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Importance of Perceived Social Support for Black Mothers of Preterm Babies

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Abstract

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Anita L. Brentley

BS, Hampton University, 1983

MEd, Miami University, 1992

Dissertation Proposal Submitted in Partial Fulfillment of the

Requirements for the Degree of

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Abstract

Social support represents a network that provides for family, relatives, and friends and is an important predictor of future health and well-being. A knowledge gap exists in the literature regarding a need for social support for Black mothers of preterm babies. This qualitative study explored the perception of social support for Black mothers of preterm babies in Southwest Ohio. The phenomenological method of inquiry was used to gain an in-depth understanding of social support Black mothers receive after preterm birth. The social ecological theory provided a framework for understanding how individual, interpersonal, community, organizations, and policy affect a Black mother's perception of social support after preterm birth. NVivo was used to organize each data category for thematic analysis. The themes included (a) father of the baby, (b) help in times of need, (c) financial assistance, (d) government assistance, (e) lack of support, (f) mom and baby, (g) transition challenges, (h) depression, (i) acknowledging hospital support, (j) uncomfortable support, (k) unrelated support, and (l) increase in assistance. The findings indicate the lack of understanding of preterm birth and its long-term implications for a child, the need for additional interventions prior to discharge, and additional culturally appropriate training of healthcare staff. The study contributed to social change by increasing the understanding of researchers and health care professional regarding social support and improving transitions after preterm birth from hospital to home for Black mothers.

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Dedication

This dissertation is dedicated to my family, my best half, my husband Thurmond whom I love with all of my heart and who provided unwavering support and whose support and encouragement facilitated my educational growth. My sons Cedric and Brian who can see through me that anything is possible when you put God first and fix your mind toward your goal. To my professors whose patience and dedication made this dissertation possible, and to the memory of my deceased parents, Johnsie Kelly Banks and Ebie Dubois Banks.

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Chapter 1. Introduction to the Study

Introduction

Many mothers and babies experience lifelong trauma after preterm birth. For mothers of these babies, a host of psychosocial stressors and anxiety issues exist long after the birth (Hoffman, Mazzoni, Wagner, Laudenslager, & Ross, 2016; Shapiro, Fraser, Frasch, & Seguin, 2013). For babies, neurological problems and poor health outcomes often appear later in life (Howson, Kinney, McDougall, & Lawn, 2013). Prematurity is possibly more prevalent than society is aware as it is the second leading cause of death for children under the age of five and is the central cause of death during the first month of a child's life (Howson et al., 2013). However, a significant ethnic disparity in preterm birth occurs as one out of every six Black babies is born preterm in the United States (Sealy-Jefferson, Giurgescu, Helmkamp, Misra, & Osypuk, 2015). Nationally, in 2016, more than 350,000 babies were born preterm, which represented 1 out of every 10 babies in the United States (Centers for Disease Control and Prevention [CDC], 2016).

Background of the Problem

Social support represents a network that provides for family, relatives, and friends (Schrag & Schmidt-Tieszen, 2014). Although research shows that women are more likely than are men to rely on social support in times of stress (Porreca, Parolin, Bozza, Freato, & Simonelli, 2017), many Black mothers do not avail themselves of this support. Black mothers may face significant social, financial, physical, and environmental challenges because of limited social support (Mendenhall, Bowman, & Zhang, 2013).

Preterm birth compounds other challenges new mothers face. Research shows that Black mothers are often the target of violence, have limited access to health care, and have a higher risk of chronic health conditions, such as diabetes, high blood pressure, and maternal stress (Aizer & Currie, 2014), which are all factors associated with preterm birth (Vohr, 2013). Bediako, BeLue, and Hillemeier (2015) found, when compared to Black Hispanic and Hispanic mothers, Black mothers had the worse prenatal actions and had a higher incidence of smoking, prepregnancy obesity, and insufficient diet (e.g., too little or excessive weight gain) than did other racial groups. These factors compound the challenges Black mothers face when giving birth to a preterm baby. Petit et al. (2016) argued that preterm birth disturbed the mother-infant bonding process. A need existed to examine the number of social, economic, and health-related factors associated with preterm birth and Black mothers.

The literature review on social supports provides additional insights into the transition from hospital-to-home after the birth of a preterm baby. The next section will give additional insight into the statement of the problem, the purpose of the study, research questions, theoretical framework, nature of the study, operational definitions, assumptions, limitations, and delimitations, the significance of the study.

Problem Statement

Preterm birth is the birth of a baby following 20 weeks gestation and in advance of 37 weeks gestation (Satterfield, Newton, & May, 2016). Preterm birth is the primary cause of neonatal death (Adama, Bayes, & Sundin, 2016). In addition, preterm birth is an important public health issue as it has detrimental effects on the quality of life for

mothers. Moreover, the birth of a vulnerable baby coupled with the stress and anxiety associated with birth can lead to higher rates of morbidity and mortality (Howson et al., 2013). Parents of preterm babies must handle various health demands, which are not usually associated with the birth of a full-term baby (Brown et al., 2016; Ghorbani, Dolatian, Shams, & Alavi-Majd, 2014).

Although the evidence points to the importance of social support for new mothers, absent from the literature is the understanding of the significance of social support after the birth of a preterm baby for a particular population of mothers. Black mothers and their children are twice as likely to experience financial difficulty and live in hardship than are other ethnic groups (Elliott, Powell, & Brenton, 2013). Also, research shows higher rates of postpartum depressive symptomology among Hispanics and Black mothers compared to White mothers (Liu & Tronick, 2013).

Social support is considered a postpartum necessity (Barkin, Bloch, Hawkins, & Thomas, 2014) that leads to the reprioritization of how even limited social networks are used and what venues exist to provide support for mothers and families. After the birth of a preterm baby, Black mothers are unaware of the resulting needs of the baby or their own needs; moreover, Black and minority mothers often do not obtain medication because of limited admission to services and the shame of mental illness (Zlotnick, Tzilos, Miller, Seifer, & Stout, 2016). A need existed to understand the perceived social support for Black mothers and the detrimental effect the lack of social support may have. The methodology and design used were qualitative phenomenological, and the population

was Black mothers of preterm babies, with their babies less than 8-years old, and who resided in Southwest Ohio at the time of data collection.

Purpose of the Study

The purpose of this qualitative phenomenological study was to explore the phenomenon of perceived social support experienced by Black mothers of preterm babies in Southwest Ohio. A qualitative phenomenological research design is appropriate as this design examines the heart of human experience and answers questions of significance by exploring how the world functions (Moustakas, 1994). The definition of social support includes emotional, informational, and instrumental support, which lead a mother to believe that she is appreciated, loved, valued, and a member of a group (Hill, Burdette, Jokinen-Gordon, & Brailsford, 2013). At the time of data collection, research regarding social support for Black mothers of preterm babies was limited; therefore, a focus in this area could advance the training of hospital personnel around hospital discharge planning and precounseling.

Research Questions

The main research question for this study was: What are the shared experiences of perceived social support among Black mothers of preterm babies?

Subquestion 1. What are the sources of social support for Black mothers during the period following the birth of a preterm baby?

Subquestion 2. How do Black mothers of preterm babies perceive change in social support as they transition from hospital to home?

Subquestion 3. What leads a Black mother during the period after the birth of a preterm baby to seek social supports?

Conceptual Framework

The objective of this qualitative phenomenological study was to explore the significance of social support for Black mothers in Southwest Ohio after the birth of a preterm baby. Social-ecological models were created to advance the awareness of the relationships of various personal and environmental factors. The social ecological framework for human development, which was established by Bronfenbrenner (1994), applies social ecological models for human development and allows for the examination of personal and environmental influences that determine behavior. Understanding these forces may increase social support for Black mothers of preterm babies by providing insight into family relationships, community, and societal factors, which affect a mother's ability to obtain support. The social ecological model focuses on reinforcement around multiple levels of guidance and generates a more maintainable effect than does one level of influence (McCormack, Thomas, Lewis, & Rudd, 2016).

Pearson (2011) found that a relationship between making healthy options a default selection for larger groups of people could promote health and help to accept recommendations for cardiovascular health. Pearson recognized that a connection between social, cultural, and environmental changes could alter the risk for a larger population. Using the social ecological model and looking at the interpersonal, intrapersonal, and community associations allows for a better understanding of the

interactions between individuals and the environment and improved retention and recruitment.

Interventions, which focus on various levels of guidance, reinforce each other and generate a more sustainable effect (McCormack et al., 2016). In a review of the social ecological model, Brownwell et al. (2010) noted a profound effect on child development was based on early life experiences and the ability of a mother to provide multiple levels of influence for her child. Families are one of the most significant social resources for support and survival during a transition. Family support is often linked with strength despite other threats (Zimmerman, Darnell, Rhew, Lee, & Kaysen, 2015).

The social ecological model comprises five levels of reinforcement (McCormack et al., 2016). First, the individual level includes individual awareness attitudes and actions. Second, the interpersonal support consists of the formal and informal networks that can affect behavior, such as family, friends, peers, coworkers, and customs. The third reinforcement is a community, which includes connections with organizations, institutions, and informational networks. The fourth level is organizational, which is social institutions with guidelines and principles. The final level of reinforcement is policy/enabling environment, which includes local, state, and national policies involving the distribution of resources.

Nature of the Study

In this study, I used a qualitative phenomenological design to examine the experiences of Black mothers of preterm babies. The selection of the research design was based on the approach that investigates narrative data to gain an understanding of a

person's experiences and focuses on a naturalistic process, which allows for the representation of data using different formats (Crosby, DiClemente, & Salazar, 2006). A promotion of inquiry with a qualitative design allows for flexibility to explore the phenomenon in a natural setting (Rudestam & Newton, 2015). The strategies associated with a qualitative design allowed me to understand the perceptions of a mother after the birth of a preterm baby from the transition to home and to understand her personal challenges of care for a preterm baby.

In qualitative research design, the researcher focuses on understanding experiences and how meaning is constructed (Merriam & Tisdell, 2016). In contrast, quantitative methodology does not allow for an understanding of meaning and value from a participant's viewpoint. Moreover, quantitative methodology provides no opportunity to explore the purpose behind the decisions made (Gravetter & Wallnau, 2017). Conversely, qualitative researchers use words, themes, and coding to show results and to study natural conditions (Rudestam & Newton, 2015). Qualitative research uses words, terms, patterns, and themes to show meaning (Merriam & Tisdell, 2016).

Researchers could use quantitative methodology, which uses numerical data and is calculated with inferential statistics (Gravetter & Wallnau, 2017). Researcher could also choose mixed methods methodology, which uses a combination of qualitative and quantitative data (Tashakkori & Teddlie, 2010). I did not use any numerical data, except for demographic data, which I calculated with descriptive statistics (Lieber, 2009).

Regarding the research design, I considered five designs: (a) narrative, (b) ethnography, (c) case study, (d) phenomenology, and (e) grounded theory. I rejected a narrative design because the purpose of this research was not to record the mothers' life stories (Burnard, Gill, Stewart, Treasure, & Chadwick, 2008). Ethnography was not appropriate for this study as it examines a culture or community (Merriam & Tisdell, 2016). The case study was rejected as it is the description of a behavior or examination of a case (i.e., an organization, an event, community, policy, or program) (Yin, 2014) and would not be effective when trying to examine a phenomenon. Of the five primary qualitative research designs considered, phenomenological research design was deemed appropriate to sample Black mothers who had given birth to preterm babies to explore their experiences (Moustakas, 1994) with perceived social support.

Operational Definitions

Anxiety. Anxiety is a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome (Phillips, Wise, Rich-Edwards, Stampfer, & Rosenberg, 2013; Spinelli, Poehlman, & Bolt, 2013).

Neonatal mortality. A neonatal death is the death of an infant during the first 28 days of life (i.e., birth to 27 days) (CDC, 2018).

Pre-term, A baby is deemed preterm if born after a pregnancy in which the mother carries the baby less than what is considered *normal* or to term (i.e., to term means 40 or more weeks), especially less than 37 weeks of gestation (The American College of Obstetricians and Gynecologists Women's Healthcare Physicians, 2016).

Social support. Social support is the care of others by friends and family in times of need or crisis. Social support is a buffer against unfavorable life events (Cutrona & Russell, 2016; Hill et al., 2013).

Social-ecological model. This model deals with personal factors that provide insight into family relationships, community, and societal factors (Bronfenbrenner & Ceci, 1994).

Stresss. Stress is a state of mental strain or worry caused by adverse or demanding circumstances (Boyd & Tervo-Clemmons, 2013).

Transition. Transition is the process or period of shifting from one state or circumstance to another (Boykova & Kenner, 2012).

WIC. Women Infants and Children government food stamps program (United States Department of Agriculture Food and Nutrition Services, 2018)

Assumptions

My assumption is that all participants responded truthfully and shared their experiences honestly. Another assumption is that the information provided is assumed to be accurate. An assumption was access the population for the study would be available.

Scope and Delimitations

The scope of this research was limited by the access to the population of Black mothers of preterm babies in the Southwest Ohio and their shared experiences of social support services. No conclusions were drawn, and no associations were identified.

Limitations

A limitation noted was the ability to reach the population chosen because of increased life events associated with the birth of a preterm baby. Another limitation was the generalizability of results to other races/ethnicities.

Significance of the Study

When looking at the pathways to improved health, Southwest Ohio ranks in the lowest quartile for a population of health and health value and the third quartile for health care spending (Health Policy Institute, 2017; see Figure 1). Social capital and cohesion worsened because of the overall health outcomes; 80% of the factors that influence health were nonclinical such as the social and economic environment (40%), physical environment (10%), and health behaviors (30%) (Health Policy Institute of Ohio, 2017). According to the Ohio Commission on Minority Health (2016), Black mothers were twice as likely as their non-Hispanic White counterparts to die during pregnancy, twice as likely to give birth to a preterm baby, and 20% more likely to receive treatment for depression.

**Health Policy Institute of Ohio 2017
Factors that Influence Health**

40%	
35%	
30%	
25%	
20%	
15%	
10%	
5%	
0%	

Social and Economic Environment Clinical Care Health Behaviors Physical Environment
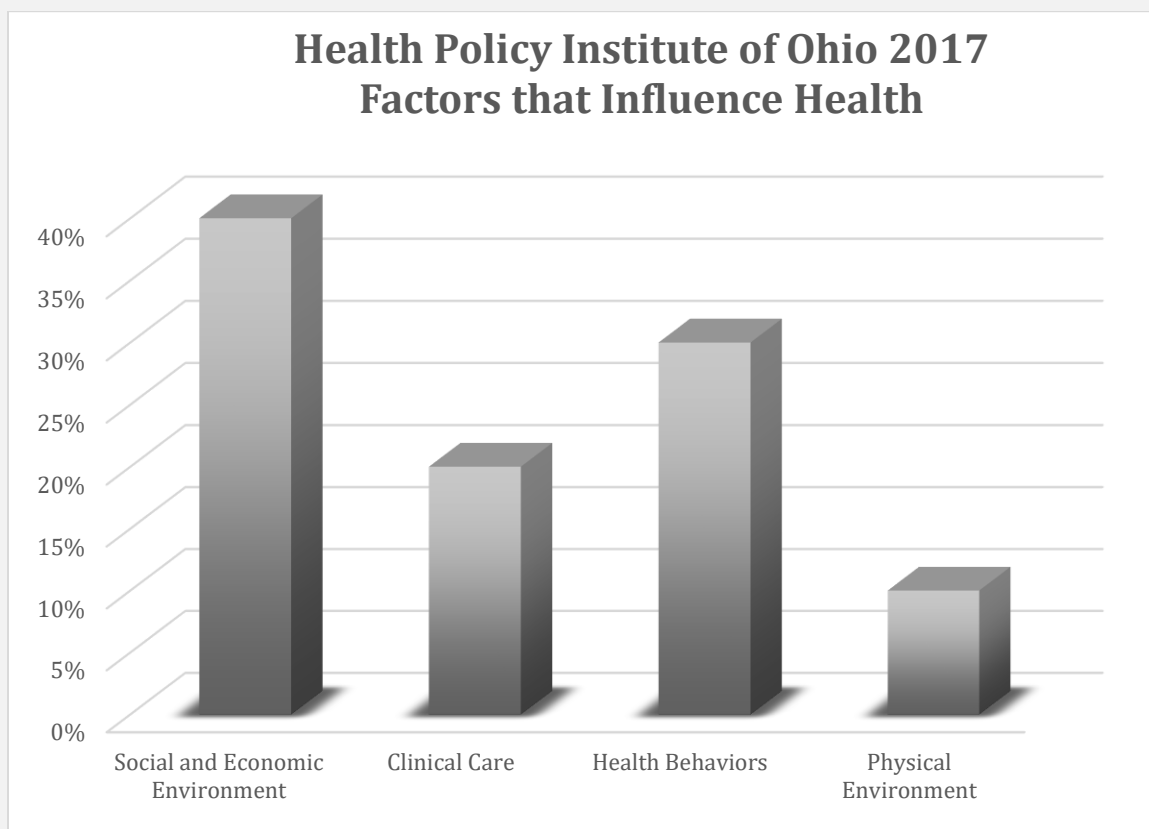
Figure 1. Statistics on factors that influence health of new mothers
Note. From "Why Does Ohio Rank 46th on health value," by Health Policy Institute of Ohio, 2017, *Health Value Dashboard*, p. 7. Reprinted with permission.

To help with this problem, The Health Policy Institute of Ohio (2017) designed a

health improvement roadmap for Southwest Ohioans. My research may provide

additional insights into the transition from hospital-to-home after the birth of a preterm

baby and assist healthcare professionals and discharge counselors with interventions to

support this population. By examining Southwest Ohio's most significant health

challenges and strengths, professionals may better understand gaps in care and the urgent need to improve social support for Black mothers and their preterm babies.

Summary

The experience after the birth of a preterm baby for any mother is filled with stress and anxiety and adjustments to the experience of caring for a child with additional medical needs (Brown et al., 2016). Preterm birth has a detrimental effect on both the baby and the mother and can lead to lifelong cognitive outcomes for the baby. Preterm infants are given space for ongoing assessment of physical and emotional needs, yet the mothers receive little or no ongoing support and are left with pervasive questions regarding their ability as parents and nurturers. These mothers are also left to wonder if they will have a support system for their children.

Social support is a transitional factor, which can indirectly affect self-esteem, boost resistance to infections, and assist with social adjustments (Ghorbani et al., 2014). Researchers have shown positive results for new mothers who had social support. These mothers were better able to reduce stress and develop stronger parent-child interaction skills than women who had limited support (Hill et al., 2013). However, Black mothers are least likely to get mental health screening and counseling. Black mothers mask the effects of stress because of the stigma associated with mental illness.

This chapter will be followed by a review of the dissertation literature review in Chapter 2. Chapter 3 contains the methodology research design and procedures for this investigation. Also contained in Chapter 3 is the role of the researcher and ethical consideration.

Chapter 2. Literature Review

Introduction

The purpose of this qualitative phenomenological study was to explore the phenomenon of social support for Black mothers of preterm babies in Southwest Ohio. A qualitative phenomenological research design was appropriate because phenomenological research examines the essence of human experience and answers questions of significance by delving into how the world works (Moustakas, 1994). The research built on the limited research regarding social support and highlighted the need for further research on Black mothers of preterm babies.

