The Role of Occupational Therapists in Perinatal Health

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LIST OF ABBREVIATIONS

AHA	Allied health assistant
AHPRA	Australian Health Practitioner Regulation Agency
AIHW	Australian Institute of Health and Welfare
CAFH	Child and Family Health nurse
CNM	Certified Nurse Midwife (USA)
CPD	Continued Professional Development
EBP	Evidence-based practice
GP	General practitioner
ICF	International Classification of Functioning
IDT	Interdisciplinary team
MCHN	Maternal and Child Health Nurse
MDT	Multidisciplinary team
NHMRC	National Health and Medical Research Council
NHS	National Health Service (UK)
NZ	New Zealand
OB-GYN	Obstetrician-gynaecologist
OPI	Occupational performance issue
OS	Occupational science
OT	Occupational therapist / Occupational therapy
PIS	Participant information sheets
RCOT	Royal College of Occupational Therapy (UK)
UK	United Kingdom
USA	United States of America
WHO	World Health Organization

GLOSSARY

Antenatal	The period during pregnancy (also referred to as *prenatal*)
Co-occupation	Reciprocal occupations inseparably shared by more than one individual which have mutual meaning for each person.
Fourth trimester	The first three months of the postpartum phase. A term developed by Tully et al. (2017) to validate and frame women's needs during the early postpartum phase. Origins in maternal health.
Maternalism	A theory and political perspective. Emphasises the influence that women have as mothers on children's health, wellbeing, and safety (Barnett, 2020). Motherhood is a feminine role and the basis of women's political and social agency (O'Reilly, 2019).
Matrescence	Likened to 'adolescence'. The development life passage of becoming a mother, involving an "experience of dis-orientation and re-orientation" (Raphael, 1975, p. 9) across biological, physical, psychological, social, spiritual and political domains. Origins in anthropology (1975).
Mother	A person who identifies themselves as such.
Motherhood	A life phase/chapter of being a mother.
Mothering	The duties and tasks of mothering occupations.
Perinatal	A period from late pregnancy through to early postpartum. This term was originally developed for medical maternal health and obstetrics and includes prenatal, antenatal, labour, birth, postpartum and postnatal stages.
Postnatal	The period following birth, usually three to 12 months.
Prenatal	The period during pregnancy (also referred to as *antenatal*).

ABSTRACT

The transition to motherhood is a significant, stressful life event that is often disruptive and transformative for women. In high-income countries, pregnancy and childbirth are predominantly serviced under medicalised obstetric and maternity healthcare models. For over a decade, there has been mounting pressure on health systems to deliver proactive, client-centred and collaborative interdisciplinary services tailored to women's needs, resolving major challenges associated with the best use of scarce resources, including health professionals. Although occupational therapists have the knowledge and skills to address difficulties with life transitions, recommendations for dynamic maternal health service reforms have continuously omitted occupational therapy in multidisciplinary teams. Whilst there are a growing number of known occupational therapists working in perinatal health, little is known about the full scope of this role. Without evidence clarifying occupational therapy's role and scope in perinatal health, the discipline faces the risk of being continually overlooked in future maternal healthcare teams.

The aim of this doctoral research was to address the knowledge gap by exploring how occupational therapists around the world are working with women during their pregnancy, childbirth, and until one year postpartum. In consolidating accounts of occupational therapists and service users, this thesis provides the first comprehensive summary documenting occupational therapists practice scope and contributions in perinatal health.

Using a qualitative multiple case study methodology, the qualitative experiences of two populations were examined; occupational therapists practicing with perinatal clients, and perinatal clients who accessed their services. Participants were from five high-income countries, including Australia, Canada, New Zealand, the United Kingdom, and the United States of America. Data were collected through interviews, questionnaires, key documents,

and field notes, which were thematically analysed to develop case summaries and descriptive themes.

The findings describe how 16 occupational therapists around the world professionally interpreted, addressed, and evaluated women's occupational performance issues, goals, and wellbeing outcomes during perinatal transitional periods. Occupational therapists' motivations and practice opportunities are described to report how and why role scope diversity is emerging in perinatal health. The lived experience of the two service users adds context and depth to the occupational therapy provider accounts, describing the perceived benefit and role of perinatal occupational therapists from a consumer perspective.

In reflexively discussing these findings, occupational therapy roles are identified as adding value to perinatal healthcare services. Through enabling and empowering women during perinatal periods, occupational therapists were addressing women's occupational issues and needs from health, wellbeing, and maternal development ('matrescence') perspectives. It is argued that the unique value of occupational therapy roles is best understood through the profession's prioritisation of client-centred care, social justice, and occupational wellbeing. In recommending a framework to conceptualise matrescence through an occupational lens, it is proposed that the role of occupational therapists has enormous potential to expand practices available to women during motherhood.

Keywords: Occupational therapy; Perinatal health; Motherhood; Maternal health; Matrescence, Maternal development; Full scope of practice; Extended scope of practice.

STATEMENT OF AUTHORSHIP

Except where reference is made in the text of the thesis, this thesis contains no material published elsewhere or extracted in whole or in part from a thesis accepted for the award of any other degree or diploma. No other person's work has been used without due acknowledgment in the main text of the thesis. This thesis has not been submitted for the award of any degree or diploma in any other tertiary institution.

All research procedures reported in the thesis were approved by the La Trobe University Human Research Ethics Committee, in accordance with La Trobe University policies and procedures (approval number HEC16-107).

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fuelling my motivation to research women's needs and the value and place for occupational therapy in maternal health.

And my precious family and friends, who have been with me every step of the way.

DEDICATION

To my parents and dearest friends, for telling me always that I can do anything I set my mind to.

In loving memory of my mum, Oma, Gran, and June, with deep gratitude for their legacy of being strong, brave, and socially conscientious women.

To my darling Hubert and Wilhelmina, for their loving patience with teaching me how to become and continue growing as a mother, inspiring me to be the strongest role model I can be, and cheering me on through this PhD. And to Ned, for his gentle presence, patience in between walks, and for always being curled by my feet.

PUBLICATIONS AND AUTHOR CONTRIBUTIONS

The following lists author contributions for the published article included in this thesis (refer Table 1). La Trobe University guidelines state that where a thesis includes published work it should include a statement of the author contributions, and specify, "The extent of collaboration with another person or persons" (La Trobe University, 2016, p. 6).

TABLE 1

Publications and author contributions

Publication	Citation	Author contributions
Article 1	Slootjes, H., McKinstry, C., & Kenny, A. (2015). Maternal role transition: Why new mothers need occupational therapists. *Australian Occupational Therapy Journal*. doi:10.1111/1440-1630.12225	**Slootjes (70%)**, McKinstry (15%), Kenny (15%). I assisted other authors with designing the Viewpoint. I searched and reviewed the literature, and prepared manuscript drafts with inputs from other authors.

All research in this doctoral thesis was conducted with guidance and contribution from my supervision team, Associate Professor Carol McKinstry, Professor Emeritus Amanda Kenny, and Associate Professor Leesa Hooker. As is usual practice, future publications will include supervisors as authors having provided guidance and who will contribute to the writing of future publications.

CONFERENCE PRESENTATIONS

NATIONAL

Slootjes, H., McKinstry, C., & Kenny, A. (2015, November 27). *Occupational therapy in maternal health: A critical review* [Research presentation]. Graduate Research Festival, La Trobe University, LRHS, Flora Hill, Australia.

Slootjes, H., McKinstry, C., & Kenny, A. (2016, September 3). *Occupational therapy in maternal health: Case study series* [Conference presentation]. OT Australia VIC-TAS Regional Conference, Melbourne, Australia.

Slootjes, H., McKinstry, C., Kenny, A., & Hooker, L. (2016, December 1). *Occupational therapy in maternal health: Case study* [Research presentation]. Graduate Research Festival, La Trobe University, CTB, Bendigo, Australia.

Slootjes, H., McKinstry, C., Kenny, A., & Hooker, L. (2018, June 29). *Occupational therapy in maternal health: A case study* [Conference presentation]. VIC-TAS Regional Conference 2018, Crown Promenade Hotel, Melbourne. https://custom.cvent.com/414B1285F06A4D5D82CD0BBFDEB69474/files/Event/4743f91a0daa4c7bba5102ef75019ea5/a4f05fd437184ee4a783ced90e9aaade.pdf

Slootjes, H., McKinstry, C., Kenny, A., & Hooker, L. (2019, July 11). *Occupational therapy in maternal health: Case study* [Conference presentation]. OT Australia 28th National Conference and Exhibition, International Convention Centre, Sydney, Australia. https://custom.cvent.com/414B1285F06A4D5D82CD0BBFDEB69474/files/b5887e35b1ba449884984cfb7699f862.pdf

INTERNATIONAL

Slootjes, H., McKinstry, C., & Kenny, A. (2016, June 15-19). *Occupational therapy in maternal health: A critical review* [Conference presentation]. 2016 - COTEC-ENOTHE Congress, Galway, Ireland. http://programme.exordo.com/cotec-enothe2016/delegates/presentation/555/

POSTER PRESENTATIONS

Slootjes, H., McKinstry, C., Kenny, A., & Hooker, L. (2017, July 19-21). *Occupational therapy in perinatal health: Case study preliminary findings* [ePoster]. OT Australia 27th National Conference, Perth, Australia. Refer Appendix A.

Slootjes, H., McKinstry, C., Kenny, A., & Hooker, L. (2018, May 21-25). *Occupational therapy in maternal health: A case study* [Poster presentation]. WFOT Congress 2018 – Cape Town, South Africa. https://congress2018.wfot.org/poster-programme.php. Refer Appendix B.

Slootjes, H., McKinstry, C., Kenny, A., & Hooker, L. (2018, December 3). *Occupational therapy in perinatal health: Case study preliminary findings* [Poster presentation]**.** La Trobe Graduate Research Festival, LRHS, Flora Hill, Australia. Refer Appendix B.

OTHER PRESENTATIONS

Slootjes, H., McKinstry, C., & Kenny, A. (2014, July 11). *New mothers need occupational therapists throughout perinatal transitions* [Research pitch presentation]. 3MT competition, La Trobe University, LRHS, Flora Hill, Australia.

Slootjes, H., McKinstry, C., & Kenny, A. (2015, June 26). *Maternal health transitions are not sequences of illness: Women need occupational therapists throughout perinatal transitions* [Research pitch presentation]. 3MT competition, La Trobe University, LRHS, Flora Hill, Australia.

Slootjes, H. (2016, July 28). *Pregnancy, birth & motherhood are not sequences of illness: New mothers need occupational therapists throughout perinatal transitions* [Research presentation]. Head2Head, Ulumbarra, Bendigo, Australia.

- Related interview: Kearney, M. (2016, July 28). *Ideas that care for women* [Newspaper article]. Bendigo Advertiser. https://www.bendigoadvertiser.com.au/story/4060924/ideas-that-care-for-women/.

Slootjes, H., McKinstry, C., & Kenny, A. (2016, August 3). *Motherhood transitions are not sequences of illness: New mothers need occupational therapists throughout perinatal transitions* [Research pitch presentation]. 3MT competition, La Trobe University, LRHS, Flora Hill, Australia.

CHAPTER 1: INTRODUCTION

"One of the factors a country's economy depends on is human capital. If you don't provide women with adequate access to healthcare, education, and employment, you lose at least half of your potential. So, gender equality and women's empowerment bring huge economic benefits."

– Michelle Bachelet (2012)

This is the introductory chapter of a doctoral thesis that aims to document and expand on what is known about occupational therapy roles in perinatal maternal health. The research topic is introduced in this chapter, and my motivation for doing this research stated. A brief background of maternity care developments, women's health needs, and evolution of occupational therapists' role in perinatal health are summarised to contextualise the need, and rationale for this study. An outline of the research aims, methodology, and research significance is provided, and the chapter concludes with description of the thesis structure.

Occupational therapists work with women throughout prenatal and postnatal transitional stages of motherhood (the perinatal period); however, little is known about the professions' role scope or place in perinatal health or maternity care teams. In Australia, midwives and obstetricians typically address prenatal and birthing needs, with paediatricians and maternal and child health nurses providing services during the postpartum period (Esdaile & Olson, 2004). Nearly two decades ago, the *Future Directions for Victoria's Maternity Services* policy (Department of Human Services, 2004) called for midwifery and general practitioner roles to be extended, moving towards more collaborative and interdisciplinary models of care. Recent service reviews have recommended significant maternal healthcare reforms to deliver high-quality holistic care models that meet

contemporary mothers' increasingly known and complex needs and expectations (Davis & Lovegrove, 2019; Fox et al., 2019; World Health Organization, 2018).

In high-income countries, healthcare during pregnancy, childbirth and motherhood often involves women who are generally healthy and well (Department of Human Services, 2004; Finlayson et al., 2020; Stevens & Alonso, 2021). Highly medicalised maternal care systems fail to adequately consider complex cultural and social influences unique to perinatal health (Barnett, 2020; Benoit et al., 2010; Vogels-Broeke et al., 2019). Contemporary recommendations to facilitate healthy perinatal transitions and parenting practices increasingly include midwifery-led care continuity models which monitor "the physical, psychological, spiritual and social well-being of the woman and family throughout the childbearing cycle" (World Health Organization, 2016c, p. 85). The shift of maternal care quality determinants towards women having satisfactory and positive experiences offers a lens to consider perinatal health from a holistic wellbeing perspective, and that pregnancy is not an illness (World Health Organization, 2016c, 2020).

Whilst the medicalisation of childbirth reduced maternal mortality significantly during the 20th Century (Johanson et al., 2002), the routine over-medicalisation of pregnancy and childbirth has considerable health-related implications for mothers and infants (Johanson et al., 2002; Kundisova et al., 2019). The complex psychological, social, physical, and spiritual issues faced by women during perinatal transitions require holistic care and culturally sensitive solutions (Barnett, 2020; Finlayson et al., 2020; Stevens & Alonso, 2021). The potential for occupational therapists to provide services during the perinatal period has been identified for more than two decades, with researchers calling for exploration into the role of occupation to address the "seemingly common-sense concerns" and "obvious, basic human needs" of women during motherhood (Esdaile et al., 2004, p. 24).

This research aims to document how, why, and where occupational therapists are working with women during perinatal transitions. In this thesis, the perinatal period includes pregnancy, childbirth, and the postnatal period up until 12-months postpartum. How and why occupational therapists address the contemporary needs and demands of women will be considered, and participant perceptions of the profession's capacity will be documented to enhance capacities of future maternal healthcare services.

MY MOTIVATION FOR THIS RESEARCH

On reflection, my journey as a person, mother, and occupational therapist shifted and shaped my perspective, which became the source of inspiration for this research. In 2010, I learned that allied health was not funded to support women who were inpatients in Victorian (Australia) public hospital maternity wards. As a new mother, I was aware of how significantly issues could impact function during perinatal periods. As an occupational therapist accustomed to working collaboratively with multidisciplinary teams in a range of hospital settings, the absence of allied health on the maternity ward seemed an illogical omission. I was curious to learn how and why this was so.

Every hospital-based health professional I spoke to confirmed that occupational therapists were not needed on maternity wards, so there was no funding for the service. I found this perspective surprising. Working this through, using medical-modelled reasoning, caesarean delivery should not be significantly different to any other major abdominal surgery. In my experience, people undergoing major abdominal surgery all received occupational therapy services in the pre-admission clinic and after surgery. Assuming the post-surgical functional restrictions were similar for anyone undergoing major abdominal surgery, why were women on a maternity ward excluded from accessing an occupational therapist?

The social injustice of this issue struck a chord in me, which still rings to this day. The idea of not funding services for women simply because they were maternal health clients was – and remains – questionable to me. I started this research curious to discover if there was evidence clarifying the role and place for occupational therapists on maternity wards. Over this last decade, my enduring personal and research journeys have led me to critically question why women are still not able to access allied health as maternal health clients. A pursuit for social justice has fuelled my passion throughout the research journey.

"We still ask women to work like they don't have kids and parent like they don't work. It's well past time to change all that."

– Amy Westervelt (2018)

When I think about motherhood, I see the only job I know of which does not have the infrastructure for initiation, transition, troubleshooting, supported learning and continuing development, or measures of success. It is also the only permanent job without recognition of overtime and leave allowances, and resignation is not an option. As a career, motherhood is plagued by a kaleidoscope of complex and subtle issues which make doing the job more difficult, most of which are nominalised as simply part of the experience.

From a sociological perspective, I see women who become mothers assume responsibility to foster and nurture the early development of the individuals who will shape and maintain the future of our society. Motherhood is so much more than just a job. It is a transformative life change for women and a social undertaking that requires the support of the village – regardless of their baby's wellbeing or health status.

"In a sane society no woman would be left to struggle on her own with the huge transformation that is motherhood, when a single individual finds herself joined by an invisible umbilical cord to another person from whom she will never be separated, even by death."

– Germaine Greer (1999)

I have deep respect and gratitude for maternal healthcare services, especially in Australia where we have such affordable, accessible, and high-quality care, with low levels of mortality risks for mothers and infants. I feel very fortunate to be a mother in Australia. The aim of this research was document and explore what – if anything – is known about the role of occupational therapy in perinatal health. The intention was to compile evidence descriptively reporting on the role of occupational therapists in perinatal health which could be useful as a basic reference for future policy development, professional advancement, and maternal healthcare team reviews. An objective of this doctoral research which emerged later in my candidature was to develop a conceptual practice model and framework to enhance understanding of women's occupational performance issues during perinatal stages and matrescence. My interpretations and understandings are framed by my personal and professional perspective of motherhood as a complex and meaningful human occupation, warranting greater holistic social investment.

BACKGROUND

Maternal health is a unique area of practice in high-income countries, and pressure to meet the increasingly complex needs and expectations of perinatal service users is mounting. With accessible high-quality medical care, high-income countries account for only 1% of

maternal deaths worldwide (Brown et al., 2021). There is a growing demand for service reforms to deliver more holistic and individualised models of care which address women's need for satisfying and positive perinatal experiences (Forster et al., 2016; Vogels-Broeke et al., 2019; White Ribbon Alliance, 2019; World Health Organization, 2018). Midwifery-led care models providing continuity of care are highlighted as a solution (Fox et al., 2019; Stevens & Alonso, 2021); however, rates of burnout, occupational stress and poor retention rates are high for midwives (Creedy et al., 2017; Sidhu et al., 2020). Pressure to deliver standalone midwifery-led care models may see chronic workforce shortages returning (Health Workforce Australia, 2014), and perpetuate the issue of siloed care restricting collaborative healthcare service advancement and quality improvement (Barnett, 2020; Commonwealth of Australia, 2009; Department of Health & Human Services, 2016).

AUSTRALIA'S MATERNITY CARE HISTORY

Australia's maternal health services have a rich history, influenced largely by pioneering English and European settlers in the early 1800s to 1880s which were predominantly guided by the English model valuing midwifery-supported obstetric care (Willis, 1983). From the 1880s, regulation and registration changes associated with heightening medicalisation and obstetric dominance of maternal healthcare saw increased formalisation of services and training. For centuries, there has been a power feud bubbling between midwives and obstetricians (Willis, 1983). The preoccupying and enduring battle for medical dominance appears to have contributed to maternal health services remaining dominated by medical professionals (Benoit et al., 2010; Willis et al., 2012).

Amidst the politics of health service developments, women have continued to conceive, birth, and raise children, whilst living in various communities and social infrastructures (Barnett, 2020; Benoit et al., 2010; Pascoe Leahy, 2020). In contemporary

healthcare, inter-, trans-, and multidisciplinary teams are common with holistic practice approaches ever evolving from the biomedical model. Yet there remains the final frontier of women's maternity care, which remains governed by a core practice alignment with medicalised models (Alexander, 2020; Dombroski et al., 2016; Neiterman, 2013).

The birthing consumer movement during the late 1960s to early 1970s marked a shift in the community's perception of maternal health care services. Routine physician attendance at birth was suddenly questioned as greater recognition of the social, emotional and spiritual needs for life and healing grew, with birth considered a "natural biological process" (Benoit et al., 2010, p. 476). Benoit et al. (2010) argued over a decade ago that Australia's two-tiered public and private health system "perpetuates the dominance of medicine and decreases the efficiency of the maternity sector" (p. 478), by over-utilising obstetricians as primary birth attendants. Over time, this shift reduced the practice capacity of midwives, who are generally employed and governed by hospitals and medical clinics, with most related services not eligible for Medicare[1] reimbursement. Contemporary practice efforts to shift beyond medicalised maternity care have seen developments such as midwifery-led care and caseload midwifery models emerging with improved outcomes for women and infants (McLachlan et al., 2016); however, uptake is limited by multiple barriers in hospital settings (Dawson et al., 2016).

GLOBAL MATERNITY HEALTHCARE SERVICES TRENDS

Global advancements in maternal health practices have significantly changed the landscape of perinatal care in recent decades. In most high-income countries, such as Australia, perinatal healthcare services are led by obstetricians and midwives. Childbirth has

[1] "Medicare is the scheme that gives Australian residents access to healthcare. It gives all Australians and some people from overseas a wide range of health and hospital services at no cost or low cost" (https://www.healthdirect.gov.au/what-is-medicare)

been “transformed” through “the increased use of life-saving medical technologies” (Dombroski et al., 2016, p. 72) so that for many women it is no longer strongly associated with mortality risk. Advances and accessibility in reproductive and medical interventions related to birth have seen significant increases in rates of assisted conception, multiple births, and caesarean, coinciding with a rise in the average age of pregnant women (Australian Institute of Health and Welfare, 2021; Byrne et al., 2011; Mishra et al., 2018). Caesarean section is one of the most common operations in the world, with research into “current trends and projections … reveal[ing] that the present-day societies are continually moving towards medicalisation and overmedicalisation of childbirth” (Betran et al., 2021, p. 7).

With the increasing prevalence of medicalised maternal care and increased awareness of related implications for complex pregnancy and postnatal health outcomes, there is mounting pressure on health systems to adapt to meet the needs of this changing population (Edmonds et al., 2020; Stevens & Alonso, 2021). There is a growing body of research which reports on women’s experiences of feeling disempowered and unsatisfied by the medicalised services provided during pregnancy, childbirth, and postnatal periods (Finlayson et al., 2020; White Ribbon Alliance, 2019; World Health Organization, 2018). In Australia, where retention and burnout rates for perinatal medical professionals are significant, there is a growing need for recognition of practice boundaries and directions for dynamic advances to expand maternal healthcare models (Creedy et al., 2017; Sidhu et al., 2020; World Health Organization, 2020).

CAUSES AND EXTENT OF THE PROBLEM

In countries such as Australia, workforce shortages, retention issues, work-related stress and burnout rates for midwives and perinatal medical professionals are significant (Creedy et al., 2017; Health Workforce Australia, 2014; Sidhu et al., 2020). Healthcare

during and after pregnancy and childbirth predominantly deliver medicalised services to women who are generally well (Neiterman, 2013). Highly medicalised maternal care systems fail to adequately consider complex cultural and social influences unique to perinatal health (Benoit et al., 2010; Tully et al., 2017). A recent Parliamentary inquiry into Victorian perinatal services found that there is mounting pressure on health systems to meet the increasingly complex and diverse health and psychosocial needs of contemporary maternal populations (Parliament of Victoria, 2018). Globally declining numbers of healthcare professionals in maternal care are associated with work-related burnout, stress, and workforce shortages, especially in rural and remote areas (Creedy et al., 2017; Department of Health, 2019a; Sidhu et al., 2020).

EXTENT AND SEVERITY OF THE PROBLEM

The needs of women becoming mothers in contemporary society are changing, and pressure on maternal health services to meet heightened consumer expectations is mounting. Many women have heightened expectations of positive perinatal experiences where their medical, developmental, psychosocial and wellbeing needs are addressed (Finlayson et al., 2020; Lederman & Weis, 2020a; Seefat-van Teeffelen et al., 2011; Vogels-Broeke et al., 2019). In high-income countries, higher living standards and deferment of parenthood have led to the average age of mothers increasing. According to Londero et al. (2019), this phenomenon reflects a multitude of social and economic transformations, including “an increasing prevalence of women aged between 35 and 45 years, the change in social customs with a rise in divorces and second marriages, [and] improvements to women’s educational and professional outlooks” (p. 5). Contemporary social change and “the availability of contraception has made women protagonists of their childbearing options” (Londero et al.,

2019, p. 5), and becoming positioned as maternal healthcare service users and consumers (Dombroski et al., 2016).

According to statistics published by the Australian Institute of Health and Welfare (2021), 298,567 women gave birth in Australia during 2019, with 97% of these occurring in hospitals. In 2019, the average age of mothers giving birth increased from 30 in 2009 to 30.8 years (Australian Institute of Health and Welfare, 2021), and over a third of all births were outside of marriage (Australian Institute of Family Studies, 2021). According to Homer (2020), one in 23 women who gave birth received some form of assistive reproduction treatment (ART). Nearly one-quarter of Australian mothers who gave birth in hospitals were discharged less than two days after giving birth, with 66% returning home after two to four days, and 13% staying for five days or longer in hospital (Australian Institute of Health and Welfare, 2021).

In 2019, one in three Australian women gave birth by caesarean section (CS) (Australian Institute of Health and Welfare, 2021), which was higher than the worldwide Organisation for Economic Cooperation and Development (OECD) average of 28%. Caesarean sections were most common for women with pre-term deliveries (50%), aged >40 years (55%), who were overweight (38%) or obese (44%) (Australian Institute of Health and Welfare, 2021), and in regional centres or private hospitals (Parliament of Victoria, 2018). In 2015, three out of five caesarean deliveries were elective and planned (Mishra et al., 2018). As mothers in high-income countries become increasingly regarded as maternal healthcare service users and consumers (Dombroski et al., 2016), pressure on medical and health professionals to reconsider and expand practices to meet service expectations is mounting.

Australian midwives play a fundamental role in providing psychosocial support to women, promoting successful transition through pregnancy and early parenting. Almost 20-

years ago, the Victorian health care system acknowledged the "growing call for innovations in maternity care" (Department of Human Services (DHS), 2004, p. 2). A "new model of maternity care" began conceptual development, which was client-centred, interdisciplinary, and designed to address the declining number of professionals working in this area of health (DHS, 2004, p. 18). While retention rates have since steadied, there are increasingly high rates of moderate to severe burnout, anxiety, depression, and stress impacting Australian midwives (Creedy et al., 2017); with similar trends echoed in other high-income countries (Sidhu et al., 2020). Growing demand and service expectations from women accessing perinatal healthcare sees pressure mounting on maternity care models to meet complex population needs (Barnett, 2020; Finlayson et al., 2020; White Ribbon Alliance, 2019).

RATIONALE

Pregnancy, childbirth, and motherhood are arguably unique areas of healthcare practice, in that most of the population are generally well (DHS, 2004). In high-income countries where maternal mortality rates are comparatively low, women's expectations of maternal healthcare services increasingly focus on positive perinatal experiences, wellbeing, and quality care (Brown et al., 2021; Finlayson et al., 2020; Vogels-Broeke et al., 2019; World Health Organization, 2018). Despite significant efforts to deliver high quality, sensitive and woman-centred care, there is growing prevalence in research reports of women feeling disempowered and unsatisfied by the medicalised services provided during pregnancy, childbirth and postnatal periods (Alexander, 2020; Barnett, 2020; Department of Health, 2018; Verbiest et al., 2018; Vogels-Broeke et al., 2019; World Health Organization, 2018). While interpretations vary widely, *women-centered care* can be understood as term describing "a philosophy applied to maternity services", and *woman-centered care* as a term used to shift "the emphasis onto each woman's individual needs" (Brady et al., 2019, p. 107).

A shift to midwifery-led care and Midwifery-Led Units (MLUs) is increasingly recommended during pregnancy, childbirth and postnatal periods in literature to improve woman-centred care quality and "curb over-medicalization" of sexual and reproductive healthcare (Edmonds et al., 2020, p. 1). Continuity of midwifery-led care through perinatal periods maximises holistic health outcomes for many mothers and infants (Fox et al., 2019), and promotes women's capacity for natural birthing experiences with minimal to no intervention (Edmonds et al., 2020; Sidhu et al., 2020). The global prevalence of MLUs are increasing, and standards for care are being developed to ensure quality of care consistency (Stevens & Alonso, 2021).

The World Health Organization (2016a) survey of midwives found their capacity for "creating the change and delivering the creative solutions they know are so badly needed" (p. 2) to provide quality and respectful care for women, infants and their families was difficult to implement. In academic forums, there is increasing evidence documenting the prevalence and impact of emotional role strain, insufficient resources, occupational trauma, and overwhelming workloads on midwives in Australia and other high-income countries (Creedy et al., 2017; Milligan et al., 2017; Sidhu et al., 2020).

Burnout is a common vocational issue impacting midwives. A systematic review by Sidhu et al. (2020) identified chronic work-related stress as the primary cause of burnout, resulting in emotional exhaustion, dissociation and energy loss which negatively impacted work role performance, job satisfaction and retention rates. As a health profession, midwives are particularly vulnerable to burnout due to inequitable access to limited resources, high workload demands, "high levels of empathetic identification with women, and struggling to process poor maternal-fetal outcomes" (Sidhu et al., 2020, p. 1). Pressure on the profession to upskill and meet the ever-increasing expectations and demands of contemporary maternity

services and maternal populations continues (Sidhu et al., 2020; Tully et al., 2017; Verbiest et al., 2018; Vogels-Broeke et al., 2019).

Becoming a mother is a significant transition and transformative life event. The complex nature of perinatal transitions is becoming increasingly understood from developmental, wellbeing, psychological, social, cultural, socioeconomic, employment, intergenerational and power perspectives (Athan, 2020; Barnett, 2020; Pascoe Leahy & Bueskens, 2020a; Sacks, 2018). The capacity of midwives to address the spectrum of women's complex needs during perinatal transitions seems questionable. Increased segregation between midwifery-led and obstetric-led care models would arguably perpetuate the restrictive siloed care model traditions in maternal health (Commonwealth of Australia, 2009), and may fuel the long-standing power-feud between the professions (Benoit et al., 2010; Willis et al., 2012).

Occupational therapists are healthcare experts in supporting the management of multidimensional needs for individuals through life transitions (Barnett, 2020; Breen-Franklin, 2018), collaboratively working within multidisciplinary teams (Department of Health & Human Services, 2016). Application of full scope of practice sees potential for occupational therapists to transpose their skillset flexibly to address many complex needs of maternal health clientele (Barnett, 2020; Grabarkewitz & Swanson, 2020; Rexe et al., 2013). The potential for occupational therapists to enhance and expand the practice scope of maternity care models by addressing women's complex occupational performance issues is worthy of consideration.

Based on the foundations of client-centred practice, enabling, and promoting occupational and role performance throughout transitional phases (Breen-Franklin, 2018; Hitch, 2017; Hitch & Pepin, 2021), occupational therapists are skilled in professionally

recognising and designing interventions based on addressing occupational performance issues. There is scope for new research into how the many common and complex challenges women experience during perinatal periods can be addressed by occupational therapists, in the context of existing perinatal health services.

Occupational therapy is a profession of seemingly endless expansion and evolution. Growth and divergence in professional practice boundaries and contexts over time has seen terms such as “folklore”, “encroaching”, and “professional inaction” linked with clinical practice (Wilding & Whiteford, 2007, p. 185). Occupational therapists have at times endured an unappealing reputation for ambiguity in representing and promoting their profession, articulating evidence-based practices in some settings, and being considered expendable in multidisciplinary teams within a predominantly biomedical setting (Rexe et al., 2013; Wilding & Whiteford, 2007). While capacity to apply a broad skillset and flexible practice scope see occupational therapists often appearing to gap-fill in multidisciplinary teams, the profession is anchored by its focus on meaningful and necessary human occupations (Fortune, 2000; Grabarkewitz & Swanson, 2020; Hitch & Pepin, 2021) and offering cost-effective solutions (Rexe et al., 2013).

Becoming a mother is a major life occupation (Horne et al., 2005; Vidmar, 2020a) and relational role (Sethi, 2019), which often begins for women as they prepare for motherhood (Acharya, 2014). Occupational therapy services are currently available to perinatal clients in some health services. In a variety of settings, adult and paediatric occupational therapy services are provided for perinatal clients living with significant comorbidities (Hayward et al., 2017; Poole et al., 2009), who require support with mothering occupations stemming from infant prematurity or illness (Briltz, 2019; Gibbs et al., 2016; Nightlinger, 2011; O'Brien & Lynch, 2011; Ross et al., 2017), and for specific populations such as teenage mothers (DeLany & Jones, 2009).

A '*mothering occupations'* textbook (Esdaile & Olson, 2004) written nearly two decades ago, is a primary resource available to guide perinatal occupational therapy practice. This textbook focused heavily on the theoretical foundations underpinning motherhood roles and occupations and offered concepts to improve understanding of women's perinatal transitional experiences. This textbook provided limited guidance for clinical practice or context for how occupational therapists might practice within existing primary or secondary maternal health service settings. Whilst there is research evidence for the role of occupational therapists supporting mothers and infants with disability, chronic illness, and disease, little is known about the role of occupational therapists working with broader populations of women during perinatal periods.

Occupational therapists routinely practice within interdisciplinary teams, as specialists in addressing occupational performance issues. To reduce the need for hospital admissions, promote health and wellbeing, and prevent illness and disability, health outcomes are optimally achieved with interdisciplinary team collaboration (Council of Australian Governments, 2011; Rexe et al., 2013). Despite these benefits, the majority of maternity care interdisciplinary teams do not routinely include allied health professionals, including occupational therapists. It is common for many women to experience changes during the perinatal period which impact their capacity to engage in routine occupations (Esdaile et al., 2004), recognisable as occupational performance issues. Although well known in other areas of healthcare (Rexe et al., 2013), the role of occupational therapists in perinatal health and maternal healthcare interdisciplinary teams requires exploration to achieve greater understanding and awareness.

Currently, the role of occupational therapists in maternal health appears to be largely dependent on perinatal healthcare disciplines creating a place within interdisciplinary teams. Consideration of historical and contemporary professional context and healthcare climates are

vital to informing interdisciplinary team decisions considering the inclusion of allied health professionals for perinatal health services, including occupational therapy. Maternity care professionals have a proven capacity to provide high quality medical and perinatal care to women during perinatal stages (Brown et al., 2021). With mounting pressure on midwifery roles and maternal healthcare services to expand and meet the increasingly well-understood and complex needs of perinatal populations, dynamic solutions must be explored. Without research evidence and strong advocacy, the feasibility of occupational therapy complementing existing maternal health interdisciplinary teams is limited, allowing the cycle of debatable professional integrity and value of occupational therapists in perinatal health to continue.

AIMS

This research aims to explore the role of occupational therapists working to support the needs of women during perinatal transitional periods. The occupational therapist role is considered in the context of supporting existing maternal health teams' capacity to meet the complex and unique needs of the maternal health population. This research seeks to explore and descriptively report on the occupational therapy role in perinatal health.

METHODOLOGY

This qualitative research was informed by a preliminary literature review conducted in 2014 to explore what was known about the role of occupational therapy in perinatal health and reveal gaps in the literature. A viewpoint article was published in 2015 to ignite interest and debate around occupational therapy in maternal health interdisciplinary teams. A systematic literature review was completed in 2018 and updated in 2021 prior to submission.

A multiple case study using Stake's (1995) methodological approach was the primary data collection method, which are considered in the chapter five of this thesis. Case study research offers a useful qualitative approach to investigate and analyse a collective case, capturing the complexity by drawing together a spectrum of methods (Hyett et al., 2014; Stake, 1995). Case study research is more flexible than phenomenology and grounded theory approaches (Hyett et al., 2014), and was beneficial in that it accommodated reflexive development during the research process as more was learned about the case (Stake, 1995).

Data collection is described in chapter six of this thesis. Qualitative data were collected through interviews, questionnaires, fieldnotes, and other key documents (Miles & Huberman, 1994; Stake, 1995; Stake, 2000). Ethical approval was obtained prior to recruitment from La Trobe University's Human Research Ethics Committee, and informed consent was obtained from all participants. Eighteen participants from five high-income counties, including Australia, Canada, England, New Zealand, and the United States of America were recruited and interviewed. Participants were assigned to two multiple case cohorts, comprising 16 occupational therapists who worked with women during perinatal phases, and two women who had accessed occupational therapy services during perinatal transitions. A cross-case analysis for the occupational therapy cohort explored differences and similarities in practices settings, practice approaches and perceived outcomes, using Attride-Stirling's (2001) qualitative data analysis methods and organised within a thematic network. Findings were descriptively reported in three sections, including case summaries for each cohort, and the cross-case analysis.

A research blog (https://hannahslootjes.wordpress.com) was launched during the recruitment phase in 2016 and continued throughout the remaining candidature duration. This provided informal communication about research updates, public interaction opportunities,

and monitored public engagement and interest in the research topic (refer Appendices C & D).

RESEARCH SIGNIFICANCE

This research is the first investigation into the full scope of how occupational therapists in multiple high-income countries are working with women during perinatal transitions, providing a snapshot into how practitioners are adapting and expanding their professional skillset to meet consumer demand. This is the first study to document a collective range of women's experiences during perinatal transitions from the perspectives of occupational therapy practitioners around the world. It is the first study to explore the lived experiences of women who accessed occupational therapy services during perinatal transitions. Efforts were made to conceptualise maternal developmental transitions ("matrescence") within occupation and propose a co-occupation-centred framework to be considered in future conceptual practice models. These insights offer a fresh perspective into how the functional issues women struggle with during perinatal transitions can be understood and managed from an occupational therapy perspective, outside of conventional medicalised and maternity care services.

Being the first study exploring the broad scope of how occupational therapists address the spectrum of issues experienced by women during perinatal transitions, this doctoral research can inform future maternal healthcare policy developments and service designs. There is potential for expansion of future tertiary curriculum development in maternity health studies and occupational therapy, and clinical justification for professional advancement opportunities in occupational therapy and perinatal health. Whilst most of this doctoral research was completed before the term 'matrescence' was learned, it is hoped that

conceptualising the concept within occupation will provide a baseline for future consideration and debate around relevance and adaption of the term for occupational therapy.

THESIS STRUCTURE

This thesis is structured according to La Trobe University's 2018 *Schedule for presentation of theses for higher degrees by research.* An outline of thesis chapters, not including this introductory chapter, is as follows:

Chapter two introduces key theoretical concepts and terminology unique to understanding occupational therapy in addressing perinatal health, wellbeing, and transitions. **Chapter three** comprises a systematic literature review exploring what is known about how contemporary occupational therapy services are being utilised around the world by maternal health clients to address their holistic health issues, needs and benefits/outcomes during perinatal transitions. **Chapter four** presents a position paper about the perceived place and potential for occupational therapists to join perinatal maternal health teams. This was written as a viewpoint article, published in the *Australian Journal of Occupational Therapy* in 2015. The methodology guiding this research, and the research method for collecting, analysing, and reporting data are discussed in **chapters five and six.**

Findings from a multiple case study are presented in **chapters seven to nine**. Case summaries are reported as two cohorts; occupational therapists, and women who were service users. The 16 occupational therapist case summaries in **chapter seven** are divided into Australian and international occupational therapists, which are then reported in a four-part cross-case analysis in **chapter eight. Chapter nine** reports on the experiences of two mothers from Australia and the USA who used occupational therapy during the perinatal period. **Chapter ten** provides a discussion on what was learned about the role of

occupational therapy in perinatal health. Occupational therapy approaches and the practice scope of occupational therapy to address women's occupational performance needs during perinatal stages are highlighted.

The broader role for occupational therapists is theoretically conceptualised in **chapter eleven**. A perinatal language for occupational therapists is proposed in the context of woman-led practice and co-occupation-centred practice in working with women through perinatal stages, motherhood, and maternal developmental transitions (matrescence). A conceptual practice model, the Person-Centered Occupational Model of Matrescence (POMM), is proposed to extend the perinatal practice paradigm for occupational therapists. Conclusions and recommendations based on the literature review and case study are outlined in **chapter twelve**, regarding practice implications, education, policy development and future research. Limitations are discussed and concluding remarks are made.

CHAPTER SUMMARY

This first chapter provides an overview of the doctoral research completed, and my personal motivation and professional perspective as an occupational therapist and student researcher in the context of existing maternal healthcare services policy, design, and future directions. The research aims have been identified, with a discussion about the methods to address the research problem and the significance of the research. In the next chapter, the key concepts informing the research design of this study are outlined.

CHAPTER 2: KEY DEFINITIONS AND CONCEPTS THAT INFORMED THIS STUDY

"Knowledge is like a garden; if it is not cultivated, it cannot be harvested."

– African Proverb

INTRODUCTION

Much time was spent early in this doctoral candidature reading, processing, reflecting, discussing, and thinking about terms and concepts that would guide this study. The starting point was a clear definition of what constituted the perinatal period. In the first part of this chapter, this definition is described. As an occupational therapist, the concepts of maternal development, occupation, and co-occupation were important in guiding my thinking. These concepts are described in the second part of this chapter.

DEFINING THE PERINATAL PERIOD

There is no singular definition of the term perinatal. Definitions of when this period begins and ends are inconsistent across medical, nursing, allied health, and health sciences literature. According to the Dictionary of Public Health (Porta, 2018b), *perinatal* technically defines, "the period from the onset of labour to restoration to normal of the maternal uterus and adnexum after delivery of the infant"; however, "for statistical purposes … lasts from the 28th week of pregnancy until the end of the first week of life of the infant" (p. 183). *Perinatal care* refers to the "medical and nursing care of a woman and her offspring 'around' the natal period; i.e., preceding, during, and for a short time after childbirth" (Porta, 2018a, p. 183).

In maternal psychology research, O'Hara and Wisner (2014) noted that "most investigators use a period ranging from four weeks after delivery to three months after

delivery" (p. 2) when defining the postnatal period. The DSM-V diagnostic criteria for a range of mental illnesses experienced by women during pregnancy and postpartum periods extends the perinatal period up to one year following birth (O'Hara & Wisner, 2014; Stuart-Parrigon & Stuart, 2014). Early postpartum periods in physiotherapy vary, usually concluding at 12-weeks for both physical and mental health outcomes; however, there is recognition that women's issues continue beyond this time if untreated (Benjamin et al., 2014; Norman et al., 2010; Woodley et al., 2020).

REFRAMING POSTPARTUM RECOVERY AS A 'FOURTH TRIMESTER'

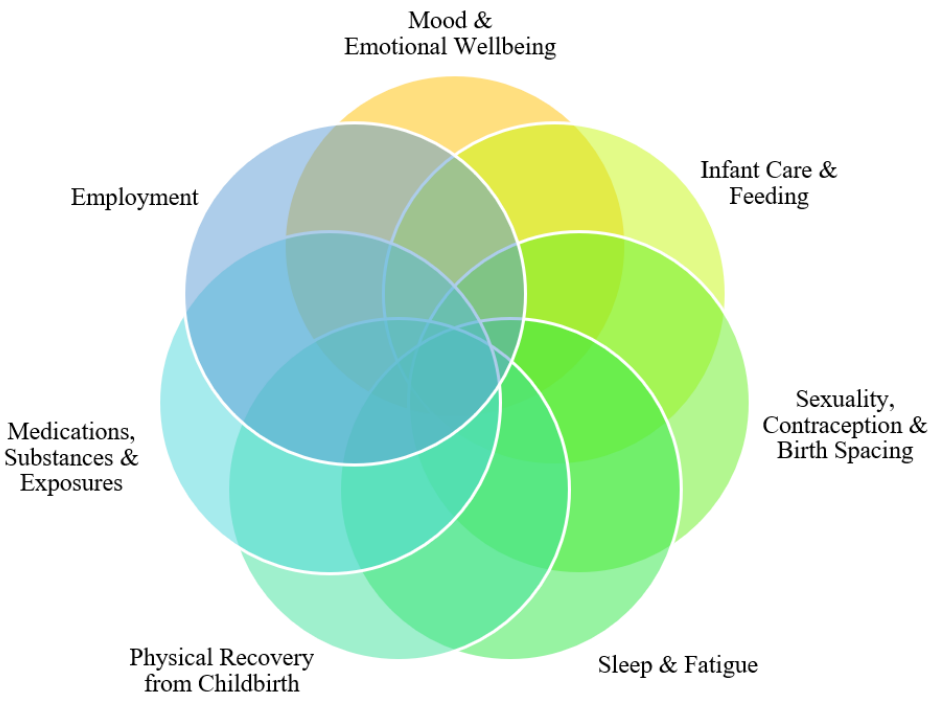
Traditionally, women's pregnancies have been conceptualised as three trimesters. The concept of a 4th trimester has merged and influenced thinking around the time span of the perinatal period (Tully et al., 2017; Verbiest et al., 2018; Verbiest et al., 2017). The *4th Trimester Project* was led by a team of American researchers between 2015 and 2017 and conceptualises how maternal health issues can intersect and compound in the early postpartum period. In the 4th trimester, the first three months of the postpartum period is recognised as "a time of considerable recovery and adaption for women" (Verbiest et al., 2018, p. 578), which require enhanced and holistic support.

The 4th Trimester Project was developed in response to input from key maternal stakeholders and is built on the six interrelated health domains that influence maternal wellbeing: maternal mood and emotional wellbeing; infant care and feeding; sleep and fatigue; physical recovery from childbirth; sexuality, contraception, and birth spacing (the amount of time between births); medications, substances, and environmental exposures (Tully et al., 2017). This model reflects women's calls for a more holistic approach to health services and support and frames the intersectionality of the connected domains to advocate for improved understanding of the complexities required throughout the whole perinatal

period (Verbiest et al., 2018). A subsequent review of this model called for 'employment' to be added as a key theme (refer Figure 1); recognising the woman's need to return to work, shifting to a co-parenting model of infant care, and the complex demands of balancing work/home/mothering occupations whilst recovering from pregnancy and childbirth (Verbiest et al., 2018).

FIGURE 1

Seven interrelated health domains influencing maternal wellbeing in the postnatal period



Note: Interpretatively adapted from the Figure titled *Interrelated health domains in the fourth trimester*, by Tully et al. (2017), in "The fourth trimester: A critical transition period with unmet maternal health needs", *American Journal of Obstetrics and Gynecology*, *217*(1), 37-41. https://doi.org/10.1016/j.ajog.2017.03.032, p. 39, to incorporate revisions recommended by Verbiest et al. (2018), in "Elevating mothers' voices: recommendations for improved patient-centered postpartum", *Journal of Behavioral Medicine*, 41(5), 577-590. https://doi.org/10.1007/s10865-018-9961-4.

This conceptually challenges the dominant care approach of delivering the bulk of maternal health services during a women's pregnancy and reinforces the importance of the postnatal period when conceptualising perinatal needs.

