐Bohler, J. (2021). Systematic Screening for Perinatal Mood and Anxiety Disorders to Promote Onsite Mental Health Consultations: A Quality Improvement Report. *Journal of Midwifery &Amp; Women's Health*, *66*(4), 534–539. https://doi.org/10.1111/jmwh.13215

Keefe, R. H., Brownstein-Evans, C., & Rouland Polmanteer, R. S. (2016). Addressing access barriers to services for mothers at risk for perinatal mood disorders: A social work perspective. *Social Work in Health Care*, *55*(1), 1–11. https://doi.org/10.1080/00981389.2015.1101045

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: Perinatal depression and anxiety. *Obstetrics & Gynecology*, *129*(3), 422–430. https://doi.org/10.1097/aog.0000000000001902

Koster, D., Romijn, C., Sakko, E., Stam, C., Steenhuis, N., Vries, D., Willigen, I., & Fontein‐Kuipers, Y. (2019). Traumatic childbirth experiences: Practice‐based implications for maternity care professionals from the woman's perspective.

Scandinavian Journal of Caring Sciences, *34*(3), 792–799. https://doi.org/10.1111/scs.12786

Lasiuk, G. C., & Ferguson, L. M. (2005). From practice to midrange theory and back again. *Advances in Nursing Science*, *28*(2), 127–136. https://doi.org/10.1097/00012272-200504000-00005

Lombardi, B. M., Zerden, L. D. S., & Thyberg, C. (2022). Social Work Answers the (Video) Call: Tele-Behavioral Health Use During COVID-19. *Journal of the Society for Social Work and Research*, *13*(1), 67–87. https://doi.org/10.1086/715621

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

Maiocchi, L., & Bernardi, E. (2012). Women's mental health: Unwanted pregnancy. *Australian & New Zealand Journal of Psychiatry*, *47*(6), 585–585. https://doi.org/10.1177/0004867412466596

Marsh, J. (2013). A middle range theory of postpartum depression: Analysis and application. *International Journal of Childbirth Education*, *28*(4), 50–54.

Martin, P. C. R. (2012). *Perinatal mental health: A clinical guide*. M&K Update Ltd.

Maxwell, D., Robinson, S. R., & Rogers, K. (2018). "I keep it to myself": A qualitative meta‐interpretive synthesis of experiences of postpartum depression among marginalised women. *Health &Amp; Social Care in the Community*, *27*(3), e23–e36. https://doi.org/10.1111/hsc.12645

McCloskey, R. J., & Ragudaran, S. (2018). Creation and evaluation of a maternal mental health course. *Social Work Education*, *38*(2), 227–240. https://doi.org/10.1080/02615479.2018.1509952

McKee, K., Admon, L. K., Winkelman, T. N. A., Muzik, M., Hall, S., Dalton, V. K., & Zivin, K. (2020). Perinatal mood and anxiety disorders, serious mental illness, and delivery-related health outcomes, United States, 2006–2015. *BMC Women's Health*, *20*(1). https://doi.org/10.1186/s12905-020-00996-6

Mirsalimi, F., Ghofranipour, F., Noroozi, A., & Montazeri, A. (2020). The postpartum depression literacy scale (PoDLiS): development and psychometric properties. *BMC Pregnancy and Childbirth*, *20*(1). https://doi.org/10.1186/s12884-019-2705-9

Moustafa, A. A., Crouse, J. J., Herzallah, M. M., Salama, M., Mohamed, W., Misiak, B., Frydecka, D., Al-Dosari, N. F., Megreya, A. M., & Mattock, K. (2019). Depression following major life transitions in women: A review and theory. *Psychological Reports*, *123*(5), 1501–1517. https://doi.org/10.1177/0033294119872209

National Association of Social Workers (n.d.). *Clinical social work*. National Association of Social Workers. Retrieved October 20, 2022, from https://www.socialworkers.org/Practice/Clinical-Social-Work

O'Connor, M., & Casey, L. (2015). The mental health literacy scale (MHLS): A new scale-based measure of mental health literacy. *Psychiatry Research*. http://dx.doi.org/10.1016/j.psychres.2015.05.064

O'Hara, M. W., & McCabe, J. E. (2013). Postpartum depression: Current status and future directions. *Annual Review of Clinical Psychology*, *9*(1), 379–407. https://doi.org/10.1146/annurev-clinpsy-050212-185612

O'Reilly, A. (2021). *Matricentric Feminism: Theory, Activism, Practice. The 2nd Edition* (Second edition). Demeter Press.