Chapter 1 contained the introduction, statement of the problem, the purpose of the study, the background of the problem, research question, and the nature of the study. Chapter 1 also contained the significance of the study, definition of terms, limitations, and lack of social support, post-partum care, socioeconomic factors, parent-child interaction, and transition from hospital-to-home after the birth of a preterm baby. Also discussed were the problems unique to Black mothers in Southwest Ohio. Chapter 2 includes a discussion of disparities in preterm birth.

Various authors have researched social support and the effects on birth; however, few have examined the effects of social support for Black mothers who have experienced preterm birth. At the time of data collection, the most available recent literature looked at the stress anxiety and social support after the Neonatal Intensive Care Unit discharge and after term birth (Boykova, 2016; Rossman, Greene, & Meier, 2015; Vohr, 2013). These

researchers did not acknowledge the vulnerable population of Black mothers or the unique experiences associated with the birth of a preterm baby.

In this literature review, I used a search strategy that focused on each element of the research question. I also expounded on the search criteria, conceptual framework, and the methodology employed to support this qualitative inquiry. To address the research question, I searched for journal articles published between 2013 and 2018. In this review, peer-reviewed journal articles were used.

Literature Search Strategy

The search conducted used established electronic data sources. Search sources included online and university libraries and Google Scholar. Sources consisted of ProQuest, CINAHL & Medline, PubMed, Psych Info, EBSCOhost, Digital and Sage Publications. In addition, I used the Black Research Starter, which provided information from the *Journal of Black Studies* and *Black Scholar.* The sources were limited to words that focused on preterm birth, social support, maternal deprivation, low-income mothers, postpartum depression, sources of support, parent-infant relationships, and transition after preterm birth.

Subtopics resulted directly from references to authors. Because of the limited publications on this subject, multiple databases and search engines were used to acquire information. Library sources were comprehensive and included more than 100 articles. In finding resources for this literature review, I used the Walden University online library and the main library in Cincinnati Ohio. Keywords used were *social support, low-income*

mothers, mother-child relationships, postpartum depression, transition, discharge readiness, and *preterm birth.*

Conceptual Framework

The Social Ecological Model

The social ecological model allows for the awareness of the individual and environmental influences that affect health behavior (McElroy, Bibeau, Steckler, & Glanz, 1998). Each level of this model is part of a tiered alignment, and each level provides a valuable approach to public health prevention and control by using a mix of interventions at all levels of the model. The model proposes that acting across all tiers of the model will more likely sustain behavior. Within this model five socially-ordered levels occur. The first level, the *individual* level, involves the qualities of an individual that influence behavior such as understanding, practice, viewpoints, sexual inclination, and financial or economic status. The second level, the *interpersonal* level, includes both official and unofficial associations, which are social support systems that can influence an individual's actions, family, friends, peers, coworkers' practices, and traditions. The third level, the *community* level, includes connections with organizations, institutions, and regular networks, which include village associations, community leaders, and businesses. At the fourth level, the *organizational* level, agencies and institutions exist with controls and regulations for procedures that can affect how services are provided and how systems work. At the fifth and final level, the *policy* level, local, state, national, and global regulations and policies affect resources.

Another component of the social ecological model is the view of the ecological environment. Bronfenbrenner (1994) posited that the ecological system was a set of structures. According to Bronfenbrenner, each system was nested within each other. First, the *Micro System* outlines events, community functions, and interpersonal associations performed by individuals in a face-to-face meeting with social and representational qualities that draw or hinder engagement and sustain more contact with activity in the environment.

Next, the *Mesosystems* are the connections and processes that take place between two or more locations, which contain the developing person (e.g., the relationship between home and school). The *Ecosystems* involve processes, which take place in two or more settings but indirectly affect the setting where the developing person resides (e.g., the relationship between the home and the parent's workplace or the relationship between the hospital and the neighborhood community group). The *Macrosystems* consist of the primary examples of Micro, Meso, and Exosystems with an emphasis on the value systems, resources, customs, and life course opportunities, which are rooted in the broader systems. Finally, *Chronosystems* expand the environment into a third element traditionally in the study of human development and includes change or constancy over time (e.g., a life course, family structure, socioeconomic status).

Literature Review Related to Key Variable or Concepts

The social ecological model allows for the understanding of how several systems, can affect individual behavior (Sandel et al., 2016). The CDC (2015) used the social ecological model for understanding violence and violence prevention strategies by

incorporating each level of the model and examining behaviors across the continuum, which led researchers to a stronger focus on how actions across many levels can lead to prevention. Sandel et al. reviewed case studies of neighborhood involvement and the relationship between people and geography. These researchers used the social ecological model and the Child Opportunity Index, which is a population level investigation tool.

Sandel et al. (2016) found that equity-directed investments in communities and diverse-funding streams provided opportunities for long-term attainment and sustainability. The researchers concluded that understanding the different qualities of community environments to child health supported a more in-depth opportunity to change population health and wellbeing. They also noted that socioeconomic characteristics of neighborhoods are a well-aligned road map through which poverty influences health.

Munn, Newman, Mueller, Phillips, and Taylor (2016) used an extensive assessment to study the influence of *baby-friendly hospitals,* which are hospitals where the staff caters to new mothers who breastfeed, and child health outcomes in the United States. The authors used the social ecological model to identify and gain insight into multiple influences of policy, organizational practices, healthcare providers, and mother-baby dyads. Through analysis of both empirical and theoretical sources, the authors discussed articles that assessed initial health results of child-friendly breastfeeding methods.

Munn et al. (2016) argued the need for studies to investigate maternal encounters and perceptions of baby-friendly procedures and assessed barriers. However, limitations

were evident in Munn et al.'s study. Mainly, the researchers did not include research from other countries. Furthermore, the researchers limited assessment of baby-friendly hospitals that did not reference results. Also, the researchers failed to investigate the focus on community and social networks as a support for breastfeeding mothers (Spencer, Wambach, & Domain, 2014).

The exposure of children to tobacco smoke remains a public health concern in low-income populations. Collins and LePore (2017) used a double-blind, randomized control, two-group design with three points: baseline, three months, and 12-month follow-up. The authors examined a multilevel social intervention to decrease tobacco smoke exposure for low-income children.

Collins and LePore's (2017) intervention strategies included nicotine reliance, depressive indications, weight anxieties, and smokers in the household of women who participated in the Women Infant and Children Program in Philadelphia. These researchers found the use of numerous strategies (e.g., state quitlines, messages about tobacco smoke exposure, smoking cessation, and nutrition) improved maintainability. Also, the authors discovered that the Living Safe and Smoke-Free Model could be implemented in existing workflow. Each of the previous studies showed the association between multiple systems, the environment, and individual human behavior.

Literature Review

In this section I share literature, which is focused on the research problem. The studies reinforce the research problem by providing literature on Black mothers, preterm birth, and social support after preterm birth.

National Problem of Preterm Birth

In separate studies, Vohr (2013) and Feldman, Rosenthal, and Edelman (2014) acknowledged the long-term outcome of preterm birth and the increased risk to infants with gestational age of 34-36 weeks. Premature babies who survive may encounter a lifespan of disability (Braverman et al., 2015; Brown et al., 2016; Howson et al., 2013; Liu, 2017; McCabe, Carrino, Russell, & Howse, 2014; Raju et al., 2017; Schieve et al., 2016; Shapiro-Mendoza et al., 2016). These risks include special education and long-term medical and social support. Because of the level of risk to preterm babies, Vohr argued to begin observation of these infants for medical, neurological, and behavioral problems. Vohr recommended skilled follow-up and review of the most vulnerable infants.

Disparities in Preterm Birth

Some researchers proposed that even with improvements in health care, preterm birth could be linked to racial and ethnic disparities (Braverman et al., 2015; McCabe et al., 2014; Shapiro-Mendoza et al., 2016). Various researchers have posited that higher rates of preterm births among Black mothers occurrd more often than among other ethnic groups (Almeida, Mulready-Ward, Bettegowda, & Ahluwalia, 2014; Callaghan, MacDorman, Shapiro-Mendoza, & Barfield, 2017; Lorch & Enlow, 2016; Misra, Slaughter-Acey, Giurgescu, Sealy-Jefferson, & Nowak, 2017; Sealy-Jefferson et al., 2015). These researchers noted that all ethnic groups had high rates of preterm births, but the cause of this public health problem was unknown. However, Romero, Dey, and Fisher (2014) studied the many paths and origins of preterm birth and concluded that

prevention could necessitate further clarification of the processes underlying each (see

Figure 2).
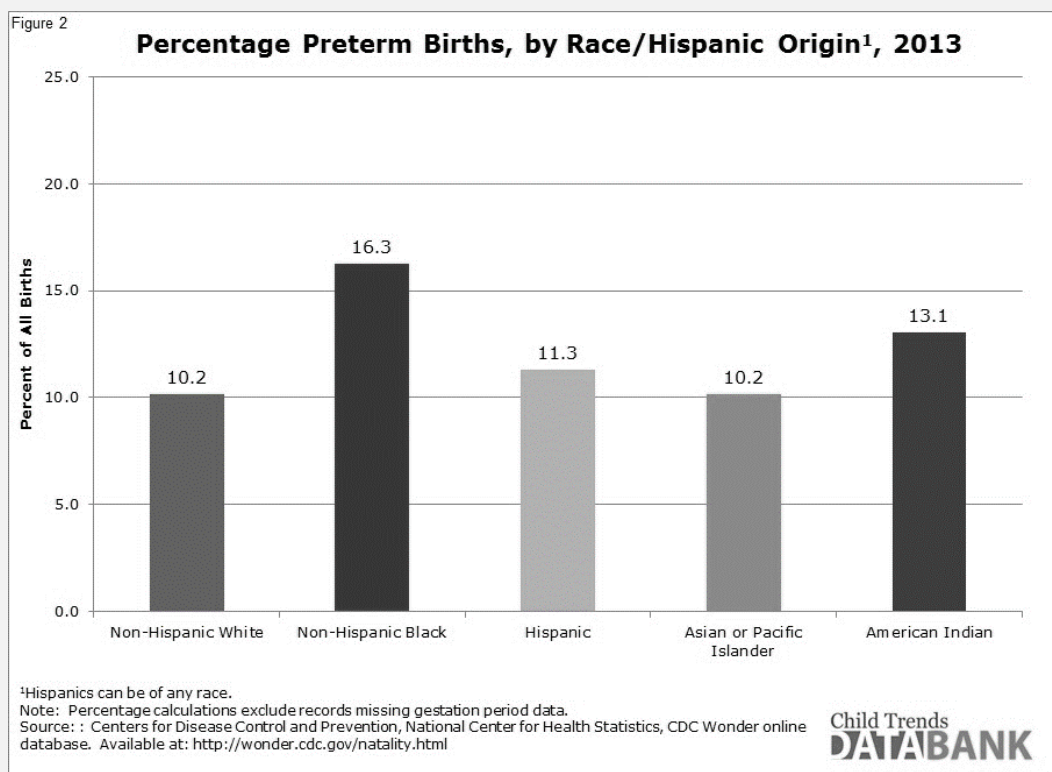
Figure 2. Statistics on differences by race and Hispanic origin
Note. Child Trends Data Bank. (2013). *Preterm Birth* [Issue Brief]. Reprinted with
permission.

Carmichael et al. (2017) used birth certificate data from the U.S. Department of

Health and Human Services Centers for Disease Control and Prevention, National Center

for Health Statistics (2015) to examine Black and White disparities in the preterm birth of

822,414 singleton births in California from 2007 through 2011. The depth of the study

was the population design and the sizeable sample size. Carmichael et al.'s research

findings correlated with the findings of McKinnon et al. (2016), Aizer and Curry (2014), and Bediako et al. (2015) who studied race/ethnicity and additional disparities that could lead to poor birth outcomes. The researchers recommended the need for more studies to determine why higher rates of preterm birth occurred in the Black population when compared to other ethnic groups.

In the United States, preterm birth rates are recorded according to racial and ethnic groups (McCabe et al., 2014). In a study of singleton live births in Canada and the United States, McKinnon et al. (2016) noted that in Canada the rate of preterm births for non-Hispanic Black mothers and White mothers was parallel to the United States. McKinnon et al. also found that in the United States, foreign-born Black mothers had a reduced risk of preterm birth when compared to Black mothers born in the United States. A limitation of the study was the inadequate quality of birth registration from the Ontario Province and the difference in race and ethnicity groupings for Black and White women between the two countries

Social Networks

Social support characterizes a network that recognizes love and attention for family members and contacts (Schrag & Schmidt-Tieszen, 2014). For clarity, social networks are connections among people with similar likes. Freeman and Dodson (2014) conducted a 3-year ethnographic study of the social networks of 73 low-income single mothers involved in an antipoverty project using qualitative consultations, field records, and group assemblies. Freeman and Dodson found that single mothers were a resource for each other. Low-income mothers shared knowledge and interests that allowed them to

work together and encourage each other. Social networks increased social capital, organized responsibilities, and worked toward self-sufficiency. A limitation of the study was the selection of mothers who were all involved in the same program. A need exists to look at the validity of this study for other programs that include low-income mothers.

Mills and Zhang (2013) reviewed the Survey of Income and Program Participation, which is a sequence of studies directed by the United States Census Bureau. The study used descriptive statistics and multivariate models, which included more than 17,000 members who received Women, Infant, and Children and Temporary Assistance for Needy Families support. The research examined measures of assistance from family members and contacts during hardships. Mills and Zhang found that family, friends, community, personal contacts, and organizations could lessen the extremities of hardships and reinforce social networks that could enrich health. The authors recommended that publicly-funded programs should be aimed at those less likely to have entry to social support linkages.

Another type of support is peer support, which is information, experience, social, emotional, and practical help from one person to another (Shilling et al., 2013). Anderson (2013) examined the meaning of support group exchange in postpartum depression. She noted the necessity to understand the weaker links of support that are available; however, she did not look at close supports. The author found that all participants revealed the significance of obtaining support from a similar other. Furthermore, one-to-one peer support during pregnancy or after birth could increase associations, build networks, and enhance emotional health and empathy rather than loneliness. Anderson's study shows

the importance of relationships and the significant support of others can provide emotional support to new mothers. Limitations of this study were the accuracy of self-diagnosis in the group setting and the willingness of women to discuss their experiences with postpartum depression.

Another type of support is the support of the church. Faith communities are significantly relevant to the cultivating of people, both spiritually and mentally, as this support helps to develop skills that are transferred throughout life (Williamson, Howell, & Batchelor, 2017). Clements, Fletcher, Childress, Montgomery, and Bailey (2016) also investigated religiosity, which is participation in religious activities. The researchers found that religiosity was related to positive, healthy outcomes and fewer depressive symptoms. Clements et al. concluded that religious commitment offered relief from the demands of life.

In a semistructured qualitative study of 30 Latina and Black postpartum women, Keefe, Brownstein-Evans, and Polmanteer (2016) examined the association with the church and coping with postpartum depression. The authors found the Black and Latino churches helped to support the needs of their members. Several themes evolved from the study as mothers expressed a break from anxiety, felt respected and less isolated, acknowledged gratefulness, and developed a spiritual understanding and acceptance of God's guidance, developed better relationships with family members, and reduced self-harm. Keefe et al. concluded that churches could meet a particular unmet necessity for women of color and act as a support system in times of trials.

Giurgescu and Murn (2016) conducted a study of 114 Black mothers and found that church services might reduce depressive symptoms. The researchers also found that a connection to a religious organization enhanced the psychological well-being of post-partum Black mothers. However, the authors did not explicitly state that social support was essential for Black mothers. In a similar study, Ward, Wiltshire, and Detry (2013) conducted an exploratory cross-sectional design and examined the coping skills of Black women and men. These authors found that religious practices, such as praying and consultation with a pastor, were robust coping mechanisms.

Taylor and Conger (2017) noted that kin support, which is the support of parents, siblings, and extended family members, was linked to positive outcomes in psychological adjustments and improvements in parenting practices. Taylor and Conger also found that poor relationships with kin were related to poor parenting, lower acknowledgment, ineffective control, and limited communication. In a similar study, Garrett-Peters and Burton (2016) examined kin support of 16 Black mothers using longitudinal ethnographic data. The researchers found that Black mothers relied on informal support from extended kin, and kin support was necessary for the mothers who lacked economic and material resources. The researchers found this support was restricted, irregular, and untrustworthy because of limited income and personal problems experienced by the family. The researchers also found the support Black mothers relied on was inadequate and added to the stress and anxiety for the mother.

The partner is usually the most significant relationship with a new mother. Straughen, Caldwell, Young, and Misra (2013) noted that Black fathers were different

than White fathers because Black fathers faced more obstacles such as educational fulfillment and economic stability. In a qualitative study of postnatal distress, Coates, Ayers, and deVisser (2014) found the baby's father was the closest relationship for a woman. Women felt they could share everything with their child's father. Hartman (2016) also found women showed lower levels of depression, worry, and smoking when there were high levels of partner support. These research findings were consistent with Sampson, Villarreal, and Rubin's (2014) longitudinal cohort study of nearly 5,000 mothers using data from the Fragile Families and Child Wellbeing Study. Sampson et al. noted that a typically ignored type of support from the partner was the quantity of reassurance and positive reactions a mother received about her parenting style. All types of partner support decreased stress with emotional support as this is the most substantial influence on stress.

Cheng, Kotelchuck, Gerstein, Taveras, and Poehlman-Tynan's (2016) results agreed with the previous research findings. Cheng et al. explained that women who reported real partner support experienced lower anxiety and reduced depression indicators from pregnancy to postpartum when compared to women who did not receive this support. In contrast, Pisoni et al. (2015) found the absence of partner support was a risk factor immediately associated with the onset of personality disorders before and after delivery. These findings show the role of social support could play a vital role for women with an absent partner.

Formal Supports

Several local, state, and national programs deliver direct support to low-income mothers. Central or immediate support is the support ongoing from an organization, program, or group. The United States Department of Agriculture Food and Nutrition Services (2018) developed the Women Infant and Children's Program (WIC) to improve the health of nutritionally at-risk women who were pregnant and received Medicaid, and were postpartum, breastfed, and had infants and children up to age five. The benefits of this program are supplemental nutritious food, nutrition education, counseling, screening, and referrals to other health and welfare services. The United States Department of Health and Human Services Temporary Assistance for Needy Families Program (TANF) offers funds to states and territories to supply financial assistance and associated support services. The program provides screening for substance abuse, mental health, and domestic violence.

Individuals who use the TANF program must design and follow a plan for self-sufficiency. Benefits differ per state, and each state and territory can develop precise criteria to receive help. The Supplementary Nutrition Assistance Program offers tuition assistance to low-income individuals and families. The program provides economic benefits to communities and organizations. The goal is to ensure that those eligible for nutrition assistance can make informed decisions on healthy food choices for mothers and their children (United States Department of Agriculture Food and Nutrition Services, 2017). The U.S. Department of Housing and Urban Developments, Housing Choice Voucher Program assists low-income families with rent. This program also helps those

who meet criteria find a place to live. The voucher system is a means of reducing rental payments.