OCCUPATIONAL THERAPY'S DEFINITION OF THE PERINATAL PERIOD

In occupational therapy, Fernandes (2018) defined the perinatal period as "during pregnancy and the postpartum period" (p. 1), without clarifying when that concludes. In 2019, the National Health Service (NHS) Health Education England funded a practice guide titled, *The Engagement of Allied Health Professionals (AHPs) and Psychologists in the maternity care pathway*. In this guide 'maternal care pathways' were described which expanded on the scope of perinatal health and covered the following areas (Davis & Lovegrove, 2019):

I. Pre-conception,
II. Antenatal,
III. Intrapartum,
IV. Post-partum,
V. First-year post-birth.

Authors describe occupational therapists working throughout these perinatal phases, naming a range of practice settings including "hospital outpatient clinics, community clinics, patients' homes, children's centres" (Davis & Lovegrove, 2019, p. 101). The *Engagement of Allied Health Professionals and Psychologists in the maternity care pathway* practice guide (Davis & Lovegrove, 2019) was commissioned to document the health promotion, prevention, and health practices by allied health professionals and psychologists from pre-conception until one-year postpartum. In the UK, the Royal College of Occupational Therapists (RCOT) website offers "good practice" examples for each maternity care pathway

stage (Payne, 2019). Table 2 is adapted from Payne's (2019) description of occupational therapy roles throughout “the maternity care pathway”.

TABLE 2

Examples of occupational therapy roles during perinatal phases

Maternity care pathway stage	Examples of occupational therapists’ role
Pre-conception	Enabling women to consider the implications of known physical or mental health conditions on pregnancy, birth, and motherhood
Antenatal	Fatigue management, preparing for a change in role, workplace adjustments, facilitating home adaptations
Intrapartum	Ensuring equipment is in place for a safe and dignified delivery
Postpartum	Supporting positive co-occupations between mother and baby, and enabling parents of infants who are premature, sick, or unwell to support their baby’s self-regulation and development
The first year of the infant’s life	Enabling mothers to develop healthy routines for themselves, their baby and family, and promoting mothers’ physical and mental health through a range of individual and group interventions

Note: Adapted from the description of occupational therapy roles throughout the maternity care pathway by Payne, (2019), in *The role of occupational therapists in the maternity care pathway*, Royal College of Occupational Therapists, retrieved 1 July 2021 from https://www.rcot.co.uk/news/role-occupational-therapists-maternity-care-pathway.

While definitions of the perinatal period vary, in this thesis the following has been adopted: the perinatal period encompasses pregnancy, intrapartum (labour, childbirth and immediate postpartum) and postpartum periods, up until the first year of the child’s life.

MATERNAL ROLE DEVELOPMENT THROUGH THE PERINATAL PERIOD

In the early stages of designing this study, much consideration was given to the concept of maternal role development. As an occupational therapist, maternal role development was deemed an important starting point when thinking about key concepts that would inform my work. Maternal role development is increasingly recognised as a key component impacting a woman's perceived competence to care for her infant's multifaceted developmental needs, and fundamental for positive mother-infant bonding and attachment (Emmanuel et al., 2011; McNamara et al., 2019). According to Lederman and Weis (2009), maternal role development refers to the process of identity transformation a woman experiences when transitioning through seven dimensions of psychosocial adaptation to become a mother. Lederman and Weis (2009) conceptualised that maternal role development predominantly occurs in the prenatal period, influencing a woman's sense of personal identity as a reflection of her experiences during pregnancy adaptation, labour, birth outcomes, and postpartum maternal psychosocial adaptation. The seven dimensions for maternal role development include: acceptance of pregnancy; identification with a motherhood role; relationship with the woman's mother; relationship with husband/partner; labour preparation; prenatal fear of pain; sense of helplessness and loss of control in labour; and prenatal fear of self-esteem loss during labour (Lederman & Weis, 2009).

Difficulties a woman experiences during maternal role development are linked to maternal stress and maternal distress in the postpartum period (Emmanuel et al., 2011; Shrestha et al., 2019) There is growing awareness of the need to support women with the prevention and management of maternal stress, particularly with first-time mothers in the first six weeks post-childbirth (Hung, 2007). Perceived difficultly with a mother's perception of her competence to positively care for her child can result in maternal distress, which has been linked to increased incidences of child abuse and neglect (Emmanuel et al., 2011).

Recognising the need and scope for addressing challenges through health promotion, prevention, early intervention, recovery, and rehabilitation during both pre- and postnatal periods, this research consolidates and relates women's health, wellbeing, and development into occupational contexts throughout the whole perinatal period.

CONCEPTUALISING OCCUPATIONAL THERAPY IN PERINATAL HEALTH

Occupational therapists have been exploring a place in maternal health for decades. During the late 1970s to early 1990s, there was a growing body of research exploring the unique role of occupational therapy in interdisciplinary prenatal and postnatal maternal healthcare (Burke et al., 1987; Ferland & Piper, 1981; Francis-Connolly, 1998; Grossman, 1991; Hamilton-Dodd et al., 1989; Morris, 1978; Tipton-Burton & Burton, 2013). Authors of more recent literature acknowledge, explore, and define mothering, maternal and perinatal occupations, including challenges, co-occupations, and role adaptation considerations (Finlayson et al., 2020; Heine, 2020; Lesley, 2012; Rouhi et al., 2019; Sethi, 2019; Vidmar, 2020a).

A textbook titled *Mothering occupations: Challenge, agency and participation* (Esdaile & Olson, 2004) was initially regarded as a primary resource to conceptually frame the role of occupational therapists. With foundations in occupational therapy and occupational science, Esdaile and Olson (2004) categorised "mothering occupations" and "co-occupations" within occupational therapy and occupational science contexts, identifying mothering as "one of the most important occupations of women" which historically has been largely "neglected" by occupational therapy (p. ix). The term 'mothering occupations' contextualises the occupations of anticipating, choosing, experiencing, performing, surviving, and developing as 'mothers', and navigating issues related to the "themes of challenge,

agency, and participation" (Esdaile et al., 2004, p. 4). In the context of mothering co-occupations, the term 'mother' refers to the primary caregiver (Esdaile et al., 2004). Pizur-Barnekow and Pickens (2019) recently illustrated how co-occupations could be understood through four interrelated aspects, including; Shared physicality, shared communication, shared emotionality, and shared intentionality.

Esdaile and Olson (2004) highlighted the unique challenges associated with mothering occupations and maternal wellbeing in the contexts of modern feminism, identity, self-efficacy, perinatal transitions, role performance, and co-occupation. Occupational performance issues were contextualised within occupational engagement and deprivation risks, lifestyle redesign issues, family-centred care, and the changeability of occupational performance dynamics throughout the lifespan. These authors offer conceptual foundations for clinical practice considerations, fundamentally calling for further research into women's physical, biological and occupational issues and needs during pregnancy, birth, and motherhood (Esdaile et al., 2004).

Occupational therapists are highly educated in the personal, cognitive, affective, and physical aspects of human performance (Rexe et al., 2013). However, a malalignment with health services often sees occupational therapists positioned with a vast range of skills and expertise that are "underused and not working to their full scope of practice" (Rexe et al., 2013, p. 70). In a non-traditional and emerging area of occupational therapy, the scope of professional practice for perinatal maternal health populations requires clarification.

THE CONTEMPORARY PARADIGM OF OCCUPATION

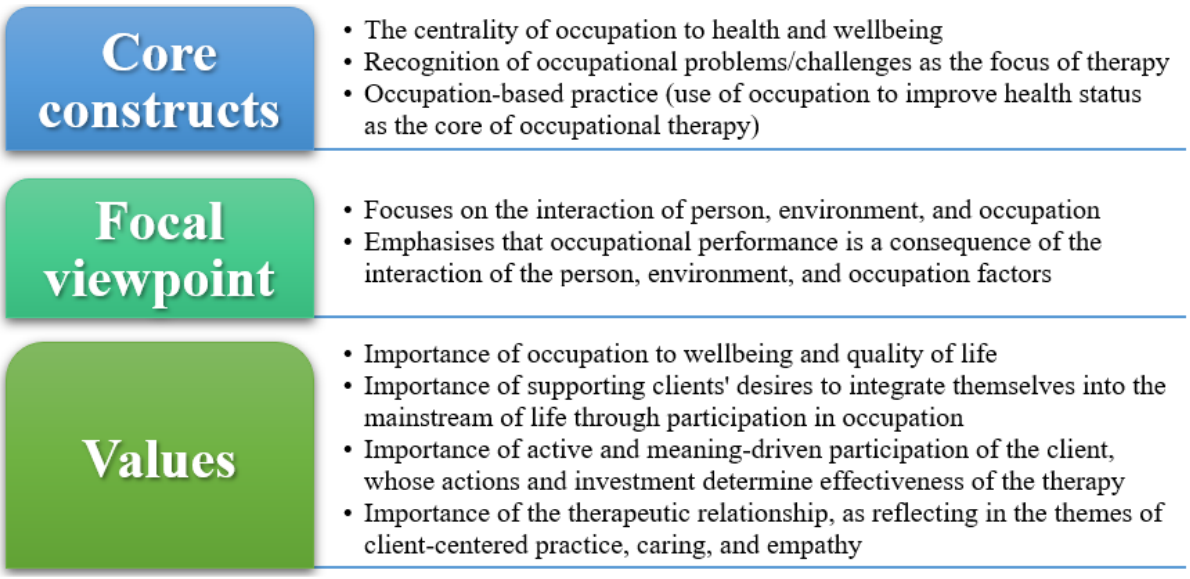
Whilst diverse at times, occupational therapy practices around the world are united by a focus on occupation, and occupational function (American Occupational Therapy Association (AOTA), 2014; Canadian Association of Occupational Therapists, 2012; College

of Occupational Therapists, 2015; Occupational Therapy Australia, 2017). The paradigm of occupation originated at the beginning of the 20th Century, developed by a diverse team of nurses, physicians, architects and craftspeople (Kielhofner, 2009). It evolved from the moral treatment movement for people with mental illness and was based on a central premise that "participation in various tasks and events of everyday life could restore persons to more health and satisfying function" (Kielhofner, 2009, p. 17). The original paradigm of occupation aimed to extend this concept to support people adjusting to life with disability or illness, using occupation to influence their transition. Concepts were based on humans as being occupational beings, the mind-body connection, balance in occupations, and managing occupational participation interruptions (Kielhofner, 2009).

From a conceptual practice philosophical perspective, the contemporary occupational paradigm informing occupational therapy practice (Figure 2) seeks to, "restore the field's original focus on occupation" (Kielhofner, 2009, p. 49).

FIGURE 2

The core constructs, focus, and values of the contemporary occupational paradigm



Note: Adapted from Table 5.1, *The contemporary occupational paradigm*, in "Conceptual foundations of occupational therapy practice", by Kielhofner, G. (2009), FA Davis, p. 49.

This approach has been described as, “an international movement that endeavours to benefit individuals and societies by focusing on the important, many would say essential, dynamic between what people do and their states of well-being” (Iwama, 2003, p. 582). Occupational therapists generally draw from six conceptual models to guide practice decisions, including the biomechanical, motor control, sensory integration, cognitive, functional group, and the model of human occupation (Kielhofner, 2009), any of which have potential relevance to women during perinatal stages and motherhood transitions.

PERSON-CENTRED PRACTICE: HOW THE OCCUPATIONAL PARADIGM REFRAMES WOMEN AS PEOPLE

Woman-centred care is valued by both women and maternal healthcare professionals in perinatal health for being sensitive, respectful and recognising women’s needs for nurturing care (Finlayson et al., 2020; Vogels-Broeke et al., 2019). Woman-centered care is a practice approach unique to maternity services which aims to prioritise the woman (Brady et al., 2019; Council of Australian Governments, 2019), and is influenced by politicised concepts of perinatal reproductive health and gestational stages, gender, and maternalism (Barnett, 2020; Brady et al., 2019; Jenkins et al., 2015; Pascoe Leahy & Bueskens, 2020b; Verbiest et al., 2018). Working with women as individuals in a culturally sensitive way can be challenging in woman-centered care (Jenkins et al., 2015), leading to recommendations for a shift towards more person-centered practice approaches (Verbiest et al., 2018).

Occupational therapists prioritise client-centred practice; a “humanist philosophy [which] provides a foundation for occupational therapy practice”, and “means occupational therapists are person-centred in their relationships with all their clients” (World Federation of Occupational Therapists, 2010, p. 1). A position statement defining client-centered practice

by the World Federation of Occupational Therapists (2010) clarifies that clients can include individuals, groups, families, communities, organisations, and populations. This approach differs from woman-centered care and provides a unique lens guiding how occupational therapists work with perinatal populations.

Person-centred occupational therapy interventions involve collaboration with clients, promoting evidence-based practices to optimise adaptive and compensatory strategies, disability prevention and health promotion, and maintain, establish or restore skills and abilities (Schultz-Krohn & Pendleton, 2013). There is a need to consciously and critically consider the 'individual' and what constitutes 'wellbeing' in client-centred occupational therapy practice (Hammell & Iwama, 2012; Iwama, 2003). Assuming that occupational performance is linked to wellbeing (Hammell & Iwama, 2012), the exploration of a role for perinatal occupational therapists had to include critical consideration of who a mother is, as a person.

MOTHER-INFANT CO-OCCUPATIONS

Working with mothers and infants to address co-occupations has been explored for over a decade in occupational therapy and occupational science (Cardin, 2020; Fraga et al., 2019; Olson, 2004; Pickens & Pizur-Barnekow, 2009; Pitonyak, 2014; Pizur-Barnekow et al., 2014; Zemke & Clark, 1996). The importance of bonding and the link between health outcomes for mothers and infants is well known (Branjerdporn et al., 2020; Department of Health, 2019c). The term '*co-occupation*' refers to the shared physicality, emotionality, and intentionality in the context of shared meaningful engagement in occupation (Pickens & Pizur-Barnekow, 2009; Pierce, 2009; Pizur-Barnekow & Erickson, 2011). In the unique mother-infant relationship, co-occupation is recognised as a fundamental client-centred

practice framework for maternal health practices and paediatric occupational therapy (Gibbs et al., 2016; Olson, 2006; Pickens & Pizur-Barnekow, 2009; Pizur-Barnekow & Erickson, 2011; Price & Miner, 2009; Turner et al., 2012; Vidmar, 2020a).

Olsen (2004, p. 29) defines that co-occupations of mothers and their young children can be understood as "the crucibles within which a young person's neuropsychobiological systems develop [their] ability to self-regulate" (p. 29). In contrast to more generalist discussions (Pizur-Barnekow & Pickens, 2019), definitions of co-occupations within the mothering context typically prioritise the child's needs, health, and developmental outcomes as central, with considerations for the mother being secondary (Branjerdporn, 2021; Branjerdporn et al., 2021; Doidge, 2012; Pitonyak, 2014; Price & Miner, 2009). This appears owing to occupational therapists mostly applying co-occupations when working with mothers in paediatric settings, where the infant's health and developmental outcomes necessarily guide practice.

Co-occupation strongly influences positive promotion of mother-infant bonding (Briltz, 2019; Doidge, 2012; O'Brien & Lynch, 2011), infant development, and maternal wellbeing and health outcomes (Aubuchon-Endsley et al., 2020; Esdaile & Olson, 2004; Pitonyak, 2014). By acknowledging this inextricable relationship dynamic, co-occupation contextualises the influence and interactions of the mother-infant dyad on the experience of altered identity, independence, and roles for mothers throughout perinatal transitions (Briltz, 2019; Doidge, 2012; Erlandsson & Eklund, 2003; Horne et al., 2005).

CHAPTER SUMMARY

In this chapter key definitions and how they informed the research design of this study were clarified and established. The following chapter reports on a systematic literature review exploring what is known about the role of occupational therapy in perinatal health.

CHAPTER 3: LITERATURE REVIEW

"You can't really know where you are going until you know where you have been."

– Maya Angelou

INTRODUCTION

This chapter reports on a literature review that outlines how occupational therapists are working with women during perinatal transitions. The diversity of women's health and wellbeing needs during perinatal transitions are being increasingly recognised. Occupational therapists working with maternal clients is an emerging area of practice, and there is a lack of awareness about how services support women's occupational needs during perinatal transitions. The rationale, background, methods, and findings for the review are reported, with discussion and conclusions highlighting the need for further research to explore and understand the role, place, and scope for perinatal occupational therapy.

BACKGROUND

As a relatively new and emerging area of non-traditional practice for occupational therapy, the scope of practice in perinatal maternal health is currently ill-defined and relatively unknown. Occupational therapy practitioners require access to relevant research to guide clinical decisions, and access evidence-based best practices and meet professional registration standards (Brayman et al., 2014; Stein et al., 2013). Full scope of practice capacities of occupational therapists may arguably offer a skillset well suited to support women transitioning to motherhood; however, evidence is needed to clarify this. A literature

review using a systematised search strategy was applied to explore what is known about contemporary occupational therapy practices with perinatal populations.

RATIONALE

A preliminary search in Google and Google Scholar indicated that most of the information describing occupational therapy practice in the perinatal period was unpublished and was not empirical research. The search revealed a dearth of relevant research before 2003. As the aim of the review was to deliver a summary of what is known about the contemporary role of perinatal occupational therapy practice for women, literature prior to 2003 was deemed not relevant. This review focused on consolidating a collection of academic literature reporting on how occupational therapists are working in perinatal maternal health.

While informed by and closely aligning with systematic review processes, this is not a true systematic literature review. Systematic reviews collate relevant evidence to answer a specific research question, "using explicit, systematic methods to minimize bias in the identification, selection, synthesis, and summary of studies" (Moher et al., 2015, p. 4). The systematic review offers methodical transparency and replicability, with a framework that demonstrates efforts to maximise research integrity (Moher et al., 2015). This framework aimed to provide a broad overview of existing literature, identify research gaps, and clarify future priorities for investigation. The literature review design followed the systematised search process used in systematic literature reviews, and study selection was performed in a systematic manner (Cooper et al., 2018; Jahan et al., 2016). Narrative synthesis of the evidence was used "instead of a specialist synthesis approach because the studies included [were] insufficiently similar to allow for this" Popay et al. (2006, p. 7).

AIMS AND OBJECTIVES

The aim of this review was to consolidate what is known about the role of occupational therapists working with women perinatally. This included documenting and exploring how occupational therapists worked in perinatal health to clarify to role and scope of existing contemporary professional practice areas.

DEFINING THE RESEARCH QUESTION

In defining the research question, an initial search was undertaken to identify the scope of the study. Most research and published literature relating to the role of occupational therapists working with the maternal population were predominantly focused on the child's health, with the wellbeing of the mother a secondary consideration. Many authors were presenting theoretical propositions rather than describing how occupational therapists were working with perinatal clients. As the focus of this study is on the role of occupational therapists in maternal health during perinatal periods the final research question to guide the search strategy was:

> *'How are occupational therapists working with women during perinatal periods until one year postpartum?'.*

METHODS

SYSTEMATIC SEARCH METHODS

Evidence was searched from 2004 to September 2021. Informed by preliminary findings from an early unpublished scoping review completed by myself and supervision team in 2014, the first systematised search was completed on 13 July 2018 and was replicated on 5 September 2021 to maintain recency prior to thesis submission.

DATABASES SEARCHED

Searches were conducted in the CINAHL, Cochrane Library, Medline, OT Seeker, ProQuest Central (Dissertations and Theses), PsychINFO and Scopus databases. Further searches were completed in Google and Google Scholar. A hand search was completed by reviewing key references of identified articles, and by searching for key authors identified through the systematised search process.

METHOD TO IDENTIFY SEARCH TERMS

The literature search terms were developed with an academic research librarian. Based on the research question, three main search concepts were developed: Occupational therapy, mothers, and perinatal stages. Key terms within the concept of perinatal were expanded to include specific maternal status descriptions, in keeping with maternity care terminology.

KEYWORD SEARCH STRATEGY

Using the modified population, intervention, comparison, and outcomes (PICO) grid (Table 3), search terms were combined within each key concept using the Boolean operator "or", and truncations in subject headings. Search results were then combined using the Boolean operator "and". Results were reviewed, noting MeSH headings and keywords relating to exclusion criteria (refer Table 4).

TABLE 3

Refined search terms in modified PICO grid

Population: perinatal* OR peri?natal* OR antenatal* or ant?natal* OR post? partum* or postpartum OR post?natal* OR pre? conception OR birth OR parturition OR mother* OR pregn* or matern*
Intervention: occupational therap*

DATA SELECTION

Results were exported to EndNote V9.3.3 (The EndNote Team, 2013), where duplicates were manually removed by one reviewer (myself). The remaining articles were imported from EndNote into the Covidence software package (Veritas Health Innovation) for sifting, sorting, and charting. Articles were screened initially according to the title and abstract, with potentially eligible articles then considered through full-text review by all four reviewers, including myself. Any further duplicates were identified and removed electronically in Covidence. All searching and sifting the articles found from database searches were completed by two reviewers; myself (100%) and one other reviewer (100% shared equally between three other reviewers), in three stages (1. Titles; 2. Abstracts; 3. Full-text) to ascertain compliance with inclusion/exclusion criteria, and screened all articles at each stage of the collection process.

SELECTION CRITERIA

Search results were further limited as per the inclusion and exclusion criteria developed and agreed upon by the research team (refer Table 4).

TABLE 4

Literature review inclusion and exclusion criteria

Inclusion	Exclusion
Occupational therapists providing discipline-specific interventions to women as primary clients, during perinatal periods (pregnancy until 12-months postpartum)	Research published prior to 2004
Mothers aged >18-years	Full-text article not available in English
Articles written in English	Articles that did not provide evidence relating to occupational therapy
Full-text available	Paediatric occupational therapy intervention focus
Theses or peer-reviewed articles	Articles that did not focus on mothers as the primary population
Mothers of infants aged <12-months	Mothers of infants aged >12-months
Women during pregnancy, birth, and postnatal stages (<12-months postpartum)	Mothers of children with disabilities/illness/ injuries, including NICU and preterm babies (where the child's additional needs are/become the focus of occupational therapy interventions)
Primary research	Fathers and other parents/guardians are the focus of occupational therapy services
Research published between 2004 to *current* (5 September 2021)	Conference abstracts
	Grey literature
	Reviews (including but not limited to; systematic, scoping and critical reviews)

STUDY SELECTION

Each article was reviewed by two (of four) reviewers, including myself, who were each blinded to the decision of other reviewers in Covidence. Decisions were tracked in Covidence and full-text decisions coded according to exclusion criteria. Where there was uncertainty or ambiguity, these articles were discussed with all four researchers until consensus was reached on whether the article met the inclusion criteria. Discrepancies were resolved with focused debate amongst the team, to clarify and establish eligibility against inclusion and exclusion criteria.

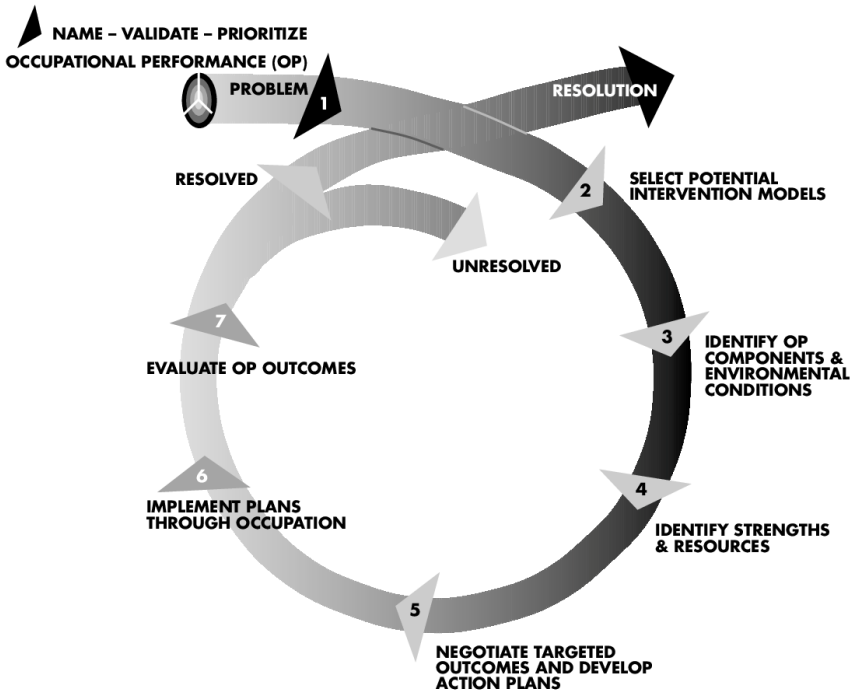
SYNTHESIS OF RESULTS

Methods for data analysis, synthesis, and interpretation integrated a combination of qualitative and narrative/descriptive synthesis (Hyvärinon, 2015; Popay et al., 2006; Torraco, 2005). Data were sifted and sorted by one research (myself) using themes adapted through a

process of deductive theoretical theme analysis (Braun & Clarke, 2006, p. 12; Saldana, 2013, p. 14) using domains of the Process of Occupational Adaptation (Kielhofner, 2002) to contextualise the occupational therapy services tailored for maternal health clients. These were structured to follow the seven stages of the Occupational Performance Process Model (OPPM) (refer Figure 3), reflecting typical client-centred occupational therapy practice across lifespan developmental phases (Fearing et al., 1997). Final themes were reviewed and refined by all four members of the research team.

FIGURE 3

Occupational Performance Process Model (OPPM)



***NOTE**:* Reprinted from Figure 4 in "An Occupational Performance Process Model: Fostering client and therapist alliances", by Fearing et al. (1997), in the *Canadian Journal of Occupational Therapy*, 64(1), 7-15. https://doi.org/10.1177/000841749706400103, p. 11.

DATA CHARTING AND COLLATION

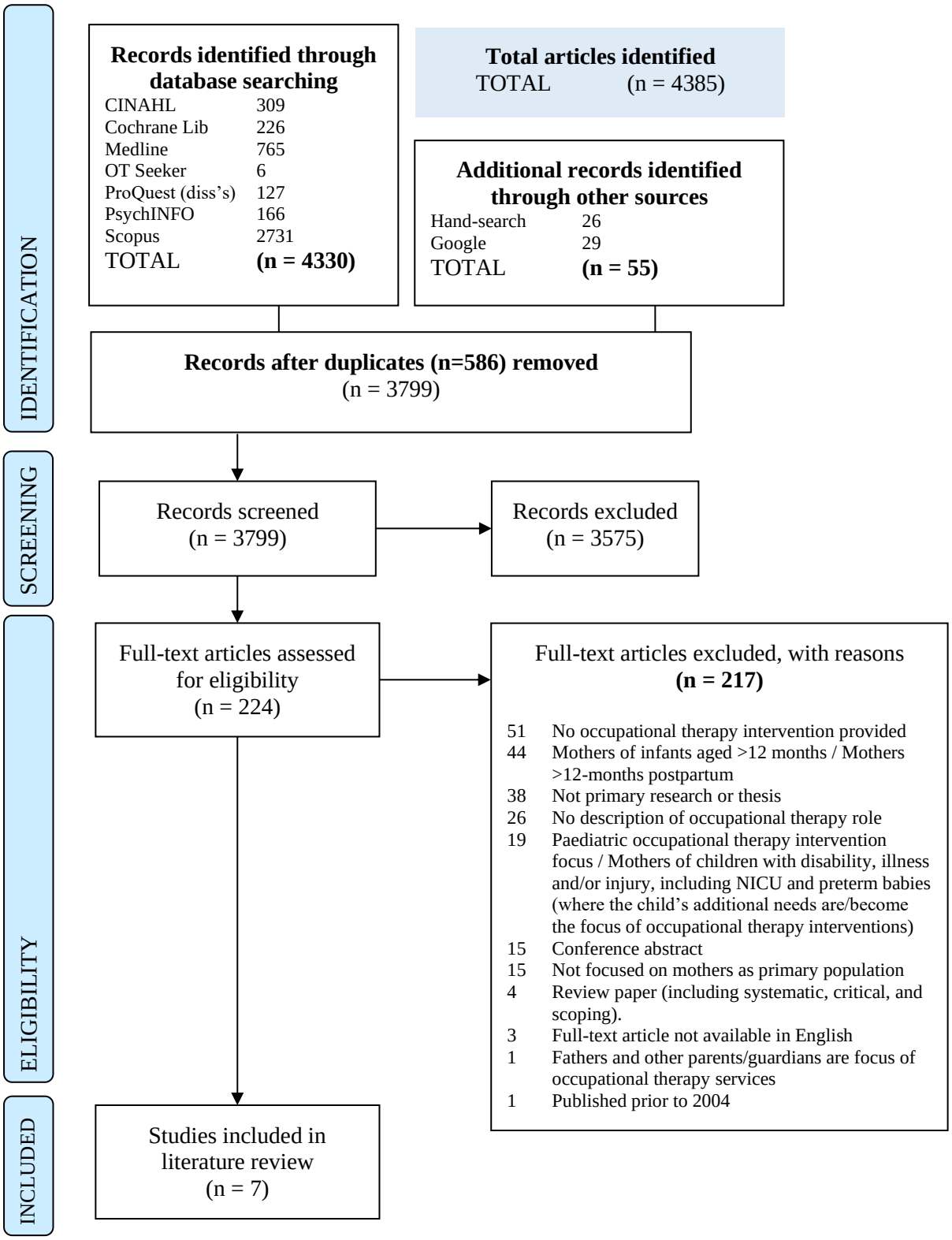
The included articles were charted and collated to improve transparency with reporting on data aligning with key inclusion criteria which addressed the research question. Efforts were made to reference common data components, which included study methods, participants and setting, interventions, process evaluations, results, and eligibility criteria (Li et al., 2021). Key defining characteristics of articles and theses were reported, search sources noted, evidence quality and levels were evaluated using critical appraisal tools and the Oxford Centre for Evidence-Based Medicine (OCEBM) matrix (2011) respectively, and each occupational therapy role was summarised.

RESULTS

The searches in 2018 and 2021 elicited a combined total of 4385 papers located. A total of 224 articles were deemed potentially relevant to the research aims. Following the full-text review, seven articles met the inclusion criteria. This process is represented in a PRISMA flow diagram (Booth et al., 2012) (refer Figure 4).

FIGURE 4

Literature review PRISMA flow diagram



Note: Adapted from "Preferred reporting items for systematic reviews and meta-analyses: The PRISMA Statement", by Moher., et al, and The PRISMA Group (2009), in *PLoS Med 6*(6): e1000097, https://doi.org/10.1371/journal.pmed.1000097

While most articles clearly met exclusion criteria, many required discussion and lengthy debate amongst the research team. The research team needed to clarify and establish if the role of the occupational therapist was focused on the mother or the child in 19 papers. This was most ambiguous when research reported on the role of occupational therapists in neonatal intensive care units (NICU). While many NICU occupational therapists considered the mother-infant dyad and focused on co-occupations, the infant's complex and fragile condition ultimately determined the cause for occupational therapy input, which was a criterion for exclusion.

STUDIES DIRECTLY RELEVANT TO THE REVIEW QUESTION

Although not a necessary component of literature reviews, papers were critical appraised and levels of evidence evaluated. Articles that directly addressed the research question and met inclusion criteria were critically appraised for quality using the Critical Appraisal Skills Programme (CASP) checklist tools for qualitative and quantitative studies (Critical Appraisal Skills Programme, 2013, 2021a, 2021b), and the Mixed Methods Appraisal Tool (MMAT) (Hong et al., 2018) for mixed methods research publications.

Acknowledging "there is no consensus on the necessity, merit, or appropriate approach to appraising the quality of qualitative research", (Majid & Vanstone, 2018, p. 2116), evidence quality was evaluated by reflectively reviewing items from each checklist and grading as low, medium, or high. Levels of evidence were evaluated by referencing the OCEBM Levels of Evidence table (Oxford Centre for Evidence-Based Medicine, 2011).

The final seven studies directly relevant to the review question are reported in Table 5, and list appraisal tools used and levels of evidence.

TABLE 5

Studies directly relevant to the searchable question

No.	Name of first author	Year	Location	Journal / Source	Research design / Methods	Sample/Setting	Main findings	Level/quality of evidence	Occupational therapy role (relevance to research question)
1	Cardinale, J.	2014	USA	*Journal:* Occupational Therapy in Mental Health *Source:* CINAHL ProQuest Scopus	Mixed-method, quantitative/ qualitative research investigation. *Data collection:* Forms for demographic/personal profile information, Personal Growth Initiative Scale, Client Satisfaction Questionnaire, researcher field notes. *Intervention:* 5 x 1.5-hour semi-structured occupational therapy group sessions, run biweekly over 14-weeks.	Purposive sample of mothers (n=3) aged 25–29 years of age, in recovery from drug addiction. All participants received occupational therapy intervention.	• Motherhood impacts recovery • Mothering roles influence identity • Motherhood routines provide structure to aid personal growth and recovery • Empowerment program improves connection between meaningful occupations and wellbeing. • Techniques for improving maternal self-efficacy and empowerment used motherhood as motivation for reflection, recovery, and personal growth, in the context of occupational adaptation.	**Level V** *MMAT = **Low***	Occupational therapists can tailor and deliver a meaningful occupation-based community group program to support mothers with children <12-months in their **recovery from drug addiction** through self-efficacy development, reflective and values-based mothering. Strategies incorporate occupational therapy, occupational adaptation, and empowerment principles.
2	Burbidge, K.	2015	England (UK)	*Thesis:* BSc (Hons) Occupational Therapy, University of the West of England *Source:* CINAHL	Phenomenological, qualitative study. *Aim:* To explore the role, interventions and outcome measures occupational therapists used in Mother-Baby Units (MBUs). *Data collection:* Participants described role, assessment methods, interventions, clinical reasoning, and outcome measures. *MBU clients:* Women requiring treatment for serious perinatal psychiatric disorders, admitted to MBU with their baby (<1 year).	Purposeful sampling of occupational therapists working in MBUs (n=6).	• Occupational therapy services are provided in 40% of MBUs in the UK. • Occupational therapy roles in MBUs meet women's needs and MBU service standards. • Occupational therapy interventions improve women's self-efficacy, wellbeing, capacity for self-care and mothering, mother-infant bonding, and home-based independent daily living. • Outcome measurement requires improvement. • Promotion of occupational therapy roles to supporting governing and funding bodies require evidence.	**Level IV** *Qualitative Studies Checklist (CASP) = **Moderate***	Occupational therapy roles in UK MBUs address the occupational nature of motherhood for women with serious **perinatal psychiatric disorders.** Occupational therapists work to support women and mother-infant dyads as perinatal clients to improve their bond and capacity to return home. Services are tailored to address the complex occupational nature of motherhood in relation to maternal mental health and **mother-infant bonding**. Interventions are supported by occupational theory and conceptual practice frameworks.
3	Sechrist, D.	2015	USA	*Journal:* Occupational Therapy in Health Care *Source:* CINAHL Medline Scopus	Pilot study. Quantitative. *Aim*: Examine the effectiveness of the Aquatic Exercise Program (AEP). *Intervention:* AEP designed and provided by an occupational therapist, in collaboration with medical staff. *Analysis:* Retrospective comparative analysis of medical record data of hospitalised pregnant women (control group/AEP intervention group). *Analysis:* Statistical differences in length of gestation, blood pressure, and amniotic fluid index (AFI) at discharge.	Hospitalised pregnant women attended an AEP (n=19); Control group received no AEP (n=12).	• Women who received an AEP had increased AFI and length of gestation compared to the control group. • No statistically significant difference to blood pressure statistics for AEP / control groups. • Use of an AEP intervention is of benefit to pregnant women on prescribed bed rest.	**Level IV** *Case-Control Study Checklist (CASP) = **Moderate***	Occupational therapists can tailor, implement and facilitate an **AEP intervention** to improve pregnant women's AFI and gestation length during **prolonged hospitalised bedrest** on maternity wards. More needs to be known about how participation in occupational therapy-led AEP improved women's psychosocial wellbeing.

4	Visser, M.	2016	South Africa	*Journal:* South African Journal of Occupational Therapy *Source:* Google	Qualitative. Observational, descriptive study design using Delphi technique. *Aim:* Define occupational therapy role in addressing breastfeeding among mothers in the public health sector (PHS). *Data collection:* 4 x iterative rounds of electronic questionnaires via SurveyMonkey. *Analysis:* Electronic Delphi (e-Delphi) to clarify occupational therapy role in addressing breastfeeding and determine the extent of agreement/disagreement. Consensus reached at 80% agreement.	*Recruitment:* Purposeful selection. Remuneration and CPD points offered for time. *Participants:* Female occupational therapists' with >6-years of paediatric experience in PHS hospitals/clinics (n=9).	• Occupational therapists provide a unique and valuable service in transdisciplinary approaches. • Occupational therapists provide a holistic and client-centred approach to support women as mother-child dyads in co-occupation of breastfeeding. • Definite agreement that occupational therapist's roles in the PHS promote and support breastfeeding is congruent with existing literature and global and national initiatives	**Level III** *Qualitative Studies Checklist (CASP) =* ***Moderate***	Occupational therapists work in transdisciplinary teams to address **issues preventing and challenging initiation and continuation of breastfeeding**. Occupational therapy roles in addressing breastfeeding include clinician, consultant, educator, trainer, advocate, facilitator. Occupational therapy approaches to breastfeeding focus on holistic client-centred co-occupational enablement, addressing occupational areas, contextual and environmental factors, performance patterns, performance skills, and personal/ client factors.
5	Ferigato, S. H.	2018	Brazil	*Journal:* Brazilian Journal of Occupational Therapy *Source:* CINAHL Scopus	Qualitative intervention approach. *Aim*: To describe and analyse the corporeality of a group of pregnant women and propose occupational therapy Primary Health Care practices. *Data collection:* Body mapping, photo-voice, image records and field diaries. *Intervention*: 4 x fortnightly group meetings with pregnant women. Aim to promote socialisation and exchange of experiences by providing activities for sensitisation, interaction and construction of other languages. Groups facilitated and evaluated by 2 x occupational therapists and 4 x graduating occupational therapy students, assisted by a Community Health Agent and nurse. *Analysis:* Triangulation through interpolations of views to systematically cross-link data and create thematic axes of discussion.	*Participants:* 1 x group of pregnant women aged 15 to 41 years old (n = 14*). Majority low-income living in city outskirts, without paid work. *Aged >18-years (n=10); Aged less than 18-years (n=4).	• Occupational therapists work with women during pregnancy by receiving and listening, and tailoring creative and meaningful interventions • Performing group and bodily activities provide women with spaces for action, empowerment and coping with situations before gestation. • Sensitive and evidenced therapeutic care promotes awareness and self-perception, addresses women's subjective and taboo needs including sexuality, desire in motherhood, social roles of women, women's protagonism and autonomy in daily life, everyday materiality, and transformations. • Occupational therapy practices promoting women's expression of sensitivities and social connectedness improve women's emancipation, autonomy and protagonism.	**Level III** *Qualitative Studies Checklist (CASP) =* ***Moderate***	Occupational therapy roles in **Primary Health Care** apply a broad and flexible practice scope to work reflexively with diverse populations of pregnant women in the community. The complex nature of issues impacting women's wellbeing can be holistically addressed by occupational therapists in creative and meaningful occupational group settings. Occupational therapy strategies to facilitate communication and social connection benefit culturally and linguistically diverse groups of pregnant women through focusing on sensitive and creative ways to **explore meaningful occupations** together, in the context of everyday life. Interventions address women's diverse experiences of being pregnant in biological, physical, physiological, emotional, social, relational, moral, economic, cultural and gender contexts.

6	Williams, B.	2019	England (UK)	*Journal:* British Journal of Occupational Therapy *Source:* PsychINFO Scopus	Small scale practice analysis. Quantitative analysis of observational assessment tool: Evaluation of Social Interaction (ESI) / Reflective evaluation of intervention quality and effectiveness. *Aim* = 1) Explore guided occupational therapy approach for MDT to provide evidence-based interventions addressing the quality of mothers' social interactions for mother-infant bonding/ attachment. 2) Evaluate if ESI results support parent-focused goals/services. *Method* = Pre/post ESI assessment, collaborative goal setting with an occupational therapist and occupation-based intervention plans. MDT approach in naturalistic settings. ESI assessment repeated after 4-6 weeks intervention. *Data analysis* = Raw scores for pre/post ESI social exchanges using ESI software (Rasch analysis). ESI measure generated graphic representation of linear scores in a comparison results report.	Mothers aged 21-39-years old admitted to MBU (n=12*) from the second trimester of pregnancy up to 12-months postnatally (with their baby if postnatal). *Re-evaluations completed with most mothers (n=8).	• ESI provides specific information on social interaction skills that support and limit competent social interactions necessary for mothering • Collaborative practices using ESI enables mothers to reflectively understand their social interaction strengths and limitations with their babies and partners during parenting occupations. • ESI helped mothers to understand the importance of good quality social interactions with babies and partners • ESI provided the MDT with a tool to document relevant and specific qualitative information, and quantitatively measure MDT outcomes. *Preliminary findings suggest:* • ESI helps to target occupation-focused interventions. • Use of ESI with occupational-based goal-setting improved collaborative MDT interventions relevant to mothers.	**Level IV** *MMSE = **Low***	Occupational therapists' role in **assessing and enhancing women's mother-infant social interaction** skills, issues, needs and goals, can be measured and supported through use of ESI. Occupational therapy designed and led approaches enhance women's self-awareness development and improve the MDT's capacity to deliver collaborative and consistent practices (including occupational therapy). Occupational-centred practices using the ESI clarify the aspects and meaning of social interaction measurably as an occupation and skill which enhances mother-infant bonding.
7	da Conceição, R. M	2020	Brazil	*Journal:* Brazilian Journal of Occupational Therapy *Source:* Scopus	Descriptive, documentary, retrospective, quantitative study carried out in a multi-professional integrated residency health program at a reference hospital in Recife-PE, from April to June 2018. *Aim:* Describe the possibilities of occupational therapist's interventions in a high-risk obstetric centre (OBC/HOC). *Data collection:* 1) Semi-structured retrospective questionnaire with women who had accessed occupational therapy services during prepartum, childbirth, immediate puerperium and other gynaecological/obstetric situations. 2) 351 professional records and 45 reports of occupational therapist residents in a public university hospital who addressed complex care needs of women in OBC. *Analysis:* Statistical analysis of type, distribution, and frequency of occupational therapy interventions in four stages during perinatal transitions.	Retrospective analysis of occupational therapy residents (n=20) professional records from 2010 to 2017. Questionnaire respondents (number of respondents *not stated*)	• Occupational therapy practices in the OBC promotes paradigm changes which makes the woman the protagonist in their performance areas • Opportunity for health promotion. • Most occupational therapy interventions were provided in the puerperium phase, followed by labour and then prenatal and other gynaecological/obstetric situations. • Intervention addressed a spectrum of emotional, social, physical, mother-baby bonding, neuromusculoskeletal, cultural, biopsychosocial, and spiritual aspects of women's function and autonomy. • Regarded the woman as a "holistic being" • Addressed satisfactory performance in the context of self-care, occupational roles, individual and family stress and anxiety, social context, expectations, fears, skills, maternal empowerment, reproductive and human rights, and preventative health.	**Level III** *Case-Control Study Checklist (CASP) = **Moderate***	**Occupational therapists in HOC settings work with women during perinatal periods including prepartum, childbirth, immediate puerperium and other gynaecological/obstetric situations, such as abortion, miscarriage and ectopic pregnancy**. The broad range of holistic practice approaches and interventions were occupation-centred, most frequently addressing ADL's, psychosocial occupations, health education, assistance in labour and childbirth, IADL's. Outcomes for women were determined according to many domains of occupational function, need and satisfaction for women during perinatal phases.

RESULTS OVERVIEW

A total of seven papers were included in the final review. The years of publication ranged from 2014 to 2020, with small sample cohorts in each research paper. The settings were hospital-based in four studies, public health settings in two, and one in the community. Five papers met the criteria for medium quality evidence, and two were deemed low quality. Two studies each from Brazil (da Conceição et al., 2020; Ferigato et al., 2018), the United Kingdom (UK) (Burbidge, 2015b; Williams & Chard, 2019) and the United States of America (USA) (Cardinale et al., 2014; Sechrist et al., 2015), and one from South Africa (Visser et al., 2016) are described. Despite their substantial differences, common themes pertained to clarifying how occupational therapists tailored a broad scope of focused practice skills to meet women's occupational performance needs during complex perinatal periods.

The perinatal population demographics varied significantly in the literature found. Occupational therapy services were provided in low-, middle- and high-income countries, from various cultural, linguistic, social, socioeconomic, health and familial backgrounds. The breadth of demographic data pertaining to women who accessed occupational therapists varied substantially and included age, household income, education level, relationship status, employment status, maternal status, and number of children. The range of causal factors determining women's potential need for occupational therapy input were vast.

The Brazilian-based study by Ferigato et al. (2018) included mothers aged 15 to 17 years (n=4; representing 28.6% of the sample), which met exclusion criteria. The research team determined to include this study, owing to the very low number of search results, the majority of participants being aged 18 years and older, and that the mother's age was not reported to represent a significant difference of the sample in this specific sociocultural population.

KEY THEMES: THE ROLE OF OCCUPATIONAL THERAPY IN PERINATAL HEALTH

Key themes generated from analysis of the articles are categorised under six headings reflecting the roles of occupational therapists in the perinatal period following the seven OPPM stages (Fearing et al., 1997), and described below: 1) The complex and diverse spectrum of women's occupational performance issues, needs and motivations during perinatal stages; 2) Multifaceted and sensitive client-centred occupational therapy approach to perinatal health; 3) The ambiguity of assessing women's issues and needs and measuring occupational outcomes; 4) Translating women's subtle and complex issues, needs and goals into meaningful and valid domains of occupational function; 5) Addressing women's holistic occupational capacities and need for autonomy in collaborative interdisciplinary perinatal teams; and, 6) Enhancing women's meaningful function, self-efficacy development, wellbeing, and satisfying relational needs during motherhood.

1) THE COMPLEX AND DIVERSE SPECTRUM OF WOMEN'S OCCUPATIONAL PERFORMANCE ISSUES, NEEDS AND MOTIVATIONS DURING PERINATAL STAGES

Describing the diversity and complexity of occupational performance issues women experience during pregnancy were approached from holistic perspectives by occupational therapists and researchers. Ferigato et al. (2018, p. 769) regarded many issues women experience were gender-related, resulting from gestation being "an exclusive condition for gendered women" which is uniquely cultural, social, and corporal in nature for each individual. Women's challenges during pregnancy were recognised by da Conceição et al. (2020, p. 112) as related to the "physiological phenomena that enable women to generate a life in their body":

It is a phase of physiological, psychological and socioeconomic changes, which require an adaptive response of women, family and community… The gestational period demands new forms of physical and mental balance, caused by metabolic and hormonal alterations associated with the construction of a new body and occupational image, and … are related to meanings attributed to childbirth and postpartum experiences.

Complex and diverse issues such as significant mental illness and recovery from drug addiction hindered women's ability to engage, perform and develop competence during maternal development and in motherhood occupations such as mother-infant bonding and developing self-efficacy (Burbidge, 2015b; Cardinale et al., 2014; Ferigato et al., 2018).