Osborne, L. M., Kimmel, M. C., & Surkan, P. J. (2021). The crisis of perinatal mental health in the age of covid-19. *Maternal and Child Health Journal*, *25*(3), 349–352. https://doi.org/10.1007/s10995-020-03114-y

Perinatal mood and anxiety disorders - center for women's mood disorders. (2019, June 5). Center for Women's Mood Disorders. Retrieved January 21, 2023, from https://www.med.unc.edu/psych/wmd/resources/mood-disorders/perinatal/

PESI. (n.d.).*Continuing education seminars - online CEU - mental health training*. https://www.pesi.com/

Postpartum Support International. (2022, December 29). *State Perinatal Psychiatry Access Programs*. Postpartum Support International (PSI). https://www.postpartum.net/professionals/state-perinatal-psychiatry-access-lines/

Puspitasari, A. J., Heredia, D., Weber, E., Betcher, H. K., Coombes, B. J., Brodrick, E. M., Skinner, S. M., Tomlinson, A. L., Salik, S. S., Allen, S. V., O'Grady, J. S., Johnson, E. K., L'amoureux, T. M., & Moore, K. M. (2021). Perinatal Mood and Anxiety Disorder Management in Multicenter Community Practices: Clinicians' Training, Current Practices and Perceived Strategies to Improve Future Implementation. *Journal of Primary Care &Amp; Community Health*, *12*, 215013272199688. https://doi.org/10.1177/2150132721996888

Rackin, H. M., & Brasher, M. (2016). Is baby a blessing? Wantedness, age at first birth, and Later-Life depression. *Journal of Marriage and Family*, *78*, 1269–1284. https://doi.org/10.1111/jomf.12357

Rhodes, A. M., & Segre, L. S. (2013). Perinatal depression: A review of US legislation and law. *Archives of Women's Mental Health*, *16*(4), 259–270. https://doi.org/10.1007/s00737-013-0359-6

Rouland Polmanteer, R., Keefe, R. H., & Brownstein-Evans, C. (2017). Social workers' screening practices for postpartum depression. *Advances in Social Work*, *17*(2), 273–284. https://doi.org/10.18060/21008

Ruel, E., Wagner, W. E., III, & Gillespie, B. J. (2015). *The Practice of Survey Research*. SAGE Publications.

Séjourné, N., Callahan, S., & Chabrol, H. (2010). Support following miscarriage: What women want. *Journal of Reproductive and Infant Psychology*, *28*(4), 403–411. https://doi.org/10.1080/02646830903487375

Siu, A. L. (2016). Screening for depression in adults: US preventive services task force recommendation statement. *JAMA*, *315*(4), 380–387. https://doi.org/10.1001/jama.2015.18392

Smith, M. V., & Lincoln, A. K. (2011). Integrating social epidemiology into public health research and practice for maternal depression. *American Journal of Public Health*, *101*(6), 990–994. https://doi.org/10.2105/ajph.2010.196576

Taylor, B., Mosse, L., & Stanley, N. (2019). Experiences of social work intervention among mothers with perinatal mental health needs. *Health & Social Care in the Community*, *27*(6), 1586–1596. https://doi.org/10.1111/hsc.12832

The Mayo Clinic. (2021, October 16). *Miscarriage - symptoms and causes*. Mayo Clinic. Retrieved March 8, 2022, from

https://www.mayoclinic.org/diseases-conditions/pregnancy-loss-miscarriage/symptoms-causes/syc-20354298

The National Association of Perinatal Social Workers. (n.d.). *What is a perinatal social worker*. Napsw.org. https://www.napsw.org/what-is-a-perinatal-social-worker#:%7E:text=Perinatal%20social%20workers%20work%20to,families%20move%20toward%20their%20future.

Uguz, F. (2016). *Psychiatric disorders during the postpartum period in light of current advances (psychiatry - theory, applications and treatments)* (1st ed.). Nova Science Publishers, Inc.

United States Department of Labor. (2022, September 8). *Social workers : Occupational outlook handbook: : U.S. bureau of labor statistics*. U.S. Bureau of Labor Statistics. Retrieved January 20, 2023, from https://www.bls.gov/ooh/community-and-social-service/social-workers.htm

U.S. Census Bureau. (2021, October 8). *Fewer babies born in December and January but number started to rise in March*. Census.gov. https://www.census.gov/library/stories/2021/09/united-states-births-declined-during-the-pandemic.html

Vignato, J., Georges, J. M., Bush, R. A., & Connelly, C. D. (2017). Post-traumatic stress disorder in the perinatal period: A concept analysis. *Journal of Clinical Nursing*, *26*(23–24), 3859–3868. https://doi.org/10.1111/jocn.13800

Wisner, K. L., Sit, D. K. Y., McShea, M. C., Rizzo, D. M., Zoretich, R. A., Hughes, C. L., Eng, H. F., Luther, J. F., Wisniewski, S. R., Costantino, M. L., Confer, A. L., Moses-Kolko, E. L., Famy, C. S., & Hanusa, B. H. (2013). Onset timing, thoughts of

self-harm, and diagnoses in postpartum women with Screen-Positive depression findings. *JAMA Psychiatry*, *70*(5), 490. https://doi.org/10.1001/jamapsychiatry.2013.87

Appendix A: Dissertation Survey

A Survey of Social Workers Perinatal Mental Health Knowledge and Competence

The purpose of these questions is to gain an understanding of your perceived knowledge or competence of various aspects to do with perinatal mental health. When responding, we are interested in your degree of knowledge, perceived knowledge, or competency.