Health and Well-being of Black Women and Mothers

Various researchers have focused on the issue of social support and the shielding effect against toxic life experiences (Freeman & Dodson, 2014; Geens & Vandenbroeck, 2014; McGowan et al., 2017; Norris & Mitchell, 2014); however, few researchers explored the overwhelming experiences that the early birth of a child can have on Black mothers' health and well being. Many Black mothers enter the maternal health arena with chronic diseases such as diabetes, heart disease, and hypertension. Substantial evidence supports that Black and low-income women have endured a multitude of disadvantages known to affect their health and wellbeing (Aizer & Currie, 2014; Sealy-Jefferson et al., 2015). However, the 2017 report on the Status of Black Women in the United States outlined the significant contributions to the productivity, wealth, and success of Black women in the United States (DuMonthier, Childers, & Milli, 2017). This report showed that for many years, Black women supported their families and worked as leaders in their communities and society. The 2017 report also listed the accomplishments of the Black women who had made their way out of poverty.

In addition, statistics show that not all Black women have escaped the issues typically correlated with poverty. The CDC figures for 2011–2013 showed that 7.6% of Black women had heart disease compared to 5.8% of White women and 5.6% of Mexican-American women. In 2016, 46 of every 100,000 Black women died from strokes compared to 35 of every 100,000 White women. The diagnosis rate for diabetes

for Black women was 9.9 per 100, which is almost double compared to 5.4 per 100 White women.

Smoking among pregnant women is a top risk factor for premature birth. Aizer and Currie (2014) noted that 18% of the most disadvantaged women smoked during pregnancy compared with 1% of advantaged women. Healthy People 2020 identified the reduction of maternal smoking as one an objective because smoking is considered preventable (Office of Disease Prevention and Health Promotion, 2017). Furthermore, the objective added a goal for the reduction in the relapse in smoking for postpartum women.

Yang, Shoff, Noah, Black, and Sparks (2014) examined racial separation and maternal smoking using the Racial and Segregation Interaction Index and found the odds of smoking for Black mothers were 32% compared to 20% for White women. However, the researchers used limited birth records and county-level data, which had limited validity, and they focused on the behavior of mothers at a point in time. The study also used self-report data, which could limit validity as the women may not have accurately reported their experiences. In a separate study that explored multiple issues that influence preterm birth, Masho, Munn, and Archer (2014) examined a 10-year, live birth registry from a racially diverse city in Virginia and found that tobacco and illicit drug use were statistically associated with preterm birth in Black women.

Liu et al. (2015) recognized that five strategies existed for improved health of mothers. These strategies included (a) identify approaches before during and after pregnancy; (b) improve value and safety of maternal health care; (c) improve structure of maternity care, including clinical and public health systems; (d) improve public

consciousness and education; and (e) increase examination and research. In a study of preterm birth and Black mothers, Misra et al. (2017) found that obesity, illicit drug use, and stress were higher for Black mothers than for other ethnicities. Misra et al.'s research was supported by Vohr's (2013) study that found mothers of preterm infants were likely to have medical problems, which included high blood pressure, diabetes, and heart disease.

Stress and Anxiety

Stress and anxiety associated with preterm birth can affect the health of the mother and her child (Elliott et al., 2013; Reid & Taylor, 2015; Shaw et al., 2014; Suttora, Spinelli, & Monzana, 2013; Taylor & Conger, 2017). The experience of becoming a mother coupled with the birth of a preterm baby can be overwhelming. Specifically, researchers have examined the stress and anxiety of Black mothers (Giurgescu et al., 2015). In a study of parenting stress and mental health, Treyvaud (2014) found that parents needed support for preterm babies because of parental distress and family dysfunction.

In a related study, Tsai et al. (2016) reviewed lifetime stress, pregnancy stress, and African ancestral stress proportions. Tsai et al. found that life stress and pregnancy stress were associated with preterm birth. The research limitations included recall bias of mothers and data collected on two questions. In addition, the researchers failed to assess the influence of socioeconomic factors.

Regarding preterm births, Schappin, Wijnroks, Venema, and Jongmans (2013) conducted a random-effects meta-analysis of 38 studies, which described 3,025 parents of

preterm and low birth weight children. The researcher measured parental stress using the Parenting Stress Index. Schappin et al. argued that preterm birth could be more stressful for parents based on uncertainty about survival, medical issues, and long-term effects of prematurity. The researchers found that parents of preterm children experienced markedly more stress than did parents of term children.

Transition from Hospital-to-Home and Social Support

For mothers of preterm babies, the transition from a neonatal intensive care unit to home can also cause anxiety. In a qualitative phenomenological study, although the researchers did not explicitly specify Black mothers, Phillips-Pula, Pickler, McGrath, Brown, and Dusing (2013) examined a vulnerable population of parents of infants. The rsearchers found those parents felt an array of emotions such as grief, depression, and anxiety. In a similar study, Brown et al. (2016) surveyed 196 Black and White mothers of preterm infants and found financial burdens, social isolation, and unsafe surroundings were challenges.

Brown et al.'s (2016) study coincided with Girgin and Cimente's (2016); Enlow et al.'s (2017); and Smith, Hwang, Dukhovny, Young, and Pursley's (2013) studies that found mothers felt hurried and unsure of their ability to care for their children after hospital discharge. In contrast, McGowan et al. (2017) argued that mothers on Medicaid expressed positive responses about well-being and assurance in caring for their children. In this study, mothers saw their assessment of Medicaid as a safety net for care.

Boykova and Kenner (2012) noted that post-discharge follow-up typically took place 100 days after discharge. Therefore, parents are left alone and without support

during this time. NICU infants arrive home under-immunized and without satisfactory transfer and mediation services. Therefore, parents are left alone and without support. Boykova and Kenner also noted that most of the rehospitalizations occurred during this period. Thus, a great deal is known of the concerns of NICU parents during the transition to home; however, less is known about Black mothers and the relationship between social support and preterm birth

Post-Partum Depression

Depressive symptoms as well as depression are widespread complications of childbirth and are leading causes of disease-related infirmity among mothers (Howell et al., 2014; Liu & Tronick, 2013; Seplowitz et al., 2014; Werner, Miller, Osborne, Kuzava, & Monk, 2015). Anderson (2013) suggested mothers who endured the experiences of postpartum depression were silenced in at least four ways: (a) a mother's reproductive illnesses were stigmatized, (b) symptoms were not physical, (c) the signs disrupted the normalcy of motherhood, and (d) the signs generated a stifling dynamic.

Researchers have shown that 70% of Black single mothers described depressive symptoms consistent with a slight diagnosis of clinical depression. Atkins (2017) used a cross-sectional correlational design and examined depression in 159 Black single mothers. Atkins found that Black single mothers who were diagnosed with depression had low levels of social support, they had poor self-care and health practices, and they had negative thoughts.

In a study of 61 mothers from midwestern states, Corrigan, Kwasky, and Groh (2015) examined the connection between social support, post partum depression, and

professional assistance using a descriptive cross-sectional study design. Corrigan et al. found that half of the mothers who screened positive self-reported that they were not depressed, had slight assistance, and were overcome by life experiences since the birth of a child. In addition, in a comparison of Black ($n = 31$) and White ($n = 30$) mothers on the Social Support Questionnaire, White mothers were shown to have greater social support than were minority mothers ($M = 22.37$, $SD = 2.58$ compared to minority mothers ($M = 20.55$, $SD = 3.55$). Finally, when looking at future consequences, Corrigan et al. suggested a need existed for individualized interventions and action plans as mothers' perceptions of support, depression, and professional care varied.

Zlotnik (2016) also found that low-income mothers who suffered from postpartum depression often did not receive treatment because of the shame linked with this disorder. However, the experience of depression does not affect all mothers. Seplowitz et al. (2014) evaluated a sample population of women and mental health diagnosis after childbirth. Seplowitz et al. found that out of 5,731 women who delivered babies and presented for postpartum follow-up, only 5% had at least one documented mental health diagnosis during the year following childbirth. The research findings suggested a need for further examination and follow-up of women after the birth of a child.

Post-Traumatic Stress Disorder

In an examination of post-traumatic stress disorder; Suttora et al. (2013) conducted an Internet-based survey through online forums related to pregnancy, childbearing, and prematurity. Respondents were mothers of infants less than one-month-old. The sample included 243 mothers (156 full-term mothers and 87 mothers of preterm

children). Suttora et al. found that mothers of preterm children reported more post-traumatic stress disorder than did the mother of full-term children. The research results confirmed previous findings that mothers of preterm babies experienced significant psychological stress (Ghorbani et al., 2014; Ionio et al., 2016; Treyvaud, 2014; Vohr, 2013).

Mother-Child Relationships

The connection and bonding between a mother and a child are rewarding. Gerstein, Poehlman-Tynan, and Clark (2015) examined mother-child interactions of 130 preterm infants and mothers. These researchers found that positive verbal involvement was related to positive parenting behavior after 24 months. Bhat et al. (2016) and Suttora et al. (2013) found that preterm birth could lead to a disturbance in the mother-child relationship. Ghorbani et al. (2014) and White-Traut et al. (2017) agreed and opined that how a mother recovered from loss and grief of premature delivery could affect the mother-child relationship. Spittle and Treyvaud (2016) also agreed with Ghorbani et al. that the mother-child interaction was significant to develop optimal outcomes for a preterm child.

In a similar study, Taylor and Conger (2017) noted that high levels of economic hardship experienced by single mothers was linked to elevated levels of depression, which could lead to unhealthy behaviors and unresponsive interaction. The researchers noted that these behaviors could lead to problems that negatively influence parenting. Hall et al. (2015) argued that no differences existed in the parent-child interaction with a preterm infant; however, sharp differences in behavior were noted.

Neighborhood Disorder and Social Support

Studies have shown that a substantial impact of socioeconomic factors affects social support. Hill et al. (2013) examined longitudinal data and found that higher levels of disorder in a neighborhood were associated with low levels of social support and self-esteem. In a related study, Jocson and McLoyd (2015) found that families from inner-city communities in Milwaukee viewed neighborhood disorder, such as visible wiring, infestation, and unruly neighbors, as psychologically distressful. For some Black mothers the transition from a medically-designed hospital environment to a home, which lacks vital resources such as electricity, water, and hygiene, is overwhelming, especially when social networks are unavailable. Another area of concern is violence, crime, and toxins in some communities. These issues make it difficult to form healthy relationships with neighbors. The health and well-being of many Black mothers who are considered vulnerable are challenged by various social barriers that can affect mother-child interaction and a new mother's ability to parent effectively (Ghorbani et al., 2014).

Aizer and Currie (2014) noted that Black mothers often lived in areas with low performing schools, low employment, exposure to contagious disease, and limited access to safe public transportation. Meng, Thompson, and Hall (2013) concluded that a mother might have limited control over neighborhood risks that impact social structure. Furthermore, the authors noted that community-focused research was necessary to reduce risk associated with low socioeconomic status.

Lack of Social Support

A strong argument exists that social support improves health outcomes and decreases the risk of premature death (Holt-Lunstad, Robles, & Sbarra, 2017). In a study of urban environments and support, Gullino et al. (2016) conducted a qualitative parent-led study from 2013 to 2015, with both preterm and full-term mothers in London, England. The researchers found that both groups acknowledged a lack of family support because of the inability to interact with other mothers. Problems occurred in developing supportive relationships because of mobility and admittance to public transportation. The findings suggested the need for additional support between mothers in the hospital setting. Gullino et al. concluded that social support could help mothers develop their own identity outside of the hospital and improve both mother and child well being.

In a similar study, Giurgescu et al. (2013) found the lack of social support and resources spurred Black mothers to take on various roles, which included mother, nurturer, and breadwinner. McLeish and Redshaw (2017) found that the lack of social support was a substantial risk factor for perinatal depression. In addition, women were more likely to experience depression if they were socially isolated. Taylor, Budescu, Gebre, and Hodzic (2014) suggested that individuals who lived in poor communities lacked entry to social and institutional support. The lack of access made it challenging to establish positive patterns of family life.

Summary and Conclusion

Preterm birth is a national issue, and many researchers have studied the long-term outcomes of preterm birth. The lack of social support for Black mothers remains a

problem, not only in Southwest Ohio, but nationally. Multiple reasons exist why a more concentrated effort is needed with this population of mothers. The on-going experience of hardship is a part of a generation of maternal deprivation, which affects the life course of low income and Black mothers

Researchers have also found that interventions, such as support, education groups, peer-to-peer learning groups, and partner support groups, were effective in the improvement of mood and well-being of the mothers. This chapter will be followed by Chapter 3, which will contain the methodology research design and procedures for this study. Also contained in Chapter 3 is the role of the researcher and ethical considerations.

Chapter 3. Research Method

Introduction

This chapter includes a narrative of the study's design, role of the researcher, instrumentation, data analysis, and ethical considerations. An overview of the study's design includes a rationale for the study and why the study design was selected. The participant selection logic and the procedure for recruitment, participation, and data collection are also discussed.

The purpose of this qualitative phenomenological study was to explore the phenomenon of perceived social support experienced by Black mothers of preterm babies in Southwest Ohio. A qualitative phenomenological research design was appropriate as this design examines the heart of human experience and answers questions of significance by exploring how the world functions (Moustakas, 1994). The definition of social support includes emotional, informational, and instrumental support, which lead a mother to believe that she is appreciated, loved, valued, and a member of a group (Hill et al., 2013). At the time of data collection, research regarding social support for Black mothers of preterm babies was limited. Therefore, a focus in this area may advance the training of hospital personnel around hospital discharge planning and precounseling

The two previous chapters detailed the experiences of postpartum depression and the increased stress and anxiety exhibited by mothers of preterm babies. The first two chapters also outlined the relationship between Black mothers of preterm babies and their

social networks. Finally, the chapters provided insight on the impact of preterm birth, social support, and mother-child interaction.

Research Design and Rationale

This study was designed to examine the experiences of Black mothers after the birth of a preterm baby and to obtain information on their perceptions of that experience.The main research question for this study was, What are the shared experiences of perceived social support among Black mothers of preterm babies?

Subquestion 1. What are the sources of social support for Black mothers during the period following the birth of a preterm baby?

Subquestion 2. How do Black mothers of preterm babies perceive change in social support as they transition from hospital-to-home?

Subquestion 3. What leads a Black mother during the period after the birth of a preterm baby to seek social supports?

Qualitative research explores how people translate their experiences and guides the reframing and the identification of multiple truths (Merriam & Tisdell, 2016). In the case of Black mothers who are fraught with life course challenges before, during, and after pregnancy, few researchers investigated the perceptions of social support. Qualitative research uses words as data (Braun & Clarke, 2014) and allows for the observation of several realities or understandings of a single experience, which is subjective (Merriam & Tisdell, 2016).

A qualitative method was selected instead of a quantitative or mixed methods approach because the issue of perceived social support for Black mothers of preterm

babies is a multifaceted problem. Quantitative research is applied when reseachers need to evaluate an event, analyze numerical data, or quantify questions, such as what is the number of mothers who experience depression after a preterm birth? Quantitative research allowed me to answer questions that provide understanding and interpretation of the human experience.

The third research methodology is the mixed methods study. The mixed methods study examines independent groups at different time points (Crosby et al., 2006); moreover, the mixed methods study combines both qualitative and quantitative approaches. Quantitative data were not gathered in this study. For this study, a qualitative methodology was appropriate. Merriam and Tisdell (2016) noted that a qualitative study is positioned within the background of the participants, uses the reseacher as a vital instrument, involves connecting and developing, and presents an inclusive approach to complicated issues.

Role of the Researcher

The researcher's role in this study was that of an observer. The researcher is the essential tool for data collection and analysis. The interviews took place using the same interview questions in the same order, and I did not interject any personal feelings or biases. During this process, limited personal conversations occurred. The participants shared their experiences in the fashion that they choose, and I practiced active listening.

Patton (2015) noted there are seven types of knowledge generating contributions that take place during qualitiative inquiry: (a) illuminating meaning, (b) studying how things work, (c) capturing stories, (d) elucidating how systems function, (e)

understanding context, (f) identifying anticipated consequences, (g) and making comparisions to discover patterns and themes. The researcher does not lead participants in any way. As a researcher, my role was to practice epoché and bracketing, which Ahern (1999) defined as the ability to remove expectations and presumed values from the research process.

Methodology

Phenomenology is a research practice in which muffled voices are heard, and meaning is transferred to practices that lead to an understanding of a construct for how people come into contact with a phenomenon (Moustakas, 1994). A phenomenological design goes beyond previous knowldedge to elecit rich and informative data (Creswell & Poth, 2018). Other methods of qualitative inquiry were reviewed; however, when compared to phenomenology, each seemed less effective to examine the perception of social support for Black mothers of preterm babies. For example, if the study focused on daily events surrounding the birth of a preterm baby, an ethnographic study would have been appropriate (Merriam & Tisdell, 2016).

If the study examined the history of the mother's life throughout her pregnancy, a narrative design would have provided the type of results needed (Merriam & Tisdell, 2016). For this study, the grounded theory approach was not selected because it uses current studies to answer questions and examines more of the process (Merriam & Tisdell, 2016). Although the process is a significant part of understanding perceptions, it does not answer the questions of what leads a Black mother to seek support. Anderson (2013) concluded that the phenomenological design includes discussions that

identify vital accounts related to the phenomenon by breaking down the of meaning into themes and then into categories.

This study used an approach developed by Van Manen (1997) who posited that the heuristic approach allowed for the understanding and analysis of language. This approach was first used in the fields of psychology and nursing. Van Manen (2007) suggested that the hermeneutic approach preforms the relationship between existence and performance. Van Manen (2007) also suggested that a participant's image of an experience can assist in the discernment of the significances discovered. In a study of Haitian mothers, Alex and Whitty-Rogers (2017) used hermeneutic phenomenology to explore the experiences associated with pregnancy problems. These researchers found that the voices of mothers and maternity care workers provided themes around the types of issues that affect maternal/newborn health in Haiti. Alex and Whitty-Rogers found this approach looked at collective experiences to interpret the meaning and allowed for a broader understanding of the voice of the participant.

Participant Selection Logic

For this study, I used purposive sampling, which is identified as sampling that pursues information that can meaningully support learning about a central issue discovered in a research project (Rudestam & Newton, 2015). Participants for this study consisted of 12 Black mothers selected from a sample of mothers from Ohio Health Department clinics. The selection of these clinics was based on the neighborhood base and where many mothers go for care. The criteria for participation in this study

included that the paricipants had to be between the ages of 18-35, and they had to have experienced a preterm birth less than 8 years ago, with no preterm birth in the interim.

The size of the sample was based on most phenomenological studies that engage a small number of participants (Rudestam & Newton, 2015). Pilling (2015) noted that gaining access to study participants was a challenge, and a researcher cannot enter a community with the anticipation of collecting data without consent. For this study, I placed flyers in health department clinics (see Appendix A), and participants voluntarily decided if they wanted to participate.

No known harm was linked to participating in this study. A referral to local services was available for any participant who experienced any residual emotionality because of this study. Each study participant completed an informed consent form (see Appendix B). I thoroughly explained the process of consent. The process included a discussion on confidentiality and how their personal data would be safeguarded.

Both during and after data collection, files and transcripts were stored in a locked cabinet in my home office. No one had access to the transcripts. Distinguishing information was removed from transcripts before validation. I took the following safeguards: No participant was chosen who had any prior relationship with me either professionally or personally, and I personally transcribed all interviews. In the event a participant revealed that we had a prior relationship, that participant would be excluded from the study; however, this safeguard was unnecessary.