Confidence and self-esteem play a significant role in how people make choices and decide their paths in life… Without a positive self-concept, a person may lack motivation affecting overall success and productivity [and] … These choices can be detrimental to one's lifestyle and ability to succeed (Cardinale et al., 2014, p. 1)

Issues related to low self-efficacy and self-confidence impacted broader maternal populations. Burbidge (2015b, p. 21) reflected that attaining mothering skills "such as weaning, baby care, child development and managing the loss of previous roles is a large part of the transition to motherhood" were difficult for contemporary women due to changing societal and familial structures.

A distinct challenge to modern motherhood is societal expectations of perfect parenting and pressure from women themselves to perform in areas such as mothering, work and relationships. The reduction of extended families, working mothers and changes in society have resulted in women often feeling de-skilled and unprepared for the parenting role.

Women experienced difficulties when their expectations of maternal and motherhood experiences were not met, and when they lacked the social interaction skills to develop bonded mother-infant relationships with their infants (Burbidge, 2015b; Williams & Chard, 2019). Development of healthy, securely attached and mutually meaningful mother-infant relationships were regarded as critical for both women and infants' holistic motivation, wellbeing, and development (Burbidge, 2015b; Visser et al., 2016; Williams & Chard, 2019). Pregnancy was not always welcome or planned for women, and the resultant shock, fear, and trepidation about becoming a mother could lead to social isolation, low motivation, role and relationship loss, and mental health issues (Ferigato et al., 2018).

2) MULTIFACETED AND SENSITIVE CLIENT-CENTRED OCCUPATIONAL THERAPY APPROACH TO PERINATAL HEALTH

Occupational therapists applied a variety of multifaceted approaches to sensitively work with women. Across low-, middle- and high-income countries, recognition of the need for occupational therapists to be socially and culturally sensitive when providing flexible, holistic, and multifaceted services to perinatal clients were consistent. Therapeutic relationship building was a priority for many occupational therapy roles (Burbidge, 2015b; Cardinale et al., 2014; Ferigato et al., 2018; Williams & Chard, 2019). Exploring avenues to support women with the occupation of breastfeeding in South Africa, Visser et al. (2016) identified the roles for occupational therapists included clinician, consultant, educator, trainer, advocate and facilitator.

In recognition that mothers recovering from drug addiction had previous experiences of abuse in childhood or adolescence, Cardinale et al. (2014, p. 62) reflected that "life-changing alterations are not possible until people take ownership of their past and are able to

identify lessons learned and strengths that they acquired through their experiences". The impact of having compromised childhoods, attachment issues as children, and low self-esteem were important in working with mothers with mental health issues, as parenting their new infant became interwoven with reparenting themselves (Burbidge, 2015b).

Many occupational therapists explored creative solutions to address the diverse and complex nature of maternal issues. These were used to facilitate a sense of safety, communication, connectedness, and social interaction for women in a range of peer-group settings (Burbidge, 2015b; Cardinale et al., 2014; Ferigato et al., 2018). Ferigato et al. (2018, p. 780) described how body movement and performance approaches in creative groups facilitated meaningful therapeutic relationships which enable venturing into "sensitive territory, [through] listening, exchanges and recognition of the most subjective or taboo needs".

3) INTERPRETING AND EVALUATING COMPLEX PERINATAL ISSUES, NEED AND THERAPEUTIC OUTCOMES

Occupational therapists assessed and measured a myriad of factors related to the complex experience of becoming a mother. In Brazil, Ferigato et al. (2018, p. 769) conceptualised how corporeity enhanced occupational interpretation of women's bodies as complex gestational environments:

> *The body is not an organism, a physiology, but something that never ends its structuring. Everything takes place in it: subjectivity, culture, society, powers, oppression, and desires, etc. Each structure of the body results in a material, psychological, social, complex, interconnected, inseparable reality.*

Occupational therapy practices supported women adapting to perinatal transitions; however, related issues were not interpreted or evaluated using this terminology. The term

perinatal was only referenced once by Sechrist et al. (2015) with regard to morbidity and mortality, and it was unclear if this described the mother, infant, or both. Williams and Chard (2019) used perinatal sparingly to describe the overall service, not the role of occupational therapists. In contrast, Burbidge (2015b) applied perinatal regularly to describe the maternal phases, healthcare strategies, health services and area of professional specialisation for healthcare providers in maternal mental health in an MBU.

Transition to motherhood was referenced once by Burbidge (2015b) and was not associated with maternal status, perinatal stages or motherhood by any other researchers. Similarly, a*daptation* was referenced once by da Conceição et al. (2020) and twice by Ferigato et al. (2018) in relation to motherhood, and Burbidge (2015b) connected the term several times in reference to maternal role adaptation. Instead, most research referenced adaptation to describe an occupational therapy intervention approach, connected with the therapeutic strategy of modifying and changing tasks, activities, occupations, and environments to enable enhanced occupational performance (Burbidge, 2015b; Ferigato et al., 2018; Visser et al., 2016).

Several occupational therapists successfully applied and adapted established models and tools to analyse and evaluate issues and outcomes for perinatal clients. In Brazil, da Conceição et al. (2020, p. 113) described how the application of *Occupational Therapy Practice Framework: Domain and Process* theoretical framework guided assessment and interventions addressing occupational performance for women in high-risk obstetric settings. Observational assessments of women's "activities of daily living (ADL), instrumental activities of daily living (IADL), work, education, leisure and social participation" were contextualised by occupations, personal factors and performance capacities, environments, and the "importance of global wellbeing" for promoting participation (da Conceição et al., 2020, p. 113).

While most occupational therapists in a mother-baby unit (MBU) in the United Kingdom (UK) used informal assessment and goal settings methods, some used occupational therapy assessment tools in initial interviews, and adapted "specialist parenting measures" to evaluate motherhood occupations (Burbidge, 2015b, p. 19). Williams and Chard (2019) explored the effectiveness of the Evaluation of Social Interaction (ESI) for evaluating observations of the quality of social interactions between mothers with significant mental illness on recovery journeys and their babies. This assessment tool, "was occupation-centred and thus supported occupation-based interventions", reasoning that, "social skills are essential for developing relationships with others and necessary for almost all desired occupations", and difficult to meaningfully evaluate with other known resources (Williams & Chard, 2019, p. 583).

4) TRANSLATING WOMEN'S SUBTLE AND COMPLEX ISSUES, NEEDS AND GOALS INTO MEANINGFUL AND VALID DOMAINS OF OCCUPATIONAL FUNCTION

Parenting was defined by Williams and Chard (2019, p. 583) as "a multi-faceted occupation that requires participation in many necessary and desired daily occupations both with and on behalf of the infant". Several papers prioritised working with the mother-infant dyad in interventions and outcomes, in the context of health, wellbeing, attachment and engagement in mutually meaningful co-occupations (Burbidge, 2015b; Cardinale et al., 2014; Visser et al., 2016; Williams & Chard, 2019). Extending on this, da Conceição et al. (2020) regarded occupational therapy interventions strengthened bonds between mother-baby-family as a triad.

Mental health issues had potential to disrupt all domains of women's occupational performance, function and engagement with co-occupations, and negatively impact all aspects of their holistic health, wellbeing and self-efficacy during motherhood (Burbidge,

2015b). For mothers with significant mental illness, difficulties applying and developing social interaction skills during parenting were occupational performance issues. Examples of these included, “playing with baby, changing baby’s nappy, bathing baby, conversing with peers and staff when preparing bottle feeds, buying goods in the local shop, catching the bus, buying a drink in the cafe´ or conversing socially with visiting family members” (Williams & Chard, 2019, p. 583).

In the community, Cardinale et al. (2014, p. 45) recognised the connection between intrinsic volitional drivers and the occupation of mothering in offering pathways during recovery and self-growth journeys, noting:

> *Motherhood can be a powerful motivator … [and] rewarding for women experiencing substance abuse, with great effort being placed on trying to become a good mother despite their addiction.*

Occupational interpretations were often culturally informed. In a Brazilian public health community role, Ferigato et al. (2018) identified that women’s occupational challenges were contextualised by sociocultural and socioeconomic power disadvantages related to gender-based societal roles, with key themes being: “sexuality, the dimension of the desire to be a mother, [and], materiality and daily life” (Ferigato et al., 2018, p. 774).

In South Africa, where nearly half the population live in poverty, Visser et al. (2016) considered breastfeeding as a meaningful instrumental activity of daily living (IADL), child-rearing occupation and mother-infant co-occupation. This multifaceted occupation had potential to improve health, socioeconomic and nutritional outcomes, prevent future issues by promoting equality and wellbeing potential for both mothers and children. Visser et al. (2016) identified the occupational domains of breastfeeding included primary occupations (ADLs, IADLs, work, education, play, leisure, social participation, rest and sleep); contextual and environmental factors (cultural, personal, physical, social, temporal, virtual); performance

patterns (habits, routines, rituals, roles); performance skills (motor process, social interaction); and client factors (values, beliefs, spirituality, body functions and structures).

5) ADDRESSING WOMEN'S HOLISTIC OCCUPATIONAL CAPACITIES AND NEED FOR AUTONOMY IN COLLABORATIVE INTERDISCIPLINARY PERINATAL TEAMS

A broad range of interventions were provided by occupational therapists in a variety of established roles, resident placements and pilot trials for women during pregnancy (n = 3), intrapartum (n = 1) and postnatal phases (n = 5), as well as perinatal '(n = 1). In hospital, primary healthcare and MBU settings, occupational therapy roles formed part of a collaborative multidisciplinary team approach (Burbidge, 2015b; da Conceição et al., 2020; Ferigato et al., 2018; Sechrist et al., 2015; Visser et al., 2016; Williams & Chard, 2019). Research by Cardinale et al. (2014) exploring a pilot trial of a community occupational therapy art program was the only study that considered the occupational therapy role in isolation.

A comprehensive analysis by da Conceição et al. (2020, p. 111) summarised that "the occupational therapist adapts women's occupations and activities to enhance "the functional and occupational performance of the woman", throughout "the pregnancy-puerperal period in the hospital context". The 20 types of interventions occupational therapists reportedly provided in the high-risk obstetric centre included ADL, psychosocial approach, health education, IADL, family care, occupational therapy reception, assistive technology, neuromusculoskeletal, sensory and mental function, labour and delivery, injury reduction and prevention, hospital discharge, work, education, and leisure. The "psychosocial approach related to interests, interpersonal skills, self-expression and self-control and motivation" (da Conceição et al., 2020, p. 115).

Interventions were tailored according to the woman's occupational issues and needs and were most prevalent during the immediate postpartum phase, followed by labour, pregnancy, and other gynaecological/obstetric situations. During *pregnancy*, the most common ADL interventions included physiological energy conservation techniques, functional mobility, bathing, and dressing. Psychosocial approaches addressed psychosocial components, the hospitalization process, stimulation of mother-baby bond, and health education regarding delivery, phases of labour, and breastfeeding. During *labour and childbirth*, interventions focused on pain relief and stimulation of labour including encouraging ambulation, breathing techniques, verticalization, lumbosacral massage, pelvic mobility using a Swiss ball, relaxing bath and music. The psychosocial approach included women's empowerment and autonomy, and supporting "psychosocial components (values, interests, self-concept, interpersonal skills, self-expression and self-control)", stimulation of mother-baby bond and health education to guide labour and delivery (da Conceição et al., 2020, p. 117).

In the *immediate postpartum phase*, ADL focused interventions included functional mobility, bed positioning, ambulation stimulation and bathing, and IADLs included breastfeeding, newborn care, routines, and organisation. The psychosocial approach related to mother-baby bond stimulation, the hospitalization process, and other psychosocial components. In *other gynaecological/obstetric situations*, occupational therapy ADL interventions related to self-care, bathing, and personal hygiene. The psychosocial approach addressed a range of psychosocial components, the hospitalisation process, and applying health education strategies for ectopic pregnancy, family planning and abortion.

In supporting women with the occupation of breastfeeding, Visser et al. (2016) described how the multiple roles for occupational therapists addressed a broad spectrum of related issues and needs. Environmental adaptations, assistive devices, and education were

interventions aiming to promote women's motivation to engage in breastfeeding. Strategies to improve women and infants' sleep quality, relaxation and improved mood were considered fundamental for mothers' wellbeing. Occupational therapists educated mothers about engaging in breastfeeding as a co-occupation, incorporating strategies for reading the infant's cues, meaningful eye contact, and enjoying breastfeeding as a mother-infant leisure activity.

Other hospital-based interventions used occupation as treatment, with Sechrist et al. (2015, p. 338) defining the occupational therapy role promoted "pregnant women's health by providing skilled services to carefully monitor the intensity and types of exercises as well as the associated risks". In MBUs, occupational therapists tailored highly individualised interventions addressing the mother's unique issues and goals relating to parenting occupations, promoting secure mother-infant attachment, social connectedness, and cultural identity (Burbidge, 2015b; Williams & Chard, 2019).

In the community, Cardinale et al. (2014) saw child-rearing responsibilities and performing the role as a 'mother' became occupation-based motivators. Women "stated that their roles as mothers were a critical source of personal identity, providing structure to the occupations they engaged in on a daily basis" (Cardinale et al., 2014, p. 59), which positively influenced their changing self-concept and habitual behaviour patterns and choices.

Working with vulnerable and linguistically diverse populations, Ferigato et al. (2018, p. 780) reported occupational therapists used receiving and listening in performance, movement, and activity groups to "provide spaces for action, empowerment and coping with situations", facilitate self-perception, awareness, and individual self-expression. These were tailored to accommodate the "diverse experiences of being pregnant in the biological, physical, physiological, emotional, social, relational, economic, cultural and gender contexts that sometimes go unnoticed in the traditional clinical visits" (Ferigato et al., 2018, p. 780).

6) ENHANCING WOMEN'S MEANINGFUL FUNCTION, SELF-EFFICACY DEVELOPMENT, WELLBEING, AND SATISFYING RELATIONAL NEEDS DURING MOTHERHOOD

The review findings indicated occupational therapy outcomes enhanced women's meaningful function, needs, maternal competence, bonded mother-infant relationships, empowerment and occupational satisfaction during perinatal stages and transitions. Outcomes were unified by a focus on the occupation of motherhood or mothering occupations, and related to holistic domains of health, function and wellbeing including personal development, mother-infant bonding, relationships, and sociocultural environments.

In the USA, Cardinale et al. (2014, p. 62) found that the "empowerment program demonstrated the connection between engagement in meaningful occupations and a person's wellbeing", with motherhood becoming a powerful motivator for women during their drug addiction recovery journeys. The pilot program found that "when self-esteem is elevated and goals are established, these women overcome these barriers" (Cardinale et al., 2014, p. 66).

Developing reflective skills and improving social confidence was a key outcome for mothers in an MBU in the UK. Williams and Chard (2019, p. 584) reported that collaborative client-centred use of the ESI as a quantitative evaluation tool to interpret and measure the quality of social interactions for mother-infant attachment and bonding motivated mothers and strengthened multidisciplinary team focus and collaboration:

> *Knowing what their strengths were enabled mothers to draw on these when interacting with social partners (often adults) and work towards improving less competent social interactions (typically with their infant). Mothers reported feeling more confident and motivated when they could see changes (improvements) in their ESI scores.*

Burbidge (2015b) defined occupational therapists in an MBU "demonstrated professional artistry" (p. 28) when they became "sensitive to the social and cultural context of working with mothers with serious mental illness and accept the fluctuating competence and manner of mothering during acute phases of perinatal illness" (p. 29). Outcomes from tailored interventions included improved mental health, maternal resilience and parenting skills competence, more secure mother-infant attachment, reduced fear of having children removed by child protection services, increased consistency with routines, prioritisation of the child's needs and positive parenting practices.

In South Africa, Visser et al. (2016, p. 66) explained that high infant mortality rates associated with malnutrition could be improved with client-centred education to increase prevalence and enjoyment of breastfeeding as a meaningful and valuable co-occupation:

> *Breastfeeding is indeed "the great equaliser" as infants from all social or economic backgrounds, who are optimally fed, have an equal start on a healthy life … It [is] an ideal solution in poverty-stricken countries, such as South Africa.*

Occupational therapists in Brazil were similarly influenced by humanitarian aspects of therapeutic outcomes. By providing comprehensive care to women during perinatal phases and other gynaecological/obstetric events in a high-risk obstetric centre (HOC), da Conceição et al. (2020, p. 124) reported that occupational therapy interventions enhanced women's "occupational performance, active participation during labor, measures to relieve pain, humanization of the birth process and to stimulate mother-baby-family bond":

> *The practice of the occupational therapist in the HOC promotes paradigm changes, making the woman protagonist in their performance areas and favoring actions of health promotion* (da Conceição et al., 2020, p. 111).

Ferigato et al. (2018, p. 780) reported that "the dynamic and intense transformations of this phase of woman's life should be valued", and that attaining "welfare, comfort, and

trust" were goals shared by occupational therapists and clients. When women felt able to meaningfully express themselves, be listened to and heard, and exchange experiences with others through facilitated creative occupations in sensitive spaces, they came to feel more valued, respectful of their bodies, encouraged, motivated, connected, empowered, competent and confident in motherhood.

DISCUSSION AND IMPLICATIONS

This systematised search and literature review found there is a dearth of information documenting occupational therapy practices in maternal and perinatal health around the world. The few known occupational therapy roles offer tailored professional services to support maternal health populations, which were client-centred, embedded within the occupational paradigm, and full scope of practice guidelines. Although limited, the review offers a glimpse into the complex and diverse scope of global occupational therapy practices in perinatal health roles.

EXPANDING AWARENESS OF MOTHERHOOD OCCUPATIONS, CONCEPTUAL FRAMEWORKS, AND PROFESSIONAL TERMINOLOGY

It was identified in this review that the roles of occupational therapists in perinatal health around the world are culturally diverse. Practitioners in a range of settings addressed women's challenges by enabling and promoting occupational performance through holistic, client-centred assessment and interventions. Through developing improved awareness of cultural sensitivity and diverse concepts such as humanising reproductive health and maternal development, women's rights, maternal empowerment, mother-infant dyads, mother-baby-family triads, and co-occupation, occupational therapists are broadening the potential scope of how healthcare services can understand and support women during perinatal stages.

Approaches considering women's occupational performance issues, needs and outcomes during perinatal phases across an intertwined complex spectrum of physical, emotional, developmental, cultural, psychosocial, social, and spiritual domains. By learning about how concepts such as mother-infant dyads, co-occupation and corporeity extend occupational therapy approaches, the notion that occupational therapists address women's "common-sense" (Esdaile et al., 2004, p. 24) issues during motherhood begins to seem an understated and reductionist assumption potentially biasing this research.

Considering the well-known relevance of the Model of Human Occupation and Process of Occupational Adaption (Kielhofner, 2002) to occupational therapy practices, it was initially assumed in this literature review that addressing perinatal transitions would be a primary role for occupational therapists. Lack of meaningful regularity and prevalence in literature review findings were insufficient to determine the relevance of *adaption*, *perinatal* and *transitions* to conceptually interpret the experiences of women and the practice of occupational therapists in this emerging field of practice.

Collectively, the literature review findings provided insight into the extensive spectrum of occupations and co-occupations relating to motherhood, maternal development and the complex occupational nature of pregnancy, labour and childbirth, the postpartum period, and obstetric events such as abortion, miscarriage, ectopic pregnancy, and family planning. Unlike other research, Sechrist et al. (2015) described the aquatic exercise program (AEP) intervention designed and delivered by an occupational therapist without contextualising practices within occupational therapy theory or meaningful domains of occupation. Failure to embed practice decision and clinical reasoning within the paradigm of occupation (Trombly Latham, 2008) sees interventions, such as the AEP, being potentially more relevant to professions other than occupational therapy. This example highlighted how

occupational therapy roles lose their meaning, uniqueness and be perceived as gap-filling when practices are not embedded in occupation (Fortune, 2000).

BARRIERS TO THE OCCUPATIONAL THERAPY ROLE

Working with women in perinatal healthcare is a non-traditional role for occupation therapists, and there is limited published research evidence clarifying clinical expectations of this specialist professional practice area. As occupational therapists, professional integrity must be maintained and promoted through practice guided by evidence. Whilst there is transferability of occupational therapy practice models, reliable and valid assessments, and interventions across various professional settings, it is important that emerging fields of specialisation are justified, strengthened, and supported by accessible and directly relevant clinical evidence. Four of the seven final research articles describe pilot trials of occupational therapy programs and four articles used qualitative approaches, reflecting the need for exploration into this emerging field of practice. The transferability of this qualitative research to clinical practice is limited; however, offers foundations to guide practice decisions and direct future research to improve evidence-based practice.

THE GAP BETWEEN PRACTICE AND ACADEMIC LITERATURE

Findings from the literature review offered an indication of the occupational therapy role and scope in a range of practice settings, around the world. When considering what is known from preliminary searches using key terms in Google, findings seem under-representative of the potential scope of occupational therapists in maternal health, perinatal transitions, and adaption motherhood.

Outside of this review, other evidence indicates occupational therapists are specialising in perinatal pelvic function in several countries, and particularly the USA (Baker

et al., 2017; Gullan et al., 2018; Hines, 2018; Lyon, 2017). No research papers reporting on the role of occupational therapy in pelvic health for perinatal populations were found or included (due to meeting exclusion criteria) in this literature review. Little is known about the practice or evidence-base, and how perinatal pelvic health and function align with occupational therapy theory and scopes of practice. Infant feeding (including breastfeeding) is increasingly considered a maternal co-occupation by some occupational therapists (Barrie et al., 2018; Fernandes, 2018; Podvey & Kern, 2018; Sponseller & Foy, 2018), with growing numbers of occupational therapists transitioning to work in this specialised field. Similarly, there is evidence of occupational therapists working with mothers following miscarriage, abortion, stillbirth, and early infant death (da Conceição et al., 2020; Hanish et al., 2019; Watson et al., 2017). With the increasing presence of perinatal occupational therapists comes the demand for continued professional development opportunities. In lieu of tertiary education opportunities, continuous professional development via webinars, and online courses to guide perinatal occupational therapists are becoming more readily available, offering an illustration of how contemporary entrepreneurs are fostering the growth of this emerging practice field (Kaupp & Desrosiers, 2018; LaPointe, 2013; Loesche, 2018; Pizur-Barnekow et al., 2010).

FURTHER RESEARCH

Further research is needed to explore the context of existing maternal healthcare services capacities to meet the demands and needs of a changing maternal health population and consider areas of professional service gaps. Clarification of the occupational performance needs of contemporary perinatal clients and how they are being met by existing healthcare services is required. In the context of increasing complexity surrounding maternal health, calls to utilise health professional's full scope of practice, health professional recruitment,

burnout and retention issues, and exploration of how occupational therapy can enhance existing perinatal services is essential (Creedy et al., 2017; Fernandes, 2018; Tully et al., 2017). Further research needs to be completed to explore and document what emerging occupational therapy practices involve, and how these roles may benefit women and maternity care services.

Identification of service gaps, health policies, and models influencing the selected professions included in interdisciplinary teams for maternal health should be explored, with the potential inclusion of occupational therapy roles considered. There is also scope to explore the role of occupational therapists working with mothers from birth as a preventative adjunct to maternal and child health and/or paediatric services (Department of Health, 2019b, 2019c; Roberts et al., 2014; Røhder et al., 2020; Sepulveda, 2019), and further exploration into if and how services are supporting women's transition between the prenatal and postnatal periods. Finally, future consideration for this area of specialisation in tertiary occupational therapy education curricula is needed.

LIMITATIONS

There are several limitations relating to this literature review. By limiting articles to the English language, research describing occupational therapy roles with perinatal populations in non-English speaking countries may have been missed. For example, an abstract and article for Brazilian research by Domínguez et al. (2018) titled, "*I gave birth to him and he gave me my life": Study of occupational transition linked to motherhood of two women with mental disorders*" were not available in English, and hint that there is still much to be learned about occupational therapist roles in countries where English is not the primary language.

Decisions about inclusion and exclusion criterion may have limited what could be learned about the role of occupational therapists in maternal healthcare. The decision to exclude articles where primary study populations were children could be a further limitation, although this was minimised by the review of full-text articles where it was suspected that these studies might meet the inclusion criteria. The low and moderate levels of evidence available to answer the research questions likely reflect that exploring the role of occupational therapy in perinatal health is an emerging area of scholarship. That all papers were published from 2015 indicate this is a recent area of academic scholarship. The relatively high number of conference papers and articles exploring proposed roles for occupational therapists working with maternal clients suggest that emerging contemporary practice field is growing.

With increasing awareness of the diverse determinants of maternal health wellbeing, and health outcomes for mothers and infants being inextricably embedded within mother-infant dyads and co-occupational performance (Doidge, 2012; Fraga et al., 2019; Lau, 2018; McNamara et al., 2019; Potgieter & Adams, 2019; Sethi, 2019), the need and role for greater occupational therapy presence in primary healthcare services is becoming evident (Ferigato et al., 2018; Halle et al., 2018; Naidoo et al., 2016; Visser et al., 2016). Development of the specialised area of practice requires further research, professional advocacy, and post-graduate tertiary curricula development.

CONCLUSION

There is evidence of a small number of occupational therapists working with maternal clients during perinatal stages from pregnancy until 12-months postpartum. These roles are not well-known, are diverse, and influenced by a myriad of factors including sociocultural and socioeconomic environments, tertiary education, employment opportunities, practice

priorities and consumer needs. In an emerging practice area, occupational therapists working in perinatal healthcare services are limited by a non-established practice field, lack of consistent and unified professional approaches, education, and published evidence to guide best clinical practice.

Divergence among emerging clinical practice developments and academic evidence defining roles for occupational therapy in perinatal health indicate a gap between practice and research. More needs to be learned about how occupational therapists are practising with maternal clients during perinatal periods and the potential benefits of these services to women.

Inspired by what was learnt during early literature reviews in this doctoral research, the following chapter presents a position statement reported as a viewpoint article published in the Australian Journal of Occupational Therapy in 2015.

CHAPTER 4: VIEWPOINT ARTICLE (PUBLICATION)

"There's a way to do it better. Find it."

– Thomas Edison (1847 – 1931)

INTRODUCTION

The publication I authored with two of my research supervisors is the focus of this chapter. This viewpoint paper was written in the early stages of my doctoral candidature, following completion of an early scoping review which revealed there was little published about how occupational therapists were practicing with women during perinatal stages. It was written with the intention of clarifying a professional opinion, to spark reflection and debate about the potential and place for occupational therapy roles in multidisciplinary maternity healthcare teams, and to highlight opportunities for emerging roles and future practice directions.

ARTICLE 1:

Slootjes, H., McKinstry, C., & Kenny, A. (2016). Maternal role transition: Why new mothers need occupational therapists. *Australian Occupational Therapy Journal, 63*(2), 130-133. https://doi.org/10.1111/1440-1630.12225.

Journal impact factor: 1.856 (retrieved 6 December 2021)

Australian Occupational Therapy Journal

Australian Occupational Therapy Journal (2016) **63**, 130–133 doi: 10.1111/1440-1630.12225

Viewpoint

Maternal role transition: Why new mothers need occupational therapists

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KEY WORDS *co-occupation, evidence-based practice, maternal health, motherhood, occupational therapy.*

Introduction

Occupational therapists make valuable contributions to women's health throughout prenatal and post-natal transitional stages (the perinatal period); despite limited research on the role. The purpose of this viewpoint was to raise awareness of the occupational therapy role in maternal health, promoting occupational therapists as part of an interdisciplinary team within a changing landscape of contemporary maternal health care.

Background and discussion points

Contemporary maternal health

Women access health services throughout pregnancy, birth and post-natal transitional stages (the perinatal period), and in developed countries are predominantly 'well' (Department of Human Services [DHS], 2004). In Australia, midwives and obstetricians typically address prenatal and birthing needs, with paediatricians and maternal and child health nurses providing services during the post-partum period (Esdaile & Olsen, 2004). The *Future Directions for Victoria's Maternity Services* policy (DHS, 2004) called for midwifery and general practitioner roles to be extended, moving towards more collaborative and interdisciplinary models of care. Declining numbers of professionals working in this area (Australian Health Ministers' Advisory Council [AHMAC], 2008) strengthens these calls. We highlight an opportunity for occupational therapists in innovative perinatal care.

While the medicalisation of maternal health improved birth outcomes, we argue that complex psychological, social and physical issues faced by women during the perinatal period require interdisciplinary solutions (Esdaile & Olsen, 2004; Gatrell, 2011; Seefat-van Teeffelen, Nieuwenhuijze & Korstjens, 2011). Highly medicalised maternal care systems fail to adequately consider complex cultural and social influences unique to perinatal health (Benoit, Zadoroznyj, Hallgrimsdottir, Treloar & Taylor, 2010). The potential for occupational therapists to provide services during the perinatal period has been identified for more than a decade, with researchers calling for exploration of occupation in pregnancy, birth and motherhood to address 'seemingly common sense' issues (Esdaile & Olsen, 2004, p. 24).

Australian women receiving perinatal care are demanding more choice in services to meet their needs (AHMAC, 2008). In a thought-provoking study by Seefat-van Teeffelen *et al.* (2011), Dutch women articulated a desire for empowerment to take responsibility, and make proactive, informed decisions during the perinatal period. They desired greater education on physical, emotional and psycho-social changes, to improve preparedness for the post-natal period, and the roles and responsibilities of motherhood. Highlighted was the need for holistic, client-centred professional interventions, and for psycho-social health to be highly regarded, prioritised and accessible (Seefat-van Teeffelen *et al.*, 2011).

Occupational therapy in maternal health

In many countries, occupational therapists are available to support women who have pre-existing disability, significant illness during the perinatal period (Poole, Willer & Mendelson, 2009), or if the infant is premature or ill (O'Brien & Lynch, 2011). Consideration of a broader role

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for occupational therapists as part of an inter-professional perinatal team is more limited. Some occupational therapists in Australia, Canada, Ireland, the United Kingdom and the Netherlands provide services to 'well' women, addressing the impact of pregnancy symptoms and post-partum issues on occupational performance (Mater Health and Wellness, 2012; Staenberg, 2012; LaPointe, 2013). They reportedly address the psycho-social, physical and emotional needs of women in inpatient, outpatient and community settings. Interventions are aimed at enhancing meaningful occupational engagement and wellbeing (Staenberg, 2012; LaPointe, 2013).

In a report by the Australian Health Ministers' Advisory Council (AHMAC), occupational therapists were not listed as working in interdisciplinary public maternity services (AHMAC, 2008), indicating a lack of awareness of the role in strengthening care for women in the perinatal period. In contrast, Australia's National Health Reform Agreement (Council of Australian Governments, 2011) indicated that collaboration between disciplines is essential in promoting health and wellbeing. There is a growing body of research guiding occupational therapy practice for women during the perinatal period with significant comorbidities. However, for the majority of 'well' women, there is limited clinical practice evidence. Greater clarification, substantiation and justification for occupational therapy within interdisciplinary maternal health services should be considered.

Theoretical foundations underpinning perinatal occupational therapy practice

Occupational therapists are united in providing client-centred models of care, which aim to address a myriad of occupational performance issues. A decade ago, pioneering authors Esdaile and Olsen (2004) considered the social, cultural, physical and psychological factors that determine maternal wellbeing, questioning how occupational therapists could contribute to maternal health services. They advocated for occupational therapists to address the uniquely complex and multifaceted health considerations of mothers living with illness and disability, parenting children with special needs, and mothers in minority groups, such as teenage mothers and mothers in prison. While they extended their discussion to the role of occupational therapists with 'well' women during the perinatal period, and offered important underpinnings for translating theory into practice, using foundations of occupational therapy, co-occupational and family-centred care, a decade later research evidence on the role is scant.

Perinatal occupational therapy: Enhancing interdisciplinary maternal health services

A woman's capacity to maintain usual occupational routines can be challenged by intrinsic and extrinsic variables experienced during the perinatal period. Lifestyle balance is acknowledged as a primary influence for self-efficacy in mothering occupations (Esdaile & Olsen, 2004). Medical and maternal health providers currently support the impacts of routine performance for women throughout transitional perinatal periods. However, occupational performance issues could be further addressed by specialist maternal health occupational therapists.

In arguing for the inclusion of occupational therapy during perinatal care, we consider that co-occupation influences maternal and infant health outcomes (Esdaile & Olsen, 2004). The term 'co-occupation' refers to shared physicality, emotionality and intentionality during meaningful engagement in occupation (Pickens & Pizur-Barnekow, 2009; Pizur-Barnekow & Erickson, 2011). Co-occupation is illustrated in the inseparable link between mother and infant, through its strong influence in promoting mother–infant bonding (O'Brien & Lynch, 2011), infant development and maternal wellbeing (Esdaile & Olsen, 2004). The unique significance of co-occupation should be considered in perinatal health services.

New mothers need client-centred support throughout the perinatal period, addressed by comprehensive interdisciplinary perinatal teams. The Canadian Model of Occupational Performance and Engagement (CMOP-E) conceptual practice framework considers clients' personal capacity to engage in and perform occupations in various environments throughout the life stages and transitions (Pendleton & Schultz-Krohn, 2013). The CMOP-E offers a framework to consider clinical reasoning in professional practice, and is adaptable to many settings. Contextualising co-occupation in perinatal care within the conceptual model of CMOP-E supports the identification and support for occupational performance issues, related to how mothering occupations are impacted on by a myriad of extrinsic and intrinsic influences, including aspects of the person, environment and occupation.

Person: Physical, affective, cognitive, spiritual

The transition from woman to mother is a significant life event (Ruble *et al.*, 1990). Complex psycho-social needs of women throughout this period are well documented with women experiencing a range of physical, affective, cognitive and spiritual changes. Self-efficacy and maternal stress impacts role adaptation throughout the perinatal period (Ruble *et al.*, 1990). There is increasing awareness of psycho-social and emotional challenges during the perinatal period such as post-traumatic stress disorder, depression, anxiety, altered self-image and identity. Perinatal mental health is strongly embedded in culture, with health supports and resources influenced by varied philosophical, social and

economically driven approaches (Benoit *et al.*, 2010; Esdaile & Olsen, 2004). The link between an infant and their mother's emotional wellbeing are well known (Esdaile & Olsen, 2004; Pickens & Pizur-Barnekow, 2009). It is acknowledged that a mother's sense of empowerment to make educated choices (Benoit *et al.*, 2010; Seefat-van Teeffelen *et al.*, 2011) and possess positive self-efficacy and self-confidence during the early post-natal period may act to prevent post-natal depression (AHMAC, 2008; Esdaile & Olsen, 2004). Occupational therapists can facilitate successful transitions for women to reduce maternal role strain, and thus incidences and severity of paediatric and maternal stress and depression (Pickens & Pizur-Barnekow, 2009; Pizur-Barnekow & Erickson, 2011).

Utilising techniques such as mindfulness, the occupational therapist can support the connection and impact between physiological, emotional and cognitive changes experienced by women during the perinatal period. Interventions used can correct hormonal imbalances, improve mood, foster mother–infant and parental bonding, and reduce stress and anxiety. Muscle strengthening and toning, improved postural alignment, improved body image and self-acceptance, and the regulation of blood pressure can be achieved (Staenberg, 2012). For women experiencing pregnancy complications and admitted for hospital-based bed rest, occupational therapists can improve emotional wellbeing and holistic health outcomes through client education, maintaining positive and meaningful occupational participation, stress/anxiety management and relaxation techniques, group engagement, sleep techniques and returning home to resume routine occupations (Mater Health and Wellness, 2012). There is a need for occupational therapists to work with women to enhance occupational performance in perinatal occupations.

Perinatal occupations: Self-care, productivity, leisure

Adopting co-occupation as a lens to view mothers, occupational therapists can play an important role not only in individual occupations for living but also in infant feeding, eating, sleeping, comforting, caring, raising children and managing a home; occupational activities that are added to women's primary occupational demands (Esdaile & Olsen, 2004; Pickens & Pizur-Barnekow, 2009).

Paid employment, pregnancy, caring for children and maintaining a household are recognised as productive occupations for these women (Gatrell, 2011; Sanders & Morse, 2005). Gatrell (2011) argues that the aims of medical management are to reduce maternal and infant mortality rates, and consideration of the 'place' of women is often discounted. Women can experience difficulties incorporating precautions into their routines, which creates increased work role difficulties. There is scope for occupational therapists to work with women during the prenatal period in their productive environments (work, home, community), to evaluate and optimise capacity for role performance (Sanders & Morse, 2005). The potential for occupational therapy functional capacity assessments, recommendations and advocacy for women in paid employment during pregnancy, parental leave, and returning to work, could achieve lowered incidences of maternal stress and workplace discrimination.

Environment: Physical, institutional, cultural and social

In the context of motherhood, work, social and familial role performance, the environment (workplace, home, community) and sociocultural expectations and requirements (employment, breast-feeding, relationships, house duties) of women should be considered (Gatrell, 2011; Parcsi & Curtin, 2013; Pizur-Barnekow & Erickson, 2011; Sanders & Morse, 2005). Access to occupational therapists as specialists in performance adaption and modification, for assessment, education and expert recommendations could reduce maternal role performance stress.

Sanders and Morse (2005) proposed that occupational therapists should work to reduce biomechanical risk and address restorative needs for new mothers through occupational performance assessment, childcare equipment selection, home environment review, and incorporate programmes such as ErgoMOMics. Ergonomic risks in caring for infants include back pain, carpal tunnel syndrome and repetitive strain injuries (Sanders & Morse, 2005). Increased regulations with safety standards (car seats, toys, infant soothing and feeding aids) and awareness of the need for health risk monitoring and management (nutrition, weight, sudden infant death syndrome) has seen greater need for parental empowerment and education. In the context of perinatal care, routine occupational therapy home-focussed parental education programmes are called for.

Future considerations

Occupational therapists are currently working as part of inter-professional perinatal teams, although their roles are not widely understood. We argue that there is capacity to expand occupational therapy roles within interdisciplinary teams to achieve greater health outcomes for women. However, the future of maternal health occupational therapy relies on strong evidence, increased education and professional championing.

As an area of non-traditional occupational therapy practice specialisation, clarification of what occupational therapists can offer maternal health clients is essential. Evidence to guide professional clinical assessments and interventions is critical. Position statements need to be

developed to facilitate educational preparation and employment opportunities, encouraging new graduates to consider this professional path. Evidence and business cases are needed to establish occupational therapy positions in maternal health, with these roles promoted to clients, educators, health policy makers and tertiary institutions.

To achieve this, research that quantifies gaps in existing maternal health services and explores current and potential perinatal occupational therapy practice is needed. Preparation of graduates is central, as current educational curriculum does not routinely include maternal health practice. We believe that this gap should be addressed with practice education placements routinely available.

Summary

Based on foundations of client-centred practice, and enabling and promoting occupational and role performance throughout transitional phases (Pendleton & Schultz-Krohn, 2013), occupational therapists can provide interventions to address occupational performance issues for women during the perinatal period. However, there is a lack of evidence guiding occupational therapy practice as part of maternal health interdisciplinary teams. The future of this specialist field requires research, education and advocacy for the role. In addition, pioneering occupational therapists need to champion dynamic models of client-centred contemporary maternal health care.

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CHAPTER 5: METHODOLOGY

"We don't receive wisdom; we must discover it for ourselves."

— Marcel Proust

"Giving birth to a child does not automatically unleash a previously contained flood of maternal behaviour. Nor… does it determine when a woman becomes a mother. The process of matrescence includes a subtle, supportive process of socialization into motherhood. In many cultures and for most women becoming a mother is their most dramatic life crisis."

— Lucile Newman (1975, p. 9)

INTRODUCTION

In this chapter, I outline the methodological approaches guiding this doctoral research. This research is designed to explore the role of occupational therapists in addressing women's occupational performance issues during perinatal transitions, through exploring the interplay of authority, power, and justice within feminist theory, contemporary occupational therapy practice, and maternal health services structures.

HOW I SEE THE WORLD

I have always viewed the world a little differently than most people. As an innately curious and observant person, I see the world as filled with boundless opportunities for exploration, learning, discovery, and growth. In writing this methodology chapter, I have reflected on the way I interpreted my parents' teachings which have significantly shaped how I see the world. In my unique and privileged upbringing, there was no space for gender roles. I approach the world considering that I am first and foremost a human being, with a role and

place in society, and a social responsibility to respect the environment and contribute to my community with whatever qualities I have.

I was fortunate to be born in the 1970s to bi-cultural parents who prioritised education, environmental sustainability, self-sufficiency, post-war survivalism, and community contribution as core family values. In my early years, my parents involved me in most aspects of life, teaching me survivalist skills, off-grid living, economic management, social conscientiousness, and self-reliance. My most memorable conversations with Dad were full of philosophical debate about biodiversity, environmental care, science fiction, cultural nuances, and socioeconomic constructs. Mum spent hours teaching me how to sew, create, and learn strategies to translate and apply what Dad and I had talked about in conservative sociocultural settings. As our family expanded, there was an expectation that everyone needed to contribute to keep the farm and household functioning, and it was our duty to give all that we could. My parents reminded us daily that we could do anything, we were all important, and that we needed to question things to learn and grow our understanding of the world.

This personal paradigm bubble popped when I became pregnant, and existence has never been the same since. The barrage of complex, surprising, and mysterious challenges I have needed to navigate throughout my motherhood journey have tested my world view, and the dust is yet to settle. I believe the primary antagonist creating this internal tension is the disparity between how I intrinsically see the world clashing with sociocultural gendered expectations of mothers. My experiences of living as a mother have challenged the way I see the world from a feminine vantage point and shifted my regard for feminism. My journey in becoming a mother is synonymous with my transition as a gendered female into a socioculturally foreign reality, my own brave new world. My passion for this research was ignited by this deeply personal conflict and paradigm shift and learning that I am certainly

not alone in my experience. These motivators are reflected in the critical realism perspective, social constructivism ontology, and feminist standpoint epistemology, which are discussed below.

CRITICAL REALISM PARADIGM

This research is embedded within critical realism; recognising that the world is complex, with phenomena impacted and influenced by ever-changing and evolving relationships between society, science, and nature (Sprague, 2005). The use of critical realism seeks to maximise adequacy of understanding in order to consider informed action, in the context of culture (Sprague, 2005). In many Westernised democratic societies there is an expectation that the political structure facilitates all people to have relatively equal opportunity and freedom to access resources, infrastructure, and other components key to maximising individual quality of life (Kincheloe et al., 2017). This normalised notion is challenged by imbalances in authority and power, with social and political structures allowing opportunity for dominance, oppression, and injustices. These stem from diversity beyond mainstream culture and relate to factors such as race, gender/sex, language, class, heteronormativity, socioeconomic status, religious intolerance, and ableism (Kincheloe et al., 2017).

Research paradigms can be characterised through questions defined by ontology (realities as they exist), epistemology (subjective nature of entities) and methodologies (hermeneutic constructs compared dialectically to achieve consensus) (Guba, 1990). The critical realist paradigm guiding this research is considered through a social constructivist ontology and feminist standpoint epistemology perspective, to explore and learn about the role of occupational therapist supporting healthy and well women in contemporary Western societies.

SOCIAL CONSTRUCTIVISM ONTOLOGY

A constructivist lens is used to investigate the research question, upholding an ontological "belief that knowledge is constructed rather than discovered" (Stake, 1995, p. 99). This perspective maintains that there are multiple ways to interpret reality, and that the research role is to construct a clearer and more sophisticated understanding of that reality by "providing readers with good raw material for their own generalizing" (Stake, 2000, p. 102). This research approach is guided by social constructivism to explore how health services have evolved and been designed, to meet women's maternal health needs and contextualise the place for occupational therapy roles. According to Given (2008):

> *Social constructivism addresses the ontological–epistemological questions of constructivism in describing the bodies of knowledge developed over human history as social constructs… Everything we know has been determined by the intersection of politics, values, ideologies, religious beliefs, language, and so on (p. 116).*

The social constructivist approach holds that contemporary knowledge and understanding of maternal development, motherhood, women's perinatal wellbeing, and reproductive stages are reflective of interacting social constructs and periodisation. It is presumed that most current academic knowledge on these topics is contextualised by maternal healthcare services and mirrors political and socioeconomic priorities, social constructions of Westernised modern motherhood, and the culturally bound role of occupational therapy (Castro et al., 2014; Hammell, 2019; Iwama, 2003).

This economically driven view of women being maternal healthcare consumers or service users does not align with the anthropological interpretation of women's human developmental transition to motherhood as a rite of passage phenomenon (Raphael, 1975). Contrasting these approaches illustrates how cultural influences guiding interpretation of women's social place as maternal beings, differs between healthcare and anthological

standpoints and raises questions about where an occupational therapy perspective on maternal health would be positioned. This diversity also suggests language and terminology applied to interpret perinatal health and wellness are likely to reflect sociocultural constructs.

The constructivist approach also recognises occupational therapy as a culturally-bound profession (Castro et al., 2014; Iwama, 2003). Western occupational practices have been rapidly evolving since the "construct of occupation" (Iwama, 2003, p. 582) renaissance sparked during the 1970s. Practices and conceptual frameworks have continuously developed in response to sociocultural influences, economics, perceived client needs, health service gaps, and complementary philosophies such as occupational science, offering new ways to see humans as occupational beings (Iwama, 2003; Yerxa, 1990; Zemke & Clark, 1996):

> *Innovative occupational therapists are striving to take their practice beyond its traditional medical institutional settings, into the community, the main social context where meanings in occupations in daily living are essentially believed to unfold. We are advancing a practice based on an ideology that is transcending the viewpoint that has traditionally connected the absence of disease with human well-being, with one that seeks to explore all facets of the mystery of human agency with the complexities of human well-being (Iwama, 2003, p. 582).*

Despite this professional practice advancement, occupational therapy models and conceptual frameworks have been criticised for reflecting Western philosophies with limited applicability beyond microcultural populations (Hammell, 2019; Iwama, 2003; Reid & Chiu, 2011; White & Beagan, 2020). Applying the social constructivism ontological approach to this research acknowledges these philosophical critiques, recognising the role and practice scope and place of occupational therapists as modern constructions within an ethnocentric social context.

FEMINIST STANDPOINT EPISTEMOLOGY

The aim of this research was to explore how occupational therapists are identifying and addressing contemporary women's perinatal needs in practice. I recognise the influence of gender from a critical realist respective in researching women's wellbeing during motherhood as supported by occupational therapists (a consistently female dominated profession). A feminist approach to this research offers a lens to critically explore women's history (Scott, 1986), and to identify and analyse, "not only gender but also other categories such as class, race, religion, ethnicity, or any other form of difference, and – crucially – the ways in which they operate together or intersect discursively to legitimate or undermine historically specific relationships of power" (Shepard & Walker, 2008, p. 456). Unlike critical feminist approaches, feminist standpoint epistemology notes that qualitative methods are at risk of bias and distortion by power and privilege (Sprague, 2005).