Consent Information

Procedures:
If you agree to participate in this study, we would ask you to do the following things: answer all questions to the best of your ability. At any time, you may revoke your participation by exiting the survey.

Risks or Discomforts, and Benefits of Being in the Study:
This study has minimal to no risks.
The benefits to participation are a potential for increased awareness surrounding the survey topic and identification of educational or training needs regarding the survey topic.

Confidentiality and Anonymity:
Records will be kept private and will be handled in a confidential manner to the extent provided by law. In any report or presentation, we will not include any information that will make it possible to identify a research study participant. You will remain anonymous.

Voluntary Participation:
Your participation is voluntary, refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled, and you may discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled.

Contacts and Questions:
The researcher conducting this study is: Ashley Sullivan LCSW, a Doctoral Student with the Social Work Department. Email: asull020@live.kutztown.edu
339 Old Main
Kutztown, PA 19530
610-683-4235
You may ask any questions you have now. If you have questions later regarding the research study, you may contact the researcher listed above. If you have any questions or concerns about the rights of research participants, please contact the IRB Committee at Kutztown University at 484-646-4167.

Compensation:
Compensation is not being offered.

By completing and submitting this survey you are indicating that you are 18 years of age or older and voluntarily consent to participate

Demographics

1. **Are you a professional social worker, i.e., having earned a BSW and/or MSW degree?**

   - ◯ Yes
   - ◯ No

2. **Do you currently possess a social work license?**

   - ◯ Yes: LSW, LMSW, or equivalent (supervised clinical practice)
   - ◯ Yes: LCSW or equivalent (independent clinical practice)
   - ◯ No

Continue responding only if you responded (A or B) to question number 2.

If your responses do not quality for continuation, thank your for your time, you may exit the survey.

3. **Is the primary job function of your social work job "clinical"?**

- ◯ Yes
- ◯ No

4. **Do you work in a mental health outpatient, partial care, inpatient setting or another setting where you provide clinical services to the general adult population?**

- ◯ Yes
- ◯ No

Continue responding only if you answered (Yes) to questions number 3 and 4.

If your responses do not quality for continuation, thank your for your time, you may exit the survey.

5. **Do you identify as a parent?**

- ◯ Yes: A Mother
- ◯ Yes: A Father
- ◯ Yes: Other
- ◯ No

Perinatal Mental Health Disorders

Please answer each question to the best of your ability

6. **Can you confidently identify and describe all perinatal mental health disorders?**

- ◯ Yes
- ◯ No
- ◯ Some, but not all

7. **The perinatal time frame is defined as...**

- ◯ Pregnancy to one-year postpartum
- ◯ Conception to six months postpartum
- ◯ Birth to one-year postpartum
- ◯ Birth to eighteen months postpartum

8. **Do you recall content on perinatal mental health topics being included in your BSW education?**

- ◯ Yes
- ◯ No
- ◯ I do not recall
- ◯ I do not have a BSW
- ◯ I do not know what perinatal mental health topics are.

9. **Do you recall content on perinatal mental health topics being included in your MSW education?**

- ◯ Yes
- ◯ No
- ◯ I do not recall
- ◯ I do not know what perinatal mental health topics are.

10. **Do you have any additional training on the topic of perinatal mental health?**

- ◯ Yes: I received additional training through my job or a past job.
- ◯ Yes: I sought additional training on my own.
- ◯ Yes: I received additional training through my job or a past job AND on my own.
- ◯ No

11. **Do you feel comfortable treating clients in a clinical setting whose primary complaint is or is related to a perinatal mental health concern?**

- ◯ Yes
- ◯ No

12. **Do you feel comfortable treating clients in a clinical setting whose primary complaint is or related to complicated grief after a perinatal loss?**

- ◯ Yes
- ◯ No

13. **Have you ever worked (in a clinical capacity) with a client/patient who was experiencing a perinatal mental health disorder?**

- ◯ Yes
- ◯ No

14. **Outside of this survey, have you ever heard or seen the term "perinatal mood and anxiety disorders"?**