My former role as a Certified Child Passenger Safety Technician from 2000-2008 involved the installation and distribution of car seats in two high-risk

communities, which meant I interacted with many new mothers. To limit the possibility that mothers either knew or had contact with me, I excluded any mother who lived in one of these communities. Also, I did not recruit from any of the health care clinics located in those two communities. Finally, if identifying information was mentioned in the interview, I would erase the identifying information; however, this was not required. During the interview, the process of satuaration was used to interview until no new information was given by the participants.

Instrumentation

Data were collected during the interview process and recorded on an audio recorder.The interview focused on the background of the participants, building connections, signing the consent form, and gathering additional information about each participant. During the interview, I described the nature of the study. Rudestam and Newton (2015) recommended that consideration be given to how data are gathered independent of the form these data might take. I addressed the elements of the participants' experiences by asking focused questions. However, I also probed for further details when needed.

Researcher-developed Instruments

At the time of data collection, a significant gap in literature existed concerning Black mothers of preterm babies and their perceptions of social support. No known study had been done that addressed this phenomenon; therefore, there were no existing interview questions. For this study, I designed interview questions to answer the research questions (see Appendix E).

Procedures for Pilot Study

A pilot study is an initial review that takes place before the planned study (Doody & Doody, 2015). For the pilot study, I adminstered the questionnaire to the first two participants to see if they understood the questions and if I was getting the right type of data. Because they did not recommend changes, I used their data. Had they recommended changes, I would have made the changes they suggested.

Procedures for Recruitment, Participation, and Data Collection

Data were collected through one-on one interviews. In advance of the interviews, participants were required to sign an informed consent form that included granting permission for the taping of interviews (see Appendix B). Data were collected during 20-40 minute interviews with participants.

Data were recorded on an audio tape and were stored on a computer with a secure passcode. Data were taken off the computer and stored on a thumb drive. The thumb drive will be kept in a safe deposit box in a local bank for 5 years. After 5 years, all data will be shredded, and all hard drives will be destroyed. At the end of the data collection process, I gave a brief debrief of the process, which included thanking the participants for their time.

Data Analysis Plan

Coffey and Atkinson (1996) noted that data analysis is the "systematic precedures to identify essential features and relationships" (p. 9). The data analysis for this research study involved interpreting the meaning of the information provided. Data analysis included sorting and organizing data into themes to identify any similarities.

The process involved categorizing or coding data in a coherent manner to allow greater discrimination and differentiation between data. I used NVivo software, which allowed for the analysis of data to gain insights.

Issues of Trustworthiness

To make certain that I understood the responses given and to assure clarity and accuracy, I used an interview strategy that included repeating back the participant's responses such as you said, is that correct, or did you want to add anything else? The participants were told that they could have copy of the published study if they wished.

Ethical Procedures

The United States Department of Health and Human Services (2018) Belmont Report is a signed document that outlines three principles that are relevant to research involving human subjects. *Respect for persons* contains two ethical components; first, individuals should be treated as independent agents. Second*, persons with reduced independence* must receive protection. *Beneficenc*e means all persons are treated in an ethical fashion, not only by valuing their decisions and defending them from harm, but by making attempts to protect their well-being. The term *beneficenc*e has two general rules: (a) do no harm and (b) maximize possible benefits and minimize possible harms. Finally, with *justice*, persons are treated ethically by valuing their choices and defending them from harm but also by making attempts to secure their well-being. Such treatment falls under the principle of beneficence. Two general rules are framed as balancing expressions of charges in this sense: (a) do not harm and (b) maximize likely benefits and lessen possible harms.

I abided by all of the principles of the Belmont Report (U.S. Department of Health and Human Services, 2016). I did not approach any potential participants until approved by IRB. I did not ask particiｐnts for any identifying identification. I only used the criteria identified for the study: Black mothers between the ages of 18-35 who had a preterm birth less than 8 years ago, who were not pregnant at the time of the interview process, and who had no preterm births in the interim. I used reflexive bracketing to shape the data collection effort. Before any interview took place, I discussed the signed consent form with each participant, and I asked permission to audio tape.

Summary

In chapter 3, key elements addressed incuded acceptable research method and design for the qualitative phenomonological research study, qualitative research methods, and the design appropriate to solicit open-ended inteviews from the participant mothers. Chapter 4 includes a detailed review of the study that includes particpant demograpics, study environment, and implementation of, or adjustments to strategies stated in Chapter 3. Chapter 4 includes specific data collection, analysis, implementation, and details about the analysis techniques. In addition; Chapter 4 addresses each research question and presents data to support each finding.

Chapter 4. Results

Introduction

The purpose of this qualitative phenomenological study was to explore the perceptions of perceived social support for Black mothers of preterm babies. In this chapter I present an examination of the findings from 12 semistructured interviews with Black mothers of preterm babies in Southwest Ohio. I used open-ended questions to gather data on various viewpoints, such as the meaning of support, types of support, targeted support, and transition from hospital to the home after preterm birth. I developed open-ended questions in the interview protocol to draw out the answers to three research questions that framed this qualitative study. Although the evidence pointed to the importance of social support for new mothers, absent from the literature was the understanding of the significance of percieved social support after the birth of a preterm baby for a particular population of mothers.

This chapter offers an analysis of key themes observed from the results of interviews that centered on gaining a better understanding of mothers' perceived perceptions of social support. This chapter is organized to present information on the pilot study, setting, demographics of participants, data collection, and qualitative data analysis. This chapter also includes evidence of trustworthiness and a presentation of findings and summary.

The Pilot Study

The pilot study and data collection began after receiving IRB approval. Pilot study reviews are conducted to allow researchers to practice and to assess the

effectiveness of their planned data collection and analysis techniques. A well-directed pilot study with clear goals guarantees methodological accuracy and can lead to higher-quality study and scientifically valid work. (Doody & Doody, 2015).

I conducted a pilot study using two participants who experienced preterm birth less than eight years ago in Southwest Ohio. I scheduled the interviews with both participants separately at a time convenient for each. Each participant received an informed consent form to familiarize herself with the study and to give consent to participate in a one-time private interview session.

Both participants completed the informed consent form and gave permission to allow a digital recorder during the interview session. I used the pilot study to test the reliability and validity of the interview questionnaire and to assess the understanding of the interview questions and proper alignment with the research questions. The pilot study participants determined if the instrument needed revision. They recommended no revisions; therefore, I included them in the analysis. Both participants completed the interview, and their responses are included in the results of the study.

Research Setting

The research study took place in locations familiar to families in Southwest Ohio. In all, I distributed 180 flyers (see Appendix A) to 6 clinic sites. Potential participants contacted me by phone to share their interest in participating in the study. During the initial screening, each participant was asked to remain anonymous; therefore, pseudonyms were used.

I identified settings for the study based on the location of the city health clinics. I looked for spaces that provided privacy, comfort, and the ability to record without interruption. The research settings were in familiar areas that were known to families and close to bus lines. In addition, the settings allowed for the flexibility to conduct the interviews without interruptions.

Site A was a board room. When entering the room there was a table with four comfortable office chairs. The room had a door for privacy. Site B was a space equivalent to site A and also included a table, comfortable chairs, and door for privacy. Site C was similar to site A and B in size and comfort; however, Site C was difficult to schedule because of the popularity of the space.

Demographic Data

The study consisted of 12 mothers from Southwest Ohio. I used purposive sampling to select participants who had knowledge of the phenomenon being studied. I identified additional criteria for the study in a brief demographic survey provided to each participant. Table 1 depicts the demographics of the participants, including age, marital status, highest level of education, and occupation. All the mothers qualified for Healthy Start, which is an Ohio Medicaid program for low income mothers with salaries up to 200% of the federal poverty level.

Table 1

Demographics Information

Participant Pseudonym	Age	Marital Status	Highest Level of Education	Occupation	Number of Children
Haven	26-40	S	HS/GED	Employed	3
Dee	26-40	S	HS/GED	Unemployed	5
Kay	26-40	S	HS/GED	Unemployed	1
Kia	18-25	S	Some College	Unable to work	2
Lashay	26-40	S	Less than HS	Unemployed	2
Sheryl	26-40	S	Some College	Employed	3
Shawn	26-40	S	GED	Self-employed	3
Ann	6-40	S	Some College	Student	3
Mariah	26-40	M	Associate Degree	Employed	2
Candy	26-40	M	Master's Degree	Home Maker	2
Veronica	26-40	S	Master's Degree	Employed	2
Joy	26-40	S	HS/GED	Self-employed	7

Data Collection

For the data collection process, I interviewed 12 Black mothers from Southwest Ohio. Data were collected over a 2½ month period. The interviews averaged about 20 to 25 minutes in length. Digital recording equipment was used to record each interview independently. I gave each participant the same protocol and set of interview questions.

The in-person interviews occurred in a private setting using the same interview protocol for all participants. In addition, I recorded observances on the interview field sheet during the interview. All interviews were supported by a semistructured interview guide (see Appendix F) to aid in consistency between study participants. Data collection occurred as outlined in the IRB application without deviations. I traveled to each interview site in advance of the interview to greet the participant and to provide some directional signage for the in-person interview. The time of the interviews varied per participant. Of the 12 mothers, one had an experienced an infant lost in her first pregnancy and others had infants with significant health problems.

Most of the interviews took place on a week day in the afternoon; however, some took place in the evening based on a mother's schedule or her children's schedule. At the end of each interview, I thanked each participant for taking the time to speak with me. Each participant received a $10.00 Kroger gift card and a 25-page community resource packet, which included resources for housing, food, clothing, and mental health services.

Evidence of Trustworthiness

I established credibility of the study by digitally recording the interviews and using them to transcribe the participants' responses accurately. When necessary, I confirmed clarity during the interviews. I accomplished transferability in the study by providing an overview of the research method, data collection process, and results from the data collected. I used phenomenology to provide a rich description of the mothers' perceptions of social support.

I accomplished dependability in the study with a pilot study consisting of two mothers who reviewed the interview questions and to help minimize bias during the data collection process. I accomplished confirmability in the study through triangulation and detailed descriptions of the research method to eliminate bias. This process involved using different participants from multiple neighborhoods in Southwest Ohio and using several quotes from the participants to support findings.

Presentation of Emerging Themes

The following themes emerged from transcripts obtained during the participants' interview sessions. Core themes emerged after reviewing each item individually. The findings yielded 12 core themes (see Table 2),

Table 2

Study Themes

Theme 1	Father of the Baby
Theme 2	Help in Times of Need
Theme 3	Financial Assistance
Theme 4	Government Assistance
Theme 5	Lack of Support
Theme 6	Mom and Baby
Theme 7	Transition Challenges
Theme 8	Depression
Theme 9	Acknowledging Hospital Support
Theme 10	Uncomfortable Support
Theme 11	Unrelated Support
Theme 12	Increase in Assistance

Research Questions

Research Question 1

Data collected from the 12 interviews answered the three research questions. The first research question was: *What were your sources of social support after the birth of your baby?* This question addressed the perception of who provided support to the mother after a preterm birth in Southwest Ohio. To answer this question, I asked a series of open-ended questions from the interview guide. The core themes that emerged during the data analysis were (a) father of the baby, (b) help in times of need, and (c) financial assistance. Research Question 1 themes corresponded with the following interview questions (IQ).

- IQI. When thinking about the stages of your pregnancy (beginning, middle and end) who were the people closest to you during that time?
- IQ2. What does social support mean to you?
- IQ3. What types of support did you receive from family or other people?

Theme 1: Father of the Baby. All 12 participants responded to the question presented in the interview protocol. When asked, "*When thinking about the stages of your pregnancy (beginning, middle and end), who were the people closest to you during that time,*" all participants remarked that the baby's father was the closest during the stages of pregnancy. Kay said, "Mom, the child's father, and the grandmother." Haven said, "My baby daddy." Sheryl said, "His dad was there." Lashay said her father: "He was very supportive." Mariah said, "My husband and our close friends." Kia said, "My boyfriend, he was always there even when I was mean to him during my pregnancy; he was always

there for me." Shawn said, "Her [the baby's] father." Candy said, "My mom and my husband." Ann said, "The dad. We are still together." Joy said, "My mom and my closest friend." Dee said, "My mom." Veronica said, "My mom was the closest trying to keep me mentally stable."

A follow up question was *Who the most helpful?* The response to this question shifted from the father of the baby to the mom and other friends. Five participants mentioned their mother. Kia said, "My mom helps me a lot; I could talk to my mom a lot." Candy said, "But my mother has been my rock." Kay said, "My mom." Dee said, "My mom was with me at home and in the hospital." Ann said, "My mom and my step mom." Lashay said, "My other children; they helped out too. My oldest daughter who's 13, she helped me with her a lot; she's a big help. After I had him, she kept him." Sheryl said, "I don't know." Haven said, "My baby daddy and my two oldest girls." Shawn said, "My child's father. He was the most helpful." Veronica said, "My oldest daughter. My 7-year-old daughter." Mariah said, "Cradle Cincinnati (city-wide program for pregnant women)." Joy said, "It's a tie. There were things my mom was able to help with and things that my closest friend wasn't able to help with." Shawn said, "My cousin and my sister. I stayed with them most of the time."

Theme 2: Help in Times of Need. All 12 participants responded to the question presented in the interview protocol: *What does social support mean to you?* Eight participants mentioned someone who helped or supported them. Lashay said, "Someone who helped you when you're down." Candy said, "People that can help you in times of need." Joy said, "Somebody to help and someone to actually listen." Haven said, "People

who help you after you give birth and before." Dee said, "It means a lot; it shows that

someone is willing to help." Kia said, "I would say social support is the support you get

from the people you interact with on a daily basis." Ann said, "It does make me think

more of the community. More of how does the hospital care for you?" Mariah said, "Um,

social support to me is pretty much support that one receives from the people around

them, doesn't have to be specifically family, but neighborhood." Veronica said, "That's

anyone who is wanting to see you do well."

Some of the participants mentioned someone they could communicate with. Kay

said, "Eases stress. Someone I can talk to. I don't ever feel alone." Shawn said, "Um, it

means a lot." Sheryl said, "Being there to talk to. They don't even have to be … it could

be a stranger."

Theme 3: Financial Assistance. During the interviews, all 12 participants

responded to the question presented in the interview protocol: *What types of support did*

you receive from family or other people? Seven participants expressed that the type of

support they received was financial support. Candy said, "Financial is number one. My

parents helped us financially." Mariah said, "Um, a lot, babysitting, uh, from time-to-time

when I needed diapers. They would give me money and wouldn't ask for it back." Kia

said, "I definitely got financial support." Veronica said, "Financial, um definitely." Kay

said, "The organizations bring books; they help me with diapers and pampers." Shawn

said, "I didn't have a bed at the time. My sister's dad, he came and got me a bed, a blow-

up bed." Joy said, "Friends helped with clothing, my cousin helped with clothing sometimes."

Some participants expressed emotional support. Ann said, "You know a back massage, a foot rub." Dee said, "People got her [the baby], so I could rest." Lashay said, "I had someone to keep the baby for me for a while, so I could rest." Haven said, "I didn't." Sheryl said, "I didn't really."

Research Question 2

Research Question 2 asked: *How do Black mothers of preterm babies perceive changes in social support as they transition from hospital to home?* The themes that emerged were (a) government assistance, (b) mom and baby (c) transition challenges (d) depression, and (e) acknowledging hospital support. Research Question 2 themes correspond with the following interview questions:

- IQ4. What sort of social supports are available from organizations?
- IQ5. Do you feel the that the support from family or friends was directed towards you or the baby?
- IQ6. Did you face any challenges as you transitioned from your hospital stay to your home?
- IQ7. How do you compare the social support you received at the hospital to what you received during your period of rest at home?

Theme 4: Government Help. All 12 participants responded to the question presented in the interview protocol, *What sort of social supports are available from organizations* Six participants remarked that they were receiving some type of

government assistance. Ann said, "I know I got Women Infants and Children (food stamps program). WIC is wonderful." Kia said, "WIC helped a lot. Because I was so hungry during my pregnancy, it was overwhelming." Mariah said, "Hamilton County JFS (food stamps and cash assistance program). Of course, I was getting food stamps, cash assistance." Joy said, "At that time, I was getting Ohio Works First (OWF) (Food Stamps, Cash Assistance Program). I also got Medicaid." Candy said, "The only organizations would be like the Medicaid." Haven said, "I was getting gift cards from my Jobs and Family Services Case Manager."

Four participants mentioned that they never received or reached out for support. Sheryl said, "I didn't really. After I tried to get some counseling, it was a dead end." Shawn said, "I didn't have any." Lashay said, **"**I never knew how. I mean …. I thought family member was for support." Joy said, "I primarily used my family more than anything." Others expressed how they were connected to the hospital support programs. Kay said, "breastfeeding / lactation support." Veronica said, "The Hospital, Neonatal Intensive care Unit (NICU) and March of Dimes."

Theme 6: Mom and Baby. All 12 participants responded to IQ5: *Do you feel that the support from family or friends was directed towards you or the baby?* Five participants expressed that the baby received more support. Ann said, "They know I am strong. We have a new baby, a new life. It is no longer about me and my temperature. It's about baby's temperature. It is baby's turn." Joy said, "It was more for the babies (twins)." Sheryl said, "The support was directed towards the baby." Shawn said, "Once I

had the baby, they were like, ain't got no choice but to help you." Kay said, "40% was for me, but the other 60% was for the baby."

Six participants remarked that support was directed toward both mom and baby. Candy said, "In the beginning, first, it was me but even now it is both." Kia said, "People are worried about my wellbeing including baby's well-being." Dee said, "It was the same. I came home before the baby did." Lashay said, "I had a friend who came um… and helped me, to make sure I was okay as well as the baby was okay." Veronica said, "Both, as I mentioned, people helped with both of us." Mariah said, "That is hard to answer. If it is helping me, it is helping them. It's been strictly for them." Haven said, "Neither one. I didn't get any support from anyone, just my baby daddy."

A follow up question from IQ5 was, *What kinds of support was provided for the baby?* Joy said, "clothing and Pampers." Candy said, "Watching and taking care of him. Mariah said, "Keeping the kids so I could make doctors' appointments." Lashay said, "They did stuff for her while I was on the medications." Ann said, "encouraging words." Kay said, "I am having a home situation, and I had to get legal aid (community lawyers/ advocacy program) involved. It wouldn't have happened if I didn't have the baby." Kia said, "A baby shower with family and friends." Veronica said, "March of Dimes." Shawn said, "Once I had the baby, I would say, 'Granny, I need to borrow money for such and such.' She would say, 'It's for the baby? Okay, I got you.'"

Two of the mothers shared that they did not get any support. Sheryl said, "When he was born, they were there, but then when he died, I feel like they were focusing on

him. Once he was gone -they were gone too." Dee said, "People helped watch her, so I could rest." Haven said, "I didn't get any support."

Theme 7: Transition Challenges. All 12 of the participants responded to IQ6: *Did you face any challenges as you transitioned from your hospital stay to your home?* Eleven participants experienced some type of challenge after transitioning from the hospital to home. Shawn said, "Honestly, I kind of did not communicate with everybody. My baby, he was sick. We were going through so many doctors and stuff. Appointments were so long, and I use to be so tired." Candy said, "My blood pressure. I went back to the hospital after he was a week old."