Feminist research is, "primarily for and about women", seeking to understand and improve women's lives, and is concerned with, "equalising or reducing power imbalances in the researcher–respondent relationship" (Gray et al., 2015, p. 759). This perspective conceptualises the complex sociocultural context of feminine in relation to masculine (Olsen, 2017). In this study, the intention of applying a feminist lens was to explore and gain, "insights into knowledge building that upend traditional epistemologies and methodologies, offering more complex understandings and solutions toward reclaiming subjugated knowledge" (Hesse-Biber, 2012, p. 5). Standpoint epistemology considers that, "knowledge is constructed in a specific matrix of physical location, history, culture, and interest, and that these matrices change in configuration from one location to another" (Sprague, 2005, p. 41).

Feminist standpoint epistemology acknowledges how systematic biases influence the construction of mainstream knowledge, considering power, sexual division of labour, and the standpoint of women (Hartsock, 1983; Sprague, 2005). This particular approach was

developed by Hartsock (1983) to provide, “an important epistemological tool for understanding and opposing all forms of domination”, and to, “help to avoid the false choice of characterizing the situation of women as either ‘purely natural’ or ‘purely social’” (p. 283). The feminist standpoint lens has relevance to this research as a construct for interpreting how power imbalances and social privilege can lead to ideologies which result in oppression (Sprague, 2005), and acknowledging the researcher role consistent with the reflexive components of qualitative feminist research methodology (Letherby & Jackson, 2003).

Application of the feminist standpoint epistemology to this research acknowledges that the meaning of women’s wellbeing and maternal wellness are constructed (Klima, 2001; O'Reilly, 2010; Pascoe Leahy, 2020), and there is a need for, “questioning dominant approaches and assumptions in health and health care” (Shaw & DeForge, 2014, p. 1569). This perspective is used to conceptualise how the current and historical context of medical dominance have influenced understanding and definition of women’s wellbeing and maternal health services (Benoit et al., 2010; Willis, 1983; Willis et al., 2012). The influence and bias of Western cultural norms are acknowledged in this research as reflecting the, “enduring pattern of inequality in power, wealth, and cultural influence that has grown out of European colonialism and North American imperialism” (Hammell, 2019, p. 13), and are not universally valid across diverse social constructs. Feminist standpoint also provides a framework to contextualise occupational therapist’s professional power struggle to articulate, validate, argue and secure their place on healthcare teams (Griffin, 2001; Rexe et al., 2013), and draws parallels with androcentrism influencing women’s historical place and roles as mothers in society (Hesse-Biber, 2012; Martin, 1989).

Subjectivist interpretation of feminist standpoint epistemology perceives occupational therapists in maternal health as a minority and likely oppressed population (Klima, 2001; Pollard & Kronenberg, 2008), predisposed towards the profession’s Western philosophical

origins (Hammell, 2019; Iwama, 2003), and limited by a reluctance to consider expressions of cultural diversity (Castro et al., 2014). Occupational therapists have an historical reputation for being "accepting, non-assertive and… are notorious for putting the client first", with a desire to uphold "feminine" posture, identity and virtues in workplace settings (Griffin, 2001, p. 29). These traits have created a professional characterisation of occupational therapists prioritising and accommodating client needs and expectations by flexing evidence-based practices and extending their scope of everyday practice to meet perceived client demands (Griffin, 2001).

A feminist standpoint approach recognises experiences and "knowledges of women among different cultures", and is, "premised on the presumption of a chasm between the knowledge of the oppressed and the oppressor in which the oppressed develop their own practices in order to develop better knowledge" (Walby, 2001, p. 486). This interpretive exploratory approach anticipates that individual occupational therapists have adapted their assessment frameworks and everyday practices to meet women's perinatal needs and fill gaps in existing maternal healthcare services, in culturally unique and diverse manners (Iwama, 2003). Prioritising reflexively balancing power and authority in the researcher-participant relationship is a feature of this research, which is imperative for gaining insight into the experiences and perceptions of oppressed populations (Gray et al., 2015; Sprague, 2005).

The epistemological approach of this qualitative research design anticipates a multitude of complex authority and power imbalances that influence the role and choices of occupational therapists working in maternal healthcare (Sprague, 2005), and the researcher-participant relationship (Gray et al., 2015). This is based on occupational therapy being a female dominated profession (Griffin, 2001; Pollard & Kronenberg, 2008), working with a distinctively female population embarking on a uniquely transformative feminine life transition (Raphael, 1975), in an emerging role situated within health services influenced by a

long history of medical dominance (Benoit et al., 2010; Willis, 1983; Willis et al., 2012). Respecting distances between biomedical and occupational paradigms, this qualitative research approach applies methods with flexibility to accommodate diversity with definitions, terminologies, and knowledge bases. This includes taking an open-minded approach to discovering how practice boundaries are navigated by occupational therapists in accordance with their interpretation of women's perinatal health needs.

CASE STUDY METHODOLOGY

Case study methodology provided an approach to investigate, document and analyse how occupational therapists are currently working with maternal health clients throughout perinatal transitions. Stake (1995) defined case study as, "… the study of the particularity and complexity of a single case, coming to understand its activity within important circumstances" (p. xi). Stake's (1995) instrumental case study methodology was chosen for its flexibility, fit with constructivist and feminist standpoint theories, and perceived usefulness in providing insights to interpret the reality and context of occupational therapy practices in maternal health.

Case studies are designed to facilitate learning, understanding and the acquisition of knowledge (Stake, 1995) through, "empirical inquiries of single cases that are contextually unique" (Harland, 2014, p. 1114). Stake's (1995) approach argues that, "the real business of case study is particularization, not generalization" (p. 8), aiming to report thoroughly comprehended unique cases to ignite thinking and inspire the reader to make their own meaningful interpretations.

Achieving an understanding of the complexity and context of occupational therapy practice supporting well women during perinatal transitions was vital to exploring if, why, and how the role benefitted maternal populations. This included inquiry into individual's

impetus for practicing in the role, the scope and nature of their work, barriers impacting on their professional capacities, and identified areas for future developments. Stake's (1995) case study design methodology was deemed appropriate for this research because it respects the uniqueness of the exploratory research journeys, and accommodates the need for flexibility in evolving methods through, "progressive focusing" (p. 9) of the research question.

In seeking to understand the complexities and uniqueness of cases, Stake's (1995) case study approach conceptualises that issues are, "intricately wired to political, social, historical and especially personal contexts" (p. 17). As little is known about women's perinatal transitional issues and needs from an occupational therapy viewpoint, women's wellbeing during motherhood transitions are contextualised in this research within the contemporary paradigm of occupation (Kielhofner, 2009). From a feminist standpoint and occupational therapy perspective (Francis-Connolly, 2004; Hesse-Biber & Leckenby, 2004), women are recognised equally as individuals, mothers and perinatal healthcare service users (Dombroski et al., 2016; Pascoe Leahy & Bueskens, 2020c). This positionality incorporated what is known about the occupational therapy role working with 'well' clients in relation to life transitions (Blair, 2000; Schwartzman et al., 2006). It was endeavoured through this perspective to understand how occupational therapists might interpret women's maternal care needs and occupational and wellbeing issues, recognising the interplay between authority, power and justice within feminist theory, occupational therapy values, and contemporary maternal healthcare services structures (Dombroski et al., 2016; Hammell, 2019; Iwama, 2003; Rexe et al., 2013; Willis et al., 2012).

CASE BOUNDARIES

Establishing that research is case oriented is a defining characteristic of case study methodology (Hyett et al., 2014; Stake, 1995). A case has been defined as, "a phenomenon of some sort occurring in a bounded context" (Miles & Huberman, 1994, p. 25), which functions as a unit of analysis in qualitative research. Stake (1995) regards cases as a bounded system of integrated and working parts, which are likely purposive and have a sense of 'self'. This description conceptualises cases as, "an object rather than a process", which are most suitable for research with "people and programs", rather than, "events and processes" (Stake, 1995, p. 2). Defining limits and boundaries characterise each case, and manage the risk of being overwhelmed by data (Boblin et al., 2013).

CASE CONTEXT

To understand the case, knowing the contextual structure is required to "appreciate the uniqueness and complexity… [and] its embeddedness and interaction with its contexts" (Stake, 1995, p. 16). Focusing on the context and complexity of the case whilst minimising attention on the situation or circumstances allows the most meaningful issues and problems to be drawn out (Hyett et al., 2014; Stake, 1995). Feminist standpoint is applied to consider social, political and cultural contexts to situate occupational therapists' experiences as competitive allied health professionals (Griffin, 2001; Muir, 2012; Rexe et al., 2013) within dominant maternal healthcare models, and women's experiences as perinatal healthcare consumers (Benoit et al., 2010; Dombroski et al., 2016; O′Reilly & Bueskens, 2016b).

CHAPTER SUMMARY

In this chapter, the rationale for the methodological lens applied to this doctoral research are described. Influences and perspectives are contextualising in the complex

backdrop of the interplay between maternal health services, women's experiences of maternal health and motherhood transitions and the contemporary role of occupational therapists in perinatal healthcare. The following chapter focuses on the methods applied to address the research questions, reflecting this methodological framework.

CHAPTER 6: RESEARCH METHODS

"The best journeys answer questions that in the beginning,

you didn't even think to ask."

— Jeff Johnson (180° South, 2010)

INTRODUCTION

In this chapter, the qualitative research methods guiding this study are outlined. Following Stake's (1995) framework for multiple case study and incorporating Oakley's (1981) recommendations for interviewing women about motherhood, the processes, decisions and boundaries guiding the research design choices are described and documented. Following on from the previous methodology chapter, it is outlined how the critical realist paradigm, constructivist ontology, and feminist standpoint epistemology are embedded within qualitative research method decisions (Denzin & Lincoln, 2017a; Stake, 1995).

The initial section of this chapter focuses on clarifying the context for this multiple case study and outlines qualitative research design elements. Methods are organised into five phases which align with Stake's (1995) case study approach. The processes for participant recruitment, data collection and analysis are described, followed by a reflexive discussion to enhance the transparency of my role in the conduct of this qualitative research study. Ethical considerations are discussed, reporting on processes of gaining informed consent and measures taken to comply with ethics guidelines. Strategies undertaken to achieve rigour are reported, with limitations and assumptions acknowledged. These decisions, as well as the relativity and transferability of the results, are detailed below.

QUALITATIVE RESEARCH DESIGN

When little is known about a topic, qualitative research offers useful methods to gain understanding of that phenomenon and generate new theories or revise existing theories. This research applied a qualitative approach to achieve a discipline-specific understanding of how occupational therapists are providing services to women during perinatal phases. Qualitative research designs typically involve gathering, analysing and interpreting a series of representations that provide evidence of how a unique reality exists for participants. Denzin and Lincoln (2017a) explain that these representations offer researchers material to, "transform the world… in terms of the meanings people bring to them" (p. 10).

The qualitative research methods chosen for this study include a multiple case study design with perspectives from both occupational therapists and service users. This strategy sought to elicit findings that represent, "the actual experiences, wishes, and beliefs of individuals and … the families, communities, and socio-economic contexts in which they are situated" (Shaw & DeForge, 2014, p. 1569), which is required for an in-depth understanding of the phenomenon. To answer the research questions and address aims and objectives, methods were guided and progressively refined by both qualitative (Stake, 1995) and reflexive feminist research processes (Hesse-Biber, 2012). Research decisions are discussed in relevant sections throughout this chapter.

Consistent with contemporary health services moving away from "traditional illness-based view[s]" of health, this research design was structured to, "explore perception and experiences to understand the phenomena" (Stein, Rice, & Cutler, 2013, p. 146), of how occupational therapists interpret women's modern-day issues during perinatal transitions. The method chosen to achieve this was a multiple case study with perinatal occupational therapists and women accessing their services. This strategy aimed to elicit information that could be analysed to reveal the landscape, history and currency of theory and social

infrastructure contextualising and influencing evidence-based occupational therapy practices for contemporary perinatal health service users.

This qualitative approach was informed by the hypothesis that two primary contexts need to be incorporated into the research question: 1) 'Well' women's needs and issues are personal, individual, unique, complex and multifaceted during perinatal phases and motherhood transitions; and, 2) The role of occupational therapy in maternal healthcare is not well known, nor the evidence-based informing practice. A critical lens was applied to clarify the nature of defining women as '*well'* in this research. The term was agreed between researchers to be commonly understood in referring to the absence of any major or chronic illness or disability that would motivate or necessitate women's access to healthcare services. What constitutes 'care' provided by occupational therapists to generally 'well' maternal populations was unclear.

The initial case study research question sought to explore: *'What occupational therapy services are being utilised by 'well' maternal health clients to support their needs during perinatal periods until one year postpartum?'.*

PHASE I: DEFINING THE UNIQUE CASE

MULTIPLE CASE STUDY

An instrumental multiple case study method was selected with the intention of developing a descriptive, "detailed portrayal" (Schwandt & Gates, 2017, p. 346) of how occupational therapists are working to support perinatal populations. This design supported the collection of a series of single-inquiry cases simultaneously, providing insight into each unique case (Hyett et al., 2014). The qualitative approach embraced diversity in participant positions, attitudes and histories, not seeking to represent typical cases but instead designed to, "best yield understanding", by honouring that multiple realities exist (Stake, 1995, p. 48).

While case studies are often limited by narrow representativeness, multiple case studies offer “a common strategy for enhancing the external validity or generalizability of findings” (Merriam, 1998, p. 40), which can be useful in improving practice, studying practice innovations, evaluating programs and informing policy. The multiple case study was designed to mitigate many common limitations of qualitative case study research. Risks of oversimplifying or exaggerating the phenomenon were considered in designing and conducting sensitive and in-depth data collection and analysis, and allowing time for research processes to be thoroughly explored and refined using repeated triangulation and reflexive practices (Berger, 2015; Houghton et al., 2017; Merriam, 1998; Stake, 1995; Yazan, 2015).

SAMPLING: SELECTION OF UNIQUE COLLECTIVE CASES

The multiple cases aimed to include perspectives from a strategic and meaningful collection of unique cases (Liamputtong, 2010). Although not essential for case study research, the research design intended to recruit a sample of both occupational therapists and service users in equal ratio, achieve balanced cohort representation for future cross-case analysis (Ayres et al., 2003; Mathison, 2005; Miles & Huberman, 1994). In keeping with Stake’s (1995, p. 6) position that, “opportunity to learn is of primary importance”, perspectives were sought from a balanced and varied sample of both service providers and service users. Participants were grouped as a multiple case study comprising two cohorts: occupational therapists working with ‘well’ perinatal populations; and, ‘well’ women who accessed occupational therapy services during perinatal phases. Cases were sought and selected according to eligibility, relevance to the research question, and sample diversity.

PARTICIPANT INCLUSION AND EXCLUSION CRITERIA

The boundaries of the multiple case study included time frame, the socio-economic definition of country, professional accreditation of the occupational therapist, the perinatal status of women, and medical definition of 'wellness'. Case boundaries and limits were established as parameters consistent with the research questions and literature review, and are reflected in criteria for occupational therapist (refer Table 6) and service user participants (refer Table 7).

TABLE 6

Key criterion for case selection (perinatal occupational therapists)

PERINATAL OCCUPATIONAL THERAPISTS	
Inclusion	**Exclusion**
• Currently working with well maternal health clients • Have worked with well maternal health clients within the last 12-months • Work currently with women during pregnancy, and within the first 12-months postpartum • Hold current registration with professional occupational therapy association • English language proficiency • Practicing in a developed country	• Only working with maternal health clients who have significant illness/disability. • Do not hold current registration with a professional occupational therapy association • Non-English language proficiency • Practicing in a developing country • Have not worked with 'well' perinatal clients within the last 12-months • Working exclusive with women before pregnancy, and after 12-months postpartum • Are predominantly focussed on working with fathers, infants and/or children

TABLE 7

Key criterion for case selection (service users accessing occupational therapy services)

SERVICE USERS WHO ACCESSED PERINATAL OCCUPATIONAL THERAPIST SERVICES	
Inclusion	**Exclusion**
• Sought occupational therapy services for maternal health issues during pregnancy, and within the first 12-months postpartum • Were medically 'well' at the time they consulted with the occupational therapist • English language proficiency • Mother of infant/s without significant illness or disability requiring occupational therapy input • Mothers aged >18 years for this child	• Had significant illness/disability during the perinatal stage for which they were consulting an occupational therapist • Accessed the occupational therapist before pregnancy and later than 12-months postpartum • Non-English language proficiency • Mother of infant/s who had a significant medical issue which necessitated and was the focus of occupational therapy services • Mothers aged <18 years for this child

PARTICIPANT RECRUITMENT

Participant selection criteria were refined, and recruitment commenced following the establishment of case boundaries. A combination of purposive, snowballing and convenience non-probability sampling strategies were used (Liamputtong, 2010; Stein et al., 2013).

Through informal Google searches and professional networking during the preliminary stages of this PhD research, several occupational therapists working with well women during perinatal transitions were identified and contacted in Australia, the United States of America (USA), Canada, and England. During preliminary correspondence (prior to case study invitations being formally extended), some therapists indicated a willingness to participate in and contribute to this research and had connections with other occupational therapists working in perinatal health not yet known to researchers. This population of therapists were initially considered as a primary sample and offered potential connections for promoting snowball recruitment and researcher networking.

Following ethical approval for the research, formal recruitment strategies for occupational therapists included a public invitation (refer Appendix E) to participate through social media connections/networks, a PhD research blog (https://hannahslootjes.wordpress.com), professional association networks, networks of primary sample participants, and direct contact with known occupational therapists (refer Appendix F). Healthy and well women who have received perinatal occupational therapy services were invited to participate by their occupational therapists. To maximise the sample catchment, all known perinatal occupational therapists were asked to invite their clients. This snowballing process gained momentum during the recruitment and data collection phases as recruitment networks expanded through word-of-mouth advocacy by participants and recruitment networks encouraged others to contribute to the research.

After an initial screening process to determine if the participants met eligibility criteria for the study, participants were sent an information and consent bundle. Recruitment was formalised when informed consent was provided. Ethical considerations for this process are described later in this chapter.

SELECTION OF PARTICIPANTS

The final multiple case study sample included 18 participants; 16 occupational therapists working with well perinatal clients, and two women who were recipients of occupational therapy services during and after pregnancy, up until one-year postpartum. Of the 16 occupational therapists, 11 were working in Australia, two in Canada, one in the United States of America (USA), one in England, and one in New Zealand (refer Table 8).

TABLE 8

Participants according to recruitment sources and country

PARTICIPANT RECRUITMENT SOURCE	NO.	COUNTRY
Direct invitation (websites and contact details found through Google search)	3	Australia (x 2) Canada (x 1)
Posts in Facebook groups (via Messenger)	5	Australia (x 1) Canada (x 1) New Zealand (x 1) United States of America (x 2)
Presentation of research at conference	1	Australia
Research blog	1	England
Snowball and word-of-mouth	7	Australia
Viewpoint article response (via Twitter direct message)	1	Australia

Participant demographic details will be provided in the findings chapters of this research. Extensive efforts have been made to eliminate identifiable characteristics of participants for their own indemnity, in accordance with ethics approval conditions.

DEFINITION OF THE CASE

The case for investigation comprises a collection of 18 first-hand accounts detailing the context, rationale and outcomes of how occupational therapists are providing tailored, client-centred services to women at various stages during their motherhood transitions. Cases are explored from the perspectives of 16 service providers and two service users from six developed countries, who have all been allocated pseudonyms for anonymity and confidentiality. Identifying data has been omitted from this study to protect the privacy of participants, individuals, employers, and workplaces. The cases are presented in narrative detail in chapters seven and nine, and as a cross-case analysis in chapter eight.

PHASE II: DATA GATHERING TOOL DESIGN

This research design adapted Stake's (1995) essential data-gathering components, using a semi structured interview schedule for primary data collection. A combination of structured demographic questionnaires, interview notes and key documents were used as secondary data collection methods.

Questionnaire items were used to clarify concepts and descriptions of context, scope, and breadth of practice, which were referred to during interviews to prompt discussion points (Phellas et al., 2011; Remenyi, 2012). Where relevant, position descriptions and role-specific documents were sought as an operations research method (Stein et al., 2013) to contextualise clinical practice and role performance expectations. Interview notes were taken to record researcher reflections and observed subtleties, tones, and nuances of participant accounts to add depth and richness in contextualising and interpreting data (Curtin & Fossey, 2007; Flick, 2017; Sprague, 2005).

SEMI-STRUCTURED INTERVIEW SCHEDULES

Stake (1995) described interviews as, “the main road to multiple realities” (p. 64), and a highly effective strategy for case study research. Semi-structured interviews are useful where little is known about a topic. They allow flexibility to explore topics, experiences or views that are meaningful for the interviewee (participant), and position the interviewer (researcher) to have greater visibility, “as a knowledge-producing participant in the process” (Brinkmann, 2017, p. 579). Interview schedules aligned with research aims and questions, informed by key learning from the literature review.

Semi-structured interviews using conversational techniques can be limited by the skills of the interviewer and interviewee, and that answers to questions are likely to vary between interviews/cases (Given, 2008). To address this, feminist standpoint and neopositivist conceptions informed question design choices aiming to elicit richness and depth of data using semi-structured, open-ended questions with reflexive conversational techniques (Brinkmann, 2017). The perspectives of Oakley (1981) and Roberts (1981), which heavily influenced feminist participatory research methods within maternal health settings from the early 1980s are now considered foundational (Doucet & Mauthner, 2008), and informed the design of interview schedules and interviewing techniques. Efforts were made to use terminology relevant to the research questions and aims, appropriate to the participants, and phrased to encourage open-ended answers.

REVISING RESEARCH QUESTIONS

The semi-structured interview schedule structure aimed to gather data that aligned with doctoral research aims and questions, guided by occupational therapy evidence-based practice principles (Cordier & Wilkes-Gillan, 2017) and informed by new learning in the literature review. An overview of the relationship between the initial hypothesis, research

aims and questions, and the interview schedules can be found in Appendix G. The research question was revisited midway through the analysis process, and then again during the thematic framework construction, and was deemed to still be relevant and appropriate for the research intentions.

DEMOGRAPHIC QUESTIONNAIRE

Self-completed questionnaires were used to obtain descriptive demographic data using structured questions. This data added context to interviews, clarified the research focus for participants, confirmed individuals' eligibility for inclusion, and promoted triangulation of data (Miles & Huberman, 1994; Phellas et al., 2011; Remenyi, 2012). Individual questionnaires were developed for occupational therapy participants and service users. Tables reporting on development of questionnaire items can be found in Appendix H, and full questionnaires for both cohorts in Appendices I and J.

INTERVIEW NOTES

Notes were taken during or immediately after each individual interview, recording topics, events, stories or quotes which conveyed meaning in a particularly poignant or powerful way (King et al., 2018). Taking notes during and after interviews provided an opportunity for both participant and researcher reflection, and prompted in-depth discussions which enhanced content clarity, richness, meaning and context to data (Brinkmann, 2017; King et al., 2018), and improved triangulation (Flick, 2017; Given, 2008; Stake, 1995).

KEY DOCUMENT REVIEW

Position descriptions were initially sought from occupational therapy participants to contextualise and add depth to interpreting individual role practice scopes and expectations

(Stein et al., 2013). It became apparent this excluded self-employed participants, who comprised nearly half the sample. Furthermore, all employed participants reported their position descriptions did not accurately describe their role or scope of practice; for example, due to their position evolving since the time of employment. Several participants had developed their own intake forms, clinical assessment and outcome measurement tools, brochures, information flyers, and client education handouts. Some of these were volunteered and received via email and became key documents for analysis and triangulation (Stake, 1995).

PHASE III: DATA COLLECTION AND MANAGEMENT

TIME FRAME

Data collection commenced in February 2017 with the first participant questionnaire and informed consent documents received, interview audio-recorded and interview notes documented. This process concluded with the final interview recorded in August 2018. Member checking of the interviews was completed by March 2019.

QUESTIONNAIRES

Demographic questionnaires were emailed to participants, who returned the completed items via email before the interview commenced. Data from questionnaires were manually entered and organised into a Microsoft Excel spreadsheet and pseudonyms were allocated to all participants.

INTERVIEWS

A total of 18 individual interviews were completed, which ranged from 42 minutes to 1 hour 48 minutes duration. Interviews were audio-recorded and then transcribed verbatim into Microsoft Word documents. Draft transcripts were emailed to participants for member checking, and corrections were made as directed by participants. Transcripts were then deidentified and participants allocated pseudonyms for data analysis.

LOCATION OF INTERVIEWS

Thirteen individual interviews were conducted via telephone and three via videoconference, accommodating the participant's preferences and availability of communications technology. Two face-to-face interviews were conducted in secure private consulting rooms at La Trobe University's Clinical Teaching Building in Bendigo, Victoria, accommodating participant preferences.

INTERVIEW NOTES AND KEY DOCUMENTS

Hand-written interview notes were deidentified when transcribed into Microsoft Word documents, referencing correlated participant pseudonyms. Logos, branding or identifying details were digitally erased to protect participants' identity and intellectual property. In keeping with Stake's (1995) position that "studying documents follows the same line of thinking as observing and interviewing" (p. 68), these documents were filed under cross-referenced pseudonyms for coding and analysis.

INTERVIEWING TECHNIQUES

Interviews were guided by the semi-structured interview schedule, cross-referencing questionnaire items and key documents as discussion points, and were conversational in nature. Questionnaire items were referred to during interviews with participants, with any issues discussed and explored in-depth during conversation as deemed relevant by the participant and/or researcher.

Feminist participatory research elements (Doucet & Mauthner, 2008; Letts, 2003) were incorporated to recognise the "importance of non-hierarchical interviewing practices", with female-dominant populations (Doucet & Mauthner, 2008, p. 329). Devault's (1990) feminist strategies for interviewing women influenced choices made about language, listening and talking, and participant-led conversation topics were routinely encouraged and followed. Introspection, self-reflection, and narrative and therapeutic conversational techniques were applied consistently to manage concerns about power imbalances between researcher and participants (Finlay, 2003; King et al., 2018). These typically emerged when participants felt uncertain, frustrated, or defensive during evidence-based practice discussions. Efforts were made to develop rapport and trust in participant-researcher relationships, and participants were prompted and encouraged to share their thoughts, opinions and experiences (Gray et al., 2015). Probing and follow-up questions were used to elaborate, clarify and add depth to participant's accounts (Given, 2008), and aimed to promote researcher-participant engagement (Finlay, 2003).

Stake's (1995) recommended flexibility in case study methods benefited interviews, especially when polarising terminology or phrasing were revealed to create tension, objection, or disconnection with several participants, such as the term '*well'* to describe women's health. In these instances, efforts were made to re-establish rapport and regain trust through restoring power balances. Modified interviewing techniques incorporated elements of

participant-led narrative, active listening, and conversational open-ended questions to enable participants to share their experiences authentically (Brinkmann, 2017; Gray et al., 2015). This approach is consistent with feminist standpoint epistemology and recognises that "crossing boundaries dividing standpoints and addressing the differences between them is a strategy for building social knowledge" (Sprague, 2005, p. 74).

PHASE IV: DATA ANALYSIS AND INTERPRETATION

DATA MANAGEMENT AND ANALYSIS

The final dataset comprised the interview transcripts, questionnaires, interview notes and key documents (for occupational therapy participants only). According to Stake (1995), analysis refers to the artful and intuitive process of "taking something apart" (p. 71) to search for meaning. This interpretative practice involves exploring the significance of and relationships between the dissected parts and considering how pieces fit to form a recognisable pattern (Stake, 1995). Data mining, management and analysis followed Stake's (1995) two recommended strategies to reach meaning, "through direct interpretation of the individual instances, and through aggregation of instances until something can be said about them as a class" (p. 74). Direct interpretations of individual instances are considered collectively as '*the case'*, and categorical aggregation of instances as '*cross-case analysis'* and are described below. The same research questions were applied to interpret both.

LEVEL 1: CASE ANALYSIS

The first level of analysis process aimed to, "develop an interpretation of the data that reflects each individual's experience and applies equally well across all of the accounts that constitute the data set" (Ayres et al., 2003, p. 871). Due to the unexpected imbalance of

participants representing occupational therapy and service users, the sample was divided between two unique multiple cases:

A. Occupational therapy services provided to healthy and well women during perinatal stages; and
B. Maternal health service user perspectives on the value and need for occupational therapy services during and after pregnancy.

CASE A: OCCUPATIONAL THERAPY SERVICES DURING PERINATAL PHASES

Five predetermined basic codes (refer Table 9) were initially developed which aligned with research objectives and occupational therapy EBP framework (Cordier & Wilkes-Gillan, 2017). This framework aimed to extract data that facilitated understanding of unique cases and their interrelatedness, meaningfully and cohesively (Miles & Huberman, 1994; Stake, 1995). Interviews were read and re-read, using line-by-line coding to mine for data corresponding with codes (Miles & Huberman, 1994). The process was repeated for questionnaires, interview notes and documents. Code names were revised multiple times during this process, and reflectively again following the completion of cross-case analysis to examine coherence between interpretive frameworks.

TABLE 9

Development of case themes (case A)

DEDUCTIVE CODING FRAMEWORK FOR OCCUPATIONAL THERAPY PARTICIPANTS			
Key research aim	**Key research question**	**EBP component**	**Deductive codes**
To explore how literature, practice models and health outcome measures inform and influence the practice of perinatal occupational therapists.	What is the role of occupational therapy for supporting well women during perinatal transitional periods?	Practice context Scientific knowledge	1) Role context and overview 2) Why are those roles needed?
To explore the perceived scope, capacity and barriers for a potential perinatal occupational therapy role to address the occupational performance needs of well women accessing primary health services.	What are the current professional service gaps in supporting women's health needs during the perinatal transitional periods, which could be met by occupational therapists?	Practice context Clinical experience and expertise	3) What roles are they fulfilling? 4) What are the barriers to this role?
To identify how the occupational performance needs of well women are being addressed during perinatal transitional phases by occupational therapists.	What are the occupational performance issues experienced by well pregnant women during the pre and postnatal (perinatal) transitional periods?	Client circumstances Clinical experience and expertise	5) What are the components of that role? - Identify and interpret issues - Providing service to support women's needs

CASE B: CONSUMER PERSPECTIVES ON THE VALUE AND NEED PERINATAL OCCUPATIONAL THERAPY

Following the same method as case A, draft themes were predetermined and reflectively refined during the data analysis process (refer Table 10). Exceptions to this were the absence of key documents in the dataset, and occupational therapy EBP components due to lack of appropriateness in accordance with feminist research principles. Due to the small sample number and considering feminist data analysis methods to preserve women's voices (Devault, 1990), a cross-case analysis was not completed for case B.

TABLE 10

Development of case themes (case B)

DEDUCTIVE CODING FRAMEWORK FOR WOMEN WHO ACCESSED OCCUPATIONAL THERAPY SERVICES		
Key research aim	**Key research question**	**Deductive codes**
To explore how literature, practice models and health outcome measures inform and influence the practice of perinatal occupational therapists.	What is the role of occupational therapy for supporting well women during perinatal transitional periods?	1) What occupational therapy approaches were used?
To explore the perceived scope, capacity and barriers for a potential perinatal occupational therapy role to address the occupational performance needs of well women accessing primary health services.	What are the current professional service gaps in supporting women's health needs during the perinatal transitional periods, which could be met by occupational therapists?	2) What are the reasons for seeing/needing an occupational therapist? 3) What are the OPIs the occupational therapist identified to work on? 4) How did the occupational therapy approaches improve issues?
To identify how the occupational performance needs of well women are being addressed during perinatal transitional phases by occupational therapists.	What are the occupational performance issues experienced by well pregnant women during the pre and postnatal (perinatal) transitional periods?	5) What goals and outcomes were achieved through occupational therapy?

LEVEL 2: CROSS-CASE ANALYSIS - CASE A

Cross-case analysis for case A was run concurrently during case analysis. This second level of analysis aimed to condense data without oversimplifying findings (Mathison, 2005; Miles & Huberman, 1994), to "explore commonalities across cases" (Ayres et al., 2003, p. 872). Following Stake's (1995) recommendation that "each researcher needs… to find the forms of analysis that work for [them]" (p. 77), Attride-Stirling's (2001) three steps of *Analysis Stage A* were incorporated as a complementary technique to streamline data analysis methods (refer Figure 5). Decisions are reported to convey how data were methodically reduced, coded, organised and interpreted as meaningful patterns in a thematic network structure (Attride-Stirling, 2001). Feminist strategies for preserving women's speech and writing about women's lives were incorporated throughout the analysis phases (Devault, 1990). NVivo 12 (NVivo by QSR, 2018) and Mindomo Mind Mapping (Mindomo, 2020) software were used for data analysis and construction of the thematic framework.

FIGURE 5

Steps in analysis employing thematic networks

ANALYSIS STAGE A: REDUCTION OR BREAKDOWN OF TEXT

Step 1. Code Material
(a) Devise a coding framework
(b) Dissect text into text segments using the coding framework

Step 2. Identify Themes
(a) Abstract themes from coded text segments
(b) Refine themes

Step 3. Construct Thematic Networks
(a) Arrange themes
(b) Select Basic Themes
(c) Rearrange into Organizing Themes
(d) Deduce Global Theme(s)
(e) Illustrate as thematic network(s)
(f) Verify and refine the network(s)

ANALYSIS STAGE B: EXPLORATION OF TEXT

Step 4. Describe and Explore Thematic Networks
(a) Describe the network
(b) Explore the network

Step 5. Summarize Thematic Networks

ANALYSIS STAGE C: INTEGRATION OF EXPLORATION

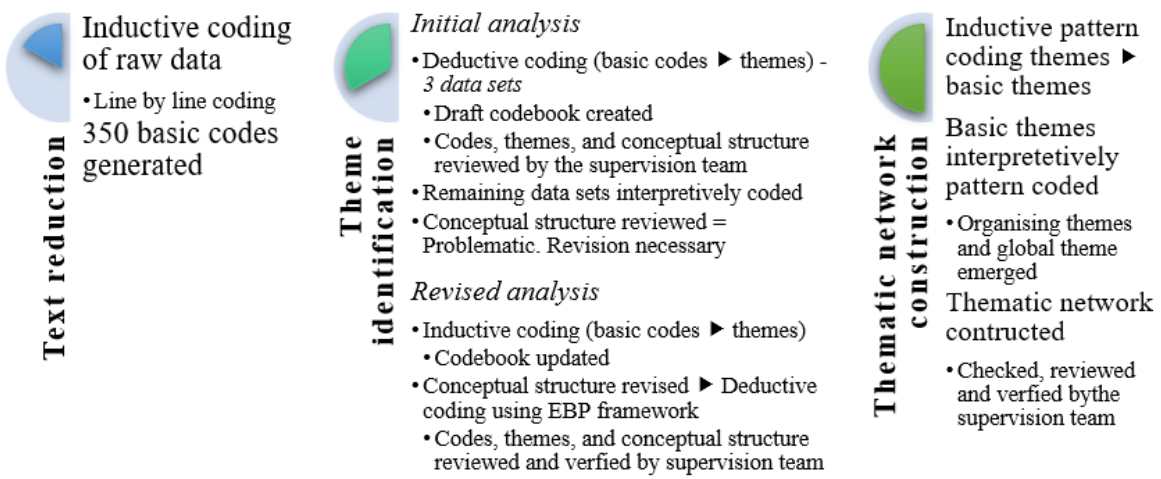
Step 6. Interpret Patterns

Note: Reprinted from Box 1 in "Thematic networks: An analytic tool for qualitative research", by Attride-Stirling (2001, p. 391), in *Qualitative Research, 1*(3), 385-405. https://doi.org/10.1177/146879410100100307.

Details about decisions and data analysis methods followed the three steps of analysis stage A, which will be described in this section and summarised in Figure 6.

FIGURE 6

Summary of processes and decisions during three steps of cross-case analysis stage A



TEXT REDUCTION

Research materials were imported and organised as data sets and then coded using NVivo 12 software (NVivo by QSR, 2018). Conventional content analysis was used to code data and develop an initial coding framework (Attride-Stirling, 2001; Hsieh & Shannon, 2005; Miles & Huberman, 1994). Inductive coding interprets information directly gained from participants and avoids imposing preconceived concepts to interpret meaning (Hsieh & Shannon, 2005). This approach is appropriate when little is known about a phenomenon, and involves inductive category development through immersion in data which allows "new insights to emerge" (Hsieh & Shannon, 2005, p. 1279).

Two sample interviews with occupational therapy participants were selected on the basis that their combined data represented a broad scope to generate initial codes with maximum relevance for future analysis. These interview transcripts were read and re-read, using descriptive codes and indicative line-by-line coding to sift and sort text segments (Miles & Huberman, 1994). This inductive process allowed the identification of thematic patterns through the frequency and prevalence of key code words and phrases. Content from the two interviews generated 350 raw codes, which were consolidated and refined according to research question relevance, to become basic codes for the next data analysis phase.

THEME IDENTIFICATION

Basic codes were then deductively reviewed and refined to contextualise how these nested within occupational therapy practice and perinatal health to answer the research question (Miles & Huberman, 1994). Deductive coding is a useful strategy to examine the variables of interest against existing research or theory to help determine the relationships between variables to develop an early coding scheme (Hsieh & Shannon, 2005) This was achieved by applying elements of two occupational therapy practice frameworks most relevant to the research aims: the Canadian Model of Occupational Performance and

Engagement (CMOP-E) (Polatajko et al., 2007), and the Process of Occupational Adaptation (Kielhofner, 2002). It also considered classifications of mothering occupations as defined by Esdaile and Olson (2004), and perinatal stages (refer Table 11).

TABLE 11

Elements of occupational therapy practice frameworks and classifications of mothering occupations for initial deductive code scheme development

CMOP-E (Polatajko et al., 2007)	Process of Occupational Adaptation (Kielhofner, 2002)	Classification of mothering occupations (Esdaile & Olson, 2004)	Perinatal stages
Person (cognitive, affective, physical), spiritual) **Environment** (physical, institutional, cultural, social) **Occupation** (productivity, self-care, leisure) **Engagement**	**Intrinsic motivators** (volitation, habituation, performance capacity) **Environment** **Occupations** (skill, performance, participation) **Occupational adaptation** (occupational identity, occupational competence)	**Motherhood** (pregnancy, birth, mothering) **Lifestyle redesign** (power, agency, occupational balance) **Mothering co-occupations** (physical, caring, play, home environment) **Maternal work** (professional, home management, paid, unpaid) **Care-giving occupations** (family, teaching children, using home-space)	**Prenatal** **Birth** (labour, birthing, immediate postpartum) **Postnatal** (1-2 days post-partum until 12-months)

The names and structural order of codes were further revised and refined after coding a further three interviews. A draft codebook was created, which was discussed and reviewed by the supervision team and adjustments were made as recommended to rename, merge, and delete codes to improve the conceptual structure, hierarchy, and order. The remainder of the data were interpretively coded according to these, with minor refinements and adjustments made to codes and/or the codebook as new or alternative themes emerged.

After all data were coded, the conceptual structure was revised for balance, appropriateness and relevance (Miles & Huberman, 1994). This review process revealed a lack of coherence between codes which made early thematic analysis problematic and relationships overly complicated. This is typical of a “garden-path analysis [generating an]… exhaustive list of themes that were found in the data, but the themes are self-contained and

unrelated" (Ayres et al., 2003, p. 881). It also became apparent that several data bulks were forced into the deductive codes, reflecting selected occupational therapy conceptual and practice frameworks (Miles & Huberman, 1994). A decision was made to overhaul the coding structure.

An inductive approach was taken to interrogate the data in a new way by adding, deleting, merging or renaming codes, considering alternative structural constructs and hierarchies, and patterns and relationships between categories, codes and emerging themes (Lincoln & Guba, 1985; Miles & Huberman, 1994). This analysis process revealed the extensively diverse spectrum of contexts and considerations, and the decision was made to connect these through a deductive coding to reflect the evidence-based practice framework for occupational therapy (Cordier & Wilkes-Gillan, 2017). Within this global structure, organising and basic themes were then inductively pattern coded (Miles & Huberman, 1994), and the thematic network construction process commenced (Attride-Stirling, 2001).

THEMATIC NETWORK CONSTRUCTION

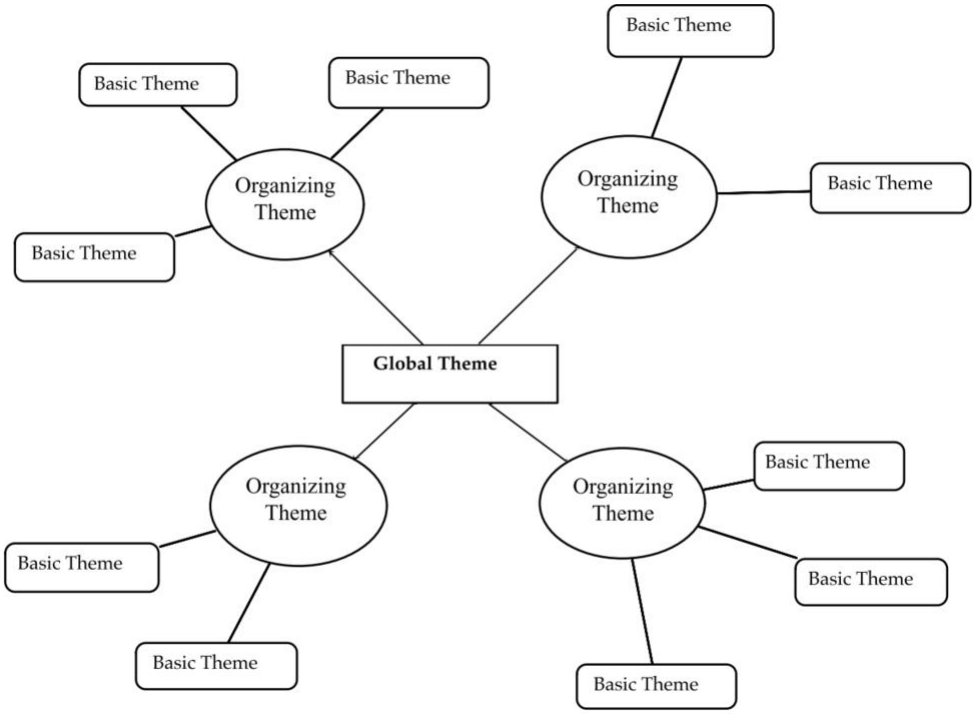
Codes relevant to research questions and case definition boundaries were selected from NVivo and arranged into basic themes. They were rearranged through interpretive pattern analysis into organising themes using Mindomo mind mapping software (Mindomo, 2020), and the global theme emerged (refer Appendix K). Thematic networks were checked, verified and refined collaboratively with the research supervision team (Miles & Huberman, 1994).

The thematic network development tiered three levels of interpreted meaning within an organisational structure of basic, organising, and global themes (refer Figure 7). Basic themes emerged from the dataset following Attride-Stirling's (2001) analysis stages and applying feminist research strategies to preserve women's voices (Devault, 1990). Four

organising themes encapsulate the significance and meaning of basic themes and were influenced by occupational therapy EBP components (Cordier & Wilkes-Gillan, 2017). The global theme is at the core of the thematic framework, reflecting principal metaphors of the data which contextualise the issues, arguments, and reality of the case (Attride-Stirling, 2001).

FIGURE 7

Structure of a thematic framework



Note: Reprinted from Figure 1 in "Thematic networks: An analytic tool for qualitative research", by Attride-Stirling (2001, p. 388), in *Qualitative Research, 1*(3), 385-405. https://doi.org/10.1177/146879410100100307.

PHASE V: TRIANGULATION

Constructivist and qualitative research philosophers argue that there is no singularly accurate way to understand data (Flick, 2017; Morse, 2017), believing, "there are multiple perspectives or views of the case that need to be represented, but that there is no way to

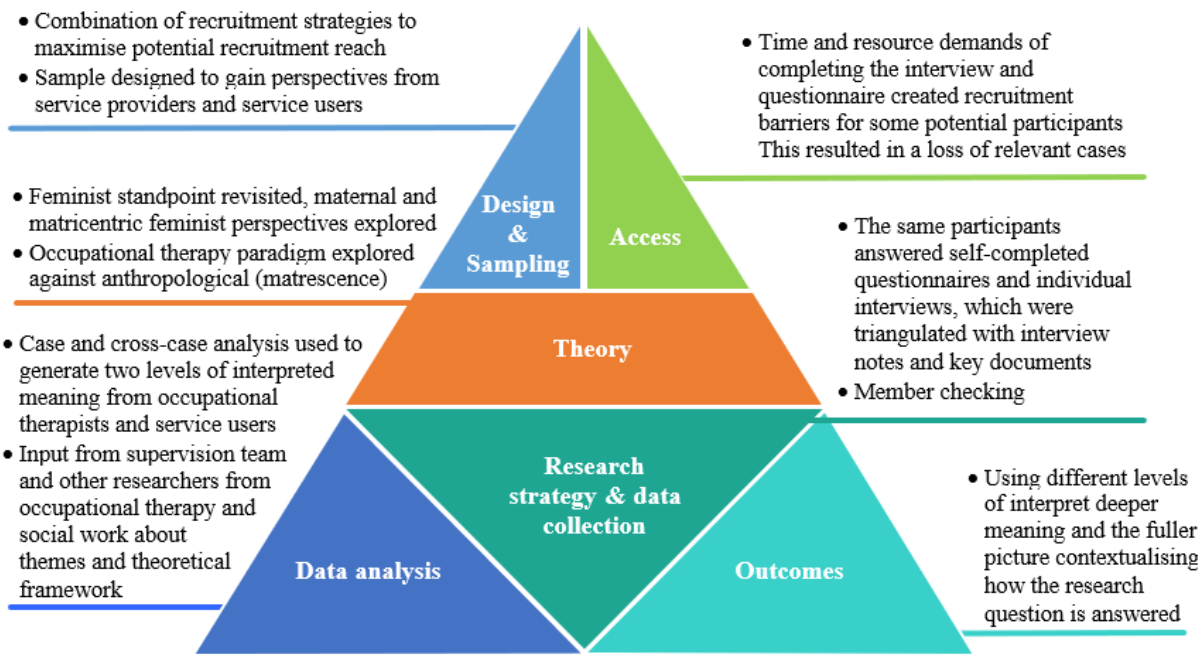
establish, beyond contention, the best view" (Stake, 1995, p. 108). This section reports on efforts made to, "minimize the misrepresentation and misunderstanding" (Stake, 1995, p. 109) of data and the case interpretations, in accordance with ethical research obligations.

RIGOR, VALIDITY AND CONFIRMABILITY

According to Stake, confirmability of data in case study research requires validation using triangulation protocols, "to increase credence in the interpretation [and] to demonstrate commonality of an assertion" (Stake, 1995, p. 112). This is achieved by considering issues from at least two perspectives, methods or data sources to produce knowledge on different levels that comparatively validate interpreted meaning (Flick, 2017; Stake, 1995). Reliable and valid qualitative research is rigorous, and efforts demonstrating this need to be built into the research design (Denzin & Lincoln, 2017b). Contemporary triangulation methods (Flick, 2017) were descriptively reported throughout this chapter, and illustratively summarised in Figure 8.