- ◯ Yes
- ◯ No

15. **Are you aware of any resources in your practicing area for individuals experiencing perinatal mental health issues?**

- ◯ Yes
- ◯ No

16. **Do you feel your social work education has prepared you to clinically treat perinatal mental health disorders?**

- ◯ Yes
- ◯ No

17. **Do you feel mental health disorders that present during the perinatal period differ from mental health disorders that present during any other period in an individual's life?**

- ◯ Yes
- ◯ No

18. **Please rate your perceived knowledge level of the topic.**

	Very Poor	Poor	Fair	Good	Very good
Perinatal Depression	○	○	○	○	○
Perinatal Anxiety and Panic	○	○	○	○	○
Traumatic Birth	○	○	○	○	○
Perinatal Post-traumatic Stress Disorder	○	○	○	○	○
Perinatal Obsessive Compulsive Disorder	○	○	○	○	○
Perinatal Bipolar Disorder and Postpartum Mania	○	○	○	○	○
Impacts on infants and children	○	○	○	○	○

Please rate your perceived competence level. Competence is defined as: the ability to do something successfully or efficiently.

19. **How competent do you feel you are clinically treating a client whose presenting problem is related to or caused by pregnancy loss?**

Very Poor	Poor	Fair	Good	Very good
○	○	○	○	○

20. **How competent do you feel you are in diagnosing perinatal mental health disorders?**

Very Poor	Poor	Fair	Good	Very good
○	○	○	○	○

Appendix B: IRB Approval

KUTZTOWN UNIVERSITY

INSTITUTIONAL REVIEW BOARD
110 Old Main, PO Box 730, Kutztown, PA 19530
(484)-646-4167

DATE:	September 27, 2022
TO:	Ashley Sullivan, Doctorate of Social Work Dr. Sharon Lyter, Department of Social Work
FROM:	Jeffrey Werner, Chairperson Institutional Review Board
STUDY TITLE:	Assessing Clinical Social Workers' Knowledge and Preparedness to Identify and Treat Perinatal Mental Health Disorders
IRB NUMBER:	IRB01082022
SUBMISSION TYPE:	Initial Application
REVIEW TYPE:	Exempt
EXEMPT CATEGORY:	2
ACTION:	Approved
APPROVAL DATE:	September 27, 2022

The Kutztown University IRB has approved the initial application for your research study. Your research study has been assigned the IRB Number 01082022. This number must be referred to in any future communications with the IRB.

In addition, the following language must be added to the consent form, "This research has been approved by the Kutztown University IRB – approval #IRB01082022."

Research approved as Exempt will have no expiration date. However, any revisions/changes to the research protocol affecting human subjects may affect the original determination of exemption and therefore must be submitted for review and subsequent determination.

Research must be conducted in accordance with this approved submission. You must seek approval from the IRB for changes and ensure that such changes will not be initiated without IRB review and approval, except when necessary to eliminate apparent immediate hazards to the subjects. You must submit the Application for Revisions / Changes form to the IRB, prior to making changes.

It is your responsibility to report all adverse events / unanticipated problems to the IRB. You must report adverse events that are unanticipated, regardless of seriousness, or report events that are more serious or more frequent than expected.

Records relating to the approved research (e.g., consent forms), must be retained for at least (3) three years after completion of the research. Refer to the IRB procedures regarding records.

Please go the IRB's website to review procedures and to obtain forms as needed. If you have any questions, please contact the IRB at 484-646-4167.

Appendix C: Revised IRB Approval

INSTITUTIONAL REVIEW BOARD
110 Old Main, PO Box 730, Kutztown, PA 19530
(484)-646-4167

DATE:	November 4, 2022
TO:	Ashley Sullivan, Doctorate of Social Work Dr. Sharon Lyter, Department of Social Work
FROM:	Jeffrey Werner, Chairperson Institutional Review Board
STUDY TITLE:	Assessing Clinical Social Workers' Knowledge and Preparedness to Identify and Treat Perinatal Mental Health Disorders
IRB NUMBER:	IRB01082022
SUBMISSION TYPE:	Revision/Changes
TYPE OF CHANGE:	Revision to survey / title change
REVIEW TYPE:	Exempt
EXEMPT CATEGORY:	2
ACTION:	Approved
APPROVAL DATE:	November 4, 2022

The Kutztown University IRB has approved the revision/changes to the initial application for your research study. Your research study has been assigned the IRB Number IRB01082022. This number must be referred to in any future communications with the IRB.

In addition, the following language must be added to the consent form, "This research has been approved by the Kutztown University IRB – approval #IRB01082022."

Research approved as Exempt will have no expiration date. However, any revisions/changes to the research protocol affecting human subjects may affect the