Other participants mentioned issues with infant health, post-partum care, and housing. Ann said, "The baby was spitting up milk. She had some acid reflux issues. Because she was preterm, she needed to sit up longer." Kay said, "I had stiches… barely walk, barely could move. Barely could hold my daughter." Joy said, "So, in between the times I had the twins, my house got lead abated. So, we had to move in with my dad. Having two newborn twins, it was kinda hard." Kia said, "Breast feeding has been a struggle for me because I wanted to breast feed the baby. Dee said, "Her oxygen. She came home on oxygen. Her stats dropped, and you had to keep rushing her back."

Lashay said, "It was more like I got to hold her, but she stayed in the Neonatal Intensive Care Unit. I didn't have her all the time while I was in the hospital. Now when I was at home, I had to cater to her." Mariah said, "The waiting times for assistance. They had to do verifications. I would have the appointment, but the appointment wouldn't be

for another 30 days, so I would have to scrounge up money for that month." Haven said, "No." Veronica said, "I was not able to pump milk. They did not want me to put her on formula." Sheryl said, "My baby passed. I was sad, I needed someone to talk to, just to listen."

Theme 8: Depression. When talking about challenges during transition, nine participants expressed that they were depressed, experienced anxiety, and stress or felt isolated. Kia said, "I get a little depressed. When my friends see me post stuff on Facebook, they check up on me." Sheryl (after infant loss) said, "I didn't feel like I had any support. After maybe a week, everybody was gone. I didn't want to be a burden. I would sit in my house by myself, and I would cry for a long time." Shawn said, "It was times where I was so depressed, I wouldn't take a bath for a whole week." Veronica said, "Depression—I actually dealt with that with my oldest daughter, but it never went away. It just got a little worse." Joy expressed the following:

> There were times I felt depressed, but I didn't tell anybody that. I just fought through it on my own. I don't know. In my house it was looked at wrong, like you don't need a counselor, you be all right. You strong and all that.
>
> Candy said, "I had to keep my anxiety down. I was like… 'just relax it's going to be all right.'" Ann said, "I was a little emotional, reading to her was not a focus or an outlet, where it could have been. Let me just read to my baby even when I am crying." Kay said, "So having a busy day and her being very bothered, it bothers me. It's like everything I do is never enough; she just cries. Sometimes it's a mental thing. Like draining." Mariah said, "Sometimes when you are younger, you are trying to figure out

what is going on in a relationship when you really have to figure out what's going on with your kids, so it's like, trying to do both; it's stressful." Haven said, "I did everything by myself." Lashay said, "She stayed a week or two longer in the hospital. I was trying to cope with that." Dee said, "It was a lot."

Theme 9: Acknowledging Hospital Support. All of the participants responded to IQ7: *How do you compare the social support you received at the hospital to what you received during your period of rest at home?* The participants shared that they received more support in the hospital than at home. Ann said, "It was a different kind of support. Family helped me a lot at home. The hospital was great too." Candy said, "I have to say that they were very good at Good Sam Hospital to the point that it was annoying." Sheryl said, "More support in the hospital." Veronica said, "I had more support in the hospital." Joy said, "I feel like the hospital spoiled me." Lashay said, "In the hospital, they always had her. She was in the NICU and I just went to visit her." Mariah made the following comment:

> Well, I felt like most of it was a domino effect. When I had her, the social worker came in and asked me if I could think of anything I needed. She said she would put a bug in the ear of such-and-such about what I needed.

Some participants mentioned that they had a pleasant experience in the hospital and at home. Kia said, "I like the support better at home because I'm in my comfort zone. Its more relaxed." Kay said, "The same people that came to the hospital to see me were the same people that came to see me at home." Dee said, "The workers at the hospital and

my social worker helped me." Haven said," I didn't have them help me. I knew what to do." Shawn answered thusly:

> Um, as far as the hospital, they came and visited and brought us food. As far as home, there was more cause they had to do more. At home they had to really step up. They didn't have to, but they did.

Research Question 3

The third research question for this study was: *What leads a Black mother during the period after the birth of a preterm baby to seek social supports?* All the participants expressed their reasons for seeking support. Some of the themes for Research Question 3 were (a) uncomfortable support, (b) unrelated support, and (c) increase in assistance. The Research Question 3 themes corresponded to the following interview questions:

- IQ8. Usually people show their support and affection according to their own understanding. Do you recall any gesture of social support that could have become an inconvenience to you?

- IQ9. Can you recall instances where the kind of social support you were receiving, either from an individual or an organization, seemed irrelevant to you?

- IQ10. If you could walk back in time and be there to extend any kind of social support to yourself, what would you do?

Theme 10: Uncomfortable Support. All 12 of the participants responded to IQ8: *Usually people show their support and affection according to their own understanding. Do you recall any gesture of social support that could have become an inconvenience to you?* Nine participants mentioned that they did not feel that the support they received was

inconvenient or uncomfortable for them. Ann said, "No." Candy said, "No. Everything was perfect." Lashay said, "No Ma'am." Sheryl said, "No." Veronica said, "No; most of it was genuine concern." Mariah said, "Um, no." Haven said, "No." Dee said, "No."

Three participants expressed situations where the support was uncomfortable for them. Joy said, "I really didn't want a baby shower with my twins. I felt like to me it was really their dad's side of the family. I felt like that was a judgmental family." Kia said, "I would have to say the only thing is my friends popping up without calling me. That could be super inconvenient, and sometimes I want to be alone; other times I don't." Kay said, "Sometimes the home visits could be inconvenient for me."

Theme 11: Unrelated Support. All 12 of the participants responded to IQ9: *Can you recall instances where the kind of social support you were receiving either from an individual or an organization that seemed irrelevant to you?* Ten participants responded in the negative when asked about support that was unrelated to them. Haven said, "Uh." Dee said, "No, I had my family." Candy said, "No. Everything was about me and my son." Mariah said, "No. Any support that I have received has been related to me or specifically for me." Kay said, "Everything I went through was relevant for me and the baby." Ann said, "Let me think. No." Joy said, "I can't answer that one. I don't know." Kia said, "I was going to be in it, but then they said that they will visit me two to three times a week, and I told them I didn't want to be in it anymore." Lashay said, "No. I can't." Sheryl said, "No." Veronica said, "No. I can't think of anything." One participant remarked about a gift she received. Shawn said," I guess all the gifts. Some people brought gifts for the baby that I didn't even use."

Theme 12: Increase in Assistance. All 12 participants responded to IQ9: *If you could walk back in time and be there to extend any kind of social support to yourself, what would you do?* Seven participants responded that they would have reached out more. Lashay said, "I probably would have reached out to an organization, so I knew how to cope with not having the baby home with me." Kay said, **"**I would've joined the programs and volunteered before I was pregnant." Dee said, "Not really." Joy said," I would utilize more of the services that were offered by Help Me Grow (a voluntary family support program for pregnant women) and all of that." Kia said, "I would also like to extend my time with a lactation consultant." Sheryl said, "Counseling would have definitely been a big support for me." Haven said, "That was a minute ago. I didn't have social support outside my family."

Other participants expressed the need to take care of themselves and work with their families. Ann said, "Taking care of myself. Take time out for myself." Candy said, "I wouldn't get pregnant right when I did. I would have waited." Shawn said, "Families need to stick together. There were times when I only wanted to talk to my family and certain people. You don't want to call them cause your pride to big; you really need them, just let the petty stuff go and stick together." Veronica said, "Embrace this, even though you don't want to. Some people feel like they can do this on their own. You can't; you can't do this on your own." Mariah said, "Stress less."

Summary

After reviewing the interview questions and transcripts, the mothers' perceptions began to become clear. All the participants viewed social support as someone available

and someone who could help. The participants found the experience after birth extremely problematic and felt that they received more support when in the hospital setting. Many saw family and friends as their source of support and the baby's father as their closest support. Many participants experienced depression coupled with significant health issues after the birth of their preterm baby.

All participants explained that they were not prepared for this adjustment in the birth experience, and the reason they sought support was because of the fear of losing their child or hurting their child. The responses demonstrate a need for a contingency plan when a baby is born prematurely. Chapter 5 provides greater insight into the study findings, limitations of the study, implications for social change, and recommendations for future research.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this qualitative study was to explore the phenomenon of perceived social support for Black mothers of preterm babies in Southwest Ohio. A sample of 12 mothers participated in this study. The objective of the study was to gain a deeper understanding of how Black mothers of preterm babies perceive social support. I examined data from Chapter 4 for interpretation of the in-depth thoughts from participants. Chapter 5 contains a thorough discussion of the study findings, including identifying themes about the research question, the relationship of themes to existing literature, limitations of the study, recommendations for leaders and future leaders, and implications and a conclusion.

Interpretations of the Findings

The findings from this study may help improve social support for Black mothers of preterm babies in Southwest Ohio and across the nation. The research findings underscored important perceptions of Black mothers concerning social support after preterm birth. The cause of this public health problem is unknown; however, it is partially attributed to mulitfaceted systems related to social inequalities (Sealy-Jefferson et al., 2015). In Chapter 2, I also showed that although Black mothers of preterm babies have some of the worst health outcomes, they also have a high incidence of depression, they experience challenges when transitioning from hospital to home, and they lack an awareness of the long-term impact of preterm birth on the physical and mental health of the baby.

Sadly, few interventions are in place to support these mothers. Futhermore, the gap in literature showed the significance of different types of perceived social supports after the birth of a preterm baby. Mills and Zhang (2013) found that family, friends, community, personal contacts, and organizations could lessen the extremities of hardships and reinforce social networks that could enrich the health of both mothers and their babies. The outcomes from my study confirm some of the findings from prior literature and add to the existing body of evidence that underlines the significance of social support after preterm birth for Black mothers

The emerging themes from this research study are consistent with findings from the literature presented in chapter 2. These themes include (a) father of the baby, (b) help in times of need, (c) financial assistance, (d) government assistance, (e) lack of support, (f) mom and baby, (g) transition challenges, (h) depression, (i) acknowledging hospital support, (j) uncomfortable support, (k) unrelated support, and (l) increase in assistance.

The social ecological model provided the framework for this study. The model is comprised of five levels of reinforcement (McCormack et al., 2016). First, the individual level includes individual awareness attitudes and actions. Second, the interpersonal support consists of the formal and informal networks that can affect behavior, such as family, friends, peers, coworkers, and customs. The third reinforcement is a community, which includes connections with organizations, institutions, and informational networks. The fourth level is organizational, which is social institutions with guidelines and

principles. The final level of reinforcement is policy/enabling environment, which includes local, state, and national policies involving the distribution of resources.

Bronfenbrenner (1994) created the social-ecological model to advance the awareness of the relationships of various personal and environmental factors. The social ecological framework for human development applies social ecological models for human development. It also allows for the examination of personal and environmental influences, which determine behavior.

Research Question 1

The following was the first research question for this study: *What are the sources of social support for Black mothers during the following the birth of a preterm baby?*

Father of the Baby. During data collection, several participants mentioned that during the stages of pregnancy, the father of the new baby was their closest support. This supports similar findings by Coates et al. (2016) whose qualitative study found the father to be the closest relationship for mothers. However, these findings are not the same as those of other researchers. Cheng et al. (2016) opined that mothers who experienced real partner support experienced lower anxiety and reduced depression indicators from pregnancy to postpartum.

Despite the father's closeness, many of the participants of this study noted anxiety and depression during the period after the birth of their preterm baby. Cheng et al.'s (2016) study examined postnatal depressive symptoms of mothers and fathers but focused on the impact on a child's early cognition function. A follow up question in this study was: Who was the most helpful? Most of the participants noted their mothers;

however, some mentioned other family members and friends. This is in line with the findings of Taylor and Conger (2017) who noted that kin support, which is the support of parents, siblings, and extended family members, was linked to positive outcomes in psychological adjustments and improvements in parenting practices.

Help in Times of Need. The data I gathered from the participants' responses showed similarities in the definition of social support. Most of the participants mentioned the word *help*. Other words and phrases used were care, support, someone to talk to, someone who could be there, and someone who would listen. The words and phrases expressed the need for someone who could provide reassurance. These findings are consistent with Geens and Vandenbroek's (2014) findings that social support is the help a person gets from close relationships. The findings from my study are also consistent with Giurgescu et al. (2015) who found that perceived social support indicated a sense of being cared for and having someone who would recommend advice and provide help if necessary. The current study adds to the existing study definitions and incorporates social support as an opportunity for on-going connection.

Financial Assistance. According to Elliott et al. (2013), Black mothers and their children are twice as likely to experience financial difficulty and live in hardship than are other ethic groups. The common patterns and phrases from the data from my study aligned with this viewpoint; participants mentioned appreciation for the purchase of items for mom and baby and monies given that did not have to be paid back. Even when the term financial was not used exactly, participants discussed watching the other children, which saved them money for a baby sitter, and rides back and forth to the doctor's office,

which saved them bus fare. These study findings do not agree with findings by Garret-Peters and Burton (2016) who noted that overall support was not sufficient and did not extend to financial support. However, it should be noted that Garret-Peters and Burton's study was conducted with rural Black mothers who had not given birth prematurely.

Research Question 2

The following was the second research question for this study: *How do Black mothers of preterm babies perceive changes in social support as they transition from hospital to home?*

Government Assistance. According to Mills and Zhang (2013), the greater the exposure to hardship associated with weaker support networks suggests that publicly-financed benefit programs should be directed to those less likely to get support. During the analysis of data gathered from the 12 participants, several of mothers shared that the use of government assistance was essential. Participants mentioned programs such as WIC, SNAP, Medicaid, and TANF, which provided much needed help and support throughout the pregnancy. The participants also noted that although pride often got in their way, these government programs were how they were able to meet their needs.

Lack of Support. A strong argument exists that social support improves health outcomes and decreases the risk of premature death (Holt-Lunstad et al., 2017). Several of the participants commented on their lack of support. The participants felt that they did not know how to get support, supports were unavailable, or they only saw family as the source of support. Two participants noted that they received support from hospital-based programs. These findings support similar findings by McLeish and Redshaw (2017)

whose descriptive qualitative phenomenological study examined pregnancy and early parenthood and found that most mothers had considerable unmet needs. It is inexcusable that some new mothers leave the hospital setting unaware of a contingency plan for support. The acknowledgement of not knowing how to seek support after preterm birth presents an opportunity for a greater understanding of education and support services in communites of color.

Mom and Baby. Several of the participants responded to the question of where support was most targeted? Six mothers remarked that "people helped with both of us." Mothers felt that a specific focus was on both mom and baby. Participants mentioned that they struggled with their own recovery and were unable to develop strong bonds with their babies. The mothers expressed fear and anxiety about their baby's health and well being. These findings support findings by Barkin et al. (2014) who found that hosptials and social service agencies focused a great deal on the care of the development of the infant. However, in Barkin et al.'s qualitative study on barriers to support during the postpartum period, the participants responded that mothers caring for themselves was vital to maternal well-being.

Transition Challenges. According to Boykova and Kenner (2012), two distinct transitions occur after preterm birth: (a) transition to motherhood and (b) transition from hospital to home. A strong disconnect exists between the expectations of bringing home a fragile infant and how that differs from a normal birth experience. The findings showed that new mother's isolation, health issues (e.g., diabetes, high blood pressure, anuerysms,

and experiences after a cesarean section) coupled with the birth of a preterm baby added to a new mother's anxiety and lessened the excitement of transition.

The findings from the current study add to the existing data regarding transition from hopsital to home. These findings are consistent with Smith et al.'s (2013) findings. Smith et al. found that mothers felt hurried and unsure of their ability to care for their children after hospital discharge. In a similar study, Phillips-Pula et al. (2013) examined a vulnerable population of parents of infants and found those parents felt an array of emotions (e.g., grief, depression, and anxiety). Phillip-Pula et al.'s findings differed from McGowan et al.'s (2017) findings. McGowan et al. argued that mothers on Medicaid expressed positive responses about well-being and assurance in caring for their children. McGowan et al. further noted that only those mothers with mental health disorders reported negative experiences after transition. These researchers also found that Black mothers were particularly vulnerable and faced significant barriers more often than other races. In summation, these mothers were not getting the support they needed.

Depression. More than half of the participants in this study expressed feelings of depression, anxiety, and stress. These findings were consistent with Schappin et al. (2013) who argued that preterm birth could be more stressful for parents based on uncertainty about survival, medical issues, and the long-term effects of infant prematurity. In a study of Black mothers and depression, Atkins (2017) found that 70% of Black mothers of premature babies described symptoms consistent with slight depression.

In this study, the findings are similar to Atkins's (2017) study, yet are more heightened, as 75% of Black single mothers of preterm babies described symptoms consistent with a slight diagnosis of depression. My findings do not support the findings of Seplowitz et al. (2014) who found that the experience of depression did not affect all mothers. Seplowitz et al. looked at Hispanic mothers of low socioeconomic status. Their findings also showed that Black mothers were not using resources and supports for anxiety and depression. Furthermore, a need exists to identify specific interventions that include education, cultural awareness, and community resouces for Black mothers of preterm babies.

Acknowledging Hospital Support. In reviewing the data from my study, I found that several participants agreed that they received more support in the hospital compared to the support they received at home. Some of the comments suggested a positive relationship with nurses, doctors, and social workers. One participant noted that she felt as though the hospital spoiled her.

Many participants felt that the support at home was different from the support given in the hospital because the doctors and nurses were there for the new mothers all the time. Many participants felt they had the support they needed in the event something happened. In line with these findings are the findings of Boykova and Kenner (2012) who examined women and their transition from hospital to home and found that the women looked to the healthcare professional for guidance. In addition, Enlow et al. (2017), whose study found that mothers valued the support that NICU nurses and HVs provided, also thought more community resources would be helpful.

Research Question 3

The following was the third research question for this study: *What leads a Black mother during the period after the birth of a preterm baby to seek social supports?*

Uncomfortable Support. According to Garrett-Peters and Burton (2016), the actual quality of social support available from kin was erratic and caused problems for the mother. These findings do not agree with the findings of the present study as several participants echoed the same or similar reasons why they felt the support they received was not awkward nor uncomfortable. One participant noted that she really did not want a baby shower with her twins. She felt it was really for the father's side of the family. She said, "I felt like that was a judgmental family." Garret-Peters and Burton suggested that support often came with a questionable quality of resources. The researchers found this support was restricted, irregular, and untrustworthy because of limited income and personal problems experienced by the family.

Unrelated Support. Most of the participants in this study felt that the support they received was relevant to them and their children. One participant said, "Any support that I have received has been related to me or specifically for me." Another participant mentioned a ceramic angel she received from a co-worker. The participant saw this as an unrelated gift for the baby. The overall perception was that the support received was for the mother and her child.

Increase in Assistance. Several of the participants in this study expressed the need to reach out for more support. The words or phrases used included reached out more, joined more programs, used more services, and extended time with existing

organizations. This finding supports the study of Anderson (2013) who examined support groups. Anderson found that all participants divulged the significance of getting support from a partner, family member, or friend would increase associations, build networks, and enhance emotional health and empathy rather than loneliness.