FIGURE 8

Triangulation of data and methods



REFLEXIVITY

In qualitative and feminist research, rigor is also demonstrated through reflexivity. Acknowledging and critically analysing how the professional and personal perspectives of the researcher have influenced the research process, design and data interpretation improves trustworthiness (Curtin & Fossey, 2007; Finlay, 2003; Hesse-Biber, 2012). An audit trail, reflexive mind map, journal, and blog documented researcher subjectivities as strategies to improve transparency and self-reflexivity. Personal, functional and disciplinary reflexivity is discussed (Gough, 2003), examining power and authority balances between the researcher and participants, and reporting biases and assumptions to improve transparency, objectivity and confirmability (Liamputtong, 2010).

RESEARCHER ROLE

Establishing roles, expectations and intentions enabled participants to feel clear, confident and safe in sharing, "their 'realities'" (Simons, 2009, p. 9), in a respectful and protective researcher-participant relationship, which is a key feature of standpoint feminist research (Given, 2008). Hesse-Biber and Leckenby (2004) state that feminist researchers acknowledge how the boundaries of their multiple roles, identities and research aims influence research design, "through conscientious reflection" (p. 211). Case researcher roles vary, and the fluidity of these reflect the researcher's constant conscious and unconscious decisions about how much focus and emphasis to place on each role (Hesse-Biber & Leckenby, 2004; Stake, 1995).

The influence of my personal and professional identities and roles on researcher-participant relationships were constantly and sensitively self-monitored and self-regulated throughout interviews, in accordance with reflexivity and feminist research interviewing principles (Devault, 1990; Doucet & Mauthner, 2008; Given, 2008; Hesse-Biber &

Leckenby, 2004; Oakley, 1981; Roberts, 1981; Simons, 2009). I transparently communicated the purpose of the interview during initial conversations with participants, respecting their unique role as experts of their own domains and experiences. I clarified my primary roles as an interpreter and student researcher were separate from my professional and personal experiences and expertise, noting that the latter would likely allow me to understand their experiences, perspectives, and attitudes.

In my role as interviewer and biographer, the conversational and active listening techniques were flexibly incorporated (Devault, 1990; Given, 2008), blending my personal approach with professional skills, training and experience as an occupational therapist, mediator, market-researcher and research student. Perceptions of expert power and information power (Griffin, 2001) featured in several interviews in ways unique to each participant-research relationship dynamic and were managed reflexively. Participants were encouraged to speak openly and freely about their own realities, ask questions and float ideas without judgement from me in my role as learner. These efforts aimed to clarify my role as a doctoral research student and participant roles as experts, to mitigate perceived power imbalances and rebalance relationship dynamics to maximise data gathering potential (Finlay, 2003). Knowledge sharing was offered periodically to validate experiences and demonstrate areas of mutual understanding. Establishing and maintaining rapport and engagement with participants was a priority in my storyteller role, selectively sharing my own personal perspectives, experiences and knowledge to meaningfully illustrate how I understood theirs (Finlay, 2003).

In my advocacy role, I presented this research as an opportunity for participants to contribute to academic research by voicing their realities and documenting their practice in a little-known specialist practice field. My advocacy role was motivated to present information in a forum that might inspire curiosity, reflection, debate, and change, and encourage further

research in this area. My role as interpreter echoes the philosophical lens described in the methodology chapter and is at the heart of all conscious and unconscious roles, decisions, ideas and reflections reported throughout this thesis (Hesse-Biber & Leckenby, 2004).

ASSUMPTIONS AND BIASES

I approached this research from a discipline-specific perspective as an Australian occupational therapist, which heavily influenced the design of research questions and aims. My experience as an occupational therapist and a mother aligned well with Esdaile and Olson's (2004) descriptions of mothering as an occupation. My interest in the roles of occupational therapists in the perinatal period was – and is – not as a replacement for other health professionals, with specialised maternal health knowledge. Rather, I saw the potential for occupational therapists to support women's occupations and co-occupations as part of an interprofessional maternity care team.

It was a prerequisite that occupational therapy participants had recency of practice experience with perinatal populations as well as holding current registration with the relevant professional association. This decision was made to ensure a consistent level of professional integrity, and ethical standards compliance was established as a defining participant quality. It was then an assumption that the data obtained regarding the occupational therapy role would meet the terms of full, extended and/or advanced practice scope specifications, and best practice guidelines (Cordier & Wilkes-Gillan, 2017; Rexe et al., 2013).

My personal positionality is described in the methodology chapter of this thesis and has influenced my interpretations of what is meaningful. During this case study, the feminist standpoint epistemology and disciplinary frameworks influencing my position in this research were increasingly challenged. Diversity in participants' experiences and realities highlighted

the cultural, gender, class, educational and social privilege biases of occupational therapy practices and conceptual frameworks, which rarely improved understanding of the case.

Considering mothers as human-beings and healthcare consumers in the context of feminist standpoint epistemology limited my capacity to understand participants' perspectives and biased my interpretation of the data. This philosophical framework neglected to aptly consider or acknowledge the significance of mother's place, power, and authority in society, which was initially considered a periphery influence in this research. When this omission was realised to be a significant oversight, alternative disciplinary and epistemological perspectives were sought to better understand the emic issues of this case study.

In exploring the place of mothers as human-beings in society, I learned of the anthropological term, '*matrescence',* describing the developmental process of becoming a mother (Newman, 1975; Raphael, 1975). Matrescence is currently being 'revived' as a conceptual term in maternal psychology (Athan & Miller, 2013; Athan & Reel, 2015), and describes ideas highly recognisable and translatable to occupational therapy. Applying matrescence as an epistemological context provided fresh insight to understand the deeper meaning in the motivations for client-centred occupational therapy services participants had described.

Maternal and matricentric feminist approaches (O′Reilly & Bueskens, 2016a, 2016b; Pascoe Leahy & Bueskens, 2020a) recognised that unique and complex issues impact women as mothers in society; however, were not developed to a level required for academic inquiry (O'Reilly, 2019). Experimental application of these emergent theoretical perspectives as epistemologies reframed my functional positionality to re-examine the case. This perspective revealed how terms such as 'perinatal' and 'well' reflected obstetric dominance in medicalised healthcare practice and research, which correlated strongly with the emic issues

influencing the case. This positional shift enabled recognition of how my own inexperience and disciplinary bias limited the case study design and interpretation of themes, which are addressed later in the discussion chapter.

ETHICAL CONSIDERATIONS

A high-risk ethics risk assessment was completed covering each stage of research, in accordance with criterion recognising the proposed sample population as potentially vulnerable. This research required a high-risk ethics approval to consider and prevent the risk to pregnant women and their infants from becoming distressed or re-traumatised during the interview process. Contact details for a free-of-charge counsellor were provided in the participant information sheets (PIS) for individuals to address issues raised for them whilst participating in this research.

Concerted efforts were made to deidentify data to prevent participant identification and protect individuals' intellectual property. According to Given (2008, p. 16), "in qualitative research, anonymity can facilitate candid disclosure of sensitive information while also protecting the privacy and safety interests of participants". Participants were assured of their partial anonymity with deidentified research reports verbally and in the PIS.

The process of snowball recruitment and open invitations in closed special-interest groups on social media meant that many participants were easily able to identify one another independently if they initiated it. This emerged as a motivating driver for many participants to engage in professional networking, as many reported feeling isolated at the time of the interview and were surprised and encouraged to connect with others after learning that they were not the only occupational therapist recruited to participate in this research. Whilst I personally avoided engagement in communication identifying participants, the snowball

recruitment method compromised the capacity to protect individual participants identities at times.

ETHICS APPROVAL AND INFORMED CONSENT

Ethics approval was granted by the La Trobe University Ethics Committee on 2 December 2016, in accordance with La Trobe University policies and procedures (approval number HEC16-107). Evidence of ethics approval and extensions can be found in Appendices L, M, and N. Informed consent was obtained prior to data collection with the target sample populations, and participants were made aware that their participation was voluntary. Consent could be withdrawn without consequence at any time; however, a sunset clause outlined in the PIS informed participants that withdrawal after data deidentification was not possible. Participants in case studies were guaranteed anonymity through the use of pseudonyms in place of participant names, and the absence of naming workplaces or identifying details in findings and reports (Piper & Simons, 2011).

PROCEDURE FOR OBTAINING INFORMED CONSENT

Participants received written and verbal information via email relating to the research project including the case study design, structure and aims, and informed consent was obtained prior to data collection. Participants were provided with PIS, along with a consent form (refer Appendix O), and withdrawal of consent form (refer Appendix P).

Refer Appendices Q and R for each the occupational therapy and service user PIS. No participants withdrew from this study or submitted withdrawal of consent forms. An item on the consent form was available for participants to indicate if they wished to be contacted prior to providing informed consent. All participants who indicated that they wanted to be were contacted by the researcher, had their concerns or issues were addressed and resolved during

conversation. Individuals were recruited following the provision of written informed consent, completed questionnaire, and gave verbal consent at interview commencement.

CHAPTER SUMMARY

This chapter addressed the methodical research approaches, designs, and decisions to contextualise the findings chapters content. The following section documents the research findings, which are introduced with a brief ‘Preface for Findings’ to clarify the reporting structure.

PREFACE FOR FINDINGS CHAPTERS

Findings from the multiple case study are presented in three sections across four thesis chapters. As detailed in chapter 6, the multiple case study data were divided into two cohorts during analysis phase IV. Data from the occupational therapist cohort were separated from the services users and considered as two multiple case cohorts, titled “multiple case A” and “B” respectively. The findings chapters reflect this, and are structured as follows:

- Case summaries (multiple case A): Chapter seven reports on practice accounts of 16 occupational therapists in five high-income countries, including Australia, Canada, England, New Zealand, and the United States of America (USA), titled ‘Multiple case A’. This reports on the first level of analysis for multiple case A.
- Cross-case analysis and thematic framework (multiple case A): Data from multiple case A were synthesised through cross-case analysis and are reported as global and organising themes in two parts of chapter eight. This reports on the second level of analysis for multiple case A.
- Case summaries (multiple case B): Finally, the two service user accounts of women who accessed occupational therapy services as perinatal clients in Australia and the USA are reported in the final findings chapter nine, titled ‘Multiple case B’. This reports on the first level of analysis for multiple case B.

The terminology and language used to describe and define women’s maternal status are inconsistent throughout the two multiple case A case summary sections in chapter seven. This diversity is consistent with individual therapists’ descriptions during interviews, respecting feminist standpoint research methods for preserving women’s voices (Devault, 1990). Attempts to resolve discrepancies are made in the cross-case analysis chapter eight, parts I and II), and analytically addressed in the discussion chapter of this thesis.

The following chapter seven is the first of three findings chapters, and reports on case summaries for multiple case A as the first tier of analytical interpretations.

CHAPTER 7: MULTIPLE CASE A

"Women don't need to find a voice, they have a voice, and they need to feel empowered to use it, and people need to be encouraged to listen."

— Meghan Markle

INTRODUCTION

In this chapter, multiple case A is presented as a collection of 16 summarised individual occupational therapy cases. The eleven cases from Australia are reported first, followed by the five non-Australian participants. The cases are descriptively ordered by chance under participants' pseudonyms, summarising each unique role working with women during maternal stages and perinatal motherhood phases. A thematic framework will be presented in chapter eight, to report the similarities, relational and defining characteristics between these cases, generated through cross-case analysis.

OCCUPATIONAL THERAPISTS IN AUSTRALIA

An overview of the eleven Australian participant's demographic and service information is detailed in Table 12 to contextualise individuals' unique practice roles and settings.

TABLE 12

Participant information summary: Australian occupational therapists

DEMOGRAPHIC AND SERVICE DATA: *Occupational therapists providing services to women during perinatal phases*

No.	Name*	Gender	Years of practice		Client maternal status	Service delivery setting/mode	Client location	Funding and accessibility	
			OT	Maternal health OT				Service funding	Client payment options
1	*Anna*	F	6	2	Perinatal	Community	Metro	Public	Free access
2	*Emma*	F	11	9	Perinatal	Outpatient; Inpatient	Regional	Public; Private	Public (Medicare); Self-funded (user pays); Private health insurance
3	*Jennifer*	F	6	4	Perinatal	Outpatient, Community	Metro	Combination (private/ public); Private	Public (Medicare); Self-funded (user pays); Private health insurance
4	*Nina*	F	12	3	Perinatal	Outpatient (groups)	Rural/remote	Public	Free access
5	*Rebecca*	F	17	3	Perinatal	Outpatient; Online; Community	Metro; National; International	Public; Private	Public (Medicare); Self-funded (user pays); Private health insurance
6	*Pamela*	F	15	9	Prenatal	Inpatient, Outpatient	Metro	Public; Private (with public funding)	Public (Medicare), Private health insurance
7	*Cath*	F	30	8	Postnatal	Inpatient, Outpatient, Online (telehealth)	Metro	Combination (private/public); Private	Public (Medicare); Self-funded (user pays); Private health insurance
8	*Jack*	M	8	0	Perinatal	Outpatient (hand therapy)	Regional	Public	Public (Medicare)
9	*Susie*	F	10	5	Perinatal	Inpatient	Metro	Public	Public (Medicare)
10	*Mary*	F	?	0.5	Preconception/ Perinatal	Community	Metro	Private	Self-funded, private health insurance
11	*Fleur*	F	10	1	Perinatal	Community	Metro	Private	Private-health insurance

CASE 1: ANNA – COMMUNITY PSYCHOSOCIAL/EARLY INTERVENTION ROLE, AUSTRALIA

CASE SUMMARY

Anna is a solo occupational therapist across two sites, facilitating groups and offering individual consultations. Her specialisation is mother-infant connection and wellbeing. Women attended groups and services via casual, self-initiated or informal referrals. Anna sees approximately 40 clients per month, with an average of 10 contacts per client each month. Clients are typically aged between 19 to 50 years.

In her role, Anna works in a multidisciplinary team of educational professionals, general practitioners (GPs), mental health professionals, speech pathologists, and social workers. She is connected with a supervision network including occupational therapist's working in similar roles, facilitated by an external clinical practice supervisor. Anna reported that her role improves mother-infant bonding and attachment, maternal capacity, and social engagement by addressing women's self-care, self-esteem and self-efficacy issues from pregnancy until the child is four years old.

The occupational therapist role is positioned with the education-based centre to improve accessibility and convenience for vulnerable women who were reluctant to utilise health services. Anna explained that women who felt ashamed, fearful, or overwhelmed during perinatal stages avoided clinical or professional resources, reflecting their reluctance for, "reaching out and getting support networks" but were "keen on the groups, and … informal support".

Anna described her role as "two-fold", tailoring and facilitating perinatal groups and services and as an educational resource for parents and educators. She regarded motherhood as a formative life occupation for women, with mothering being a "vital and important role". Anna addressed mothering occupations and managing maternal role performance pressure,

promoting mother-infant bonding and attachment, developing mother-infant routines, and promoting community and social connectedness. In this context, Anna works with women to address low self-esteem, reprioritise self-care and improve confidence with decision making. Her role aims to foster development of women's psychological wellbeing and self-efficacy, with tailored groups offering women, "meaning and routine".

CASE 2: EMMA – SENIOR HAND THERAPIST AND OCCUPATIONAL THERAPIST, AUSTRALIA

CASE SUMMARY

Emma works in a public hospital-based outpatient clinic and specialises in hand and upper limb therapy, and lymphoedema management. She sees a range of clients including women during perinatal phases, estimating seeing one to two public and four to six private clients per month, with an average of four contacts per client each month. Her role within a multidisciplinary (MDT) team includes GPs and physiotherapists. Emma treats women's hand conditions including carpal tunnel syndrome, De Quervain's tenosynovitis, acute hand fractures and tendon issues during perinatal stages, explaining these clients have unique needs owing to their maternal status, diverse lifestyles and motherhood demands.

Emma consults with many pregnant women who experience night pain, difficulty sleeping, and tingling, numbness and burning in their fingers overnight. She noticed that they often deprioritised their care and had difficulty being accurately diagnosed by GPs, commenting "women, particularly with De Quervain's and they've got new babies, they're just exhausted… They've got lots of pain and they're in tears, and they're just really upset". In her role, Emma often discusses sleep routines and writes letters to GPs advocating for clients' need to take personal leave to bank sleep before their baby's arrival.

Emma highly values clinical collaboration with physiotherapists, reflecting that occupational therapists' focus differed from the conceptual approach used by physiotherapists:

> *… We delve a lot deeper into individual functional components... the nitty-gritty and the specifics of things; like the capsule that they're using in the car, what grip postures they're using to do activities, how they set up their pram.*

Through occupational analysis, Emma observed new mothers had a spike in physical activity due to increased domestic and new mothering occupations. Fluid retention and being underconditioned for the physical demands of labour intensive and repetitive tasks were common, resulting in many women experiencing hand pain, back pain, fatigue, and muscle strain. Emma educates women on how to ergonomically perform daily infant caring tasks.

Client-centred conversations were key to Emma exploring and understanding the unique functional and occupational performance issues women struggle with:

> *It's the little conversations … that often help the most… A lot of the time I think as an OT you don't realise that you're doing it…, and then when … you're writing your notes about all the other things that you've discussed in the session, you're like, "Oh, [it wasn't] really about their hand at all".*

Recovery from injury was optimised when women proactively sought help, and Emma stressed, "it's about being able to see them and treat them and address it early". She often validates women's symptoms and tailors hand therapy interventions, activity modifications and routine adjustments to improve their function.

CASE 3: JENNIFER – COMMUNITY PSYCHOSOCIAL ROLE AND PRIVATE PRACTICE, AUSTRALIA

CASE SUMMARY

Jennifer works in two part-time occupational therapy positions, including a State government-funded perinatal position across two sites, and in private practice with perinatal and paediatric populations. Both roles focus on women's health and wellbeing during motherhood.

Jennifer's public position is situated in a children's centre, focused on connecting with families "struggling" during pregnancy and early motherhood, as "a time where mums are very vulnerable". She "provides "a therapeutic presence" for women, helping them to make sense of issues, and empowering them to do the things they want to. Jennifer's role is strategically positioned to, "bridge the gap between the education system and health, and to try and connect with our most vulnerable families, who will not go to a health service".

In private practice, one-quarter of Jennifer's caseload are women with babies aged under 12-months. She describes this as, "more of a clinical role", to support new mothers referred for, "emotional wellbeing and concerns about that [mother-infant] relationship". Jennifer works to develop a connected, positive, and secure mother-infant bond as a core occupational and developmental need, shared equally by the mother and child. She re-educates women with a history of traumatic, difficult, unhealthy, or abusive relationships who are not always aware of how to develop a securely bonded attachment with their baby.

Across both positions, Jennifer addresses a broad range of issues impacting women's wellbeing. These include the sudden onset of feeling overwhelmed, exhausted, and overloaded with competing occupational and role demands in early motherhood, especially when there was more than one baby. Jennifer regards these as complex issues, providing therapy addressing cognitive processing changes, psychosocial pressures, deprioritised

personal care, community disengagement and social isolation. She works with women struggling with identity loss due to becoming a mother, loss of confidence, energy, and lack of motivation to leave the house.

Jennifer adopts an informal, interpersonal practice approach. She explained women usually needed time to develop rapport with therapists and services before they felt 'safe' talking about their issues, which is a primary aim for her. Assessments are based on what is occurring, "developmentally for the parent", incorporating attachment frameworks, trauma-informed practice, and occupational therapy concepts to interpret perinatal occupational performance issues. These are contextualised by daily/nocturnal routines and occupations and include psychotherapy, mindfulness, sensory integration, groups, education, parental capacity building, maternal empowerment, secure attachment, and emotional intelligence.

CASE 4: NINA – PREVENTATIVE/EARLY INTERVENTION MENTAL HEALTH, AUSTRALIA

CASE SUMMARY

Nina has specialised in perinatal mental health for three years and currently practices in a hospital-based outpatient clinic one day, every three weeks. She describes her service as "free" for women to access, estimating her caseload is seven to eight clients, with 12 contacts on average per person. She usually receives referrals from midwives, child health nurses and maternity ward staff when women scored above 10 on an Edinburgh Postnatal Depression Scale (Cox et al., 1987). Women can self-refer when they feel their mental health is at risk during or after pregnancy. Nina had completed additional training in developmental psychology, mental health, and a Post-Graduate Certificate in Paaediatric Occupational Therapy, which were prerequisites for her employment in this role.

Nina typically works with women to manage their expectations, addressing occupational changes, occupational deprivation, transitioning into new roles, identities, relationships and "moving from occupations to co-occupations". She explained that women's "developmental changes" including identity transitions and role loss when becoming mothers are not routinely acknowledged or addressed. Nina observed that stressful partner relationships, communication difficulties and unrelenting role performance standards commonly resulted in women experiencing occupational overload, feeling isolated, anxious, and doubtful of their maternal competence.

Nina regards her position as unique and isolated. She provides early intervention and antenatal mental health prevention and promotion services to women in remote and rural areas, without a formal diagnosis or a mental health care plan. Nina weaves psychology, "couple therapy" and occupational therapy theory into her practice, "always through an occupational lens". Nina reflected that being an occupational therapist enables a unique interpretation of women's maternal mental health challenges, focusing on occupation and roles to support women and their partners during parenthood transitions. The therapeutic process of tailoring treatment approaches improves maternal self-esteem, self-efficacy, and maternal competence, which was particularly needed in strained early-parenting partner relationships and following traumatic birth experiences.

CASE 5: REBECCA – SOLE PRACTITIONER, PRIVATE PRACTICE, AUSTRALIA

CASE SUMMARY

Rebecca is a "sole practitioner", self-employed in private practice. She had completed a Certificate in Infant Mental Health, Graduate Certificate in Soft Tissue Injury Management, Diploma of Pilates Rehabilitation, and '*The OT Role in Prenatal Care'* training. Rebecca sees three to four perinatal maternal health clients each month who have children aged under 12-

months. Most self-referrals follow casual conversations at childcare centres with mothers who are “struggling”. Formal referrers included GPs, midwives and hypnobirthing practitioners, but not obstetricians or Child and Family Health (CAFH) nurses. At the time of this interview, Rebecca was establishing connections with a major university and Occupational Therapy Australia to advocate for better recognition and promotion of occupational therapy roles in women’s health.

Rebecca supports women to “adjust to the physical and emotional challenges of motherhood”, identifying that her client cohort is typically, “professional women, quite driven in their careers and have been... very driven, goal-oriented, task focused women, who love their list and love their ‘to do schedules’, and… being able to control their lives”. Services are provided in individual and group programs from a private consulting suite, and online services locally, nationally, and worldwide.

By providing a “mentoring or facilitatory role for women”, Rebecca works collaboratively with women through challenges “specifically related to the fact that they’re now a mum”. She provides a range of interventions to manage women’s physical, ergonomic, functional performance, sociocultural, hormonal, mental, emotional, psychosocial, and cognitive issues. These include strategies for lifestyle reconfiguration, adjusting to new roles, routines, and identities, addressing role loss, occupational deprivation, and imbalance, changing partner relationships, mother-infant bonding, injury rehabilitation, pain management, holistic recovery and recuperative needs and goals.

When the arrival of a new baby “completely upends their life”, Rebecca supports women to emotionally adjust as their identity, personal causation and volition shifted when “everything else that you do is [suddenly] somehow filtered by the process that you’re also a mother”. She addresses socio-economic and financial challenges women experience during motherhood, as well as anxiety, worries, feelings of sadness, and proactively preventing risk

of maternal depression. Rebecca works to improve women's self-esteem, identity, independence, and values when taking leave from work, to become mothers, and balance expectations when striving to achieve idealised and unrealistic contemporary representations of 'happy' motherhood.

CASE 6: PAMELA – INPATIENT WOMEN'S HEALTH WARD, AUSTRALIA

CASE SUMMARY

Pamela's inpatient role is positioned within a specialist team of women's perinatal health occupational therapists in a major metropolitan women's hospital. Her role has the flexibility to work with women, "who are having trouble adjusting to their new role as a mum in the postnatal period" in inpatient and outpatient settings. In both settings, she practices within an established multidisciplinary team and referral network. Pamela sees 10 clients per month, with an average of 20-30 contacts per client.

Supporting women during prolonged bedrest was Pamela's "main work". Her role focuses mostly with women during pregnancy because "that's when we're noticing a lot of occupational change or disruption in several domains". Addressing a broad spectrum of occupational performance issues, Pamela's role strongly focused on psychosocial adaptation and wellbeing during perinatal transitions. The vastly diverse needs of women experiencing occupational performance issues during perinatal phases require Pamela to apply a full range of flexible practice skills and frameworks to address holistic issues relating to psychosocial, mental, physical, emotional, and cognitive wellbeing.

Pamela regarded occupational issues impacting women's wellbeing as being "about the adjustment" to motherhood, because "it's a life transition". Her role addresses occupational disruption and disengagement impacting maternal roles and wellbeing, by nurturing women's emotional health and development, and building a sense of competence to "manage" with

“confidence to become a mum… to be a mum and do… mum jobs”. Pamela asserts nurturing women’s wellbeing and self-efficacy during perinatal phases, strengthening family dynamics, stating, “when women are looking after themselves, they’re better able to be great mums and great partners. And the whole family does well if mum is doing well”.

Pamela adopts a “gentle” client-centred approach to build rapport and understand women’s experiences of occupational disruption and deprivation, role loss, motherhood transitions, relationship changes, and processing traumatic and difficult experiences. She provides interventions to navigate changes during maternal development, promote mother-infant bonding and partner relationships. Her role also aims to revive women’s sense of competence, self-esteem and self-efficacy in motherhood, mothering, work, personal, social, partner and familial roles and daily occupations.

CASE 7: CATH – INPATIENT/OUTPATIENT ROLE | OCCUPATIONAL THERAPY TEAM LEADER - MOTHERS, WOMEN'S AND BABIES STREAM, AUSTRALIA

CASE SUMMARY

Cath is a senior occupational therapist specialising in “psychosocial” perinatal practice in a major metropolitan women’s hospital. She leads a team of perinatal and women’s health occupational therapists and occupational therapy assistants (OTA) and works with an extensive multidisciplinary team. Cath sees an average of 35 clients per month, most of whom are pregnant.

In the antenatal period, Cath usually works with women on prolonged bedrest experiencing occupational disruption and “struggling with the notion of the admission”. Immediately postpartum, Cath supports women to therapeutically debrief and process traumatic birth experiences. Women “experiencing stress or anxiety” when their babies

stayed in special care nurseries, feel emotionally overwhelmed or distressed and struggle to enjoy engaging in early maternal occupations with their baby. In an outpatient setting, Cath finds it difficult to sum up her role, explaining, “we work really differently”. Using conversational interview techniques, Cath applies a “very client centred” approach for “getting to the core” of women’s occupational issues. She uses occupation to promote women’s development of self-confidence, capacity, and competence during perinatal transitions to enhance their sense of wellbeing and satisfactory life role performance.

Prioritising women’s need for resilience as parents, Cath works with women to feel positive in mothering roles and develop a “sense of self-efficacy” to independently manage life challenges. She supports women to adapt to motherhood by learning a range of practical skills and coping strategies to structure their time and maintain a sense of role competence. The main issues she addresses with women include pregnancy and postpartum symptoms, sleep, maternal guilt, exhaustion and fatigue, stress, anxiety and worries, prolonged bedrest, procedural anxiety and needle phobia, disrupted partner relationships, traumatic birth experiences, and “uncertainty, about whether they can actually do this mothering job”.

Cath’s role is specialised, valuable and unique. Her role’s flexibility and holistic consideration of the whole person, meaningful occupations and environmental contexts are the key elements underpinning how occupational therapy benefits perinatal populations. Through providing sustainable and practical strategies to address women’s mental wellbeing and “emotional role adaptation” needs when becoming a mother, Cath’s occupational therapy role supports women’s perinatal wellbeing needs in a way no other profession does.

CASE 8: JACK – OUTPATIENT HAND THERAPY CLINIC ROLE, AUSTRALIA

CASE SUMMARY

Jack works in an outpatient hand therapy clinic, collaborating closely with physiotherapists within a multidisciplinary team. He typically sees one perinatal client per month, with an average of two contacts per client, explaining maternal clients are "a small part of my role". General practitioners (GPs) are primary referrers, and Jack mostly refers clients to physiotherapists for further treatment. Jack works with, "maternal health patients for hand/wrist injuries either directly or indirectly related to pregnancy [or] being a new mum", predominantly relating to carpal tunnel syndrome, De Quervain's, and hand, wrist, or finger fractures. His practice approach was "always occupation focused", which he considers occupational therapy's "strong point" in the hand therapy clinic.

Identifying women's goals and interpreting what degree of outcome they wanted to achieve from interventions is a priority in Jack's client-centred role. He works collaboratively with clients, explaining, "it's about aligning our expectations and the expectations of the person coming in… especially with new mums". Jack's assessments typically focus on grip strength and, "the ergonomics of how you're using your hand and your wrist". He applies "a functional approach", incorporating hand positioning to reduce functional pain and irritation, compensatory strategies, and adaptive movement techniques, and "aids and adaptive equipment" such as splints. Jack also modifies car capsule transfer methods, provides education, and tailors recommendations to reduce the frequency of repetitive movements during mothering roles and occupations.

A large part of Jack's role is assessment to confirm or query GPs diagnoses, because common misdiagnosis of hand issues hinders women from accessing quickly appropriate treatments. Jack routinely asks how women were managing stress and anxiety during motherhood, and screens for, "the signs of depression or [not] coping, …[because] if they're

having trouble with their hands, it might just be compounding factors" and issues. These conversations are pivotal for exploring and validating women's struggles, as Jack explained; "it's sometimes just giving them permission to say, 'I need some help'".

CASE 9: SUSIE – SENIOR OCCUPATIONAL THERAPIST, WOMEN'S HOSPITAL ACUTE WARD INPATIENT ROLE, AUSTRALIA

CASE SUMMARY

Susie's role was contracted to service women's perinatal health needs during hospital admission, working with an extensive maternal multidisciplinary team and referral network. She predominately works on the acute ward, flexibly servicing referrals for women on other hospital wards, outpatient, and community settings. Susie sees two to three clients per month, with an average of two to three sessions per person. Her role provides "really classic OT" work within the multidisciplinary team, contextualising that, "acute is acute, isn't it?".

In the maternal health multidisciplinary team, Susie's role adds value to the "existing team's expertise". She typically receives referrals for maternal inpatients experiencing, "complex… challenging and difficult", issues presenting as discharge risks. Her service aims to identify and manage discharge risk factors, "from an environment, a personal, a physical, a mental, [or] a social… perspective", to enable the woman and her baby to return home safely. Susie stressed that upholding core occupational therapy principles and client-centred philosophies were key to her role's value, remarking, "as soon as you start complicating it by too many other things, then it loses its magic".

Susie addresses women's physical, mental, emotional, functional performance issues for women who experienced birth injuries and trauma, surgical interventions during childbirth, pelvic organ prolapse, caesarean deliveries and unresolvable pain following birth.

She applies clinical understanding of birth, maternal development, women's anatomy, physiology and physiological systems to interpret occupational performance implications of, "what do these things mean, [and] how does that impact on the woman?". Her role in supporting women to return home with an infant into a home environment with complex or high-risk relationships and psychosocial issues is often difficult, requiring a sensitive client-centred approach. Susie also works with women preparing to return to work soon after birth.

CASE 10: MARY – BIRTH, PARENTING AND WOMEN'S PELVIC HEALTH, PRIVATE PRACTICE, AUSTRALIA

CASE SUMMARY

Mary works in her own women's health private occupational therapy practice specialising in birth, parenting and pelvic health. She offers both occupational therapy and abdominal therapy ("Arvigo") to restore uterus positioning and balance services to perinatal clients. The women Mary works with usually experience "debilitating" symptoms which impact their wellbeing, roles, and capacity for occupational performance. Mary's approach contextualises women's occupational performance issues within "mental, emotional, spiritual" wellbeing aspects. She prioritises women's role transition experience within the motherhood rites of passage which have become lost in contemporary "baby-centric" maternal health practices.

Mary regards occupational therapy's role in perinatal health is to address the symptoms, issues and challenges impacting women's wellbeing that are outside the scope of existing maternal healthcare services. Adopting a client-centred approach in maternal health is at the core of Mary's practice, with her therapeutic approach, "determined by the woman and what her particular needs are". She approaches client's issues, goals, and outcomes

within an occupational performance framework, explaining, “I keep it really functional, so I go back to the COPM [Canadian Occupational Performance Measure] goals”.

For women who sustained pelvic injuries and dysfunction, Mary provides a range of interventions including manual therapy and education about adaptive strategies to manage scar pain, discomfort, or pain during sex, reduce fear of birth, restore core strength, manage/reduce incontinence, improved positive body image and performance in life roles. Mary works with women to “reclaim their body as their own” following birth, promoting identity development and spirituality in her practice approach. Her approach contextualises maternal empowerment and psychosomatic recovery from birth within a ‘*fourth trimester’* postnatal phase.

Mary’s delivers practice that incorporates functional movement, ergonomics and positioning to support women during pregnancy to optimise the baby’s position leading up to birth. She addresses mothering occupational performance issues, including sleep, habits and routines, functional nutrition, continence management, financial management, pelvic and abdominal healing following birth, pelvic and abdominal scar pain. Addressing the practical aspects of motherhood, Mary provides client-centred education to women preparing and upskilling through “actual mothercraft skill development”. Mary explained these are typically skills “that previously we would’ve learnt from… our mothers…, aunties and our siblings”, which are no longer being passed down through generations.

CASE 11: FLEUR – SOLE PRACTITIONER, PRIVATE PRACTICE, AUSTRALIA

CASE SUMMARY

Fleur is in the early stages of starting her private practice and had seen one maternal client. She has previously worked with maternal clients in a rural generalist role, including

hand therapy, adaptation to motherhood, and remote Indigenous populations. Her private practice role has emerged in response to witnessing "the impact of being disempowered [during]…, pregnancy…, postnatal, birthing… [on] the quality of life of women", which she addresses by providing validation and re-education to women "that birth matters". Her practice approach uses meaningful occupation and occupational performance during perinatal transitions as conduits for "education and… re-culturalisation… [which] leads onto healthy occupations and … better health" outcomes for women.

Fleur works with women to maintain performance and engagement with self-care, leisure, quality personal time activities, "working in paid employment… the occupations around relationships with your spouse" and adjusting to motherhood throughout perinatal phases. During the prenatal phase, Fleur prioritises women's needs and issues by addressing, "the occupation around pregnancy", explaining "for some women it's really hard, physically, mentally, [and] emotionally. And that impacts on their ability to be able to function in their daily occupations". Following the birth of their baby, Fleur works with women to address how changes to postpartum pelvic function impacted "their ability to perform in their daily roles" which often resulted in "development of some social anxiety", and questioning, "do I want to go out of the house?". From a psychosocial perspective, she supports women to improve a sense of dignity, self-esteem, body image, and social confidence during motherhood stages.

Fleur provides interventions including "splinting, hand therapy… exercises", equipment and "referring-on" to specialist services. She applies counselling skills to educate women "around how they can better look at the routines in their life", and adapt their parenting styles to, "better support their children to continue developing". She also coaches women to recognise their strengths and "building empathy for the child", in the context of

mother-child interactions based on a guided exploration of their motherhood roles and relationships.

OCCUPATIONAL THERAPISTS IN COUNTRIES OTHER THAN AUSTRALIA

In this section, a collection of five summarised individual occupational therapy cases from locations outside Australia, including Canada, England, New Zealand, and the United States of America are presented. The cases are descriptively reported under participants' pseudonyms, summarising each unique role working with women during maternal stages and perinatal motherhood phases. An overview of participant demographic and service information is detailed in Table 13 to contextualise individuals' unique practice roles and settings.

TABLE 13

Participant information summary: Occupational therapists in Canada, England, New Zealand, and the United States of America

DEMOGRAPHIC AND SERVICE DATA: *Occupational therapists providing services to women during perinatal phases*

No.	Name*	Gender	Country	Years of practice		Client maternal status	Service delivery setting/mode	Client geographical location	Funding and accessibility	
				OT	Maternal health OT				Service funding	Client payment options
12	*Helena*	F	Canada	12	4	Preconception/ Perinatal	Outpatient; Online; Community	International; Regional; Rural	Combination (private/public); Private	Self-funded (user pays); Private health insurance
13	*Alex*	F	United States of America	14	3	Preconception/ Perinatal	Online	International	Private	Self-funded (user pays)
14	*Nellie*	F	Canada	12	2.5	Preconception/ Perinatal	Community (individual, clinic, groups), online, retreats	National, Regional	Private	Self-funded (user pays); Private health insurance
15	*Audrey*	F	England	30	8	Perinatal	Community	Metro	Public	Public (NHS)
16	*Corrie*	F	New Zealand	20	3-months	Perinatal	Community	National, Regional	Private	Self-funded (user pays)

CASE 12: HELENA – OCCUPATIONAL THERAPIST, WOMEN'S HEALTH COACH, INTERNATIONAL (ONLINE)/REGIONAL AND RURAL (COMMUNITY), PRIVATE PRACTICE, CANADA

CASE SUMMARY

Helena offers pre/postnatal health services in her own private practice. She has gradually expanded her practice scope to women's health and paediatrics, included consulting and teaching, running workshops, and providing online courses. She sees approximately ten women per month, providing two lengthy sessions per person. Women accessing her services are typically aged between 21 to 42 years. She has developed a multidisciplinary referral network, including GPs, obstetrician-gynaecologists (OB/GYNs), public health nurses, physiotherapists, doulas, yoga studios, Pilates studios and childbirth education class facilitators. Her practice focus is shifting to online, and she is mentoring another occupational therapist to take over direct client services.

Through using "different language that is welcomed outside of the medical profession", Helena's role as an occupational therapist shifts the healthcare provider role from being the "expert" and gives "the power back to the client". Helena valued how occupational therapy approaches empowered women to understand and manage their own holistic wellbeing during perinatal phases by offering, "a different perspective into the body as a whole". Her role as an occupational therapist extends maternal healthcare services by going "beyond the healthcare system in terms of being 'healthy'", prioritising client-centred practice to explore "what does that look like to [women]? …, and really holding space for them to do some… deeper thinking on that".

Helena feels the "emerging speciality" of occupational therapy in perinatal health meets the changing needs and demands of women in current social climates. Her initial

consultations holistically explore women's individual issues and goals in-depth, and typically include, "a postural screen… [and] some functional movement" to, "set the stage, and …talk… about what their goals are". Using therapeutic conversations to allow women's occupational performance issues, "fears" and "insecurities" to emerge, Helena then discerned which issues could be addressed within her scope of practice.

By, "talking about stuff that no-one else is talking about", Helena valued that occupational therapy offers an alternative health professional option for women. In her practice, she utilises a range of assessments and interventions to address biomechanics, functional movement, rhythmic and dynamic movement, core strength and ergonomics. She connects this to pelvic health and function, mental health, healing and trauma, self-regulation of the parasympathetic nervous system. Helena addresses mother-infant connection, early intervention, psychosocial wellbeing, and empowering women through integrative health and client-centred education to make informed decisions during perinatal transitions. She identifies her role as a "resource person", tailoring respectful and sensitive strategies for, "giving [clients] resources in a way that's not overwhelming". Helena has also worked with women preparing to adopt children to another family, supporting them to emotionally process the experience and maintain their wellbeing and life roles during and after pregnancy.

CASE 13: ALEX – INTEGRATED WOMEN'S HEALTH SPECIALIST, PRIVATE PRACTICE, NATIONAL/ INTERNATIONAL (ONLINE/TELEPHONE), USA

CASE SUMMARY

Alex has worked for 14-years as an occupational therapist, following 10-years as a Certified Occupational Therapy Assistant (COTA) with the United States (US) Military. She has completed extensive training and professional development, including accreditation and

certifications as an integrative nutrition health coach, craniosacral therapist, myofascial therapist, yoga teacher, colon hydrotherapist, yoni[2] steam practitioner[3], and practical nurse.

Alex began specialising in maternal health three years ago, and at the time of this interview was in the preparation phase of registering her services as billable under occupational therapy registration and accreditation. Alex is consolidating her skills as a health coach, yoni steam practitioner, and occupational therapist into an integrated women's health specialist, noting: "I've been doing this work as a 'health coach' and… a 'wellness practitioner'… and I'm working now to transition into adding more of the OT aspect of it and doing it that way".

Alex describes her caseload as sporadic. She usually sees two clients per month, and predominantly focuses on fertility and the preconception phase, working with couples and women to prepare their bodies to conceive naturally, and following miscarriage. Alex's role adds value to existing perinatal health care services by offering "gentle, but firm support" to women when addressing their holistic health and wellness issues and needs. This involves working "as a facilitator…, bridging the gap between the information that they're needing and don't have, and they don't know where to get it".

Providing "wellness intervention[s]" to women with a range of holistic health issues and needs was a core practice for Alex. She interprets women's determinants of wellness and health needs through a client-centred, goal-focused occupational therapy lens. During pregnancy, Alex aims to prepare women mentally, emotionally, and physically about "proper body technique[s]" for labour and birth. She has designed a holistic maternal development

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[2] "*Yoni* is a Sanskrit word that has been interpreted to literally mean the 'womb', the 'source', and the female organs of generation [and] connotes the female sexual organs such as vagina, vulva, and uterus". Wikipedia contributors. (2022, 9 March 2022). *Yoni*. Wikipedia, The Free Encyclopedia. Retrieved 23 March 2022 from https://en.wikipedia.org/wiki/Yoni.

[3] Also "*vaginal steaming*: "An alternative health treatment whereby a woman squats or sits over steaming water containing herbs such as mugwort, rosemary, wormwood, and basil" for a range of holistic, spiritual, and cleansing therapeutic benefits. Wikipedia contributors. (2022, 29 January 2022). *Vaginal steaming*. Wikipedia, The Free Encyclopedia. Retrieved 23 March 2022 from https://en.wikipedia.org/wiki/Vaginal_steaming.

program to teach women about “body mechanics…, breathing and the relaxation, and… mindfulness technique[s]... so that their pregnancy and their delivery would be one that’s not as stressful”. She is applying strategies addressing the biomechanics and ergonomics of movement during pregnancy, in the context of a holistic birth preparation program.

Alex observed many women were, “stressed out during their pregnancy, and eating things that are not helpful to them”. She detailed how her therapeutic process explored intergenerational, developmental, and sociocultural, familial, and biopsychosocial influences which informed women’s “ideas and beliefs that they have around pregnancy and becoming pregnant”, and food choices. In this way, Alex addresses functional nutrition and meaningful food choices to enhance women’s wellbeing during motherhood phases. She facilitates women’s exploration of their experiences, thoughts, feelings, reactions, and behaviours to help them develop a strengthened sense of identity and self-efficacy during perinatal phases.

CASE 14: NELLIE – SOLE PRACTITIONER, SELF-EMPLOYED (OUTPATIENT/ COMMUNITY, ONLINE AND RETREATS), PRIVATE PRACTICE, REGIONAL AND NATIONAL, CANADA

CASE SUMMARY

Nellie has specialised in maternal health for nearly three years. Her private practice role includes home-based individual sessions, online group faciliation, and services for women attending retreats (which she co-facilitates with an equine therapist). Nellie has an extensive referral network of traditional and alternative health professionals, and she works with a “full interdisciplinary team” when attending a birth. In addition to occupational therapy qualifications, Nellie has completed further education including doula training and was a level two Reiki practitioner. Nellie’s clients are predominantly women during and after

pregnancy, and women “dealing with baby loss or pregnancy loss”. She sees four to 10 clients per month on an ongoing basis, with an average of one to four sessions per month.

Defining her occupational therapy role in perinatal health is difficult for Nellie. Her role brings “the energy, spiritual side” of women’s wellbeing into focus, and provides, “space for people to reflect and… in a non-judgmental… way… And then to also inspire a small doable change… and a shift in perspective”. Her role addresses factors influencing women’s occupational performance during motherhood and provides facilitated education in a client-centred way. She typically works with women’s physical, cultural, societal, energetic, and sensory environments, emotional, psychosocial, sensory processing, spirituality, and wellbeing issues and needs.

Nellie believes “motherhood is a spiritual journey”, recognising the transitional process in the context of “co-creation”, where both a mother and child are developing. She frames “the event of birth” as an acute and rapid phase of significant transformation for women, which needed recognition as “the adjustment period”. With this approach, Nellie works with women in the birthing suite as an occupational therapist, providing advocacy, partner relationship guidance, “support[ing] her ergonomically in terms of positioning”, and sensory regulation. In the postnatal period, Nellie works with women to manage sudden occupational overloading during new motherhood, and addresses “loss or grief, whether it’s a miscarriage or baby loss”.

Working with women and mothers, Nellie explores and addresses their “values of the environment, rituals and rhythms, schedules… a lot of very OT kind of stuff”. She facilitates simplicity parenting groups for women online and works with mothers to improve self-efficacy by recognising and reflecting about their reactions to social media exposure, “distractions, and what… steers you away from… that internal compass”. Nellie facilitates workshops working with a “niche” population of, “highly sensitive parents and kids”,

providing “temperament training” and “shame resilience” to address some “deeply emotional and perceptive” needs for women and families.

CASE 15: AUDREY – COMMUNITY PERINATAL MENTAL HEALTH PROMOTION AND CO-OCCUPATION, NATIONAL HEALTH SYSTEM (NHS) | UNIVERSITY LECTURER, ENGLAND

CASE SUMMARY

Audrey has worked for 30-years as an occupational therapist, with eight years specialising in perinatal health. She has completed further training, holds a Masters in Psychoanalytical Studies and is a perinatal mental health “champion” in her workplace. In her community preventative mental health role, Audrey works collaboratively with a psychiatric nurse. She is an occupational therapy lecturer at a major UK university. Audrey works with approximately 15 clients per month, with an average of 10 contacts per person. She provides individual sessions and facilitates group programs during school terms. Audrey provides services to women living in a refugee hostel who need culturally sensitive approaches to address their unique issues and goals.

In the small team, Audrey’s occupational therapy role focuses on promoting perinatal mental health and preventing the development of maternal mental illness. The focus of her role was difficult to clarify. She explained, “it’s about trying to resist … the whole medicalisation of perinatal work… It’s about just maintaining that task focus… and thinking more about co-occupation”. Audrey addresses women’s individual and mothering occupations and co-occupations in the context of maternal mental wellbeing issues and needs. Referrals are typically for women experiencing mental health issues emerging during perinatal phases who “don’t hit the threshold for perinatal services”. Audrey contextualised

how her role fits within the broader perinatal healthcare spectrum, explaining her team offers "quite a unique service, because we are key prevention".