Limitations of the Study

Limitations existed in generalizing this population of participant Black mothers in Southwest Ohio. The themes emerged after one interview with each of the 12 Black mothers of premature babies. During this process, communication was difficult as many potential participants did not have their own phones and had to borrow phones from their mothers, boyfriends, family members, or friends. This made it difficult to set up interviews. I had to leave messages with family and friends to get a mom to call back and identify a date for the interview. This smaller sample size of 12 participants does not reflect the entire population of Black mothers of premature babies in Southwest Ohio. For generalization to a larger population, possibly a quantitative study would be more representation of the Black mothers of premature babies.

The data collection in this study allowed for potential participants to contact me if they were interested in the study. Further, the inclusion criteria for this study called for participants who had a preterm birth less than 8 years ago and did not live in or seek healthcare services in the communities of Avondale and Price Hill, which excluded individuals who lived in those communities.

Recommendations

The emerging data and themes from this study add new information about the needs of Black mothers of preterm babies in Southwest Ohio and their perceived social support. According to the research findings, a lack of knowledge about preterm birth and the experiences before, during, and after birth of a preterm baby can affect the health and wellbeing of Black mothers who experience anxiety and depression. Many participants in this study saw the hospital as an important source of support. Recommendations to the findings include the following: (a) pre-discharge assessment, (b) Ronald McDonald House Charities, (c) the use of a quantitative prenatal questionnaire, (d) in-hospital culturally appropriate training for staff and patients, and (e) a discharge process review.

Transition Plan

According to the findings, a need exists to identify a transition plan for mothers before they bring a preterm baby home from the hospital. Based on insurance constraints, a premature baby could stay in the hospital for several months. Developing a transition plan should include an assessment of all Black mothers prior to discharge, and hospital staff should ask the mother if she feels she needs more time in the hospital (for example, a step-down process plan).

Ronald McDonald House

The Ronald McDonald House Charities (RMHC) provide the opportunity for new mothers and babies to stay together and be close to needed hospital resources. However, at the time of data collection, this was not an option for mothers who lived within the community. The RMHC are designed to strengthen families, help them cope with their

situations, and provide guidance and support. What this study found was new mothers need more support before bringing their premature babies home from the hospital. The opportunity for a mother of a premature baby to spend time in a home/hospital setting before transitioning home could ease some of the burden and stress on the mother. The findings indicated that Black mothers see hospital supports as more appropriate than home. The RMHC are located inside or near hospitals to provide a smooth transition for families. However, they are not designed as a step down or training space.

Prenatal Questionnaire

According to the findings, a need exists for a better understanding of preterm birth and the long-term impact on the baby. A questionnaire that outlines the experiences of preterm birth could assist in preparing mothers for what could happen, how it can affect their birth experience, and their overall life course. Quantitative data could assist the obstetricians or healthcare professionals by providing the understanding of the mother's knowledge regarding premature babies and their needs, and how these healthcare professionals can better support the mother during her visits.

In-hospital Culturally Appropriate Training for Staff and Patients

The socioecological model gives insight into the need for multiple levels of support among the individuals, families, and the community. This support can reinforce the need for consistency for the Black mother of a preterm baby. Identifying family-centered care opportunities may guide individuals in the development of contingency plans after the birth of a preterm baby. The findings outline the challenges new mothers face, not only with their own health, but with the health of the baby.

Social Change Implications

This qualitative research study explored how Black mothers of preterm babies perceived social support. I wanted to understand how the cultural perception and interpretation could influence the decision to use social supports after the birth of a preterm baby. Research studies regarding social supports for Black mothers of preterm babies were limited at the time of data collection. However, the need to address social support for Black mothers after the birth of a preterm baby is a growing need and one that may change the life course for mothers and their babies.

From the data analysis, the 12 themes were important to address the research questions. In addition, these themes provided new understandings and knowledge to address the gap in literature regarding the needs of Black mothers. This study, together with available literature, provides a strong basis for obstetricians to develop a strategy to support Black mothers better at all levels of their pregnancy, and to explain what may occur when an infant is born preterm. For hospital professionals, this study provides guidance on the planning process during an early birth. Many mothers shared that they were ill-prepared for what was happening to them and their babies.

Positive social change could take place because of this study. At present, pregnant women expound on the book, *What to Expect When You're Expecting* (Murkoff, & Mazel, 2016). The book provides pictures, discusses symptoms, and illustrates the different stages of birth. Nothing could be found for the mother who had given birth prematurely. Nothing exists that provide a cultural framework for these mothers. The results of this study may provide obstetricians, healthcare workers, and healthcare

practices with additional culturally-responsive training that may meet the needs of a diverse population. The mother-child relationship is affected by the experience of preterm birth, and the lack of knowledge often accompanying this experience could represent a lifelong course of disability for the child.

Recommendation for Future Research

Based on the findings from the 12 participants, future research recommendations include expanding the sample size to gain additional knowledge. Future researchers should also consider expanding their studies to other communities and to other races and ethnicities. Additional information is needed regarding a father's perception of social support. In addition, future researchers should address NICU nurses to obtain their perceptions of social support given to mothers of premature babies.

Recommendations for Practice and Policy

Discharge Process Review

The findings suggest that Black mothers of premature babies are leaving the hospital without resources, in poor health, and unable to care for their babies. The mothers in this study experienced fear and anxiety regarding their child's survival and their ability to take care of their premature child. This amount of time without support is not prudent, can lead to additional hospital stays for the baby, and increase depression in the mother.

Dissemination

The results of this study will allow me to see and share the issues with community stakeholders, council leaders, and policy makers. My plan is to present the findings in

peer- reviewed journal articles. I also plan to disseminate the results of the study locally, statewide, nationally, and globally. I plan to conduct presentations, seminars, podcasts for Black women's organizations, community stakeholders, community councils, churches, city councils, health departments, and community and social organizations that work with mothers of preterm babies.

I will also conduct presentations, seminars, podcasts for state-wide organizations such as Health Policy Links-Ohio, Ohio Department of Health, Governor of Ohio, and the Office of Minority Health (Families USA, 2014). On the national level, I will conduct presentations, seminars, podcasts for the American Public Health Association, City Match, YWCA, Zero to Three, CDC, NICHQ-National Head Starts Organizations, and Maternal Child Health Organizations and Pediatric Societies. Finally, I will conduct presentations, seminars, podcasts globally for the World Health Organization, UNICEF, and other global organizations that look at maternal child health and post-partum care for women.

Conclusion

This study allowed me to see social supports through the eyes of 12 Black mothers. During this process I realized that additional supports are needed that address this population. Social supports are designed to act as a buffer during adverse life events. The life events for these participants are on-going. A need exists for a doctor/nurse/patient consultation before discharge. Although several packets are provided to mothers, some mothers are not ready or are unable to read through the host of materials to find what they need.

The increase in preterm births is a reflection on poor maternal health, system analysis, and socio-economic conditions. The participants in this study did not mention the joys of motherhood or what it meant to hold their new child because they were too busy dealing with health issues, locating food, and handling medications. Mothers used the words *afraid, fear, tired, needed help, unable, lonely*, and *scared* when talking about their experiences after the birth of a premature baby. After reviewing the results, I felt mothers have the ability and knowledge to coproduce solutions. I also felt that a part of the patient-family centered model should include ideas and suggestions from the mothers.

According to the World Health Organization (2015), recommendations and guidelines for postnatal care for mother and newborns' postnatal care should begin the first 24 hours after birth, mothers need at least 4 postnatal checkups the first 6 weeks, and mothers need to remain in the hospital with their newborns at least 24 hours without discharge. In addition, the guidelines include psychosocial support and the use of mental health strategies for those mothers difficult to reach.

Most if not all these guidelines can lessen the burden on the mother and the child after birth. Even in baby-friendly hospitals, the process after preterm birth leads to anxiety, confusion, and insecurity in the ability to care for a child. The participants in this study made it clear that they needed more support, they were not well themselves, and they were not prepared for what was to come.

A unique bonding occurs with mother and child after birth that appeared nonexistent in most of the participants' perceptions of their birth experience. An even greater need exists to build support networks in neighborhoods of color. This study noted

that mothers were unclear of the expectations of preterm birth and transition of care from hospital to home. This study illustrates the need for trusted relationships amongst the health professions and their patients, so that mothers can share their needs.

The findings of this study also highlight the issues of depression among low income mothers and the need to focus strongly on social support networks that can encourage mothers and help remove some of the hardships. Recognizing that moms felt that they received more support in the hospital than at home is a resounding signal that many homes are not ready for a fragile, preterm new born. Just the thought of bringing a child into an environment that is ill prepared for his or her care brings on anxiety and stress, which is coupled with the inability to provide adequately for that child. Black mothers are particularly vulnerable for multiple reasons; therefore, new strategies must be designed to meet the needs of this population of mothers.

References

Adama, E., Bayes, S., & Sundin, D. (2016). Parents experiences of caring for preterm

    infants after discharge from neonatal intensive care units: A meta-synthesis of the

    literature. *School of Nursing and Midwifery, 22*(1), 27-51.

    doi:10.1016/j.jnn.2015.07.006

Ahern, K. J. (1999). Ten tips for reflexive bracketing. *Qualitative Health Research, 9*,

    407-411. doi:10.1177/104973239900900309

Aizer, A., & Currie, J. (2014). The intergenerational transmission of inequality: Maternal

    disadvantage and health at birth. *Science*, *344*, 856-861.

    doi:10.1126/science.1251872

Alex, M., & Whitty-Rogers, J. (2017). Experiences of pregnancy complications: Voices

    from central Haiti. *Health Care for Women International*, *38*, 1034-1057.

    doi:10.1080/07399332.2017.1350179

Almeida, J., Mulready-Ward, C., Bettegowda, V. R., & Ahluwalia, I. B. (2014).

    Racial/ethnic and nativity differences in birth outcomes among mothers in New

    York City: The role of social ties and social support. *Maternal Child Health*

    Journal, 18, 90-100. doi:10.1007/s10995-013-1238-5

The American College of Obstetricians and Gynecologists Women's Healthcare

    Physicians. (2016). *Preterm (premature) labor and birth.* Retrieved from

    https//www.acog.org/Patients/FAQs/Preterm-Premature-Labor-and-Birth#what

Anderson, L. N. (2013). Functions of support group communication for women with postpartum depression: How support groups silence and encourage voices of motherhood. *Journal of Community Psychology*, *41*, 709-724. doi:10.1002/jcop.21566

Atkins, R. L. (2017). Outcomes of depression in Black single mothers. *Clinical Nurse Research*, *26*, 464-483. doi:10.1177/1054773816633440

Barkin, J. L., Bloch, J. R., Hawkins, K. C., & Thomas, T. S. (2014). Barriers to optimal social support in the postpartum period. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, *43*, 445-454. doi:10.1111/1552-6909.12463

Bediako, P. T., BeLue, R., & Hillemeier, M. H. (2015). A comparison of birth outcomes among Black, Hispanic, and Black Hispanic women. *Journal of Racial, Ethnic Health Disparities, 2*, 573-582. doi:10.1007/s40615-015-0110-2

Bhat, A., Grote, N. K., Russo, J., Lohr, M. J., Jung, H., Rouse, C. E., . . . Melville, J. L. (2016). Collaborative care for perinatal depression among socioeconomically disadvantaged women: Adverse neonatal birth events and treatment response. *Psychiatric Services*, *68*, 17-24. doi:10.1176/appi.ps.201600002

Boyd, R. C., & Tervo-Clemmens, B. (2013). Exploring maternal and child effects of comorbid anxiety disorders among Black mothers with depression. *Journal of Depression Anxiety*, *2*(129), 1-15. doi:10.4172/2167-1044.1000129

Boykova, M. (2016). Life after discharge: What parents of preterm infants say about their transition to home. *Newborn and Infant Nursing Review, 16*, 58-65. Retrieved from http://dx.doi.org/

Boykova, M., & Kenner, C. (2012). Transition from hospital to home for parents of
    preterm babies. *The Journal of Perinatal and Neonatal Nursing, 26*(1), 81-87.
    doi:10.1097/JPN.0b013e318243e948

Braun, V., & Clarke, V. (2014). What can "thematic analysis" offer health and wellbeing
    researchers? *International Journal Quality Studies Health and Well Being*, *9*.
    doi:10.3402/qhw.v9.26152

Braverman, P. A., Heck, K., Egerter, S., Marchi, K., Parker-Dominguez, T., Cubbin, C.,
    & Pearson, J. (2015). The role of socioeconomic factors in Black-White
    disparities in preterm birth. *American Journal of Public Health, 105*, 694-702.
    doi:10.2105/AJPH.2014.302008

Bronfenbrenner, U. (1994). Ecological models of human development. *International
    Encyclopedia of Education, 3,* 37-43. doi.org/10.1016/j.jad.2015.09.059

Bronfenbrenner, U., & Ceci, S. J. (1994). Nature-nurture reconceptualized in
    developmental perspectives: A bioecological model. *Psychological Review:
    American Phycological Association*, *101*, 568-586. Retrieved from
    https://www.apa.org/pubs/journals/rev/

Brown, S. G., Hudson, D. B., Campbell-Grossman, C., Kupzyk, K. A., Yates, B. C., &
    Hanna, K. M. (2016). Social support, parenting competence, and parenting
    satisfaction among adolescent, Black mothers. *Western Journal of Nursing
    Research*, 1-18. doi:10.1177/0193945916682724

Burnard, P., Gill, P., Stewart, K., Treasure, E., & Chadwick, B. (2008). Analyzing and presenting qualitative data. *British Dental Journal, 204,* 429-432. doi:10.1038/sj.bdj.2008.292

Callaghan, W. M., MacDorman, M. F., Shapiro-Mendoza, C. K., & Barfield, W. D. (2017). Explaining the recent decrease in US Infant mortality rate, 2007-2013. *American Journal of Obstetrics & Gynecology*, e1-e6. doi:10.1016/j.ajog.2016.09.097

Carmichael, S. L., Kan, P., Padula, A. M., Rehkppf, D., Oehlert, J. W., Mayo, J. A., . . . Wise, P. H. (2017). Social disadvantage and the Black-White disparity in spontaneous preterm delivery among California births. *PLOS One*, *12*, 1-12. doi:10.1371/journal.pone.0182862

Centers for Disease Control and Prevention. (2015). *The social-ecological model, A framework for prevention.* Retrieved from https://www.cdc.gov/violenceprevention/overview/social-ecologicalmodel.html

Centers for Disease Control and Prevention. (2016). *CDC grand rounds: Public health strategies to prevent preterm birth* [Issue brief]. Retrieved from https//www.cdc.gov/mmwr/volumes/65/wr/mm6532a4.htm

Centers for Disease Control and Prevention. (2018). *Preterm birth.* Retrieved from https://www.cdc.gov/features/prematurebirth/index.html

Cheng, E., Kotelchuck, M., Gerstein, E., Taveras, E., & Poehlman-Tynan, J. (2016). Post-natal depressive symptoms among mothers and fathers of infants born preterm: Prevalence and impact on children's cognitive function. *Journal of Developmental Behavioral Pediatrics*, *37*, 33-42. doi:10.1097/DBP.0000000000000233.

Child Trends Data Bank. (2013). *Preterm Birth* [Issue Brief]. Retrieved from https://www.childtrends.org/indicators/preterm-births

Clements, A. D., Fletcher, T. R., Childress, L. D., Montgomery, R. A., & Bailey, B. A. (2016). Social support, religious commitment, and depressive symptoms in pregnant and postpartum women. *Journal of Reproductive and Infant Psychology*, *34*, 247-259. doi:10.1080/02646838.2016.1152626

Coates, R., Ayers, S., & DeVisser, R. (2014). Women's experiences of postnatal distress: A qualitative study. *BMC Pregnancy & Childbirth*, *14*, 1-14. doi:10.1186/1471-2393-14-359.

Coffey, A., & Atkinson, P. (1996). *Making sense of qualitative data: Complimentary research strategies.* Thousand Oaks, CA, Sage.

Collins, B. N., & LePore, S. J. (2017). Babies living safe & smoke-free: Randomized controlled trial of a multilevel multimodal behavioral intervention to reduce low-income children's tobacco smoke exposure. *BMC Public Health, 17*, 1-9. doi:10.1186/s12889-017-4145-7

Corrigan, C. P., Kwasky, A. N., & Groh, C. J. (2015). Social support, postpartum depression, and professional assistance: A survey of mothers in the midwestern United States. *The Journal of Perinatal Education, 24*, 48-60. doi:10.1891/1058-1243.24.1.48

Creswell, J. W., & Poth, N. (2018). *Qualitative inquiry & research design: Choosing among five approaches* (4th ed.). Thousand Oaks, CA, Sage.

Crosby, R. A., DiClemente, R. J., & Salazar, L. F. (2006). *Research methods in health promotion*. San Francisco, CA: Jossey-Bass.

Cutrona, C. E., & Russell, D. W. (2016). Autonomy promotion, responsiveness, and emotion regulation promote effective social support in times of stress. *Current Opinion in Psychology, 13*, 126-130. doi:10.1016/j.copsyc.2016.07.002

Doody, O., & Doody, C. (2015). Conducting a pilot study: Case study of a novice researcher. *British Journal of Nursing, 24*, No. 21. doi:10.12968/bjon.2015.24.21.1074

DuMonthier, A., Childers, C., & Milli, M. (2017). *Status of Black women in the United States.* Institute for Women's Policy Research. Retrieved from https://iwpr.org/publications/status-black-women-united-states-report/

Elliott, S., Powell, R., & Brenton, J. (2013). Being a good mom: Low-income, Black single mothers, negotiate intensive mothering. *Journal of Family Issues*, *36*, 351-370. doi:10.1177/0192513X13490279

Enlow, E., Faherty, L. J., Keeshen, S. W., Martin, A. E., Shea, J. A., & Lorch, S. A. (2017). Perspectives of low socioeconomic status mothers of premature infants. *Pediatrics*, *139*, 1-8. doi:10.1542/peds.2016-2310.

Families USA. (2014). *Infographic:African American health disparities compared to non- Hispanic Whites.* Retrieved from https://familiesusa.org/product/african-american-health-disparities-compared-to-non-hispanic-whites

Feldman, R., Rosenthal, Z., & Edelman, A. I. (2014). Maternal-preterm skin to skin contact enhances child physiologic organization and cognitive control across the first ten years of life. *Biological Psychiatry, 75*, 56-64. doi:10.1016/j.biopsych.2013.08.012

Freeman, A. L., & Dodson, L. (2014). Social network development among low-income mothers: Potential for bridging, bonding, and building. *Family Relations*, *63*, 589-601. doi:10.1111/fare.12088

Garrett-Peters, R., & Burton, L. M. (2016). Tenuous ties: The nature and costs of kin support among low income rural Black women. *Women, Gender and Families of Color, 4*(1), 4-35. doi:10.5406/womgenfamcol.4.1.0004

Geens, N., & Vandenbroeck, M. (2014). The (ab)sence of a concept of social support in parenting research: A social work perspective. *Child & Family Social Work*, *19*, 491-500. doi:10.1111/cfs.12048

Gerstein, E. D., Poehlman-Tynan, J., & Clark, R. (2015). Mother-child interactions in the NICU: Relevance and implications for later parenting. *Pediatric Psychology*, *40*, 33-44. doi:10.1093/jpepsy/jsu064

Ghorbani, M., Dolatian, M., Shams, J., & Alavi-Majd, H. (2014). Anxiety, post-traumatic stress disorder and social supports among parents of premature and full-term infants. *Iranian Red Crescent Medical Journal*, *16,* 1-8. doi:10.5812/ircmj.13461

Girgin, B., & Cimente, G. (2016). Rehospitalization of preterm infants according to the discharge risk level. *Journal for Specialists in Pediatric Nursing*, 1-11. doi:10.1111/jspn.12165

Giurgescu, C., & Murn, N. L. (2016). Church member support benefits psychological well-being of pregnant Black women. *Journal of Christian Nursing*, *33*, 87-91. doi:10.1097/CNJ.0000000000000256

Giurgescu, C., Kavanaugh, K., Norr, K. F., Dancy, B. L., Twigg, N., McFarlin, B. L., . . . White-Traut, R. C. (2013). Stressors, resources, and stress responses in pregnant African American women. *Journal Perinatal Neonatal Nursing*, *27*, 81-96. doi:10.1097/JPN.0b013e31828363c3.

Giurgescu, C., Misra, D., Sealy-Jefferson, S., Howard-Caldwell, C., Templin, T., Slaughter, J., & Osypuk, T. (2015). The impact of neighborhood quality, perceived stress, and social support on depressive symptoms during pregnancy in Black women. *Social Science Medicine*, *130*, 172-180. doi:10.1016/j.socscimed.2015.02.006

Gravetter, F., & Wallnau, L. (2017). *Essentials of statistics for the behavioral sciences* (9th ed.). Boston, MA: Cengage Learning.

Gullino, S., Kaiser, A., Khan, H., Phillips, A., Elwin, A., & Edwards, A. (2016). New

   mothers' experiences of the urban environment with their preterm infants involve

   complex social, emotional, and psychological processes. *ACTA Paediatrica*, *106*,

   405-410. doi:10.1111/apa.13715

Hall, R. A., Hoffenkamp, H. N., Tooten, A., Braeken, J., Vingerhoets, A., & Van Bake,

   H. J. (2015). The quality of parent-infant interaction in the first two years after

   full-term and preterm birth. *Parenting Science and Practice*, *15*, 247-268.

   doi:10.1080/15295192.2015.1053333

Hartman, S. (2016). The importance of antenatal partner support. *Journal of Women's

   Health, 25*, 659-661. doi:10.1089/jwh.2016.5773

Health Policy Institute of Ohio. (2017). *Health value dashboard*. Columbus, OH: Author.

   Retrieved from https://www.healthpolicyohio.org/

Hill, T., Burdette, A. M., Jokinen-Gordon, H. M., & Brailsford, J. (2013). Neighborhood

   disorder, social support, and self-esteem: Evidence from a sample of low-income

   women living in three cities. *City and Community*, *12*, 380-395.

   doi:10.1111/cico.12044

Hoffman, M. C., Mazzoni, S. E., Wagner, B. D., Laudenslager, M. L., & Ross, R. G.

   (2016). Measures of maternal stress and mood in relation to preterm birth.

   Obstetrics Gynecology, *127*, 545-552. doi:10.1097/AOG.0000000000001287

Holt-Lunstad, J., Robles, T. F., & Sbarra, D. A. (2017). Advancing social connection as a

   public health priority in the United States. *American Psychologist*, *72*, 517-530.

   doi:10.1037/amp0000103

Howell, E. A., Deren, S. B., Balbierz, A., Loudon, H., Mora, P. A., Zlotnick, C., . . . Leventhal, H. (2014). An intervention to reduce postpartum depressive symptoms: A randomized control trial. *Archives of Women's Mental Health, 17*(1), 57-63. doi:10.1007/s00737-013-0381-8

Howson, C. P., Kinney, M. V., McDougall, L., & Lawn, J. E. (2013). Born too soon: Preterm birth matters. *Reproductive Health, 10*(S1) 1-9. doi:10.1186/1742-4755-10-S1-S1

Ionio, C., Columbo, C., Brazzoduro, V., Mascheroni, E., Confalonieri, E., Castoldi, F., & Lista, G. (2016). Mothers and fathers in NICU: The impact of preterm birth on parental distress. *Europe's Journal of Psychology*, *12*, 604-621. doi:10.5964/ejop.v12i4.1093

Jocson, R. M., & McLoyd, V. C. (2015). Neighborhood and housing disorder, parenting, and youth adjustment in low-income urban families. *American Journal of Community Psychology*, *55*, 303-313. doi:10.1007/s10464-015-9710-6

Keefe, R. H., Brownstein-Evans, C., & Polmanteer, R. R. (2016). "I find peace there": How faith, church, and spirituality help mothers of colour cope with postpartum depression. *Mental Health, Religion & Culture*, *19*, 722-733. doi:10.1080/13674676.2016.1244663

Lieber, E. (2009). Mixing qualitative and quantitative methods: Insights into design and analysis issues. *Journal of Ethnographic and Qualitative Research, 3*, 218-227. Retrieved from http://www.jeqr.org/

Liu, C. (2017). *Psychosocial factors and preterm births: National register-based studies*. (Unpublished doctoral thesis). Karolinska Institutet, Stockholm, Sweden. Retrieved from https//openarchive.ki.se/xmlui/handle/10616/45943

Liu, C. H., & Tronick, E. (2013). *Rates and predictors of postpartum depression by race and ethnicity: Results from the 2004 to 2007 New York City. PRAMS Survey (Pregnancy Risk Assessment Monitoring System)*, *17*, 1599-1610. doi:10.1007/s10995-012-1171-z

Lorch, S. A., & Enlow, E. (2016). The role of social determinants in explaining racial/ethnic disparities in perinatal outcomes. *Pediatric Research, 79*, 141-147. doi:10.1038/pr.2015.199

Lu, M. C., Highsmith, K., De la Cruz, D., & Atrash, H. K. (2015). Putting the "M" back in the maternal and child health bureau: Reducing maternal mortality and morbidity. *Maternal Child Health Journal, 19,* 1435-1439. Retrieved from https://doi.org/10:1007/10995-015-1665-6

Masho, S. W., Munn, M. S., & Archer, P. W. (2014). Multi-level factors influencing preterm birth in an urban setting. *Urban Planning and Transport Research, 2*, 36-48. doi:10.1080/21650020.2014.896223

McCabe, E. R., Carrino, G. E., Russell, R. B., & Howse, J. L. (2014). Fighting for the next generation: U.S. prematurity in 2030. *Pediatrics*, *134*, 1193-1199. doi:10.1542/peds2014-2541

McCormack, L., Thomas, V., Lewis, M., & Rudd, R. (2016). Improving health literacy and patient engagement: A social, ecological approach. *Patient Education and Counseling*, *100*, 8-13. doi:10.1016/j.pec.2016.07.007

McElroy, K. R., Bibeau, D., Steckler, A., & Glanz, K. (1998). An ecological perspective on health promotion programs. *Sage Publications*, *15*, 351-360. doi:10.1177/109019818801500401

McGowan, E. C., Du, N., Hawes, K., Tucker, R., O'Donnell, M., & Vohr, B. (2017). Maternal mental health and neonatal intensive care unit discharge readiness in mothers of preterm infants. *Journal of Pediatrics*, *184*, 68-74. doi:10.1016/j.jpeds.2017.01.052

McKinnon, B., Yang, S., Kramer, M. S., Bushnik, T., Sheppard, A. J., & Kaufman, J. S. (2016). Comparison of Black-White disparities in preterm birth between Canada and the United States. *Canadian Medical Association Journal, 188*(1), E19-E26. doi:10.1503/cmaj.150464

McLeish, J., & Redshaw, M. (2017). Mothers' accounts of the impact on emotional well-being of organized peer support in pregnancy and early parenthood A qualitative study. *BioMedCentral Pregnancy and Childbirth, 17*, 1-14. doi:10.1186/s12884-017-1220-0

Mendenhall, R., Bowman, P. J., & Zhang, L. (2013). Single Black mothers' role strain and adaptation across the life course. *Journal of Black Studies*, *17*, 74-98. doi:10.1007/s12111-012-9220-7

Meng, G., Thompson, M. E., & Hall, G. B. (2013). Pathways of neighborhood-level socioeconomic determinants of adverse birth outcomes. *International Journal of Health Geographics*, *12,* 1-16. doi:10.1186/1476-072X-12-32

Merriam, S. B., & Tisdell, E. J. (2016). *Qualitative research: A guide to design and implementation* (4th ed.). San Francisco, CA: Jossey-Bass.

Mills, G. B., & Zhang, S. (2013). *Social support networks and their effects on hardship: Avoidance among low income households* [policy brief]. Retrieved from www.urban.org

Misra, D. P., Slaughter-Acey, J., Giurgescu, C., Sealy-Jefferson, S., & Nowak, A. (2017). Why do Black women experience higher rates of preterm birth? *Epidemiology Reports*, *4*, 83-97. doi:10.1007/s40471-017-0102-3

Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage.

Munn, A. C., Newman, S. D., Mueller, M., Phillips, S. M., & Taylor, S. N. (2016). The impact in the United States of the Baby-Friendly Hospital Initiative on early infant health and breastfeeding outcomes. *Breastfeeding Medicine*, *11*, 222-230 doi:10.1089/bfm.2015.0135

Murkoff, H., & Mazel, S. (2016). What to expect when you're expecting (5th ed.). New York, NY: Workman.

Norris, C. M., & Mitchell, F. D. (2014). Exploring the stress-support-distress process among Black women. *Journal of Black Studies, 45*, 3-18. doi:10.1177/0021934713517898

Office of Disease Prevention and Health Promotion. (2017). Maternal, infant, and child

   health: *Morbidity and mortality.* Retrieved from

   https//www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-

   child-health/objectives

Patton, M. Q. (2015). *Qualitative research and evaluation methods* (4th ed.). Thousand

   Oaks, CA: Sage.

Pearson, T. A. (2011). Public policy approaches to the prevention of heart disease and

   stroke. *Circulation, 124*, 2560-2571.

   doi:10.1161/CIRCULATIONAHA.110.968743

Petit, A., Eutrope, J., Thierry, A., Bednarek, N., Aupetit, L., Saad, S., . . . Rolland, A. C.

   (2016). Mother's emotional and post-traumatic reactions after a preterm birth:

   The mother-infant interaction is at stake12 months after birth. *PLoS One*, *11*.

   doi:10.1371/journal.pone.0151091

Phillips, G. S., Wise, L. A., Rich-Edwards, J. W., Stampfer, M. J., & Rosenberg, L.

   (2013). Neighborhood socioeconomic status in relation to preterm birth in a U.S.

   cohort of Black women. *Journal of Urban Healthsaid, Bulletin of the New York

   Academy of Medicine*, *90*, 197-211. doi:10.1007/s11524-012-9739-x

Phillips-Pula, L., Pickler, R., McGrath, J., Brown, L., & Dusing, S. (2013). Caring for a

   preterm infant at home: A mother's perspective. *Journal of Perinatal Neonatal

   Nursing*, *27*, 335-344. doi:10.1097/JPN.0b013e3182a983be

Pilling, S. A. (2015). *A qualitative analysis of migrant women farmworkers' perceptions of maternal care management* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses. ()

Pisoni, C., Garofoli, F., Tzialla, C., Orcesi, S., Spinillo, A., Politi, P., . . . Stronati, M. (2015). Complexity of parental prenatal attachment during pregnancy at risk for preterm delivery. *The Journal of Maternal-Fetal & Neonatal Medicine*, 1-6. doi:10.3109/14767058.2015.1017813

Porreca, A., Parolin, M., Bozza, G., Freato, S., & Simonelli, A. (2017). Infant massage and quality of early mother-infant interactions: Are there associations with maternal psychological well-being, marital quality, and social support? *Frontiers in Psychology*, *7*, 1-14. doi:10.3389/fpsyg.2016.02049

Raju, T. N., Pemberton, V. L., Saigal, S., Blaisdell, C., Moxey- Mims, M., & Buist, S. (2017). Long-term healthcare outcomes of preterm births: An executive summary of a conference sponsored by the National Institutes of Health. *The Journal of Pediatrics*, *181*, 309-318. doi:10.1016/j.jpeds.2016.10.015

Reid, K. M., & Taylor, M. G. (2015). Social support, stress, and maternal postpartum depression: A comparison of supportive relationships. *Social Science Research, 54*, 246-262. doi:10.1016/j.ssresearch.2015.08.009

Romero, R., Dey, S. K., & Fisher, S. J. (2014). Preterm labors: One syndrome, many causes. *Science*, *15*, 760-765. doi:10.1126/Science.1251816

Rossman, B., Greene, M. M., & Meier, P. P. (2015). The role of peer support in the development of maternal identity for "NICU moms". *Journal of Gynecology Neonatal Nursing, 44*, 3-16. Retrieved from https://doi.org/10.1111/1552-6909.12527

Rudestam, K. E., & Newton, R. R. (2015). *Surviving your dissertation: A comprehensive guide to content and process* (4th ed.). Thousand Oaks, CA: Sage.

Sampson, M., Villarreal, Y., & Rubin, A. (2014). A problem-solving therapy intervention for low-income pregnant women at risk for postpartum depression. *Research on Social Work Practice*, *26*, 236-242. doi:10.1177/1049731514551143

Sandel, M., Faugno, E., Mingo, A., Cannon, J., Byrd, K., Acevedo-Garcia, D., . . . Boynton-Jarrett, R. (2016). Neighborhood-level interventions to improve childhood opportunity and lift children out of poverty. *Academic Pediatrics*, *16*, S128-S135. doi:10.1016/j.acap.2016.01.013

Satterfield, N., Newton, E. R., & May, L. E. (2016). Activity in pregnancy for patients with a history of preterm birth supplementary issue: Health disparities in women. *Clinical Medicine Insights Women's Health*, *9*, 17-21. doi:10.4137/CMWH.S34684.

Schappin, R., Wijnroks, L. M., Venema, U., & Jongmans, M. J. (2013). Rethinking stress in parents of preterm infants: A meta-analysis. *PLOS One*, *8*, 1-19. doi:10.1371/journal.pone.0054992

Schieve, L. A., Tian, L. H., Rankin, K., Kogan, M. D., Allsopp, M., Visser, S., &
Rosenberg, D. (2016). Population impact of preterm birth and low birth weight on
developmental disabilities in US children. *Annals Epidemiology, 26*, 267-274.
doi:10.1016/j.annepidem.2016.02.012

Schrag, A., & Schmidt-Tieszen, A. (2014). Social support networks of single young
mothers. *Child Adolescent Social Work*, *31*, 315-327. doi:10.1007/s10560-013-
0324-2

Sealy-Jefferson, S., Giurgescu, C., Helmkamp, L., Misra, D. P., & Osypuk, T. L. (2015).
Perceived physical and social residential environment and preterm delivery in
Black women. *American Journal of Epidemiology*, *182*, 485-493.
doi:10,1093/aje/kwv106

Seplowitz, R., Miller, H., Ostermeyer, B., Sangi-Haghpeykar, H., Silver, E., & Kunik, M.
E. (2014). Utilization of psychiatric services by postpartum women in a
predominantly minority, low-socioeconomic-status, urban population. *Community
Mental Health Journal, 51*, 275-280. doi:10.1007/s10597-014-9808-6

Shapiro, G. D., Fraser, W. D., Frasch, M. G., & Seguin, J. R. (2013). Psychosocial stress
in pregnancy and preterm birth: Associations and mechanisms. *Journal of
Perinatal Medicine*, *41*, 631-645. doi:10.1515/jpm-2012-0295

Shapiro-Mendoza, C. K., Barfield, W. D., Henderson, Z., James, A., Howse, J. L.,
Iskander, J., & Thorpe, P. G. (2016). CDC Grand Rounds: Public health strategies
to prevent preterm birth. *Weekly, 65*(32), 826–830. Retrieved from
https://www.cdc.gov/mmwr/volumes/65/wr/mm6532a4.htm

Shaw, R., Lilo, E., Benitz, W., Storfer-Isser, A., Ball, M. B., Proud, M., . . . Horwitz, S.
M. (2014). Screening for symptoms of post-traumatic stress in a sample of
mothers with preterm babies. *Issues Mental Health Nursing, 35*, 198-207.
doi:10.3109/01612840.2013.853332

Shilling, V., Morris, C., Thompson-Coon, J., Ukoumunne, O., Rogers, M., & Logan, S.
(2013). Peer support for parents of children with chronic disabling conditions: A
systematic review of quantitative and qualitative studies. *Developmental Medicine
and Child Neurology*, *55*, 602-609. doi:10.1111/dmcn.12091

Smith, V., Hwang, S., Dukhovny, D., Young, S., & Pursley, D. (2013). Neonatal
intensive care unit discharge preparation, family readiness, and infant outcomes:
Connecting the dots. *Journal of Perinatology, 33*, 415-421.
doi:10.1038/jp.2013.23

Spencer, B., Wambach, K., & Domain, E. W. (2014). African American women's
breastfeeding experiences: Cultural, personal, and political voices. *Qualitative
Health Research*, 1-14. doi:10.1177/1049732314554097

Spinelli, M., Poehlman, J., & Bolt, D. (2013). Predictors of parenting stress trajectories in
premature infant-mother dyads. *Journal of Family Psychology*, *27*, 873-883.
doi:10.1037/a0034652

Spittle, A., & Treyvaud, K. (2016). The role of early developmental intervention to
influence neurobehavioral outcomes of children born preterm. *Seminars in
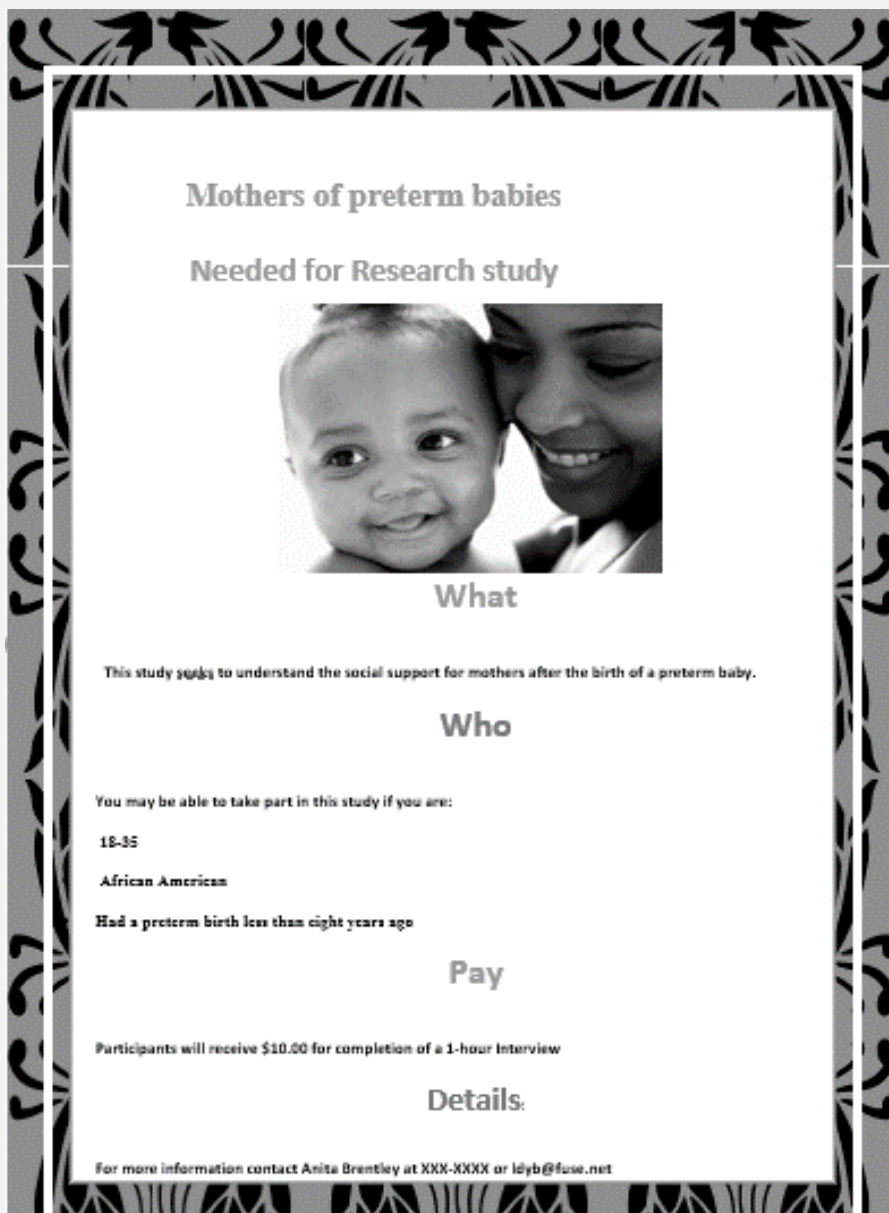Perinatology*, 542-548. doi:10.1053/j/semperi.2016.09.006

Straughen, J., Caldwell, C. H., Young, A. A., Jr., & Misra, D. P. (2013). Partner support in a cohort of Black families and its influence on pregnancy outcomes and prenatal health behaviors. *Pregnancy and Childbirth, 13*(187), 1-9. doi:10.1186/1471-2393-13-187

Suttora, C., Spinelli, M., & Monzani, D. (2013). From prematurity to parenting stress: The mediating role of perinatal post-traumatic stress disorder. *European Journal of Developmental Psychology*, *11*, 478-493. doi:10.1080/17405629.2013.859574

Tashakkori, A., & Teddlie, B. C. (2010). *SAGE handbook of mixed methods in social & behavioral research.* Los Angeles, CA: Sage.