Audrey's practice "frame of reference" is defined by, "always thinking about occupation…, I'm always reverting back to the doing and the being". She focuses on maternal roles to ascertain "how somebody is spending their day, how they're doing their tasks, how they're thinking about daily structures… [and] all of your daily aspects of life". This process of analysing daily routines explores, "getting up in the morning", dressing, cooking, shopping, socialising, going back to work, and relationships with family and friends. She addresses women's mental wellbeing challenges and ability to bond with their baby during co-occupational performance in the context of social isolation, sleep deprivation, lifestyle disruption, financial restrictions, performance pressures, breastfeeding pressures, and expectations as they became mothers.

The interventions Audrey provides are client-centred, and typically involve spending time with the person, talking, goal setting, providing practical education through occupational modelling, referring on to services, facilitating social connectedness and nurturing positive maternal development. She clarified groups are "not like from social care, about whether you're a good or bad parent". Instead, Audrey aims to upskill parents about the practical aspects of parenting from a co-occupational perspective, encouraging maternal competence and self-efficacy by identifying and managing issues impacting women's performance capacity. Co-occupations are central to Audrey's practice approach as an occupational therapist, presenting avenues for maternal role upskilling, bonding, attachment, and mother-infant connection. She described working with women to engage them as mothers around meaningful participation in feeding, food relationships, sleep, daily and nocturnal routines, and play.

CASE 16: CORRIE – SOLE PRACTITIONER, PRIVATE PRACTICE (COMMUNITY/ ONLINE/TELEHEALTH), NEW ZEALAND

CASE SUMMARY

Corrie has 20-years of experience as an occupational therapist and has been working as a maternal health specialist in her own practice for three months. Corrie is in the early stages of establishing her practice and has worked with three clients. The first woman was "four-months pregnant with her fifth child", the second had a baby aged six-months, and the third had a six-week-old baby and a two-year-old child. She sees approximately two clients per month. Corrie is in the process of developing a referral network and private practice model multidisciplinary team.

Corrie's role focuses on health promotion "for mothers, to support their quality of life through using occupational therapy". She feels social expectations on women to cope with the demands of motherhood and nurture their child's development result in occupational performance issues, which she addresses in practice. Interventions aim to work through women's subconscious investment in sociocultural trends compromising their behaviours, coping, nutritional intake and food relationships, guiding them back to their own values, beliefs, and priorities. These involve "really practical strategies" to improve women's awareness and self-care behaviours when they became mothers. Corrie explained that by "supporting mothers with their identity", social connectedness, confidence, physical, psychological, and cognitive "performance domains, then that will have a knock-on effect on… their quality of life, their sense of self, their ability to cope and their relationships".

Improving self-efficacy, competence and capacity for motherhood occupations was a core focus in Corrie's role. These include breastfeeding, sleep development and routines, neurodevelopment, mother-infant play, partner relationships, self-regulation and managing

family dynamics. Corrie uses informal conversations to complete initial assessments, with questions guided by occupational therapy conceptual frameworks about occupational performance domains. She has expanded these conceptual approaches to address women's health, pain, neuroplasticity, wellness, sensory regulation and processing, family dynamics, "streamlining the environment", "ergonomics and functional movement, [and] biofeedback".

Corrie works with women towards "managing the internal processes that are happening" for them during motherhood. Interventions are tailored to manage anxiety, wellness, fatigue, confidence, self-efficacy, stress in the context of work, lifestyle management, daily routines, organise home environments, and simplify tasks. Corrie adapts cognitive reframing strategies to improve women's capacity for "coping with memory difficulties and concentration, problem-solving… [and] alternating between competing demands". She also works with women whose primary issues were around social engagement as a mother, feeling "accepted by…. mother-baby groups". Corrie provides women "support with looking at identity and harnessing a sense of self after having a baby". She provided women with validation to build efficacy and confidence, explaining it was important for them to "know they've been heard".

CHAPTER SUMMARY

This chapter reports on the 16 cases comprising multiple case A as the first tier of analytical interpretations. Chapter eight is presented in two parts, reporting on the cross-case analysis which is contextualised within a thematic framework as the second tier of data analysis. Multiple case B is descriptively reported in chapter nine.

CHAPTER 8, PART I: CROSS-CASE ANALYSIS (MULTIPLE CASE STUDY A)

"If they don't give you a seat at the table, bring a folding chair."

— Shirley Chisholm

INTRODUCTION

In this chapter, a thematic framework was used to report the relational and defining characteristics between the 16 occupational therapy case studies summarised in the previous chapter, and reports on a secondary level of analysis. The purpose of this cross-case analysis was to examine similarities, differences and common themes (Stake, 1995) between the occupational therapy case-cohort; multiple case A.

The thematic network development comprised 17 basic themes from the dataset (refer Table 14), following Attride-Stirling's (2001) analysis stages and applying feminist research strategies to preserve women's voices (Devault, 1990). All themes address the research question in exploring, "*What is the role of occupational therapy in supporting women during perinatal transitions?*". Themes were inductively elicited from participant data and are consistent with the Occupational Therapy Intervention Process Model (OTIPM) guiding client-centred and occupational-based approaches to performance analysis and therapeutic interventions (Fisher & Bray Jones, 2017)..

Four organising themes encapsulate the significance and meaning of basic themes and were influenced by occupational therapy evidence-based practice (EBP) components (Cordier & Wilkes-Gillan, 2017). The global theme is at the core of the thematic framework (refer Appendix K), reflecting principal metaphors of the data which contextualise the issues,

arguments and reality of the case (Attride-Stirling, 2001). Cross-case analysis themes are defined in Tables 15 to 19, and presented as a thematic network in Table 14, and descriptive reported across two chapters: Parts I and II.

TABLE 14

Cross-case analysis themes

BASIC THEMES	ORGANISING THEMES	GLOBAL THEME
"What's wrong with me?" Making sense of difficult experiences and navigating changes to mental and emotional health and cognitive processing	Just because it's 'normal' doesn't mean they're OK: *The impact of OPIs during perinatal phases*	Empowering women through occupational therapy practice to reframe maternal wellbeing paradigms and expectations
"We're different now": Navigating psychosocial dynamics and changing friendships, familial and partner relationships		
"My body is broken": Managing the complex impact of physical changes and injuries on women's occupations		
"Things aren't going as expected": Adapting to changing identities, life roles and occupations when becoming a mother		
"Am I doing this right?": Adapting to motherhood requires cultural awareness, self-belief, education, upskilling and connection		
"OT's just get it": Identifying and addressing women's issues as OPIs	We should be here: *This is a role for occupational therapists*	
Adding a link to strengthen the chain: Occupational therapist's place in perinatal healthcare teams		
"We make a difference": Defining the value of occupational therapy		
We're right here: Becoming visible and accessible for women looking for help with OPIs		
I'm here for a reason: How occupational therapists' individual experiences inform practice decisions	Reframing practice: *Role confidence, imposter syndrome and looking outside the box*	
"Don't over-think it": This is basic occupational therapy, just for mothers		
Find it or create it: Reinterpreting, adapting, and expanding occupational therapy practices to address women's unique OPIs, needs and goals		
Listen, reflect, learn, do: Tailoring occupational therapy client-centred practices to address OPIs during perinatal and motherhood transitions		
Expanding maternal health paradigms: Building tailored knowledge banks with professional 'expert' networks	Ready for "the OT Police": *Adapting scientific knowledge for ethical and professional integrity*	
"Is this still OT?": Finding the fit between evidence, scope of practice and professional accreditation.		
Shaping practice field directions together: Occupational therapists' roles as advocates and change agents		
Bottom-up meets top-down: Listening to learn and map women's trending OPIs		

Note: Abbreviations: Occupational performance issues (OPIs), Occupational therapy/ist (OT)

Individual descriptions are provided and then summarised. The global theme representing the occupational therapy systematic practice paradigm is defined in Table 15.

GLOBAL THEME | EMPOWERING WOMEN THROUGH OCCUPATIONAL THERAPY PRACTICE TO REFRAME MATERNAL WELLBEING PARADIGMS AND EXPECTATIONS

The role of occupational therapy in working with women during perinatal and motherhood transitions covered a broad therapeutic spectrum. Participants collectively described applying full, extended, and advanced scope of practice skills (Broome & Kennedy-Behr, 2017), and worked with women throughout motherhood stages in a range of diverse practice areas. Not every occupational therapist regarded themselves as a maternal health specialist or defined their practice as specialising in maternal or perinatal health. All participants; however, identified that maternal populations had unique needs which required occupational therapy input.

TABLE 15

Descriptive summary of global theme, with definition

Global theme definition

THEME	DEFINITION
Empowering women through occupational therapy practice to reframe maternal wellbeing paradigms and expectations	The core role of occupational therapy aimed to empower women to improve their own wellbeing, functional capacities, and self-efficacy throughout the developmental journey of becoming a mother, and motherhood. This involved a range of practices aiming to upskill women to manage their perinatal health issues, mothering occupations and maternal transition needs. Roles and practice frameworks diversified according to client-centred practices and each occupational therapist's unique workplace and specialist skill set, creating a broad full scope of practice spectrum.

The occupational therapy role in working with women to navigate challenges when becoming a mother encompassed a myriad of different components, as Rebecca (participant

5) endorsed; “OTs are pretty good problem solvers”. The primary goal of occupational therapy practices was to prioritise client-centred practice aiming to improve women’s occupational function, self-efficacy and wellbeing as both individuals and mothers through identifying and managing OPIs. This was represented by Susie’s (participant 9) articulation of her foundational practice approach being: “We break it down to the bare bones of; What does the person want to do, and how can we empower them in that, and enable them to do it”. In this shared intention, therapists aimed to empower women by hearing their needs, validating their issues and challenges, and working collaboratively with them to achieve satisfactory and meaningful goal-focused outcomes.

Recognising women’s unique, multifactorial, and complex needs during motherhood transitions, participants described exploring a diverse range of occupational therapy and other resources to provide ethical and evidence-based practices. This process was reflected in inconsistencies with terminology describing and defining women’s maternal status. Whilst occupational therapists used a range of descriptive language when referring to women’s perinatal and motherhood stages, clustered patterns of terms and expressions emerged revealing alternative ways to perceive women during perinatal motherhood stages. This may be due to diversity in the therapist’s personal experiences, geographical location, cultural awareness, professional networks, practice settings and formal education.

Although woman-centred practice is commonly prioritised in maternal health, the language and terminology occupational therapists used reflected their *client-centred* practice focus. These descriptions were reviewed and organised into key conceptual terms, as follows:

1) **Maternal**: Relating to the woman’s status as mother-becoming, usually framed by developmental biology and medicalised maternal and child health frameworks. Typically used when the woman is a perinatal health service user or patient.
2) **Mother**: A person who identifies themselves as such.

3) **Motherhood**: The life stage of actively being a mother. Typically commences from the birth of a child. Can be flexible depending on when the woman identifies herself as a ‘mother’.
4) **Perinatal**: Encompasses stages of maternal status including prenatal, labour/birth and postnatal. Informed and categorically structured by developmental trimesters as stages of motherhood when women access maternal healthcare services.
5) **Woman**: A person who identifies themselves as such. In this case study, the woman is always connected with motherhood or perinatal transitions.

Descriptive interpretations of the data within each thematic network branch follow. A sample of the codebook with descriptions for each code within each thematic network is included as Appendix S.

ORGANISING THEME 1 | JUST BECAUSE IT'S 'NORMAL' DOESN'T MEAN THEY'RE OK: THE IMPACT OF OPIs DURING PERINATAL PHASES

Identifying the issues and challenges impacting women’s functional wellbeing was a major focus in all roles and practice settings, which are framed as OPIs. Applying a client-centred practice lens, occupational therapists collectively identified a range of physical, emotional, psychosocial, spiritual, personal, relational, cognitive, and occupational issues impacting women’s wellbeing during perinatal and motherhood stages. Data were analytically sorted into key codes which revealed five basic themes of a thematic network branch regarding OPIs.

Women’s OPIs set the stage to contextualise the role, scope, intentions, and perceived purpose in maternal healthcare. Occupational therapists collectively identified a range of

OPIs impacting women's function and wellbeing during perinatal stages and motherhood transitions, which provided the foundation for exploring how and why their unique role was needed. The vast spectrum of OPIs occupational therapists described generated five basic themes under a single organising theme, which are reported with definitions in Table 16.

TABLE 16

Descriptive summary of first organising and basic theme branch, with definitions

ORGANISING THEME	DEFINITION
Just because it's 'normal' doesn't mean they're OK: *The impact of OPIs during perinatal phases*	Occupational performance issues (OPIs) identified and reported by occupational therapists which challenge women's wellbeing throughout perinatal stages and motherhood transitions
BASIC THEMES	**DEFINITIONS**
"What's wrong with me?"	Supporting women to make sense of difficult experiences and navigating changes to mental and emotional health and cognitive processing
"We're different now"	Working with women to navigate psychosocial dynamics and changing friendships, familial and partner relationships
"My body is broken"	Working with women to manage the complex impact of physical changes and injuries on their occupations
"Things aren't going as expected"	Supporting women to adapt to changing identities, life roles and occupations when becoming a mother
"Am I doing this right?"	Adapting to motherhood requires cultural awareness, self-belief, education, upskilling and connection, which occupational therapists can address in client-centred practice

Most occupational therapists challenged the application of the term, *well* to describe maternal clients. Although deemed 'well' from a medical perspective during perinatal stages, many normal symptoms women experienced impacted their wellbeing and capacity for participation in daily occupational roles and routines. As Mary (participant 10) explained, "it's interesting that whole notion of well women in that perinatal period because… there's so much that women put up with and tolerate, because they're told it's normal". She commented that often women, "wouldn't identify it as being a disability or even being unwell, but it's actually impacting their functioning so significantly".

Whilst some occupational therapists reported that normalising issues positively reassured women, most reflected how normalising issues during motherhood transitions challenged women's health beliefs, expectations, and standards. This often led to women's self-perception of their wellbeing potential reducing, which cyclically filtered into a compromised sense of self-efficacy and self-worth. Mary (participant 10) was concerned that the normalisation approach changed women's health priorities and behaviours, preventing them from seeking support owing to, "when you think of yourself as well, you don't ask for help do you?".

Other therapists echoed this, observing that when health professionals downplayed the impact of issues, women began to doubt or question their feelings, experiences, and instincts, which resulted in lowered health and wellbeing expectations, and deprioritised self-care. When women delayed connecting with health services, occupational therapists recognised that women experienced an exacerbation of symptom severity and complexity over time. Fleur (participant 11) was particularly frustrated by this, commenting: "the women that have come to me from [the OBGYN and physicians] could've been referred years ago, or months ago… [The women] for lack of a better word, … they're very, very broken".

Breaking down the complex dynamics and unpacking women's OPIs to isolate causal factors impacting their occupational capacities and wellbeing was usually complex. Rebecca (participant 5) regarded occupational therapy in women's health during motherhood was, "such an enormously complex … area to work in… You never quite know what you're going to… come up with next", adding:

> *It's not just about… physically recovering from childbirth. Or… being… mentally well enough to be a mum. There's all of these extra psychosocial and socioeconomic and financial factors, and relational factors between husband and wives, that come into play as well.*

"WHAT'S WRONG WITH ME?": *SUPPORTING WOMEN TO MAKE SENSE OF DIFFICULT EXPERIENCES AND NAVIGATE MENTAL AND EMOTIONAL HEALTH AND COGNITIVE PROCESSING CHANGES*

Becoming a mother was a core occupation and goal for maternal clients during perinatal phases. Low self-esteem, poor maternal self-efficacy and stress were identified by therapists as the leading and most impactful factors underlying women's OPIs. Self-doubt in their ability to be a 'good' mother challenged women's capacity to manage and adapt to emotional and cognitive processing changes and challenges, and the increased occupational demands and pressures of motherhood. Reduced capacity to cope and adapt through the changes and challenges of becoming a mother often resulted in women experiencing anxiety, depression, and low mood, which negatively impacted their motivation to participate in all daily occupations during motherhood.

Occupational therapists perceived that maternal guilt and performance pressure had a major impact on women's wellbeing and self-efficacy development. Becoming a 'good' mother was an occupational performance outcome goal for many women. Most occupational therapists interpreted that guilt and performance pressure was emotional reflections of women's self-perceived underperformance in being a 'good' mother. For example, Cath (participant 7) recalled working with a woman who was struggling with unrelenting pain, low mood and difficulty bonding weeks after returning home with her new baby, illustrating the potential manifestations of maternal guilt:

> *After we had been talking for about fifteen minutes or so she started crying, and she's like, "I hadn't realised how guilty I felt about having a caesarean" … For four weeks, she'd been just feeling really guilty and terrible that she had failed, you know, the golden goal of having a vaginal delivery.*

Cath (participant 7), Alex (participant 13), and Nellie (participant 14) noted the impact of maternal grief and loss on women who were working through their experiences of early infant death or miscarriage. Grief experienced in the event of pregnancy or infant loss often caused major maternal occupational disruption, impacting women's capacity to return to daily routine performance and engagement. Occupational therapists observed women with histories of unresolved or under-acknowledged grief usually experienced heightened anxiety, fear, stress, and post-traumatic stress disorder (PTSD) symptoms during subsequent pregnancies, labours, and births. Grief also impacted women whose pregnancy, labour, birth, or early parenting experiences did not match their expectations. When this manifested into feelings of shame and guilt, several occupational therapists recognised that women struggled with added stress, worries and performance pressure burdening their capacity for engagement with motherhood occupations and development of maternal self-efficacy.

Birth was identified by many occupational therapists to be a pivotal occupational milestone event activating transformational change for many women. Most occupational therapists observed that women's coping capacities, mental and emotional wellbeing suffered when their pain expectations, birthing plans or labour experiences were unexpected, traumatic, or disempowering. Several occupational therapists explained that underacknowledged traumatic maternal health experiences could evolve to acute stress syndrome, anxiety, and PTSD, which impacted women's capacity for occupational performance and self-efficacy development.

Unresolved distress could evolve into ongoing worries, fears, and trauma, which affected women's confidence, coping and self-regulation in approaching upcoming births and subsequent pregnancies. Pamela (participant 6) identified that sometimes pregnant women developed birth-fear, feeling, "terrified about a 'C' section, or they've had a traumatic labour

first time around, [or] a traumatic birth… They're scared. They're just not wanting to go through with it".

"WE'RE DIFFERENT NOW": *NAVIGATING PSYCHOSOCIAL DYNAMICS AND CHANGING FRIENDSHIPS, FAMILIAL AND PARTNER RELATIONSHIPS*

The changing natures of partner, primary and co-parenting relationships during motherhood stages influenced women's wellbeing, sense of identity, occupational priorities, and lifestyle choices. Fleur (participant 11) described how women changed, "from just thinking of yourself and your partner, maybe, through to having to take care of this new human being". Women's adaption to develop their identity and relationships were recognised by occupational therapists to be complex and multidimensional, influenced by a range of social, cultural, personal, environmental, occupational, socioeconomic, spiritual, intergenerational, and institutional components.

A woman's psychosocial transition to becoming a mother involved others, with Nina (participant 4) explaining, "this is a journey that affects, … your relationship with your partner and with your family". She observed issues with changes to couple-relationship dynamics contributed to maternal OPIs, stating, "seventy-five percent… of the women I see have got problems with their partner". Communication was identified as the primary factor underlying many difficult relationship issues adding to maternal stress.

Shifting relationship dynamics in marriages, partnerships and co-parenting relationships presented challenges and pressure for many women and families. Redefining equality in relationships was challenging for many women, especially during maternity leave and early motherhood. Rebecca (participant 5) described how the arrival of a new baby often sparked sudden and unexpected segregation of gendered workload duties in families, particularly for first-time parents.

Changing roles and relationships with partners influenced women's changing identity, occupations, and wellbeing journeys during parenthood. Nina (participant 4) observed that "women… and their partners struggle. And… sometimes that's in silence because there's this cultural expectation that you just do it". Financial constraints compounded this segregation when family decisions were made to reduce funding available for usual wellbeing and leisure activities. Women's confidence and empowerment to negotiate their familial, social, and productive roles whilst developing maternal role competence was a challenge, often shared with their partners.

Women's emotional and psychosocial wellbeing in unhealthy or abusive partner and primary relationships suffered during perinatal transitions, which had negative implications for their self-efficacy, maternal role engagement and mother-infant bonding. Susie (participant 9) expressed concern that becoming a mother led to women remaining in disempowering and damaging partner relationships to maintain a sense of security, explaining:

> *It makes our population… by having a baby, far more vulnerable. Because they are then reliant on someone who may be abusive, because they have a child to look after… They're dependent financially… So… they may endure a really horrid time, just for that child.*

Maintaining a bonded and harmonious family unit sometimes became challenging for women. Several therapists noted that many women experienced unexpected anxiety, guilt and worries about their capacity to love and value additional children as their family grew. Preparing for the arrival of a second child often triggered women's fears about their maternal capacity to bond and attach with another infant, with Audrey (participant 15) explaining that some women, "may feel like, 'I don't have the capacity to love this child as much as I did this one'". She noted women struggled when, "their feelings towards their first or their second

child have changed…, or they're resentful that they can't give the new baby as much attention".

Changing friendships, social connections and intergenerational relationship dynamics impacted women's wellbeing as they became mothers. Women with new babies could experience difficulties returning to their previous familial place or social occupations. This became problematic when important and meaningful relationships were dependent upon the woman's active participation in specific occupations and roles, including work. Losing a sense of connectedness and belonging within communities affected women who were from culturally diverse backgrounds, and who made parenting decisions polarising them from their local social networks. Fleur (participant 11) felt that women's difficulty maintaining a sense of feeling engaged, supported, and connected was a by-product of contemporary societies, noting, "there is a lack of village".

"My body is broken": *Managing the complex impact of physiological changes and injuries on women's occupations*

Women's sense of control and ability to have a successful pregnancy and birth influenced maternal self-efficacy development. Managing bodily and physiological changes and injuries impacted women's holistic wellbeing. Occupational therapists named issues such as feeling unwell, fatigue, pain, discomfort, hand and wrist injuries, exhaustion, swelling, and fluid retention caused dysfunction. In the hand therapy clinic, Emma (participant 2) described how women with carpal tunnel often experienced fluid retention resulting in, "performance mobility challenges… [such as] getting in and out of bed, driving cars for long distances, [and] managing … stuff around the house". She described how the wearying impact of unresolved or chronic pain compounded issues, with many women presenting to the clinic with, "lots of pain, and they're in tears, and they're just really upset".

Pain was a significant occupational issue impacting women's functional performance capacities throughout perinatal stages. Fluctuating or imbalanced hormone levels reduced women's capacities for coping and self-regulation, which increased feelings of stress and anxiety. Stroke or cardiac episodes during birth, gestational diabetes, being overweight or obese, hip dysplasia, brachial plexus injuries, nerve damage, kidney and respiratory issues were some issues and medical events impacting women's functional capacities during perinatal phases. On the acute ward, Susie (participant 9) explained the conservative treatment protocols often recommended movement restrictions to reduce risks had implications for maternal wellbeing, occupational and role performance abilities.

Many occupational therapist's observed women experienced occupational disruption following medical assistance and interventions during labour or birth. Several identified the issues women experienced following prolonged labour, complicated deliveries, and assisted caesarean section births were common, unrecognised, unacknowledged, downplayed, or dismissed in the early postpartum period. These were often subtle and presented as OPIs relating to poor self-esteem and low self-efficacy, unresolved pain, mental health challenges, social isolation, difficulty coping or emotionally adjusting to motherhood and bonding with the baby.

Resuming occupational performance was a challenge for women recovering from caesarean delivery and pelvic organ prolapse. Susie (participant 9) commented that the post-surgical protocol for caesareans of, "do not lift anything heavy, other than your baby", restricted women's capacity to perform essential maternal tasks such as lifting capsule seats in and out of the car and pushing their pram. Occupational performance restrictions similarly applied for women with pelvic organ prolapse following birth, who also struggled with dysfunction, incontinence, body shame and pelvic discomfort. Susie (participant 9) explained that these added restrictions particularly impacted women who needed to routinely lift and

carry heavier infants or other younger children. The six-week driving restriction following a caesarean-delivery resulted in women having reduced capacity to independently access the community for social connectedness, self-care activities, shopping, and medical appointments.

"THINGS AREN'T GOING AS EXPECTED": *ADAPTING TO CHANGING IDENTITIES, LIFE ROLES AND OCCUPATIONS WHEN BECOMING A MOTHER*

Maternal occupations were considered from a broad perspective by occupational therapists. Becoming a mother was considered a profoundly transformative and meaningful occupation by many therapists, as Rebecca (participant 5) framed, “motherhood as an occupation that … alters all other occupations… Motherhood [is] like a lens that you put on that you can’t ever take off…. There’s a big adjustment that comes with that”. She explained that motherhood required, “not just about learning how to be a mother; it’s about learning how to integrate this new role or occupation of motherhood with all of your other roles and occupations in your life”.

Adapting to new motherhood was marked by periods of heightened activity, substantial multitasking, managing changing and competing roles and occupational demands, and personal transformation. With the relentless need to adjust, adapt and develop skills to manage everchanging mothering and usual daily activity and duty loads, Anna (participant 1) pointed out, “motherhood is one of the biggest occupations that women undertake in their lives”. Occupational therapists interpreted women’s OPIs stemming from how occupational change, imbalance, overwhelm, disruption, and deprivation influenced capacity for engagement and participation in a spectrum of meaningful and essential activities, roles, duties, and responsibilities.

Occupational deprivation impacted women on bedrest who were no longer able to access familiar self-regulation strategies, such as shopping, exercising, and having quality time with their partners. Cath (participant 7) explained this compromised women's capacity to manage their stress and emotional wellbeing, and their self-care engagement declined as their capacity for usual occupational performance became restricted. She explained, "a lot of the usual kind of things that women do to maintain their emotional wellbeing are not available to them… Obviously, [this] impacts on how people feel about themselves". Disrupted engagement in maternal preparation occupations such as nesting and birth planning impacted women's wellbeing. Pamela (participant 6) advocated that "it's very distressing if you can't actually do that", adding, "you wouldn't believe… the emotions that come up about cot-sheets and bedding décor for nurseries … [It] can be really distressing".

Cath (participant 7) explained pregnancy was an occupation and key motherhood "milestone", which involved, "being able to actually carry your baby until it's developed enough to be born without problems". She observed that "a lot of women are struggling with that, despite their best efforts… They can't guarantee they can provide what their baby needs, which is to stay inside [the womb]", stressing, "that sense of self-efficacy is… big."

Whilst pregnancy was regarded as a primary maternal occupation, occupational therapists perceived the meaning of pregnancy differed for women. Women preparing to adopt the child after birth, who were displaced as refugees, or carrying children conceived through rape, could have difficulty accessing culturally sensitive, flexible, and client-centred maternal healthcare services. For example, in Canada, Helena (participant 12) recalled working with a pregnant woman who was adopting the baby to a family immediately after birth. This woman did not consider herself a mother, and "really wanted to know, 'How can I prepare for childbirth, without knowing anything about the baby?'". Helena (participant 12) listed the OPIs this woman needed support with, which related to her goals to conceal the

pregnancy, continue working as a horse-back rider in the saw-mill industry and maintain emotional distance from the baby to prevent emotional attachment.

"AM I DOING THIS RIGHT?": *ADAPTING TO MOTHERHOOD REQUIRES CULTURAL AWARENESS, SELF-BELIEF, EDUCATION, UPSKILLING AND CONNECTION*

Learning how to be and become a mother, and feel competent in the role and identity, was considered challenging for many women. Cath (participant 7) observed this was, "particularly [difficult] for first-time women … Because … we only learn that we can be mothers by doing it". Developing a sense of personal and maternal confidence, competence and self-worth were often difficult for women, which occupational therapists considered were foundational traits for resiliently adapting through motherhood changes. Audrey (participant 15) identified that, "feeling really anxious and feeling a bit rubbish as a … new parent", created significant performance and wellbeing issues for women, stressing that, "whether it's for the first or second or third or fourth time, it doesn't really matter".

Sociocultural pressure on women during motherhood was a common component impacting their wellbeing. Rebecca (participant 5) observed women perceived there were expectations and pressures to feel, "happiness, and being a happy mum". This included demonstrating an immediate strong bond with their baby and aiming towards "gold" standards in motherhood roles. Helena (participant 12) observed that pressure to demonstrate successful mothering was often at a cost to women's self-care and hindered women's development of maternal self-efficacy.

Women's sense of accomplishment in motherhood was often deeply personal. Their perception of maternal competence and self-efficacy reflected their feelings of independence, empowerment, control, accomplishment, and contributions. Occupational therapists discussed how the pressure to live up to perceived identity and role expectations during motherhood

often resulted in women feeling isolated, anxious, worried, overwhelmed, unsupported and doubtful of their maternal competence.

Parenting styles and infant feeding were identified as a common source of stress, worry and guilt for women, which was strongly linked to their sense of maternal self-efficacy and competence. Several occupational therapists described how breastfeeding occupational performance challenges related to milk supply, attachment, feeding, learning to interpret when the baby was full, and monitoring weight gain impacted women's maternal self-efficacy development.

Occupational therapists observed that when women perceived they were "failing" as mothers, they struggled to cope with parenting demands and challenges confidently and resiliently. Jennifer (participant 3) explained women often held themselves accountable to high standards, observing, "a lot of that judgement is coming back from themselves. Not necessarily from the community or the people around them". Audrey (participant 15) saw that women's sense of maternal failure could lead to anxiety, social isolation, poor time management, and difficulty regulating, "how your thoughts affect the way that you behave and your relationships".

Women's sense of intuition, self-esteem, self-worth, and self-efficacy often became compromised during perinatal stages, both as individuals and mothers. Women's deprioritisation of their self-care accelerated when they prioritised their children's and family's health and wellbeing over their own. As women's wellbeing declined, Audrey (participant 15) described the flow-on effect into their motivation for occupational engagement became compromised by, "how difficult it is… when they're [lacking] the energy required to … get out of the house and do anything and have a structure to their day". Fleur (participant 11) explained this often led to occupational disruption and social anxiety.

ORGANISING THEME 2 | WE SHOULD BE HERE: *THIS IS A ROLE FOR OCCUPATIONAL THERAPISTS*

Opportunities for occupational therapists to work with maternal clients were diverse, covering a range of established and non-traditional roles, and private practices, around the world. Their individual experiences of reflectively applying their core practices to work with women during motherhood and perinatal phases were sorted into key codes, then interpreted as basic themes. The primary role for occupational therapists was focused on addressing women's functional and wellbeing needs as they became mothers, contextualised by the woman's occupational identity, roles, and responsibilities. Whilst this included mothering occupations, women's needs, and issues were contextualised holistically by their motherhood transition and adaptation experiences. How therapists described their role and practice in women's maternal health are organised according to basic themes below and summarised with definitions (refer Table 17).

TABLE 17

Descriptive summary of second organising and basic theme branch, with definitions

Summary of themes, with definitions

ORGANISING THEME	DEFINITION
We should be here: *This is a role for occupational therapists*	How occupational therapists consider and justify their practice in perinatal maternal health
BASIC THEMES	**DEFINITIONS**
"OT's just get it"	How occupational therapists identify, conceptualise, and address women's issues as occupational performance issues
Adding a link to strengthen the chain	Occupational therapist's place in perinatal healthcare teams
We make a difference	How occupational therapists define the value of occupational therapy across various domains of maternal health
We're right here	How occupational therapists navigate to be visible and accessible for women looking for help with occupational performance issues when becoming mothers

"OT'S JUST GET IT": *IDENTIFYING AND ADDRESSING WOMEN'S ISSUES AS OPIS*

Occupational therapists applied a client-centred practice approach to explore and address the root causes underlying women's health and wellbeing challenges. Susie (participant 9) stressed that applying client-centred principles was critical when working with maternal populations, because "it's not like you're going to see… the same person ever… Because no pregnancy is ever the same, even within the individual". This holistic approach for considering needs and wellbeing was considered unique and core to identifying, interpreting, and addressing OPIs, with Rebecca (participant 5) affirming, "that's where our expertise is". Pamela (participant 6) contextualised how her occupational therapy approach prioritised and valued women's wellbeing during motherhood, explaining: "when women are looking after themselves, they're better able to be great mums and great partners. And the whole family does well if mum is doing well." The primary aim consistent across occupational therapy roles was to enable and empower women to achieve satisfactory, meaningful, and fulfilling occupational performance in all daily roles, routines, and relationships.

Occupational therapists conducted individual assessments with women, sometimes including their infant, partner, or other family members. Groups were regularly used to facilitate therapeutic engagement, participation, and connection, where therapists could informally assess issues and measure progress and outcomes through observational analysis. Women's functional performance of usual and motherhood occupations was the primary focus of occupational therapy roles, and performance context was considered critical for delivering client-centred practice. Interventions were designed to enable, promote, and restore functional capacities to achieve meaningful goals identified by the woman.

Developing rapport, active listening, and reflective collaboration with the woman to identify and manage the source of OPIs was considered by all occupational therapists to be

fundamental throughout practice approaches. Informal and narrative conversational interviewing techniques with observational functional analysis were valued by occupational therapists as primary methods for assessing women's occupational performance issues, needs, satisfaction and goals. This method enabled flexibility to consider each client's unique circumstances. Therapists felt women were often unable or reluctant to recognise, prioritise, disclose, and discuss issues experienced during perinatal stages due to their struggles being normalised to motherhood, or feeling embarrassed, ashamed, overwhelmed or overloaded.

Occupational therapists interpreted that whilst becoming a mother was a transformative life event, women's OPIs were not defined by motherhood or isolated to mothering occupations. Emma's (participant 2) felt while occupational therapy practice approaches in the hand therapy clinic were consistent, "the occupational profiling [is] different" with maternal clients. Participants collectively interpreted women's person-centred issues and needs as a mother, individual, mother-becoming, and perinatal health services user.

Occupational therapists collectively pooled a vastly diverse range of core practice skills in working with women to achieve client-centred goals and promote women's wellbeing, maternal development, and positive sense of self-efficacy. This included maternal role upskilling, splinting, ergonomics, functional movement therapies, occupational adaption and activity modification, assistive aids and equipment, emotion coaching, self-efficacy development client-centred education, mindfulness and relaxation, therapeutic groups, environmental modification, neurocognitive therapies, sensory modulation, and physiological systems regulation.

Most occupational therapists used assessment forms in their practice to record and analyse women's OPIs and monitor progress towards goal-focused outcomes. Forms used by

participants were highly relevant to their workplace setting, were causally focused and drew from a range of screening and assessment tools (refer Table 18).

TABLE 18

Assessment and screening tools used by occupational therapists for perinatal populations

Focus of assessment	Name of assessment tool	Purpose	Setting		
			IP	OP	C
Generic psychological/ mental health	Depression Anxiety Stress Scales (DASS-21)	S, R	•	•	•
	Kessler Psychological Distress Scale [10] (K10)	S, P, T	•	•	
	Likert scale (rating/measuring anxiety and stress)	S, P, O	•		•
	Mental State Assessment (MSE)	S, R	•		•
	Wellbeing Outcome Measure	I, O, P			•
Maternal mental health	Edinburgh Postnatal Depression Scale (EPDS)	S, R, O, T		•	•
	Parenting Stress Index (PSI-4)	F, R, S			•
Mother-infant bonding/ attachment	Maternal Postnatal Attachment Scale (MPAS) – *Also known as 'Condon Attachment Scale'*	S, O			•
	Parenting Stress Index (PSI-4)	F, R, S			•
Psychosocial/cognitive	The Life Compass	I, F, O			•
	OT Psychosocial Assessment (Antenatal Initial Interview) - *Privately developed and used by one organisation*		•	•	•
Neurological, including pain	Sensory Profile	F, S	•	•	
	Visual Analogue Scale (pain rating)	S, O, P		•	
Physical function	Boston Carpel Tunnel Questionnaire – *Also known as 'Levine Symptoms of Severity Questionnaire'*	F, O, P		•	
	Carpal Tunnel Questionnaire	F, O, P, T		•	
	Disabilities of the Arm, Shoulder & Hand (DASH)	F, O, P		•	
	Upper Extremity Functional Index	F, O, P		•	
Goal identification and setting	Canadian Occupational Performance Measure (COPM)	I, O, F, P		•	
	Functional Goal Assessment	I, F, O		•	
Occupational analysis and profiling	OT initial assessment form - *Privately developed and used by eight organisations*	I, F, O. S, R, P	•	•	•
	Antenatal Bed Rest Initial Interview - *Privately developed and used by one organisation*	I, F, S, R, T	•		

Key							
Setting:		Inpatient	**IP**	Outpatient	**OP**	Community	**C**
Initial assessment	**I**	Function	**F**	Outcome measure	**O**	Pre-test/post-test	**P**
Risk assessment	**R**	Screening tool	**S**	Triage screen	**T**		

The perceived usefulness of these assessments was as tools for communicating with referral networks and multidisciplinary teams (MDT's), funding, reporting, and auditing requirements, confirming diagnoses, and quantitatively measuring and monitoring the impact of issues. Eight occupational therapists developed and used non-standardised forms uniquely tailored for their role, including triage, assessment, goal setting and outcome monitoring.

ADDING A LINK TO STRENGTHEN THE CHAIN*: OCCUPATIONAL THERAPIST'S PLACE IN PERINATAL HEALTHCARE TEAMS*

The place and role for occupational therapists were predominantly influenced by funding in employment settings and shaped by perceived need and practitioner skillset in private practice. The workplace structure typically determined their role's scope, focus, purpose, presence, and place. Few occupational therapists saw their role situated within maternal healthcare teams, and most therapists felt separate and disconnected from hospital-based perinatal health services. Occupational therapists mostly worked in established or self-constructed MDT's, with their role and practice scope boundaries being contextualised by professional settings. All therapists regarded their roles as cogs within larger care-coordination frameworks. They valued building trusted referral networks, collaborative care opportunities and clarifying professional practice scope limitations (refer Table 19).

TABLE 19

Occupational therapists working with multidisciplinary teams, and referral networks

REF.	PRACTICE SETTINGS	PLACE	MULTIDISCIPLINARY TEAM (MDT)	REFERRAL NETWORK
Alex	Private	USA	*No*	*Not reported*
Anna	Community	Australia	GP; Mental health professional; Speech pathologist; Social worker; Educators	GP; Social worker; Speech pathologist
Audrey	Community	UK	Psychiatric nurse	MDT
Cath	Hospital (outpatient)	Australia	Lactation consultant; Mental health professional; Midwife; Obstetrician; Physiotherapist; Social Worker; Psychologist; Aboriginal and Torres Strait Islander liaison; Bereavement counsellor; Dietetics; Volunteers	MDT
Corrie	Private	NZ	*Not yet, but I will*	*Not as yet*
Emma	Outpatient clinic	Australia	GP; Physiotherapist	GP; Physiotherapist
Fleur	Private	Australia	*No*	Hypnobirthing therapist; Doula
Helena	Private	Canada	Family doctor/GP; OB-GYN; Maternal nurse; Women's health physiotherapist	Family doctor/GP; OB-GYN; Maternal nurse; Women's health physiotherapist; Social worker
Jack	Outpatient clinic	Australia	Physiotherapist	Physiotherapist; GP
Jennifer	Community	Australia	GP; Maternal and child health nurse; Physiotherapist; Speech pathologist; Paediatrician; Dietician; Psychologist	Paediatrician; Speech pathologist; Psychologist; GPs; Nurse; Physiotherapist; Dietician
Mary	Private	Australia	GP; maternal and child health nurse; Midwife; Physiotherapist	Midwife; Maternal health nurse; GP; Physiotherapist
Nellie	Private	Canada	Mental health professional, midwife, obstetrician, speech pathologist, full IDT when attending a birth	Naturopaths; Psychologist; Holistic nutritionist; Mental health therapist; Social worker/psychotherapist; Chiropractor; Equine therapist (retreats)
Nina	Outpatient clinic; Community	Australia	Informally: Private practice model. I liaise with midwives, child health nurse and ward staff as I am based at the hospital.	Child health nurse; Midwife; GP; CAMHS team
Pamela	Hospital (inpatient)	Australia	GP; Lactation consultant; Maternal and child health nurse; Mental health professional; Midwife; Obstetrician; Physiotherapist; Social Worker; Psychologist; OT Assistant	Midwife; Physiotherapist; Social worker; Psychologist; Obstetrician; OT Assistant
Rebecca	Private; Community and clinic	Australia	*No*	*Not reported*
Susie	Hospital (inpatient)	Australia	Lactation consultant; Maternal and child health nurse; Mental health professional; Midwife; Obstetrician; Physiotherapist; Social Worker	MDT, and hospital services: Inpatient rehabilitation, post-acute care (PAC)

Four maternal health occupational therapy positions were funded by inpatient hospital wards, outpatient clinics and hospital-funded community services. These individual roles uniquely supported women with medical and health issues to achieve a range of holistic functional performance capacity goals enabling them to successfully transition from hospital and remain home with their baby. Susie (participant 9) explained how her role extended capacities of acute inpatient MDTs, explaining, “maternal nurses are extraordinary, and very holistic in the way they treat people… As soon as a physical or mental challenge comes into it, then it becomes problematic for them. And so we tend to jump in then”. Across practice settings, all therapists clarified that having an illness, disability or medical diagnosis did not determine a woman’s potential to benefit from occupational therapy during motherhood transitions, except for mental health disorders. Whilst all therapists informally screened for emerging emotional or mental health challenges, significant mental illness was considered beyond scope of practice and required referral to specialist services.

‘Gap filling’ was a common practice concept adopted by occupational therapists. Most comfortably identified and valued their role’s capacity, flexibility, and scope to fill gaps in perinatal health services, and for some this carried a sense of professional pride. All confidently regarded their service’s primary objective as value-adding to existing teams and services, and none considered occupational therapy as a stand-alone service adequate for meeting women’s needs during motherhood or perinatal transitions.

Pamela (participant 6) valued her role as unique in that it enabled her capacity to work with “normal healthy women and their adjustment”. She explained her role allowed time, “to be able to sit down and, and coach people through the wellbeing aspects of pregnancy and emotional adjustment to that transition”, adding, “we do it well here…, but I know we’re one of the only services… that provide that OT input”. Most occupational therapists identified

their person-centred focus filled the gap that emerged in postnatal periods when women felt overlooked as services shifted focus to the new baby.

Occupational therapists considered maternal transitions to be continual and cyclical for women; however, were rarely acknowledged or addressed by perinatal health services. Fleur (participant 11) felt “there’s a lack of recognition that what happens in pregnancy can impact birthing and postnatal. What happens in birthing can impact postnatal periods. What happens in postnatal can impact the next pregnancy. and so on, and so on”. Several occupational therapists saw their role bridged this gap by supporting women during motherhood stages and between birth experiences, guided by trauma-informed practice.

Therapists worked with mother-child dyads in an early intervention capacity (EI), bridging practice boundaries between paediatric and perinatal health services, extending the reach of preventative care. Occupational therapists in educational settings strengthened service connections for vulnerable families who were reluctant to access mainstream healthcare. Providing client-centred education as women needed it was usually contextualised by the goal of maternal empowerment, which for Fleur (participant 11) involved, “advocacy, … informing and educating and journeying with women, and taking the expert nature out of healthcare, and being a resource”.

Addressing non-traditional personal and family dynamics, spirituality and cultural diversity through client-centred practice was unique strength occupational therapists felt they contributed to perinatal healthcare teams. This included working sensitively and flexibly with adoptive and foster parents, women preparing to adopt their child to another family, families who wanted to co-sleep with their infants, LGBTQ+ families, single mothers, women in co-parenting relationships, women in Indigenous communities, and refugees in foreign communities.

WE MAKE A DIFFERENCE: *DEFINING THE VALUE OF OCCUPATIONAL THERAPY*

All occupational therapists perceived their role was unique and valuable. Prioritising and improving women's wellbeing were regarded as an occupational therapy specialist practice, and the primary way the profession complemented existing maternal and child healthcare services. Advocating for their service to referrers and funding bodies was a role requirement, concern, and challenge for most participants.

Occupational therapists regarded their unique approach to interpretively analysing issues to identify causes underlying OPIs benefitted women and perinatal healthcare teams. This guided how occupational therapists worked with women through subtle and complex challenges, which Susie (participant 9) regarded was the profession's strength; "we will always be called upon to solve challenging situations, and that's what we do… That's where our specialty is". Pamela (participant 6) also felt occupational therapist's unique application of pragmatic problem-solving skills benefited maternal populations, explaining, "OTs are really great at helping with … [and] managing … your expectations and goals. We have skills in being able to do that in a really practical way".

Outcome measures evaluating the value and benefits of occupational therapy for women were subjective and qualitative in nature. Occupational therapists routinely monitored and evaluated women's progress and changing issues and goals, to subjectively measure the impact and outcomes of occupational therapy services. Subjective outcome measures were based on occupational therapist's observations, analysis, and interpretations of women's functional capacity changes, and women's self-reported feelings and experiences (refer Table 20).

TABLE 20

Motherhood goals and subjective outcome measures, reported by occupational therapists

GOAL FOR INTERVENTION	SUBJECTIVE OUTCOME MEASURE
Occupational adaptation	Women's perceived stress at transitioning holistically, satisfactorily, and meaningfully through/into a challenging aspect of a new life and/or motherhood phase and stage
Enhanced maternal interpersonal and community connectedness	Women re-engaging with culturally appropriate communities and friendships, in a way that is meaningful and satisfactory to them
Maternal competence, performance, and engagement	Women develop an improved sense of self-belief, resilience, and self-efficacy through occupational performance, engagement, and goal setting and attainment during motherhood
Maternal identity, empowerment, and self-efficacy	Women start shifting their sense of identity to 'mother', find a sense of empowerment and self-efficacy in their new identity, and maintain and nurture their individual identity
Strengthen mother-infant dyad	Development/improved sense of connectedness with their baby and adapting to life in a functional and meaningful way. Mindfully invested in and emotionally/spiritually connected with their baby (mother role/identity specific)
Health promotion and early intervention	Successful prevention of the risk of issue/s developing into an occupational performance issue impairing women's personal and maternal functional capacities, or an acute/chronic illness/injury warranting medical diagnosis and treatment

Several occupational therapists preferred subjectively measuring outcomes for clients in groups, explaining women were more likely to regularly attend and participate in group sessions than one-to-one appointments. Audrey (participant 15) described her outcome measurement assessment in group settings was "far more through observation", followed up with reflective focus group discussions on discharge:

> *We ask people to come in and look at things that they've achieved, what they've done, … where they were, and what they're doing… Often the things that you'll notice are that people are going out more, they're attending things more, they're more attached, [and] they've got a social network of some description.*

Defining the quantitative value of occupational therapy was difficult for many therapists, and often a challenging requirement to secure role security and future service funding. This varied according to their role's purpose, workplace funding structure and guidelines, reporting requirements and outcome expectations. Occupational therapists unanimously felt there was no singularly effective method or tool to articulate or measure the more quantitative values, benefits or outcomes for women accessing their services. Cath (participant 7) explained that this was particularly difficult in maternal healthcare, because "in the medical reductionist … model, OT doesn't sit easily there, because it is subtle".