Taylor, R. D., Budescu, M., Gebre, A., & Hodzic, N. (2014). Family financial pressure and maternal adolescent socioemotional adjustments: Moderating effects of kin social support in low Black families. *Child Family Studies*, *23*, 243-254. doi:10,1007/s10826-012-9688-8

Taylor, Z., & Conger, R. (2017). Promoting strengths and resilience in single-mother families. *Child Development*, *88,* 350-358. doi:10.1111/cdev.12741

Treyvaud, K. (2014). Parent and family outcomes following very preterm or very low birth weight births: A review. *Seminars in Fetal & Neonatal Medicine*, *19*, 131-135. doi:10.1016/j.siny.2013.10.008

Tsai, H., Surkan, P., Yu, S., Caruso, D., Hong, X., Bartell, T., . . . Wang, X. (2016). Differential effects of stress and African ancestry on preterm birth and related traits among the US-born and Black immigrant mothers. *Medicine*, *96*, 1-9. doi:10.1097/MD.0000000000005899

U.S. Department of Health and Human Services Centers for Disease Control and
Prevention, National Center for Health Statistics. (2015). *Health, United States,
2015 with a special feature on racial and ethnic health disparities* [Annual
Report]. Retrieved from https://www.cdc.gov/nchs/data/hus/hus15.pdf

U.S. Department of Health and Human Services. (2016). *The Belmont report.* Retrieved
from https://www.hhs.gov/ohrp/regulations-and-policy/belmont-report/index.html

United States Department of Agriculture Food and Nutrition Services. (2018). *About
WIC.* Retrieved from https//www.fns.usda.gov/wic/about-wic

Van Manen, M. (1997). *Human science for an action sensitive pedagogy* (2nd ed.). New
York, NY: Routledge.

Van Manen, M. (2007). Phenomenology of practice. *Phenomenology and Practice, 1*(1),
11-30. Retrieved from
https://journals.library.ualberta.ca/pandpr/index.php/pandpr/index

Vohr, B. (2013). Long-term outcomes of moderately preterm, late preterm, and early
term infants. *Clinical Perinatology, 40*, 739-751. doi:10.1016/j.clp.2013.07.006

Ward, E., Wiltshire, J. C., & Detry, M. A. (2013). African American men and women's
attitude towards mental illness, perceptions of stigma, and preferred coping
behaviors. *Nursing Research, 62*, 185-194. doi:10.1097/NNR.0b013e31827bf533

Werner, E., Miller, M., Osborne, L. M., Kuzava, S., & Monk, C. (2015). Preventing
postpartum depression: Review and recommendations. *Archives of Women's
Mental Health*, *18*, 41-60. doi:10.1007/s00737-014-0475-y.

White-Traut, R., Rankin, K., Fabiyi, C., Liu, L., Cheung, I., & Norr, K. (2017). Maternal characteristics associated with social support in at-risk mothers of premature infants. *Journal of Obstetric, Gynecologic & Neonatal Nursing, 46*, 824-833. doi:10.1016/j.jogn.2017.07.008

Williamson, H., Howell, M., & Batchelor, M. (2017). *The State of the Black Women & Reproductive Justice Policy Report.* Retrieved from http://blackrj.org/wp-content/uploads/2017/06/FINAL-InOurVoices_Report_final.pdf

World Health Organization. (2015). *Postnatal care for mothers and newborns* [Issue Brief]. Retrieved from https://www.who.int/maternal_child_adolescent/publications/WHO-MCA-PNC-2014-Briefer_A4.pdf

Yang, T., Shoff, C., Noah, A., Black, N., & Sparks, C. (2014). Racial segregation and maternal smoking during pregnancy: A multilevel analysis using the racial segregation interaction index. *Social Science Medicine*, *107*, 26-36. doi:10.1016/j.socscimed.2014.01.030

Yin, R. (2014). *Case study research: Design and methods* (5th ed.). Thousand Oaks, CA: Sage.

Zimmerman, L., Darnell, D. A., Rhew, I. C., Lee, C. M., & Kaysen, D. (2015). Resilience in community: A social, ecological development model for young adult sexual minority women. *American Journal Community Psychology*, *55*, 179-190. doi:10.1007/s10464-015-9702-6

Zlotnick, C., Tzilos, G., Miller, I., Seifer, R., & Stout, R. (2016). Randomized controlled

trial to prevent postpartum depression in mothers on public assistance. *Journal of*

Affective Disorders, *189*, 263-268. doi:10.1016/j.jad.2015.09.059

Appendix A. Site Flyer Permission

This study is independent of clinic activities or services and is unaffiliated academic research.

Appendix B. Informed Consent Form

You are invited to take part in a research study about perceived social support after the

birth of a preterm baby. Perceived social support is how an individual views support from

family, relatives, friends, churches, community organizations, social service agencies and

health care provider programs. We are inviting Black mothers between the ages of 18-35

from any community other than Avondale and Price Hill who had a preterm birth less

than 8 years ago and have not had one in the interim. This form is part of a process called

"informed consent" to allow you to understand this study before deciding whether to take

part. This study is being conducted by a researcher named Anita L. Brentley, who is a

doctoral student at Walden University.

Background Information

The purpose of this study is to explore the perception of social support for Black mothers

of preterm babies.

Procedures

If you agree to be in this study, you will be asked to:

- Participate in an interview in an in-depth face to face interview
- In a location of your choosing for approximately 20-40 minutes

Voluntary Nature of the Study

This study is voluntary. You are free to accept or turn down the invitation. No one at

Walden University will treat you differently if you decide not to be in the study. If you

decide to be in the study now, you can still change your mind later. You may stop at any time.

Risks and Benefits of Being in the Study

There are no known risks associated with participating in this study. The potential benefit of participating in this study may come in the form of providing more inclusive support services. In the event you experience stress or anxiety during your participation in the study, you may terminate your participation at any time. You may refuse to answer any questions you consider invasive or stressful. No one at the Cincinnati Health Department will treat you differently if you decide to decline the study.

Payments

A $10.00 stipend will be provided for your time and babysitting expenses. The stipend will be provided after the interview. Any participant who chooses to shorten the interview will still receive the incentive.

Privacy

Reports coming out of this study will not share the identities of individual participants. Details that might identify participants, such as the location of the study, also will not be shared. The researcher will not use your personal information for any purpose outside of this research project. Data will be kept secure using data security measures, including password protection, data encryption, use of codes in place of names, storing names (when necessary) separately from the data, discarding names (when possible), etc. Data will be kept for a period of at least 5 years, as required by the university.

If criminal activity or child abuse are discussed during the interview, I will ask participants if the incidents have been appropriately reported to authorities. If they were not reported, I will report the incident to the authorities.

Contacts and Questions

The researcher conducting this study is Anita L. Brentley. The researcher's advisor is Dr. Jeanne Connors. Participants will be told they can ask any questions they have. If a participant has questions later, she can contact me at xxx-xxx-xxxx or email xxx@waldenu.edu. The research participant advocate at Walden University is Walden University's Research Participant Advocate (USA number 001-612-312-1210 or email address IRB@mail.waldenu.edu). Participants can contact me if they have any questions about their participation in this study.

My approval number for this study is 08-07-18-0303214 and it expires on **August 6, 2019**

The researcher will give you a copy of this form to keep.

Obtaining Your Consent

I have read the above information. I have asked questions and received answers. I consent to participate in the study.

Printed Name of Participant

Date of consent

_____

Participant's Signature

_____

Researcher's Signature

_____

Appendix C. Introduction Letter

Name of Participant

Address

Date

Dear (Name),

My name is Anita L. Brentley, and I am a doctoral candidate at Walden University. I am conducting dissertation research on the importance of perceived social support for Black mothers of preterm babies. There are multiple studies that focus on social support and preterm birth. What is not known, however, are the perceptions of Black mothers. This research will provide insight into what these mothers experience after the birth of a preterm baby.

I realize that your time is important and I appreciate your consideration to participate in this study. In order to fully understand your experience, we need to meet on one occasion for 20-40 minutes. Our meeting can take place at a location of your choosing and will not require you to do anything you do not feel comfortable doing. The meetings are designed to simply get to know you and learn about your experience. All information gathered will be kept confidential.

Please contact me at your earlies convenience to schedule a date and time that we can meet. My telephone number is (XXX)XXX-XXXX. You can also e-mail me at first name. Last name @waldenu.edu. I look forward to hearing from you.

Anita L. Brentley

Doctoral Candidate

Walden University

Appendix D. Letter to Health Director

Name of Participants, Director, Health Department

Address

Date

Dear (Name),

My name is Anita L. Brentley, and I am a doctoral candidate at Walden University. I am conducting dissertation research on the importance of perceived social support for Black mothers of preterm babies. There are multiple studies that focus on social support and preterm birth. What is not known, however, are the perceptions of Black mothers. This research will provide insight into what these mothers experience after the birth of a preterm baby.

I am interested in recruiting 10-15 Black mothers for this study. I would like to post a flyer in the following Health Department Clinics XXXXXXXXX. I will contact you by phone to further discuss the study and see if you have questions. If you would like to contact me, my telephone number is (XXX)XXX-XXXX. You can also e-mail me at first name. Last name @waldenu.edu. I look forward to hearing from you.

Anita L. Brentley

Doctoral Candidate

Walden University

Appendix E. Letter of Cooperation

Community Research Partner Name

Contact Information

Date

Dear Researcher Name,

Based on my review of your research proposal, I give permission for you to conduct the study entitled Importance of Perceived Social Support for Black Mothers of Preterm Babies within the Insert Name of Community Partner. As part of this study, I authorize you to Insert specific recruitment, data collection, member checking, and results in dissemination activities. Individuals' participation will be voluntary and at their own discretion.

We understand that our organization's responsibilities includesaid, Insert a description of all personnel, rooms, resources, and supervision that the partner will provide. We reserve the right to withdraw from the study at any time if our circumstances change.

I understand that the student will not be naming our organization in the doctoral project report that is published in ProQuest.

I confirm that I am authorized to approve research in this setting and that this plan complies with the organization's policies.

I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the student's supervising faculty/staff without permission from the Walden University IRB.

Sincerely,

Authorization Official

Contact Information

Walden University policy on electronic signatures: An electronic signature is just as valid as a written signature as long as both parties have agreed to conduct the transaction electronically. Electronic signatures are regulated by the Uniform Electronic Transactions Act. Electronic signatures are only valid when the signer is either (a) the sender of the email or (b) copied on the email containing the signed document. Legally an "electronic signature" can be the person's typed name, their email address, or any other identifying marker. Walden University staff verifies any electronic signatures that do not originate from a password-protected source (i.e., an email address officially on file with Walden).

Appendix F. Interview Protocol

Dates: _____

Location: _____

Name of Interviewer: _____

Name of Interviewees: _____

Interview Questions

Interview Protocol (Guiding Interview Questions)

The guiding interview questions are designed around the sub-research questions. Three

interview questions are asked per sub-research question to probe deeper insights into the

subject matter.

1. Introductions

2. Discussion with the participant on the type of information that will be collected

   during the interview.

3. Discuss the Informed Consent Form and obtain the participants signature.

4. Review the interview process with the participant by reminding them of the

   interview duration and need for private, uninterrupted time.

5. Inform the participant that the interview will be digitally recorded, and I will use

   audio recording to accurately transcribe their responses.

6. Inform the participant that their participation in the interview is voluntary, and

   they have the right to stop the interview at any time.

7. Explain to the participant that the information obtained in the interview will

    remain confidential as stated in the Confidentiality Agreement.

Appendix G. Interview Questions

Interview Protocol (Guiding Interview Questions)

The guiding interview questions are designed around the sub-research questions. Three interview questions are asked per sub-research question to probe deeper insights into the subject matter

Sub-question 1: What are the sources of social support for Black mothers during the period following the birth of a preterm baby?

Interview question 1: Who were the people closest to you during various stages of your pregnancy.?

Interview question 2: What does social support mean to you?

Interview question 3: What kinds of social support did you receive from family members or other individuals?

Sub-question 2: How do Black mothers of preterm babies perceive change in social support as they transition from hospital-to-home?

Interview question 4: What sort of social support was available from organizations?

Interview question 5: Do you feel that the support from family or friends was directed towards you or more towards your baby?

Interview question 6: Did you face any challenges as you transitioned from your hospital stay to your home?

Interview question 7: How do you compare the social support that you received at the hospital to what you received during your period of rest at home?

Sub-question 3: What leads a Black mother during the period after the birth of a preterm

baby to seek social supports?

Interview question 8: Usually people show their support and affection according to their

own understanding. Do you recall any gesture of social support that could have

become an inconvenience to you?

Interview question 9: Can you recall instances where the kind of social support you were

receiving either from an individual or an organization that seemed irrelevant to

you?

Interview question 10: If you could walk back in time and be there to extend any kind of

social support to yourself, what would you do?

Appendix H. Participant Demographic Survey

1. Please indicate your age category:

    ____ 18 – 25   ____ 26 -40   ____ 41-60   _____ over 60

2. Please indicate your gender: _____ Female   _____ Male.

3. What is your race?

    ____American Indian or Alaska Native

    ____Asian

    ____Black or African American

    ____Native Hawaiian or Other Pacific Islander

    ____White

4. What is your marital status?

____Single (never married)

____Married, or in a domestic partnership

____Widowed

____Divorced

____Separated

1.What is the highest degree or level of school you have completed?

___Less than a high school diploma

____High school degree or equivalent (e.g. GED)

____Some college, no degree

____Associate degree (e.g. AA, AS)

____Bachelor's degree (e.g. BA, BS)

____Master's degree (e.g. MA, MS, MEd)

5. Are you currently (please check all that apply)

____employed for wages

____a homemaker

____Self-employed

____a student

____out of work and looking for work

____military

____out of work but not currently looking for work

___unable to work

Appendix I. Participant Interview Log

No.	Participant	Interview Date	Interview Location	Duration
1	Haven	8/17/18	In-person CPC	20.00
2	Dee	8/15/18	In-Person CPC	22.00
3	Kay	8/22/18	In -person/CPC	25.44
4	Kia	8/29/18	In-person / CPC	37:00
5	Lashay	9/10/18	In Person/CPC	20:00
6	Sheryl	9/10/18	In / Person CPC	31:00
7	Shawn	9/19/18	In / Person CPC	26.00
8	Ann	9/19/18	In / Person CPC	27.11
9	Mariah	10/3/18	In / Person CPC	20.11
10	Candy	10/11/18	In / Person ARC	26.23
11	Veronica	10/11/18	In / Person CPC	27.00
12	Joy	10/18/18	In / Person ARC	28.00

Appendix J. Request to Use Figure

FROM: Anita Brentley

TO: Nick Wiselogel, Vice President, Strategic Communications

Health Policy Institute of Ohio

Dear Mr. Wiselogel:

I am a doctoral learner from Cincinnati Ohio, working on a degree from Walden

University. I am conducting dissertation research. In the 2017 Health Value Dashboard

you provide a chart on how Ohio ranks on health value. You also provided a figure that

shows the factors that influence health. I would like to use this figure in my research

study. I would greatly appreciate your permission to use this Figure B.

Thank you for your time and consideration.

Anita L. Brentley

Doctoral Candidate

Walden University

Appendix K. Permission Granted to Use Figure

From: Amy Stevens <xxxx@healthpolicyohio.org>

Sent: Wednesday, April 11, 2018 9said,21 AM

To: Anita Brentley <xxxx@fuse.net>; Nick Wiselogel <xxxx@healthpolicyohio.org>

Subject: Re. Request for use of table- Attention Nick Wiselogel

Amy Stevens <xxxxx@healthpolicyohio.org>

Re. Request for use of table- Attention Nick Wiselogel

Anita- Thank you for reaching out. I'm glad to hear that you've found our work to be

useful. You are welcome to use any of our graphics as long as you cite HPIO as the

primary or secondary source.

-Amy

Sent from my iPad

On Apr 10, 2018, at 8said,25 PM, Anita Brentley <xxxx@fuse.net> wrote,

Dear Ms. Stevens,

Can you please forward this e-mail to Mr. Wiselogel?

Thank you.

Anita Brentley

Appendix L. Request to Use Figure

FROM: Anita Brentley

TO: Child Trends Data Bank

Dear Sir or Madame,

I am a doctoral student from Cincinnati Ohio, working on a degree from Walden University. I am conducting dissertation research. In the Child Trends Data Bank Indicator, you provide a figure entitled "Differences by Race and Hispanic Origin in 2013". I would like to use this figure in my research study. I would greatly appreciate your permission to use this figure

Thank you for your time and consideration.

Anita L. Brentley

Doctoral Candidate

Walden University

Appendix M. Permission Granted to Use Figure

From: August Aldebot-Green <xxxx@childtrends.org>

To: Anita Brentley xxxx@fuse.net

RE: , Contact from ChildTrends Website

Hi Anita,

Feel free to use the figure, with attribution.

Best,

August Aldebot-Green | Director of Communications

7315 Wisconsin Ave, Ste 1200W | Bethesda, MD 20814

(xxx) xxx-xxxx

Research to improve children's lives