Measuring women's occupational performance outcomes specific to motherhood and maternal function, transition and adaption were highly challenging for all occupational therapists. Audrey (participant 15) explained this was owing to the issue that, "no specific occupational therapy outcome measures [exist]", which led to many therapists developing their own assessments and outcome measures. Initial assessment ratings, scales and OPI descriptions were often revisited or reassessed to measure occupational performance change and outcomes after six-weeks by most therapists. These were effective in quantitatively measuring changes to symptoms such as reduction in pain severity and frequency, improved range of motion, and depression scale ratings; however, rarely conveyed women's experience of changes to occupations, domains of function, quality of life or wellness during motherhood.

WE'RE RIGHT HERE: *BECOMING VISIBLE AND ACCESSIBLE FOR WOMEN LOOKING FOR HELP WITH OPIS*

Achieving and maintaining visibility and accessibility to maternal clients was difficult for all occupational therapists. Susie (participant 9) felt this reflected "three-fold" influences, including poor awareness of occupational therapy roles or scope outside the profession,

inconsistent perinatal MDT awareness of how occupational therapy can support women, and constant need for role promotion to secure places in perinatal healthcare teams. Being accessible often relied on individual therapists regularly championing and advocating for the role, with Susie (participant 9) observing that referrals to occupational therapy plummeted whenever she took leave from her role.

Occupational therapists explained that their professional ambiguity required regular role introductions and constant campaigns for service recognition and referrals. Following a lack of employment opportunities, this was identified as the main barrier to women accessing occupational therapy services. In educational settings, occupational therapy role ambiguity was supportive for women accessing services. Jennifer (participant 3) explained that when women felt vulnerable or reluctant about attending psychology services because of their "perceived idea … that profession might [carry] too much risk", occupational therapy offered an alternative that improve access to mental health support.

Financial accessibility influenced access to occupational therapy services. Occupational therapists working in Australian inpatient hospital settings could be accessed with both public funding and private health insurance. In three different hospital outpatient services, including hand therapy, referrals were needed from a GP, midwife or OBGYN to access services, funded by public or private health insurance. Nina's (participant 4) hospital outpatient service was unique, where women could access occupational therapy without a referral, and no payment or funding was required.

Alex (participant 13) discussed occupational therapy's professional place within the USA maternal healthcare structure, explaining women could seek referrals through their GP with health insurance cover. Meeting this need in practice was an essential component of Alex's (participant 13) role, required, "knowing and understanding … billing codes and … and being able to appropriately bill … the insurance company with a certain code and help

the person get the benefits of your services", and was similar for private practice occupational therapists in Canada and Australia. Rebecca (participant 5) felt service funding pressures reflected women's changing motherhood priorities, explaining, "one of the biggest challenges… is convincing mums to invest in themselves. They'll happily go and spend $1,300 on a pram, but then spending $500 on… a course of treatment sessions to support their emotional wellbeing seems… gratuitous".

Women and children from low socioeconomic backgrounds were identified by several occupational therapists to be vulnerable due to their reluctance to access health services. Meeting the healthcare accessibility needs of low socioeconomic families was a recognised need and service gap, with Jennifer (participant 3) explaining, "we're not capturing a lot of our vulnerable mums". Nina (participant 4) advocated that "young mums" were also vulnerable to poor health and social outcomes, needing highly accessible occupational therapy services to proactively prevent and manage emerging mental wellbeing issues. Many therapists aimed to improve service accessibility for women with histories of mental health issues, complex or traumatic family backgrounds, low-range neurodiversity, significant cultural and spiritual diversity, and language barriers.

Free and informal access to occupational therapy services were considered critical for vulnerable populations, which needed to be provided in hospital and non-medicalised community settings including the woman's home. Therapists described how their practice approach and environmental settings considered these needs, aiming to improve accessibility for women with such backgrounds. Anna (participant 1) and Jennifer's (participant 3) roles were situated in children's community-based education centres, as "hubs" to improve access for families by amalgamating education and paediatric early intervention services. This offered women and children the opportunity to informally access playgroups facilitated by

occupational therapists and have casual access to therapists' directly or indirectly through teachers and educational staff.

CHAPTER 8, PART II: CROSS-CASE ANALYSIS (MULTIPLE CASE STUDY A)

"Two's company and three's a crowd, but seven can be an uprising. And the seven can become 70 or 700 or 7000 very quickly if the sense of being wronged is felt broadly and truly enough."

— Michael Leunig

INTRODUCTION

This chapter is a continuation of the previous chapter seven, part I, and reports on third and fourth branches of the cross-case analysis thematic framework: Reframing practice: *Role confidence, imposter syndrome and looking outside the box;* and, Ready for "the OT Police": *Adapting scientific knowledge for ethical and professional integrity* (refer Table 14, in chapter eight, part I). Continuing with the previous chapter format, descriptive summaries of the coded data within each thematic network branch are provided in tables, figures, and text. This is followed by a single concluding chapter presenting the final findings as case summaries of multiple case B (occupational therapy service users).

ORGANISING THEME 3 | REFRAMING PRACTICE: ROLE CONFIDENCE, IMPOSTER SYNDROME AND LOOKING OUTSIDE THE BOX

Whilst many core occupational therapy skills and approaches were directly transferable to work effectively with maternal populations, prioritising client-centred practice

often challenged participants' clinical reasoning process and practice boundaries. Many occupational therapists felt subsequently compelled to explore, clarify, and redefine practice boundaries and reflectively reframe their practice. Decisions to prioritise and address client-centred occupational needs by expanding practice scope often led to a sense of professional isolation and imposter syndrome. A professional attitude of being prepared to venture "outside the box", as Nellie (participant 14) described it, was a reflective practice approach applied by most occupational therapists. This process is reported within four basic themes, defined in Table 21.

TABLE 21

Descriptive summary of third organising and basic theme branch, with definitions

Summary of themes, with definitions

ORGANISING THEME	DEFINITION
Reframing practice: *Role confidence, imposter syndrome and looking outside the box*	How occupational therapists adapt their practices and reframe conceptual frameworks and evidence to provide client-centred care to women in the context of motherhood and perinatal health transitions, compliant with best-practice principles
BASIC THEMES	**DEFINITIONS**
I'm here for a reason	How occupational therapists individual and personal experiences inform practice decisions
Don't overthink it	This is basic occupational therapy, just for mothers. How occupational therapists recognise core practices apply to maternal populations
Find it or create it	How occupational therapists are adapting and expanding practices to address women's unique occupational performance issues, needs and goals
Listen, reflect, learn, do	How occupational therapists are tailoring client-centred practices to address occupational performance issues during perinatal and motherhood transitions

Providing client-centred care was at the core of all occupational therapy roles and practice intentions. This, in conjunction with evidence-based practice, role setting and scope, and compliance with professional accreditation guidelines, was a formulaic approach that participants considered fundamental in tailoring services for maternal health clients. Practice directions were driven by the identification of women's OPIs during motherhood, and the

practitioner's clinical reasoning ability to reframe these within occupational therapy frameworks.

The process of reframing occupational practices to work with women during motherhood was two-tiered. The first level required occupational therapists to apply core practice skills and philosophies to address the needs of maternal populations, which is reported in the previous chapter. The second level saw occupational therapists' question and develop their clinical and theoretical frameworks to consider if they were able to address client-centred goals in their practice scope.

The strongest concept in reframing practice was bringing women's holistic occupational performance needs and maternal capacities to the forefront of client-centred care. Mary (participant 10) defined this as needed in contemporary "baby-centric" maternal healthcare services culture. All occupational therapists applied and reflectively reframed their professional practices to assess, interpret and address women's occupational performance issues and needs during perinatal stages.

Audrey, Helena, Nina, Nellie, Anna, and Rebecca (participants 1, 4, 5, 12, 14 and 15) were the only occupational therapists familiar with the term, "perinatal", and no participants used it to define their practice. Occupational therapists tailored client-centred practice to women during motherhood stages focused on exploring, identifying, addressing, and managing their occupational needs, issues, and goals. Motherhood stages discussed by participants included pre-conception, pregnancy or antenatal, preparing for labour, birth, and mothering, performing labour, and birthing as maternal occupations, postnatal, mothering and co-parenting. All identified the mother as their primary client and addressed women's motherhood occupations within their practice scope.

"DON'T OVER-THINK IT": *THIS IS BASIC OCCUPATIONAL THERAPY, JUST FOR MOTHERS*

All participants applied basic occupational therapy skills when working with maternal clients. Many of the functional implications relating to women's OPIs during perinatal phases could be addressed within the core practice scope. Susie (participant 9) defined her acute ward role as comprising, "really classic OT stuff ", using occupational analysis to determine, "what is it that they need to be able to do? … How efficient are they at doing it, given whatever restrictions? … And how that is impacting on the things that they need to do on an everyday basis?". She clarified the process for assessment with maternal health clients was, "exactly the same as you would for someone who wasn't pregnant". In a community setting, Jennifer (participant 3) applied basic occupational therapy assessment skills to identify and prioritise women's occupational performance goals, enabling them to "process [issues] in a way that makes sense and … empowers them to be able to do what it is they want to be able to do".

Most occupational therapists named "problem-solving" as the core professional skill they used in maternal healthcare. Cath (participant 7) felt that the profession's clinical reasoning process reframed women's developmental changes and difficult experiences as OPIs impacting wellbeing and function. She clarified, "they're some of the challenges that women experience and … what OT contributes is an understanding of all of that, and how important that all is".

Providing sensitive and holistic client-centred care to women was a core attribute that occupational therapists were proud of in their profession. They applied this in practice by interpreting the physical, cognitive, mental/emotional, neurological, spirituality, and functional domains of women's wellbeing during maternal development and life stages, considering self-efficacy development and occupational enablement reflected in meaningful and necessary occupational choices, participation, and engagement (refer Figure 9).

FIGURE 9

Core 'holistic' occupational therapy practice components participants applied when working with women during motherhood stages

All occupational therapists felt confident drawing from a range of core practice skills to establish clear foundational practice approaches to commence working with women holistically during motherhood. Maintaining the use of grass-roots practice philosophies was critical to all participants. In a traditional occupational therapy role, Susie (participant 9) advocated that 'occupation' was relevant, central, and powerful in working with maternal

clients, asserting, “as soon as you start complicating it by too many other things, then it loses its magic”. Rebecca (participant 5) described her core practice approach aimed to, “help people to understand better their occupational roles and how that is impacted by their health and wellbeing”. In a hand therapy clinic, Emma reflected that working with women reminded her to return to foundational occupational therapy practice philosophies.

In an educational setting, Jennifer (participant 3) contextualised how focusing on occupation made her services more accessible for women who felt vulnerable to health services judgement, explaining, “OTs are really great at… the doing stuff, and supporting, and [are] very much about functional performance”. She valued that occupation- and activity-based interventions were, “about the ability to slow down as well and really be present in the moment and provide an opportunity for caregivers to be present in the moment and mums to be present”, which strengthened their investment in therapies. Cath (participant 7) echoed this, recognising and utilising, “the value of occupation as a treatment” to facilitate improving women’s functional capacities and achieving their occupational performance goals during motherhood.

I'M HERE FOR A REASON: *HOW OCCUPATIONAL THERAPISTS INDIVIDUAL EXPERIENCES INFORM PRACTICE DECISIONS*

Most occupational therapists were passionate about providing non-judgmental, compassionate, and accessible services for women, which were client-centred and focused on enablement and empowerment. All occupational therapists drew from their own experiences and values to guide practice directions when tailoring services for maternal clients. Participants’ backgrounds and employment histories, personal experiences of parenthood and accessing perinatal healthcare became motivators shaping their practice in maternal health.

These foundations provided a backdrop to contextualise role choices and guide practice directions made when working with maternal clients.

Many participants, including Pamela (participant 6), were motivated by a desire for "social justice", endeavouring to provide women with sensitive, accessible, and tailored client-centred education about their bodies to make informed and empowered choices during perinatal phases. Equity of access to care inspired several occupational therapists, including Alex (participant 13), who had previously worked with maternal populations in the US Military. She explained that in military roles she worked with any person requiring her skillset irrespective of ward setting, which she was not able to continue in the "civilian world". Like many other participants, Alex's (participant 13) decision to transition into maternal health was cemented following her personal experience of being an occupational therapist and perinatal health services user.

Eight occupational therapists described how their parenthood experiences, and sharing friends and family's experiences of becoming parents, shaped their perception of how motherhood impacted women's occupations, function and wellbeing. The key concepts participants incorporated into their practice included addressing women's experiences of traumatic and disempowering perinatal events and validating issues that were not medically significant.

Trauma was a frequent, complex, and subtle issue impacting women's perinatal health experiences. Helena (participant 12) addressed women's experiences of perinatal disempowerment and trauma sensitively, explaining validation and debriefing were critical when maternal medical decisions and interventions compromised women's choices and basic rights:

In maternal health, so often consent is a blurry subject… and even sexual trauma… We don't talk about the trauma that woman has endured and … how that's going to impact her for the remainder of her life, because … we needed to do it for the baby.

Most therapists regarded a trauma-informed approach was critical for working with women during perinatal phases. Nina (participant 4) supported women to make sense of their experiences, and "to feel like they have a voice". Being heard and feeling validated was imperative for women's emotional healing and recovery, and essential before they were ready to work through OPIs. Several participants used therapeutic conversation to guide women navigating their way through difficult occupational blockages. Rebecca (participant 5) "focused on values-based decision making, … goal setting and also mindfulness practices", contextualised by meaningful occupational engagement.

Perceived failure to be a 'good' mother was a primary source of shame, occupational overwhelm and social isolation for women, and an occupational performance goal addressed by many occupational therapists. Determining what being a 'good' mother constituted was uniquely complex and diverse for each woman. Causes of emotional or mental distress, discomfort and challenges were commonly connected to women's self-perception of failures as mothers. These included feeling underprepared, ill-equipped, underperforming, dysfunctional, ill-informed, invalidated, or powerless during motherhood phases and perinatal transitions. Developing skills to overcome this was addressed on a client-centred basis. Susie (participant 9) articulated her practice aimed to "empowering [women]… to be as good as they possibly can be in the roles that they choose to participate in".

Lived experiences motivated and guided how most occupational therapists evolved their practices in perinatal health roles. These related to a spectrum of occupational performance domains including managing maternal occupational overloading, sensory and hormonal changes, labour and birth trauma, grief and loss (including miscarriage),

relationship changes, recovery from birth injuries and surgeries, desire for better education, functional performance challenges, maternal upskilling and preparation, pelvic dysfunction, spiritual transformations in becoming a mother, changing identities and priorities, and disempowerment as a perinatal health services user.

FIND IT OR CREATE IT: *REINTERPRETING, ADAPTING, AND EXPANDING OCCUPATIONAL THERAPY PRACTICES TO ADDRESS WOMEN'S UNIQUE OPIS, NEEDS, AND GOALS*

Understanding women's occupations and interpreting OPIs during motherhood was a significant component of all occupational therapy roles, which often proved challenging. Client-centred practice with women during perinatal health and motherhood transitions saw many common occupational therapy approaches falling short or becoming inadequate. To resolve these limitations, occupational therapists applied flexible clinical reasoning skills to reframe, reinterpret and adapt core practice skills for maternal clients. This process clarified the scope of core practice boundaries for working with maternal populations and revealed areas for professional expansion.

Several therapists prioritised spirituality in their core therapeutic approaches to working with women, with Nellie (participant 14) highlighting that "spirituality is at the core of OT". Fleur (participant 11) advocated that the "spirituality element" was key to working respectfully with Aboriginal clients during motherhood, to sensitively contextualise the influence of culture on women's identity, wellbeing, and maternal expectations. Nellie's (participant 14) work focused on spiritual wellbeing for women adapting to identity, energetic, emotional, sensory, relational, and personal changes during motherhood. She explained that spirituality was particularly relevant to "highly sensitive" women, who wanted "to feel, more calm, and more present" during birth and motherhood.

The principles of biomechanics were applied in most occupational therapy practices. These approaches aimed to enhance women's functional conditioning when preparing for birth, reframing the process of birthing as both a maternal occupation and female reproductive biomechanical function. Alex's (participant 13) holistic practice to birth incorporated relaxation, education, visualisation, mindfulness, and "the affirmation of preparing their mindset", during pregnancy to address the "biomechanics of preparing their body … so that when they're ready to give birth it's not going to be … constrictive and restrictive". She amalgamated the mind-body components of birth preparation, providing education to foster an association between women's sense of maternal biomechanical capacity and self-efficacy.

Many occupational therapists addressed the cyclical process of fear-avoidance, anxiety and re-traumatisation risks when considering women's OPIs relating to pelvic pain, back pain, core muscle weakness, and fear of future births. Helena (participant 12), Corrie (participant 16) and Rebecca (participant 5) combined mindfulness, biofeedback, functional movement, and ergonomics in their practice to improve women's strength, control and awareness of ergonomics, postural control, positioning, mindful movement and manual handling. These approaches combined restorative, rehabilitative and health promotion principles to create wellness approaches.

Occupational therapists addressed OPIs relating to pelvic function including incontinence, pain, birth, discomfort, body shame, and engagement in sexual or intimate occupations. Helena (participant 12) combined biomechanics with sensory modulation to improve women's core strength and pelvic function during pregnancy and after birth. She incorporated this with restorative exercise, reflexive movement hormonal regulation techniques, trauma-informed practice, cognitive behavioural therapy (CBT), neurodevelopmental theory (NDT) and psychosocial approaches. Mary (participant 10)

recommended activity adaptions for women's engagement in intimate occupations, noting "c-section scars and painful sex often go together". Mary (participant 10) addressed the mind-body connection in women's sexual wellbeing, pelvic health, and functional issues, combining biomechanics and mental health practice to address OPIs. She addressed the biomechanical and psychosomatic impact of perineal and caesarean scars following birth.

Several occupational therapists reframed practice approaches to meet women's needs in the context of maternal development, perinatal transitions, co-occupations, and identity adaptation. Helena (participant 12) designed and delivered occupational therapy online education about women's maternal wellbeing. She addressed the need for a deeper and more holistic understanding of the connection between mental, physical and core and pelvic floor health, commenting, "when I just look at women's health, we have a long ways to go".

Addressing women's occupational performance capacities, wellbeing, relationships, self-regulation, identity and self-efficacy, Pamela (participant 6) advocated, "OTs do 'transition' really well and, … can help facilitate a smoother transition … [for women] who are having trouble adjusting to their new role as a mum". Several occupational therapists contextualised women's transitions by translating mother-child caring occupations into co-occupations, which were fundamental in their preventative and early intervention mental health roles. Nina (participant 4) identified the transition of, "moving from occupation to co-occupation with the infant" was challenging for women. Co-occupations were contextualised by meaningful occupational engagement, healthy mother-infant attachment, mental health promotion and facilitating women's volitional development into a reciprocated psychocognitive bond with their baby.

LISTEN, REFLECT, LEARN, DO: *TAILORING OCCUPATIONAL THERAPY CLIENT-CENTRED PRACTICES TO ADDRESS OPIS DURING PERINATAL AND MOTHERHOOD TRANSITIONS*

Learning on the job was considered necessary by most participants to address women's OPIs during motherhood. Anecdotal evidence informed and guided best-practice practice decisions with maternal populations. The core and expanded practice approaches and skills occupational therapists used when working with women during motherhood were extensive. These practices shared a focus on promoting women's holistic, functional, and occupational health and wellness, and all were reportedly consistent with professional occupational therapy accreditation guidelines.

Listening to women and understanding what it individually meant to feel competent, functional, and capable during motherhood was common in client-centred practice. All occupational therapists mentioned that listening, hearing, and validating issues helped women work through feeling disempowered, lost, or overwhelmed during motherhood. This guided assessment methods and outcome measures, identification of relevant resources and evidence-based references.

Tailored, client-centred education was often highly sought after by women during motherhood. In private practice, Rebecca (participant 5) explained women, "want to have as much information as possible". Interventions typically involved "a fair bit of psychoeducation" about anxiety, depression, learning how "the chemical structure of the brain and the hormonal profile of a woman change through pregnancy, and how that can impact on the physical and emotional wellbeing".

Most participants interpreted women's motherhood occupations were whatever the client identified, and not defined by their perinatal stage or maternal health status. Recognising what was important to each woman during pregnancy was imperative for maximising the suitability and benefit of interventions. Occupational therapists collectively

identified a range of occupational domains associated with motherhood transitions. Many related to maternal preparation and co-occupations, such as nesting, which Pamela (participant 6) explained were unrecognised and overlooked by healthcare services:

> *Nesting is a big part of becoming a mum. It seems like it's shallow and silly, but it's actually not. You're preparing your nest… This is a physical way that you're preparing to welcome a new member into your family.*

Cath (participant 7) and Pamela (participant 6) both routinely used cooking sessions and groups to facilitate women's occupational engagement through "familiar life roles" during prolonged inpatient admissions. Pamela (participant 6) worked with the occupational therapy assistant (OTA) to tailor client-centred opportunities for women to prepare and serve a meal for their family. She explained doing "normal things that they really miss when they're on bedrest" addressed occupational deprivation by facilitating meaningful role re-engagement, relationship strengthening, and self-worth:

> *They're doing something that is part of their mum job, that is their usual occupation, which is cooking a meal for the family. And then they're also able to have that beautiful engagement with their kids and … be a mum, basically.*

Women's self-care choices, performance and meaningful engagement emerged as significant wellbeing indicators, and key issues impacting self-efficacy development during motherhood. Related OPIs were typically indicated by experiences of role loss, occupational disruption, and psychosocial issues. These hindered women's capacity for meaningful and fulfilling occupational engagement, adaptation, and development. Self-care engagement and performance were often indicative of women's mental, emotional, neurocognitive, psychosocial, and psychosomatic states of occupational being, function and capacity. The process of working with women through self-care deprioritisation, neglect, disruption and

avoidance challenges usually involved therapeutic conversation and reflective cognitive reframing.

For women wanting to feel calmer, less worried, or anxious during or after pregnancy, occupational therapists aimed to nurture the development of women's capacity to self-regulate their emotions, behaviours and reactions in response to triggering stimulus. Interventions typically included cognitive behavioural therapy (CBT), sensory regulation and modulation, acceptance commitment therapy (ACT), dialectical behaviour therapy (DBT), mindfulness, education, and environment and activity modification. Co-regulation was often considered for the mother-infant dyad client, contextualised by attachment theory, neurodevelopmental science, and co-occupations.

ORGANISING THEME 4 | READY FOR "THE OT POLICE": ADAPTING SCIENTIFIC KNOWLEDGE FOR ETHICAL AND PROFESSIONAL INTEGRITY

The final organising theme, *Ready for "the OT police"* reflected the strong sense of obligation to deliver ethical and evidence-based professional practice. Helena (participant 12) recalled the pressure and challenges associated with "being told again and again, 'OTs don't work in women's health'", and practicing "defensively" in her early career:

> *I was so fearful. I always joked that … the OT police [were] coming to get me … So anything I did I was always ready to defend… The OT police never came. But for so long… I was really afraid of having to leave the OT profession.*

Inadequate evidence-based literature informing wellbeing approaches were challenging for all occupational therapists working in perinatal health, and often undermined the value, validity, and promotion of their practice. Whilst this was professionally

disheartening and isolating, it also motivated many participants to become change agents. Participants prepared their evidence-base for delivering ‘best-practice’ in unique ways that were relevant and appropriate to their roles. Most made substantial efforts to explore, gather and select non-traditional scientific evidence to inform and enhance their practice. This resulted in a myriad of expanded conceptual approaches and practice paradigm shifts, drawing from an extensive range of literary sources, and was guided by professional networks and women’s voices across social media.

All participants were registered with professional occupational therapy associations or registration boards and confirmed their practices were within accredited regional or national practice scope guidelines. Occupational therapists perceived that their tertiary training provided them with a solid platform to interpret women’s occupational performance issues during perinatal phases; however, further specific professional development, supervision and practice experience were critical. Participants drew from an extensive range of literature, knowledge, personal experience, professional expertise, and practice skills, which had been individually pooled by each participant to suit their unique role.

EXPANDING MATERNAL HEALTH PARADIGMS: *BUILDING TAILORED KNOWLEDGE BANKS WITH PROFESSIONAL 'EXPERT' NETWORKS*

Women’s health, maternal development and motherhood occupations were identified as significant gaps in core tertiary occupational therapy education. Participants identified the need for education on women’s development as they became mothers, maternal and perinatal health, and knowledge of occupations during motherhood. Most identified a need for better profession-specific frameworks, resources, and tools to validate and holistically provide evidence-based practices appropriate to maternal clients.

Expanding knowledge about maternal development and contextualising and critiquing the fit with occupational therapy practice required high levels of clinical reasoning by occupational therapists. Participants drew from anecdotal evidence cross-referenced with scientific knowledge about women's health and occupational therapy human occupation frameworks to understand women's motherhood transitions.

Knowledge gaps typically included perinatal health and maternal development, mother-infant wellbeing and understanding how familial psychosocial dynamics influenced women's wellbeing during motherhood. Participants identified the 'client' by clarifying and setting boundaries between the mother, child, and family's health; and addressed knowledge their own gaps owing to a lack of discipline-relevant education about women's health, development, wellbeing, and occupations during motherhood. When existing occupational therapy conceptual practice frameworks failed to accommodate the diversity, complexity, and fluidity of women's OPIs during motherhood, participants navigated and resolved professional disorientation by making practice decisions based on client-centred practice and meaningful occupations.

Participants observed that mothering occupations, occupational choices and OPIs were often shrouded with taboo, expectations, and judgement. This sometimes made it difficult for women to be honest about their issues, seek help and receive guidance. Rebecca (participant 5) argued that scientific evidence and motherhood self-help books were often overly prescriptive and were difficult to apply within the reality of contemporary motherhood, explaining:

> *It's that … difference between co-sleeping and …. controlled crying, or formula-fed and bottle [feeding] … There's all these different kinds of extremes. But there's very little kind of understanding that the majority of mums live in that grey area, somewhere in between.*

Addressing the “grey areas” of motherhood, being non-judgemental, and applying broad-mindedness to EBP approaches aligned strongly with participants’ client-centred practices.

Several approaches associated with paediatrics were applied to expand maternal occupational therapists’ recognition of women’s health, wellbeing, and maternal development needs. Early intervention framed preventative and health promotion approaches, which occupational therapists stressed were key in proactive care approaches. This was motivated and guided by participants’ perception of many maternal and children’s health and wellbeing issues being preventable, and best managed working with women both as individuals and relationally as mother-infant dyads. From a family-centred psychosocial perspective, Jennifer (participant 3) advocated:

> *If OTs can get in and work with mums and bubs earlier within the first twelve months and work relationally…, then quite often we can see that three, four years down the track then the child is actually really thriving and not having behavioural challenges or developmental challenges.*

Play was reframed as a maternal role occupation which was often unfamiliar and uncomfortable for women to engage with. Audrey (participant 15) explained engaging in play was “such a new concept for many people”, and difficult for new parents when they perceived it being an exclusive childhood occupation. She regarded play as maternal, child and mother-infant co-occupations, which was not always socioculturally appropriate for women from culturally diverse backgrounds. She integrated play into practice to enhance mother-infant communication, bonded attachment, and relationship development.

The process of interpreting mother-infant occupations saw occupational therapists reframe infant feeding both as a primary motherhood occupation and a co-occupation, which included breastfeeding, bottle-feeding, introducing solids, and weaning. Occupational

therapists considered breastfeeding OPIs from an attachment and bonding perspective, as a nurturing occupation promoting child development and addressed positioning and ergonomics during infant feeding to reduce the risk of pain, injury, and distress during sustained occupational engagement. They regarded that cluster-feeding[4] contributed to occupational overloading for women trying to manage completing demands during mothering routines.

Occupational therapists addressed sleep as a woman's occupational need and health priority, contextualised by motherhood demands and embedded within family routines. Participants adapted a range of resources from occupational science, the disability sector, neurodiversity, paediatrics and parenting to work with mother-child sleep routines, environments and achieving family sleep needs. Children's sleep was considered within the motherhood occupation and mother-infant co-occupation of "settling". Co-sleeping was regarded as a taboo mothering choice for women due to well-known infant health and mortality risks, which was addressed as a co-occupation by four occupational therapists. They explained that co-sleeping was a cultural norm for some families and offered a solution for new mothers struggling with sleep-deprivation due to the infant waking multiple times overnight. Participants provided tailored education and advice to minimise risks of cot death.

"Is this still OT?": *Finding the fit between evidence, scope of practice and professional accreditation*.

All occupational therapists were confident they were providing services within the scope of core, advanced and extended practice parameters. Whilst all participants valued

[4] "Cluster-feeding" is a normal behaviour for babies which often happens in the early periods of breastfeeding and describes a period of the baby wanting to and being breastfeed more frequently in period 'clusters'. Australian Breastfeeding Association. (2019, December). *Cluster feeding and fussy babies*. Retrieved 23 October 2021 from https://www.breastfeeding.asn.au/bf-info/common-concerns%E2%80%93baby/fussy

ethical and evidence-based practice, private practitioners felt significant pressure to be transparent and produce evidence justifying and validating how their roles were compliant with occupational therapy accreditation. Rebecca (participant 5) identified occupational therapy's core primary objectives of optimising "wellbeing… [and] meaningful occupation" were being called for in maternal healthcare. The occupational components of women's wellbeing participants addressed during motherhood were extensive, and aligned with the six conceptual models outlined by Kielhofner (2009) for guiding practice decisions, including the biomechanical, motor control, sensory integration, cognitive, functional group, and the model of human occupation. Occupational therapists drew from a spectrum of familiar and expanded therapeutic approaches and advanced practice skills to address these, which are reported in Table 22.

TABLE 22

Domains of women's wellbeing during motherhood occupational therapists addressed using familiar and expanded therapeutic approaches and advanced practice skills

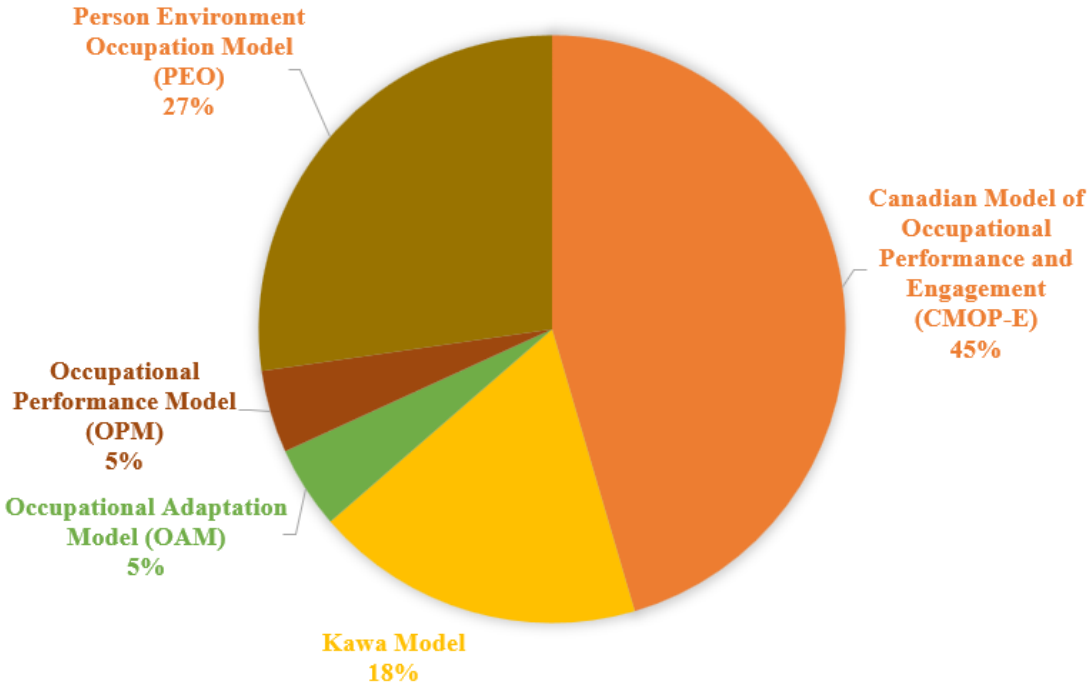
	Common occupational therapy practice skills and interventions used when working with women during motherhood	**Emerging therapies and advanced practice skills occupational therapists provided to address client-centered occupational performance issues (OPIs) meaningful occupational performance needs**
Cognitive processing, emotional wellbeing and mental function during occupational performance	Cognitive Behavioural Therapy, meditation, and relaxation strategies; Mindfulness; fatigue management; cognitive reframing; stress and anxiety management; prioritisation of engagement in meaningful occupations; grief counselling; positive behaviour therapy; health promotion and preventative health.	Illness prevention and early intervention (maternal mental health); dialectical behavioural therapy (DBT); acceptance commitment therapy (ACT); developmental psychology; hypnobirthing; 'Keeping Baby-In-Mind'; 'beditation' (bed-based meditation for women on prolonged bedrest); occupational overwhelm; trauma-informed practice; validating difficult experiences; needle phobia and fear-avoidance behaviours, including social anxiety; emotionality of maternal birth injuries and scars; intergenerational trauma; cognitive switching; stomatal-emotional relief; "biology of belief"
Physical, physiological systems and biomechanical function during occupational performance (including sensory and neurological)	Sensory profiling, processing, regulation, integration, modulation; biomechanics and functional movement (hand splinting, remedial exercises, posture and positioning [static and dynamic/daily and nocturnal], transfers and mobility); sleep (needs, positioning; sleep hygiene, circadian rhythm management); ergonomics; pain management and education; scar healing/management; stroke rehabilitation; health education (functional implications and adaptive occupational performance strategies); neuroplasticity; neurodevelopment (paediatric); self-regulation.	Sensory diets (maternal); 'living sensationally'; neurodiversity (including "highly sensitive" women); neurodevelopment (maternal); neuro-developmental therapy (NDT); baby massage; epigenetics; co-regulation; pelvic health, wellbeing and function (including pelvic organ prolapse, pessaries, incontinence management, and psychosomatic symptoms), spinning babies; Arvigo therapy; holistic pelvic care training; core function rehabilitation (diastasis recti); contextualising hand therapy interventions into motherhood; biomechanics; craniosacral therapy; myofascial therapy; Pilates; ergonomics of mothering, co-occupations and physically demanding/ repetitive occupations during motherhood; maternal anatomy, physiology and physiological development (including organ function, physiological processes, hormones, mind-body-gut connection.), and common morbidities associated with perinatal stages.
Psychosocial wellbeing, occupational contribution, engagement and participation in roles, relationships and communities	Family-centred care; social and community occupations; familial relationships; referrals to supportive and necessary health and community services; interpersonal relationships.	Partner, co-parenting and intimate relationship development; interpersonal communication skill development; attachment theory; co-occupations (attachment and bonding, sleep (including co-sleeping), routines, changing, feeding (breast, bottle, solids, weaning), bathing, caring, communication, play); friendships and community connection; regaining empowerment, confidence and secure identity as a mother, partner, family member, friend, community contributor and worker; 'think family' model; family partnership approach; social media influences; circle of security; Marte meo; tuning into kids; adverse childhood experiences; transitioning from coercive relationships; domestic violence; family partnership approach.

	Common occupational therapy practice skills and interventions occupational therapists reported directly transferring to work with women during motherhood	**Emerging therapies and advanced practice skills occupational therapists provided to address client-centered occupational performance issues (OPIs) meaningful occupational performance needs**
Participation and engagement in meaningful occupations and enabling environments	Activities of daily living (ADL's): personal (including self-care), domestic, instrumental, productive, community; home environment modification and set-up; return to work planning; time use, schedules, routine rhythms and management and occupational prioritisation; activity analysis and redesign to improve function; occupational disruption and occupational deprivation; activity grading.	Motherhood, perinatal, mothering and maternal milestones roles, relationships, activities and occupations; self-care (nutrition, weight, food relationships, gut health, yoni steaming; exercise, shopping, friendships); managing daily and nocturnal routines with a baby (sensory, occupational, environmental, fatigue management, support networks, grading); lifelong occupational deprivation (hobbies, meaningful occupations and securely attached relationships) for women from low-socioeconomic backgrounds; employment security and return-to-work planning (childcare arrangements, social justice issues); maternal performance expectations and standards; conscious parenting; simplicity parenting
Development of self-esteem, self-efficacy and confidence through occupational performance	Goal setting and attainment; doing, being, becoming and belonging; self-mastery; occupational adaptation; supporting women to develop confidence, competencies, and healthy self-esteem through facilitated occupational performance mastery experiences; client-centred education.	Body image changes during motherhood (including relationships with birth scars and injuries); sexual identity post-birth and resuming intimate relationships; maternal functional performance and capacity building; developing a sense of competence to perform motherhood and infant caring roles and occupations (problem-solving, upskilling, education, validation, empowerment); informed consent education and self-advocacy development as a perinatal and child health services consumer; working through personal, familial and sociocultural motherhood standards and expectations (including social media); navigating life choices and obstacles; maternal role preparation and transitions adaptation
Spirituality, cultural identity and personal values aligning with occupational choices and engagement	Improving alignment of personal values and occupational engagement choices; motivational interviewing; volition; rituals; cultural diversity	Maternal identity development; developing identity as a mother and woman; adapting and coping with maternal developmental changes and motherhood occupations; adaptation to gendered roles and occupations; self-care (financial wellbeing; yoni steaming, occupational balance); life compass (ACT); primary occupational environments (clutter, flow, meaningful spaces [e.g. Feng shui]), such as labour and birthing spaces, homes; exploring the volition and meaning of motherhood; "spirit babies"; motherhood 'rites of passage'.

Occupational therapists relied on practice models to guide and validate practice focus and scope. Several practice models were applied in usual practice. These included the Canadian Model of Occupational Performance and Engagement (CMOP-E), Occupational Performance Model (OPM), Kawa Model, and the Occupational Adaptation Model (OAM). Whilst PEO components of the occupational paradigm were referenced by all occupational therapists, the Person-Environment-Occupation (PEO) Model was used as a practice model by six participants (refer Figure 10).

FIGURE 10

Occupational therapy practice models participants applied to interpret women's OPIs during motherhood and perinatal stages, and clarify their role focus and scope



Pamela (participant 6) found the OPM was generally useful for women on prolonged bedrest and working through difficult motherhood OPIs. The Kawa model was valued by Mary, Helena, Nellie and Audrey (participants 10, 12, 14 and 15) for its perspective on life change

fluidity and identification of OPI components as obstacles to manage and move through women's transitional changes and adaptations. Alex (participant 13) connected most with the OAM model for nurturing women's personal growth using a scaffolding framework for habitually improving positive occupational choices, behaviours, and routines into, through and beyond motherhood, because:

> *It focuses on mastery and learning something 'til you get, not 'perfect' with it, but you get to a stage where you master it and you're doing it on a regular basis. And it becomes easier to use as just a part of your flow, and then you just build on that.*

The CMOP-E was the model most often identified as a versatile framework for interpreting and organising women's OPIs. It was used in private practice roles by Rebecca, Mary, Helena, Fleur, Nellie, and Corrie (participants 10, 12, 14 and 16), and in public health by Nina (participant 4) for preventative/EI mental health, and Emma and Jack (participant 2 and 8) in hand therapy roles. Nellie (participant 14) valued spirituality as being at the CMOP-Es core, making it the only model conceptually aligned with her practice focus on working with women during motherhood. On the acute ward, Susie (participant 9) combined the CMOP-E with the International Classification of Functioning, Disability and Health (ICF) framework to analyse women's capacity for returning home from hospital with their new babies, explaining, "you need to look at function… [It's] really really important".

Whilst occupational therapists were confident applying theoretical principles and conceptual practice frameworks to guide how they worked with women, Jennifer (participant 3) felt, "frustrated, …[that] there's not just one model that you can just follow [for]… OT in maternal health". She felt traditional models lacked the capacity to be flexible and dynamic for women's complex needs during motherhood, explaining, "the core models are there of working

relationally and developmentally, but then there are also there's other layers to it", which they do not have the capacity to address. This short-fall was noted by most participants, who felt the way they practiced to support women during motherhood developmental changes and perinatal phases were not aptly framed by existing occupational therapy practice models.

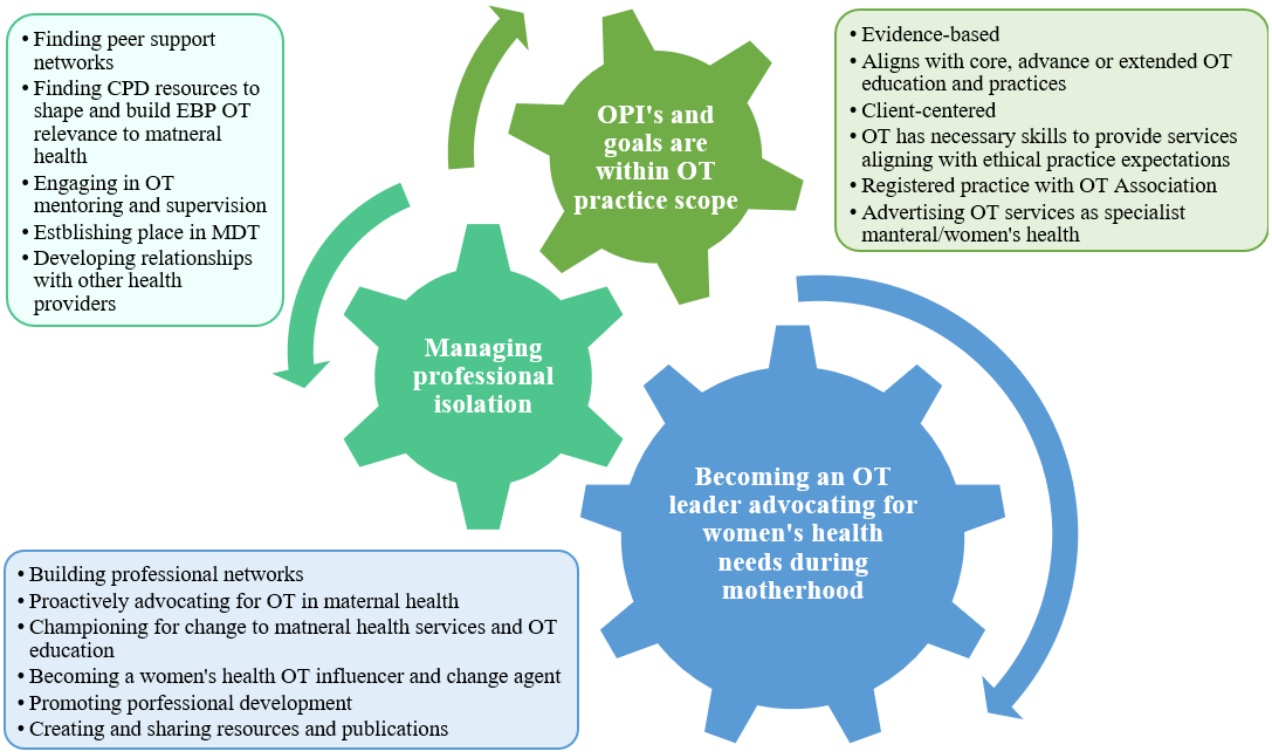
SHAPING PRACTICE FIELD DIRECTIONS TOGETHER*: OCCUPATIONAL THERAPY ROLES AS ADVOCATES AND CHANGE AGENTS*

Professional isolation was an issue for most occupational therapists, who considered themselves "pioneers", "trailblazers" and "unique" service providers, distanced from both traditional occupational therapy and maternal healthcare models. Identifying and pursuing new knowledge to enhance practice was a time-consuming responsibility and scaffolded process, which needed to be done with other occupational therapists. All participants experienced and managed professional ambiguity, doubt, and isolation to various degrees.

The most significant factor negating professional isolation was being connected within a collegial, supportive, and established MDT or peer network. Each therapist strived to establish professional network connections supporting their role and practice setting to validate, guide and inform their practices. Several occupational therapists took the next step of becoming change agents, practice influencers and industry leaders, championing for better acknowledgement, recognition, and inclusion of occupational therapy in women's healthcare services during motherhood (refer Figure 11).

FIGURE 11

Common factors influencing and shaping occupational therapists' professional development journeys into becoming women's maternal health specialist providers



Note: Abbreviations: Occupational performance issues (OPIs); occupational therapy/ist (OT); continuing professional development (CPD); multidisciplinary team (MDT).

Resolving isolation by building occupational therapy's professional integrity, identity and validity in women's health motivated several participants. Rebecca (participant 5) and Helena (participant 12) were both highly proactive in championing this, both for themselves and other occupational therapists. They had both taken on industry leadership positions and established special interest groups aiming to unite, strengthen and promote the movement of occupational therapy into women's health and wellbeing during motherhood. Helena (participant 12) articulated how peer-group forums were critical for shaping collaborative practice field

directions because “when you’re trailblazing in women’s health you can build your practice in any way that you want”.

Many participants perceived a global women’s health movement was starting. They felt that collective efforts were needed to be made for a united occupational therapy movement to advocate and claim a place in this dynamic development. In Canada, Helena (participant 12) worried that occupational therapy was “missing the boat” for professional expansion into perinatal health, adding, “there is certainly a role for us, and … there are a lot of women … asking for the info … If OTs aren’t going to step up”, then another profession will. In Australia, Rebecca (participant 5) saw similar developments, declaring, “it’s a huge opportunity for OTs to … really take a bit of ownership of this role”.

The professional network connections occupational therapists made shaped their professional and private practice directions. Helena (participant 12) and Rebecca (participant 5) provided mentorship, education and coaching to therapists wanting to upskill in women’s maternal and perinatal health. Both were endeavouring to have the specialised field acknowledged by occupational therapy associations and included in tertiary curriculum. Mary, Fleur, Nellie, Alex, and Corrie (participants 10, 11, 14, 13 and 16) had professionally connected with Helena (participant 12) for professional supervision and guidance. Fleur (participant 11) and Mary (participant 10) had connected with Rebecca (participant 5) in a similar capacity. Rebecca (participant 5) was predominantly focused on advocating to tertiary institutions for women’s health to be included in occupational therapy curricula, and to Occupational Therapy Australia for practice advancement recognition and legitimisation.

In Australian public-funded roles, Jennifer (participant 3) and Anna (participant 1) were both members of a “group supervision” team comprised of five occupational therapists, led by

the lecturer who had educated them about women's perinatal health. Jennifer (participant 3) valued group supervision as a practice compass shaping practice directions, explaining, "it's about building a network of OT's who also work in maternal health around you, to then learn from each other and bounce ideas off each other and how can we actually be doing this better". Like many other therapists, she stressed that "having access to good quality reflective practice" was essential.

BOTTOM-UP MEETS TOP-DOWN: *LISTENING TO LEARN AND MAP WOMEN'S TRENDING OPIS*

Listening to women's needs was the professional attribute all occupational therapists felt they championed in being holistic client-centred healthcare providers. Many looked to social media to gain insight and monitor trends in "real life" issues impacting women during contemporary motherhood. Mary (participant 10) branded this, "informal CPD", adding, "it really is the biggest … place of learning". Examples of women's lived perinatal experiences were sought as informal case studies via online mothering forums, Facebook, and Instagram social media platforms, leading to many participants identifying 'wellbeing' as a trending maternal lifestyle goal. Helena (participant 12) saw social media content often informed and validated her work, recalling a pivotal "online research" moment when she realised, "that blog post just completely defended all the work that I do in women's health".

Understanding the social climate of women's motherhood challenges was formative in Rebecca's (participant 5) practice. She explained many women felt caught up with, "the mummy wars" where, "a sub-set of mums … [who] align themselves with certain ways of doing things" was at odds with others in online forums with "a whole another group of mums on the other end

of the spectrum, that are saying, ‘Well no, this is what a good mum means’”. Rebecca (participant 5) worked with women to work through how social media forums could fuel complex psychosocial antagonism impacting women’s mental health, emotional wellbeing, and self-esteem as mothers.

One of the most impassioned concepts emerging from informal CPD was strengthening women’s call for “feminised” health care. Mary (participant 10) identified her primary influencer promoted, “that we need feminine solutions to feminine problems”, because “the perinatal period … slams you in the face with the feminine and the differences that are there between men and women”. Rebecca (participant 5) and Mary (participant 10) felt many complex OPIs were resultant of the dissonance between women’s “feminine” wellbeing needs and the “masculine” medical model informing maternal health services design. They addressed these issues in their roles in relation to empowerment for women during perinatal transitions, maternal development, and motherhood.

Mary (participant 10) integrated feminine wellbeing into her practice to focus on nurturing maternal development. This expanded traditional healthcare approaches by focusing on *“*mental health [and] emotional wellbeing …, self-love …, nurturing our body and giving our body what we need in this pre and postnatal period, and ongoing as well”. Mary (participant 10) felt this reframing process was critical to paving the way for occupational therapy’s evolution into maternal health services, advocating, “OT can offer that … balance of … those things”.

In listening to women’s needs, occupational therapists applied client-centred practice to address the spectrum of women’s occupational performance issues through upskilling and expanding knowledge. These professional development choices led all occupational therapists to consider themselves as specialists in addressing various domains of women’s occupational needs

during motherhood, including women's health, hand therapy, psychosocial wellbeing, and pelvic health. As they reached practice scope boundaries and skill-base thresholds, several gained additional qualifications, which are visually depicted in Figure 12.

FIGURE 12

Additional qualifications occupational therapists acquired to deliver client-centred practice in maternal health

Building wellness into occupational therapy practice was difficult and frustrating for several participants. Rebecca (participant 5) questioned how prepared the profession was for this emerging competitive field, commenting, "I sometimes feel like other professions do 'wellbeing' better than OTs do". Pamela (participant 6) identified women's wellbeing during motherhood as a significant knowledge gap. She reflected on the significant investment her organisation and department had made in upskilling occupational therapists, "to be able to sit down and, and coach people through the wellbeing aspects of pregnancy and emotional adjustment to that transition", adding, "we do it well here …, but I know we're one of the only services … that provide that OT input".

CHAPTER SUMMARY

This final cross-case analysis findings chapter reported how occupational therapists collectively sought and pooled evidence-based resources and expanded knowledge banks to enhance their practice capacity whilst complying with best-practice standards, and professional association governance requirements. Further directions for the occupational therapy profession perceived by participants were discussed, identifying rationale, strengths and barriers described by participants. The following chapter is the concluding findings chapter, reporting on two consumer accounts of accessing occupational therapy services as clients during perinatal stages.

CHAPTER 9: MULTIPLE CASE B

"A woman with a voice is by definition a strong woman. But the search to find that voice can be remarkably difficult."

— Melinda Gates

INTRODUCTION

In this chapter, the multiple case study B is presented as a pair of two summarised individual service user cases, from Australia and the United States of America (USA). The cases are descriptively reported using pseudonyms to deidentify individuals, summarising each woman's experience and perception of accessing occupational therapy services during maternal stages and perinatal motherhood phases.

CASE 1: KATE – ACCESSED PREVENTATIVE MENTAL HEALTH OCCUPATIONAL THERAPIST, PERINATAL, AUSTRALIA

CASE SUMMARY

Kate is a 26-year-old-mother to a 23-month-old son, *Henry**, and 30-weeks pregnant with her second child. She lives with her husband, *Tom**, in a small rural Australian town, which they both grew up in. Kate and Tom have been a couple for 11 years and married for four. Kate stated that she and Tom, "had a great relationship – we always have", and both feel well connected with family and friends within their local community.

Throughout her first and second perinatal journeys, Kate has accessed a general practitioner (GP), lactation consultant, maternal and child health nurse, midwife, paediatric

speech pathologist and occupational therapist. A midwife referred Kate to a preventative mental health occupational therapist (*Nina, multiple case A, participant 4*) in a hospital-based outpatient clinic when she was 36-weeks pregnant with Henry, for emerging maternal anxiety management. She has remained engaged with this service intermittently in the three years since. Before this referral, Kate had not heard of occupational therapy and was unsure what kind of services to expect from the appointment.

Kate does not identify as having perinatal mental health issues and instead explained how anxieties and fears associated with a previous traumatic life event had been triggered during late pregnancy with Henry. In the last few weeks before birth, worries about how she would cope and adjust to motherhood had compounded, with Kate recalling, "I started to get really, really anxious about … the big change that [motherhood] was going to be for me".

Recognising her anxiety was returning, Kate distracted herself with preparing the baby's nursery to quiet her worries and emotions. She remembered denying symptoms when completing mental health questionnaires for the midwife, confessing, "I seriously would lie every single time, because I was … not going to acknowledge it". The midwife was concerned for Kate's wellbeing, asking, "are you feeling ok? … You've [scored] ten out of ten for this form. You're perfectly fine, by the looks of it. But I just feel like you're off?".

Kate accepted the opportunity to acknowledge her difficult emotions with the midwife, who then suggested, "Let's fill out that form again, Kate, and let's be honest about it. I'm not gunna judge what you're putting down, and you're certainly not going to get help unless you do speak up about it". Kate agreed, laughing, "so that's when I filled it out, … properly, and … I only scored about a four out of 10!".

From this turning point, Kate then shared her fears, worries and concerns with the midwife, revealing, “I’ve got heaps of anxiety and I’m just stressing out about the baby and I’m not sure how I’m going to be alone with it”. This fear had grown as Kate became increasingly mindful that she was going to be alone with the baby when her husband returned to work following parenting leave. The midwife referred Kate to Nina (participant 4), a mental health occupational therapist, for early intervention support and preventative management of emerging maternal anxiety.

REASONS FOR SEEING AN OCCUPATIONAL THERAPIST

Kate remembered her first occupational therapist appointment was a casual conversation about who she was as person, and how she was going in motherhood. She identified that managing emerging and increasing anxiety was her greatest challenge during motherhood, clarifying that while she “never actually felt depressed …, it’s [a] depressing thought to feel anxious all the time. I hated it”. Kate found unrelenting anxiety draining and created an exhausting cycle of morning dread, remembering, “I would wake up in the morning, and be like, ‘Ohhh. I’m going to have to live my whole day with my anxiety … I don’t even really want to get out of bed’”.

Believing her fear of feeling underprepared and inadequate to face the changes of motherhood alone, Kate clarified, “my kind of anxiety wasn’t based around [Henry] as a baby and being a newborn. It more… [about being alone] when I needed to go places with him and do things for him”. Becoming a mother shifted how Kate prioritised her health and wellbeing, and she reflected that “having Henry really sparked the fact that I needed to get better, and I needed to [get] help”.

OCCUPATIONAL THERAPY APPROACH TO ADDRESS ISSUES

Through working with Nina (participant 4), Kate came to understand her issues during motherhood were related to, but not defined by, anxiety. She explained in the process of "being able to overcome my anxiety and to really understand who I am… made me realise that it wasn't just my anxiety… I really needed to get to understand the whole of me, to be happy and healthy". In early motherhood, Kate learned to implement an occupation-focused approach to perform and complete daily routines whilst mindfully compartmentalising her anxiety enabled her to reclaim a sense of functional wellbeing and accomplishment.

Initial occupational therapy sessions were based on getting to know Kate and then establishing a basic level of functional performance in daily routines. Kate described how Nina (participant 4) helped her to prioritise achievement of core needs in her role, respecting that, "being a new mum, I needed … to just deal with the day-to-day". They collaboratively applied a scaffolding approach with graded tasks, activities, and sequenced routines to facilitate Kate re-establishing daily routines to restore function and return to daily living. This focused on: "Do what you have to do to get through the day. And then the next day. And then the next day. And eventually you'll find you're actually living".

CASE THEMES

THEME 1: LEARNING TO LIVE WITH ANXIETY BESIDE ME

Kate recalled Nina (participant 4) had explained that a base level of function and routine was required before she could be receptive to receiving help and utilising resources to manage anxiety. She recalled the occupational therapist taught her strategies to, "stop talking [and]

thinking about my anxiety all the time. Put it aside and think of how I could live every day". Through this cognitive reframing process facilitated by the occupational therapist, Kate realised how her habits of independent "online research" to understand anxiety was negatively influencing her thoughts, mental health, and sense of identity. She recalled, "the amount that I Googled about my anxiety is ridiculous… It's so bad… There's no strategies on there to really help you. It's just … depressing, actually".

Kate felt Nina's (participant 4) approach as an occupational therapist was different to other mental health services she had previously accessed, explain, "we don't even talk about anything to do with my anxiety. It's just about being a mum, and a parent, and a wife, basically". Instead of focusing on anxiety, Nina (participant 4) worked with Kate to reframe her issues and goals in the context of meaningful occupations, roles, relationships, daily routines, and achieving wellbeing needs. For Kate, conversations with the occupational therapist about anxiety were focused on getting through daily routine activities, building self-identity, developing self-efficacy, establishing sleep routines, accepting breastfeeding issues, and the challenge of learning to confidently perform these occupations 'alone'.

THEME 2: DEVELOPING SELF-CONFIDENCE AND BUILDING ENDURANCE TO WORK THROUGH RELENTLESS BREASTFEEDING CHALLENGES

Kate reflected on her intrinsic motherhood values and ideas, explaining, "I was just a massive believer that I was going to breastfeed". Henry was born with lip and tongue-tie, and Kate's breastmilk took 11 days to come in. She needed to pump, express, and breastfeed multiple times daily for 13-months to maintain supply, remembering, "we had lots of things going on".

Kate was determined to make it work, and expressed, “I’m so glad I had lots of support. … I wouldn’t have been able to breastfeed without that support… it’s just too overwhelming”.

Whilst Kate was grateful for the support she received with breastfeeding, she felt relieved to discuss her breastfeeding challenges with the occupational therapist, reflecting:

> *It was great to break away and see someone who… wasn’t going to tell me how to breastfeed … but was just going to listen to what I’d been through, and listen to what my days had been like, and just to … offer some relevant advice.*

Kate knew she felt confident in her breastfeeding, even though it was difficult and not what she had expected it to be; however, realised she needed someone to share her challenges with. She described the impact of this informal therapeutic style, explaining, “[Nina] would just help you have a conversation, and you’d walk out of there a more confident mum, and more confident about what you’re doing. And … I think that is why I am so confident [now]”. She felt strongly that women “need to be told about an OT … as well [as] a lactation consultant”, clarifying, “the lactation consultant’s going to be a great help with helping you breastfeed. But … [the occupational therapist] actually there for you, and your mental health”.

THEME 3: GETTING ENOUGH SLEEP HELPS ME FEEL BETTER IN MYSELF, AND CONNECTS ME WITH HENRY

In the first year of motherhood, Kate struggled with sleep deprivation, recalling, “I would get three hours of sleep a night if I was lucky. And that was broken”. She and Tom had hired a sleep consultant to help with Henry’s sleep. Kate described how Nina (participant 4) incorporated the sleep consultant’s recommendations with client-centred education about neurodevelopmental theory and attachment theory. This involved learning to build sleep into

rituals and routines providing opportunities to emotionally bond, connect, communicate, and co-regulate. Kate reflected on the impact this had on her mothering and self-regulation, “I am way more patient than I used to be”. She explained the occupational therapist, “taught me so much about being … on [Henry’s] level. I am absolutely obsessed … with his behaviour, and how his brain works, and the best way… to parent him …, emotionally”.

The occupational therapist then supported Kate to implement the consultant’s recommendations and address her own sleep issues and needs. Nina (participant 4) taught Kate that sleep deprivation was impacting on her overall wellbeing and ability to function, and helped her and Tom to, “realise that sleep is really really really important… not just for Henry, but for myself as well”.

THEME 4: LEARNING WHO I AM HELPED ME BE THE PERSON AND MOTHER I WANT TO BE

The occupational therapy process of working to identify issues and learn strategies to deal with them enabled Kate to become the person and mother she wanted to be. Through education and reflective practice, Kate slowly felt more self-aware, self-confident, and competent in motherhood and self-manage issues, commenting, “I know so much about myself now from the techniques that [Nina] has taught me to use with my anxiety, [and] for everyday life. Like being a parent”. These included breastfeeding, sleep, improving partner relationships, establishing healthy daily routines, and learning how to feel safe, capable, and competent in being alone.

Learning about her strengths and weaknesses had a restorative impact on Kate’s occupational performance capacities. She exclaimed, “I literally am back to doing things that I

haven't done for five years. I now leave the house with my son, and go and do … the grocery shopping, [and] jobs up the street". As Kate developed confidence in her identity and capacities, she eventually discovered doing activities with Henry could be enjoyable. She remarked, "I enjoy going out with him. I actually love it … I can't wait to go out with him, every day … I never used to be able to do that".

Kate's development of identity and self-efficacy extended beyond mothering. She reflected that knowing herself as an individual as well as a mother improved her development of a sense of self-efficacy and individualism, "because that's really big… When you're a mum, you feel like you're just that kid's mum". Kate felt that learning to communicate about her anxiety, "helped my marriage … Tom and I would have been fine anyway, but… [we] are better than we've ever been".

THEME 5: FEELING CONFIDENT HELPS ME TO MAKE MOTHERING DECISIONS

As a mother, Kate was newly enjoying feeling "really really confident with how I am with Henry, and how I am as his mother, and … how I parent". She reflected on how developing self-confidence in her own mothering choices made her see how she had grown, feeling now, "I'm really confident to say who I am, and how I am with things". As Kate became mindful of her own mothering style, she developed a greater awareness of diversity and individual approaches to mothering and motherhood. She now feels a sense of respect and acceptance that "everyone is different".

In working with an occupational therapist to learn about and understand herself as an individual person, Kate was able to develop a clearer sense of self and felt stronger in her relationships. She reflected on how "when you work out who you really are" influenced her

perspective and approach to mothering, commenting, “[Nina] made me see what my beliefs were, and she made it all clear to me … how I wanted to raise Henry, and how I wanted to treat him”. She attributed her newfound confidence to the intrinsic values-based work she had done with the occupational therapist.

THEME 6: ONGOING OCCUPATIONAL THERAPY SUPPORT THROUGHOUT MOTHERHOOD JOURNEYS HELPS ME ADJUST THROUGH TRANSITIONS AND PERSONAL DEVELOPMENT

Kate valued having occupational therapy support during, after and in between pregnancies. She came to understand that her fear and anxiety of being alone during motherhood needed long-term support. She valued the occupational therapist’s capacity to provide continual care flexibly throughout motherhood stages and transitions.

With her first pregnancy, Kate remembered it was a supportive time, when “you have … a lot of helpful family [and] friends around”. She reflected how the meaning of occupations, relationships and parenting slow changed during pregnancy. With each change, she addressed, navigated, or avoided, her anxiety was gradually being triggered and slowly compounded. In her second pregnancy, Kate valued that the occupational therapist was able to help her navigate and make sense of the changes. She had learned through experience that, “it’s really important that I established my relationship with [Nina] beforehand… [because]… the last six weeks of your pregnancy [are] when things are getting real”.

Kate reflected that the challenges of being pregnant whilst parenting a toddler, was stressful, “it was really important for me to continue seeing [Nina] for this long”. She explained feelings of anxiety had been recently triggered as fears of being alone whilst pregnant and caring

for a toddler made her second pregnancy, “a lot more challenging because … I felt like I could never leave the house”.

Kate felt strongly that occupational therapists were needed in preventative maternal healthcare teams, proposing, “I would love [OT’s] to be really common – as common as the GP, [and] your midwife”. She saw the occupational therapy role was, “so relevant in every part of motherhood life”, and valued how the occupational therapy approach accommodated, “every mother has issues, their *own* issues. They’re all different”.

CASE 2: ROSALIND – ACCESSED SPECIALIST MATERNAL HEALTH OCCUPATIONAL THERAPIST DURING AND AFTER PREGNANCY, PERINATAL, USA

CASE SUMMARY

Rosalind is a 33-year-old first-time mother to a 10-month-old daughter, *Harriet**, and was preparing for her second pregnancy. She lives with her husband in a major metropolitan city in the USA. Rosalind is a qualified and accredited occupational therapist, who works in an outpatient clinic and assisted living facility. She heard about recruitment for this study through professional networks and made contact independently of her treating occupational therapist. The occupational therapist providing services to Rosalind was not a participant in this multiple case research.

Rosalind accessed a lactation consultant, certified nurse-midwife (CNM), occupational therapists, neuro-developmental therapist (NDT), and craniosacral therapist (CST) for support

with her issues during and after pregnancy. She was referred to an occupational therapist twice during perinatal phases; once during pregnancy, and again three-months following the birth. At the time of this interview, she was still seeing the occupational therapist for support with occupational performance issues relating to motherhood, and for pre-conception support in preparation for her next pregnancy.

REASONS FOR SEEING AN OCCUPATIONAL THERAPIST

During the third trimester of pregnancy, Rosalind experienced significant issues with back pain, lower-extremity weakness, and oedema, and was struggling to get through her daily routine of maintaining her work role as an occupational therapist. She began experiencing physical pain and dysfunction starting in her second trimester of pregnancy, recalling, "I would just wake up and have issues". Her ankle swelling reached "elephantine" levels, which were not resolving with compression stockings during the day and elevating her legs overnight in bed. Rosalind remembered it was "just getting harder and harder", and reached a point where she realised, "this is insane, … how much stuff I am having to do."

Following Harriet's birth, Rosalind experienced significant difficulties with incontinence. Despite regularly performing Kegels[5], she felt constant dragging pressure in her pelvis, needed to wear large incontinence pads constantly, and experienced leakage whenever she held Harriet, bent, or reached. There were no assessments or treatments available to address incontinence

[5] "Kegels" is a term describing exercises to strengthen pelvic floor muscle which support the urethra, bladder, uterus, and rectum. Kegel exercises are often recommended to women in the lead up to birth and "after pregnancy to promote perineal healing, regain bladder control, and strengthen pelvic floor muscles", p. 1, from Hassan, H. (2020). Kegels Exercises: A crucial issue during woman's lifespan. *American Research Journal of Public Health, 3*(1), 1-5. https://doi.org/10.21694/2639-3042.20001

through the Certified Nurse Midwife (CNM) program, and at three-months postpartum Rosalind asked the CNM to refer her to the same occupational therapy clinic to address these issues.

Breastfeeding had been consistently difficult and "very painful" for Rosalind, explaining, "I had … odd issues". She had seen "many lactation consultants". She suspected her breasts was not completely emptying and had "still really heavy feeling" when she finished each breastfeed. As Harriet was feeding more regularly and for longer periods, Rosalind recalled it started feeling, "like it was twisted inside my breast a little bit", adding, "it's so hard to describe these internal things … It just didn't feel right". At four-months postpartum, Rosalind independently sought assistance from the occupational therapist.

Rosalind emotionally and mentally struggled during mid to late pregnancy due to her degree of physical dysfunction, and remembered feeling, "anxious about having to quit work". Being able to work was imperative for her self-efficacy, and Rosalind started "feeling a little bit like I was a bit of a failure". She became increasingly fearful that her disruptive pregnancy issues were jeopardising her career prospects as an occupational therapist, realising, "that's so much of [my] identity… I struggled … feeling like 'Well if I don't work, then what do I do? … Who am I? … What am I good for?'."

OCCUPATIONAL THERAPY APPROACH TO ADDRESS ISSUES

Rosalind's perspective on how the occupational therapists helped her to work through her issues reflect her sound knowledge of core occupational therapy approaches and practices. She regarded the interventions from an extended scope perspective. Rosalind described in detail how the new practices she learned during occupational therapy sessions enhanced her capacity in her

usual role. Themed descriptions about how these influenced Rosalind's functional capacity are reported first, followed by her professional practice reflections.

CASE THEMES

THEME 1: OCCUPATIONAL THERAPIST'S UNIQUE APPLICATION OF BIOMECHANICAL, MENTAL HEALTH AND DISABILITY MODELS ADDRESSES WOMEN'S ISSUES AND NEEDS DURING MOTHERHOOD

Rosalind's lower back pain, incontinence, and lower limb oedema and dysfunction were treated by the occupational therapist using conservative techniques throughout perinatal stages. Treatments included "very light touch techniques …, Bowen work…, ligament stimulation methods… [and] cardio, [which] was the most helpful". These targeted her sacroiliac joint issues during pregnancy, and broader pelvic function and physiological systems during postpartum recovery. As an occupational therapist, many of these treatments were new to Rosalind. She found the treatment, "was very interesting", and "extraordinarily helpful for me".

The occupational therapist's client-centred approach to working with Rosalind involved, "using huge amounts of therapeutic use of self and … cognitive behaviour techniques … to help people effect change in their lives". Feeling overwhelmed with her complex issues and significant level of physical dysfunction, Rosalind valued the occupational therapist's working knowledge of mental health, chronic conditions, and disabilities models to interpret and contextualise her "anxiety and depression". The occupational therapist taught Rosalind compensatory methods to integrate restorative movements mindfully into her usual motherhood daily routines. Over time, she was able to, "improve my ability to squat and do some of these exercises and incorporate them with lifting up my daughter".

THEME 2: THE OCCUPATIONAL THERAPIST USED MOBILITY AND MOVEMENT TO TREAT MY LEG PAIN AND OEDEMA

To manage Rosalind's oedema and physical dysfunction during pregnancy, the occupational therapist predominately applied a combination of manual therapy with client-centred education. Rosalind described that "the Bowen work" included a range of "circulation moves for the lower legs". She recalled how the occupational therapist modified manual therapy techniques in "side-lying …, standing and sitting" positions, to be safe for pregnancy. Rosalind found these treatments provided her with "immediate relief" from the pain, discomfort, and dysfunction, and "was really helpful".

The occupational therapist's recommended strategies included pacing and increasing activity during daily routines to get, "more movement in my legs, so I wasn't just sitting". These started by incorporating a seated, floor-based movements and pelvic shifting into Rosalind's daily routine activities, within a graded sit-to-stand program. Rosalind continued seeing the occupational therapist fortnightly throughout her pregnancy and experienced few symptoms with regular sacroiliac joint management.

THEME 3: WORKING DURING PREGNANCY WAS IMPERATIVE FOR MY MENTAL WELLBEING, IDENTITY AND SELF-EFFICACY

Rosalind described how the occupational therapist applied biomechanics, ergonomics, and strength analysis to design a safe, achievable, and sustainable graded return-to-work plan. Recommendations included mindfulness strategies to enhance mind-body connection and quality of movement to gradually relieve pain and enhance core strengthening, pelvic stability, and

circulation in her lower limbs during daily routine activities. She felt this “blend of things to work on … was very, very helpful. It kept me working”.

Rosalind explained that being able to maintain employment during pregnancy empowered her with “that sense of efficacy, and… be[ing] able to contribute to my family, [and] our future”, and enabled her to feel “really successful”. She recalled being “very pleased, because I was able to keep working, and just kept modifying things … at work to help my clients reach their goals”. She was ultimately able to continue working eight to ten hour days up to and past her due date, feeling, “like I really had a handle on what was happening with my body”:

Being able to work, and “feeling like I could actually do a good or a great job”, was critical for Rosalind’s sense of positive identity, wellbeing, and self-efficacy. This was important for her quality of life: “It was really affirming to have my body feel okay, to find ways to deal with work, and to be able to enjoy work and really have a great time”. Achieving this goal alleviated much of Rosalind’s anxiety, explaining, she needed to know “that I had it within me to still do that”.

THEME 4: THE OCCUPATIONAL THERAPIST’S RESTORATIVE FUNCTIONAL APPROACH RESOLVED MY POSTPARTUM INCONTINENCE

To identify the cause of Rosalind’s postnatal incontinence, the occupational therapist initially focused on abdominal separation and pelvic function. Rosalind relayed how the assessment involved “myofascial ligament testing … of these fascial lines and how the muscles are interacting with each other, based on fascial pull”, using specialised tools to determine the degree of muscle separation. Rosalind measured “on the edge” of diastasis recti, noting, “there is a lot of debate … over how bad it needs to be before it’s a clinical problem”.

The occupational therapy interventions to treat incontinence were focused on restoring Rosalind's postural alignment, internal organ positioning and physiological function. Rosalind understood the rationale for this approach was based on promoting functional systems recovery after internal organs, "have been pushed down during the birthing process, and … all around during the pregnancy". She likened the occupational therapist's method to adjust internal organ positioning to acupuncture, applying, "eight to ten-inch-long tuning forks … on these places that have … fascial lines going through them …, using the soundwaves to … help them align". Rosalind enjoyed being educated by the occupational therapist during this process, as she learned about how the "lateral stabilisers [influenced] collagen" levels, and balancing "strength, versus elasticity and how those things are aligned", to regain function.

Rosalind was amazed at how rapidly her continence improved from the first treatment. She remembered, "there was a major difference for a couple of weeks that I had absolutely no leakage… I didn't have to wear pads; I could wear just like a panty liner". After another two treatments, Rosalind's urinary incontinence was resolved. She was relieved that, although "sometimes … I felt like there was too much pressure down there, … I haven't had any leakage since".

THEME 5: OCCUPATIONAL THERAPIST'S APPROACH TO BREASTFEEDING FROM A HOLISTIC FUNCTIONAL PERSPECTIVE

After seeing multiple lactation consultants with minimal benefits, having the occupational therapist's support with breastfeeding was a relief for Rosalind. She valued that the occupational therapist validated that her issues were real and treatable, expressing, "I really appreciate … when you tell them something just doesn't feel quite right, that they take it so

seriously". She was comforted that the occupational therapist approached her issues from a fresh angle and were prepared to try and range of different interventions until the issues were resolved.

The occupational therapist determined Rosalind's issues stemmed from biomechanical and physiological system components of breastfeeding and were treatable using modified Bowen therapy. Rosalind described the occupational therapist's "holistic, whole body-mind [approach]", treatment in detail, explaining that they applied soft-tissue manual therapy near the nipples to release the fascia attached to the mammary glands and pectoral muscles. This improved Rosalind's breastmilk flow and emptying capacity, which, "in that moment, [provided] this wave of relief… [that] was extraordinarily helpful for me". The occupational therapist then trained Rosalind in manual therapy techniques and adaptive breastfeeding modifications so that she could continue to self-manage her issues at home. After several self-treatments, her breastfeeding issues were resolved.

REFLECTIONS FROM AN OCCUPATIONAL THERAPIST DURING FIRST-TIME MOTHERHOOD:

As a recently graduated occupational therapist, Rosalind was well educated and familiar with transitions from a discipline-specific perspective. When asked her opinion about when and how occupational therapists could best support women during the transition to motherhood, she queried the question's meaning, commenting, "there are so many transitions… There's more to it than typically gets addressed".

Rosalind felt becoming a mother started with, "a transition to being pregnant, and then there's … so many transitions within pregnancy". She identified that pregnancy transitions were marked by changes, "in terms of how it feels, and how it looks, and how people treat you",

particularly during the third trimester. Rosalind saw, “the birth transition, and the transition to parenthood with your significant other” was challenging, and also, “that transition back to work” was notable. Throughout “all the transitions after birth”, Rosalind felt perturbed that, “no one talks about it, in terms of the mother”. She regarded this phase of motherhood was underacknowledged and overlooked, commenting, “everybody is all about getting the baby born… But I feel like after [birth] is actually a lot harder”. She listed the challenges she faced when transitioning to “a new normal” as a new mother, including trying to sleep, regaining continence control, and “financial transitions”.

Rosalind explained that new mothers in the USA were typically entitled to unpaid maternity leave for six-weeks after birth. Many felt financial pressure to maintain their income, which meant that financial transitions were “a major thing” for women who were “trying to *not*… go back to work right away”. She expressed concern about how mothers in less privileged positions dealt with the income loss, stress, and financial pressures of motherhood.

Rosalind felt the unique focus of occupational therapy on mental health, compensatory techniques, remediation, and “mindfulness, [and] breathing techniques”, optimised their ability to address women’s issues throughout pregnancy, labour, and childbirth. Reflecting on her observations and experiences with friends, other mothers, peers and clients, Rosalind felt occupational therapists added value to maternal healthcare by knowing:

> *How to gauge when something is a … functional problem versus an annoyance. Because I think a lot of women don’t know when it’s one versus the other … And when they do find it’s a functional problem, I think a lot of women can give up.*

CHAPTER SUMMARY

This final chapter marks the conclusion of the findings section of this thesis. The key themes from these two service user case summaries echoed the themes of the occupational therapists' cross-case analysis. By the occupational therapist applying person-centered practice, listening to the woman's issues and needs, and applying a broad practice skillset to work towards woman-led goals, the service users felt heard, validated, enabled, and empowered as individuals, mothers, workers, and partners. They bring to life the lived experience of having issues during perinatal periods that were addressed by occupational therapists. In this way, the key themes from these case summaries validated a substantial quantity of cross-case analysis findings and were predominancy focused on developing self-efficacy during motherhood, meaningfully engaging in co-occupations, and re-prioritising their own needs after the birth of their baby. For Kate, this was anchored by her need for personal identity development. For Rosalind, it was about using restorative movement and learning to listen to her body, reclaiming an empowered sense of self-efficacy and identity, and reflectively adapting her own approach to enhance her occupational therapy practice skills. The following chapter ten is the discussion chapter, where the role of occupational therapists in perinatal health will be explored in the context of evidence, literature, and practice.

CHAPTER 10: THE ROLE AND PRACTICE SCOPE OF OCCUPATIONAL THERAPY IN PERINATAL HEALTH

"The differences that separate human beings are nothing compared to the similarities that bond us together."

– Sophie Gregoire Trudeau

INTRODUCTION

In this chapter, I explore and clarify the approaches and practice scope for occupational therapy roles during the perinatal transitions of motherhood. Women's health and wellbeing needs during perinatal phases of motherhood are multifaceted and complex. How these needs are interpreted, reframed, prioritised, and addressed by occupational therapists are considered.

BROAD SCOPE OF OCCUPATIONAL THERAPY PRACTICE: THE PERINATAL PERIOD IS COMPLEX

The perinatal period is a complex time of change and transformation for women in contemporary society. This study has demonstrated that emerging occupational therapy roles supporting women during perinatal stages are diverse and evolving. Working flexibly with women, mother-infant dyads, families, and communities, the occupational therapists interviewed in this study focused on occupation, development, enablement, and empowerment, which often included acting and advocating for social justice. Their client-centred professional practice response was consistent with growing calls from women for more individualised services, care-

continuity, and educated choice as maternity health service users (Barnett, 2020; Jenkins et al., 2015).

Contemporary occupational therapy practice is described by Pentland et al. (2018, p. 42) as “a complex dynamic process reflect[ing] the wide array of techniques, skills and activities”, used to flexibly tailor interventions and achieve person-centred outcomes. In complex areas of practice, such as perinatal health, occupation becomes the means of change and development through doing, being, becoming and belonging, appreciating the interconnection between people and contexts (Pentland et al., 2018). The approaches of all multiple case study participants in this study aligned with Pentland et al.’s (2018) definition of complex interventions in contemporary practice, indicating that contemporary occupational therapy in perinatal health is a complex and dynamic practice area. The broad spectrum of assessment and intervention practices described by participants were consistent with general, extended and advanced practice scopes for applying occupational therapy professional skills (Broome & Kennedy-Behr, 2017; Occupational Therapy Australia, 2017).

Exploring complexity in occupational therapy requires an understanding of the relationship between occupation with health and wellbeing (Pentland et al., 2018). Having a “healthy occupational life” is a common goal of complex occupational therapy interventions (Pentland et al., 2018, p. 4). In this study, the occupational therapists described perinatal outcomes related to lifestyle balance, strengthened relationships, empowerment, and wellbeing. The breadth, complexity, and dynamic nature of their tailored client-centred approaches in perinatal health focused on enabling and empowering women through using occupation.

OCCUPATIONAL THERAPY PRACTICE APPROACHES

The occupational therapists in this study saw women and mothers as clients, interpreting their needs during perinatal transitions from a human occupation perspective. They stated that women's issues, needs, and goals for occupational therapy were not always defined by maternal status, perinatal stages, or motherhood. Their client-centred practice with maternal populations was unique and reflected "the ultimate outcome [and] common goal of occupational therapy to facilitate participation in the occupations of everyday life" (Occupational Therapy Australia, 2017, p. 5). While beyond the focus of this thesis, exploring why some therapists were practicing in roles such as doulas and Reiki practitioners may warrant future research to reflect the continuing evolution of occupational therapy practice in perinatal health.

INTRODUCING OCCUPATIONAL THERAPY PRACTICE TO MATERNITY HEALTHCARE

The occupational therapists used client-led goal-setting as a collaborative method of establishing measurable and meaningful outcomes for therapy, and a primary driver guiding their occupational therapy approaches (Hitch & Pepin, 2021). The combined use of client-led goal setting and occupation-centred practices are unique to occupational therapy (Ford et al., 2021; Graham, 2021) and unfamiliar to most maternity care models.

Whilst some women adapt to maternal role transitions feeling supported and confident, the occupational therapists in this study described the need to address the complex implications for those who did not. The occupational therapists understood that the difficulties women experience during maternal role development are often linked to maternal stress and maternal distress in the postpartum period (Emmanuel et al., 2011). Preventing the impact of maternal burnout, impaired self-esteem, and partner relationship strain due to occupational imbalance and

overloading during early parenthood was a priority and evidence-based therapeutic goal for many occupational therapists (Finlayson et al., 2020; Mikolajczak et al., 2018a; Sethi, 2019).

Occupational enablement, empowerment, and promoting women's maternal development as human occupational beings were common goals of the occupational therapists in this study. They used occupational analysis to contextualise issues within the complex and transformative life event of motherhood and aligned recommendations to address women's occupational engagement and deprivation risks (Burbidge, 2015b; Francis-Connolly, 2004). This included factoring in the influence of societal norms, lifestyle redesign issues, family-centred care, taboos, activism, constructs of perfect mothering, and the changeability of occupational performance dynamics throughout the life course (Francis-Connolly, 2004).

ALL WOMEN 'STRUGGLE' WITH 'NORMAL' OCCUPATIONAL ISSUES DURING MOTHERHOOD

The occupational therapists in this study regarded struggling with occupational issues during perinatal phases as normal and argued that women needed support when those issues restricted, prohibited, or posed risk to their wellbeing and/or usual ability to function and perform daily routine activities. This client-centred practice approach is consistent with health promotion, restorative, and rehabilitative occupational therapy conceptual practice frameworks (Barcelos Pontes & Polatajko, 2016; Fernandes, 2018; Hinojosa et al., 2020a).

Conceptualising how the '*normal'* issues women '*struggled'* with during and after pregnancy impacted their functional capacities, health, and wellbeing was a fundamental role for occupational therapists. The case study participants insisted that pre-existing conditions or disabilities had minimal influence on the services they provided to women during perinatal

periods. This position was strongly endorsed by the two women interviewed who accessed occupational therapists. This aligns with studies exploring disability and mothering occupations (Farber, 2000), the WHO's holistic health domains (Bickenbach, 2015), and the social model of disability in contemporary occupational therapy practice (Harrison et al., 2021; Holler et al., 2021).

PSYCHOSOCIAL PRACTICE APPROACHES

Many occupational therapists regarded that they offered psychosocial services to women during perinatal stages. There is no singular definition of '*psychosocial'* in occupational therapy (Ramsey, 2004). In behavioural medicine, the term describes "the influences of social factors on an individual's mental health and behaviour" (Vizzotto et al., 2013, p. 1578). Psychosocial aspects of occupation influence an individual's occupational behaviours and personal development (Ramsey, 2004), and can be considered in the context of social environments and emotional wellbeing (Berglund & Peterman, 2021). The psychosocial factors influencing women's occupational health and wellbeing in the case study aligned with developmental, behavioural, rehabilitative, restorative, and trauma-informed approaches across the lifespan (American Occupational Therapy Association, 2020; Lederman & Weis, 2020a; Sundaram & Kumar, 2018; Upton, 2013)

Application of psychosocial practice approach in the multiple case study saw occupational therapists working flexibly with mothers, mother-infant dyads, and including partners in mother-infant-family triads. This aligns with research exploring the contemporary role of occupational therapy in perinatal health (Berglund & Peterman, 2021; da Conceição et al., 2020; Grabarkewitz & Swanson, 2020; Vidmar, 2020a), and recommendations for safe and

respectful maternity care approaches (Stevens & Alonso, 2021). Occupational therapists determined the need to work with the woman as an individual or relationally on a case-by-case basis, consistent with both client-centred and collaborative relationship-focused occupational therapy practice approaches (Restall & Egan, 2021).

PRACTITIONER ROLE SCOPE: ADDRESSING WOMEN'S OCCUPATIONAL PERFORMANCE ISSUES, WELLBEING AND DEVELOPMENTAL NEEDS

Occupational therapists provided tailored client-centred practice to meet women's needs during their developmental transitions to and through motherhood. Consistent with occupation-centred practice (Barcelos Pontes & Polatajko, 2016; Ford et al., 2021), the roles for occupational therapists working with perinatal health clients were based on a two-tiered practice approach:

1) Addressing occupational and co-occupational performance issues to restore, improve or regain function; and,
2) Using occupation and co-occupation to promote wellbeing, adaption and development through perinatal transitions and motherhood as a transformative life event.

Role scope boundaries for their roles reflected individual practitioner skillset, practice context and employer expectations, all of which considered but were not determined or restricted by the woman's maternal, disability, health and/or medical status. Occupational therapists applied generalist approaches to work with maternal health clients, exploring issues, goals and evaluating outcomes for women and their new infants, many of which aligned with occupational therapist's full scope of practice skills (Department of Health & Human Services, 2016; Occupational Therapy Australia, 2017; Young et al., 2020). Their scope of practice expanded as

occupational therapists tailored conceptual approaches and interventions to analyse and address woman-led and client-centred issues, needs and goals uniquely contextualised by maternity care and motherhood.

OCCUPATIONAL WELLBEING DURING ACTIVITY RESTRICTION AND HOSPITALISED BEDREST

The impact on pregnant women's mental and physical wellbeing during prolonged bedrest has been documented for over two decades (da Conceição et al., 2020; Heaman & Gupton, 1998; Michelitch, 2009; Yeager, 2019). Prolonged bedrest is a common treatment strategy for managing high-risk pregnancies, with an estimated one million women in the USA annually prescribed hospitalised bedrest (Yeager, 2019). A small number of hospitals employ occupational therapists to support women to manage the detrimental side-effects of activity restriction through prolonged hospital-based bedrest (da Conceição et al., 2020; Sechrist et al., 2015; Yeager, 2019). In this study, occupational therapists' analysis of the impact of activity restriction on women's wellbeing aligned with research by Michelitch (2009) in that, "the experience of activity-restricted pregnancy is complex and permeates all occupational domains… [and] has a negative impact on occupational health and involvement" (p. 63).

Therapeutic outcomes in the case study were woman-led and client-centred, typically focused on reducing the impact of occupational disruption and deprivation on women's health, identity, and self-efficacy. Occupational therapists worked with women to regain a sense of control, self-efficacy, and occupational balance. The use of tailored 'beditation', mindfulness, relaxation, systems regulation, psychoeducation and sensory modulation interventions provided by occupational therapists to support women's capacity to physically and emotionally adjust and

cope with occupational disruption and deprivation was in keeping with recent literature (Yeager, 2019). Being well versed in supporting sleep hygiene, routines, and fatigue management (Brayman et al., 2014; Roberts et al., 2014; Watkins, 2019), occupational therapists across the case studies supported women on prolonged bedrest with designing, implementing, and managing meaningful routines and rituals on the ward.

Aligning with research outcomes reported by Michelitch (2009), occupational therapists identified that promoting women's sense of self, regaining a sense of control, and empowerment during prolonged bedrest were critical wellbeing components. Interventions mitigated the risk of occupational deprivation, role loss and isolation by enabling role performance, adapting self-regulation techniques, and promoting community connectedness and sense of identity. Tailoring interventions to be client-centred and women-led was asserted by practitioners as essential, focusing on women's individual issues relating to self-efficacy, sensory modulation and physiological systems regulation, psychosocial wellbeing and promoting healthy partner and family roles and relationships. Occupational therapists achieved this through adapting ward environments, using technology to establish virtual connections, and structuring routines to balance occupational engagement opportunities.

PREPARING FOR LABOUR AND BIRTH

Occupational therapists in the study supported women to prepare their minds, bodies, and environments for the experiences of labour and childbirth. This was especially important for women on prolonged bedrest struggling with impaired maternal self-efficacy, and women with a history of birth trauma or disempowerment who needed additional support to feel confident, informed, and well prepared for subsequent births. They supported women with setting up

ergonomic, safe, and empowering labour and birthing environments, addressing women's sensory, physical, emotional, psychosocial, and self-regulation needs. In the lead up to labour, occupational therapists provided client-centered education and tailored interventions to help women physically, emotionally, spiritually, and personally feel conditioned and prepared for birthing. Labour and birthing environments were regarded as complex, impactful, and meaningful, and occupational therapists considered the functional, physical, sensory, emotional, and psychosocial aspects of these for women.

While seemingly outside maternity healthcare scope, these approaches align with occupational therapy frameworks including biomechanics, ergonomics, sensory modulation and adaptive techniques (Kielhofner, 2009), and the role example of occupational therapists in 'maternal care pathway' intrapartum phase "ensuring equipment is in place for a safe and dignified delivery" (Payne, 2019, p. 2). The occupational therapists' practices align with research by da Conceição et al. (2020), highlighting how occupational therapists have the technical skills "to evaluate and intervene on the functions and structures of the body related to the reproductive and movement system" (p. 121), which enhance meaningful and satisfying labour and delivery experiences for women:

> *Satisfactory performance of women during delivery… involves the execution of mental functions (affective, cognitive, perceptual), sensory (visual, auditory, tactile, proprioceptive, vestibular, pain, sensitivity temperature and pressure) and neuromusculoskeletal (joint and bone, muscular and movement) ... The occupational therapist … promote[s] quality at birth, expanding the meaning of the moment for women and their families* (da Conceição et al., 2020, p. 121).

The need for women to feel sensitively respected and emotionally supported by a companion of their choice during labour and childbirth has been recognised as a standard for maternal wellbeing by the World Health Organization (2016b). While occupational therapists offered preparatory support, attending childbirth was considered outside their scope of practice.

Recovery from birth injuries

During labour and birth, preventing maternal and infant death is a significant priority for health services (Australian Institute of Health and Welfare, 2017; Klima, 2001). The risk and impact of neonatal childbirth injuries such as clavicular fracture, cerebral palsy and brachial plexus injuries have been extensively researched, with health professionals able to access evidence-based clinical management pathways (Rendle-Short et al., 2013; Rodríguez-Sáez et al., 2017). Beyond mortality, the maternal wellbeing priorities for health services during labour and childbirth are less known. Assuming occupational therapists have roles outside mother-infant mortality rates, clarifying health and wellbeing priorities are critical for conceptualising where the role for occupational therapists in maternity care fit.

Women's healthcare experiences during the postnatal period can include recovery from a broad spectrum of birth issues and physiological and neurological birth injuries, such as episiotomy, vaginal tearing, pelvic-organ prolapse, pelvic disorders, musculoskeletal pain, nerve damage, and intrinsic obstetric palsy (Borg-Stein et al., 2006; Brouard, 2011; Dalal et al., 2014; Hakeem & Neppe, 2016). Several Australian occupational therapists in this study supported women following caesarean deliveries. This is consistent with research by da Conceição et al. (2020), who writes about tailoring client-centred interventions to enhance women's functional capacities for ADLs and IADLs, such as dressing, bathing, toileting, bed mobility and infant

caring. Occupational therapists' intervention strategies included client-centred education, provision and fitting of adaptive aids and equipment, energy conservation techniques, functional ergonomic recommendations complying with post-surgical movement restrictions, pain management, lifting and driving restrictions, and successfully returning home.

THE OCCUPATIONAL IMPLICATIONS OF PELVIC DYSFUNCTION

Trauma to the pelvic floor is common after pregnancy and childbirth, which can be addressed by occupational therapists through preventative, recovery, and rehabilitation perspectives (Baker et al., 2017; Burkhart et al., 2021; Grabarkewitz & Swanson, 2020; Woodley et al., 2020). While occupational therapists are not routinely educated in women's pelvic or obstetric health, physiology or function in tertiary curricula, several participants had upskilled with qualifications to address the occupational implications of pelvic trauma. A range of occupation-centred biomechanical, adaptive, and neurocognitive retraining techniques were applied to address a range of issues women experienced following traumatic pelvic floor injury.

Pelvic health and function were a contentious area of occupational therapy practice. Professional debate around pelvic health and function appeared to reflect practice focusing on 'dysfunction' rather than 'occupation', resulting in several participant's suggesting that pelvic health was best suited to physiotherapy. Recent research exploring the relationship between pelvic floor dysfunction and functional pelvic mobility with occupations aims to clarify practice relevance for occupational therapy (Burkhart et al., 2021; da Conceição et al., 2020; Elkins-Bushnell & Boyle, 2019; Vidmar, 2020a; Walker et al., 2020).

There are a growing number of occupational therapists specialising in perinatal pelvic health and function in several countries, including Australia, Canada, and the USA (Baker et al.,

2017; Gullan et al., 2018; Hines, 2018; Lyon, 2017). Little is known about the practice or evidence-base, and there is a lack of clarity as to how this field fits within occupational therapy scope of practice. According to Neumann et al. (2009), “all occupational therapy practitioners have the education and clinical skills to provide basic intervention for incontinence” (p. 10), which is a common symptom of pelvic dysfunction. Within their general practice scope, occupational therapists felt confident exploring strategies with women to adjust routines, postural positioning, use adaptive aids and equipment, and access the community to conservatively manage urinary incontinence. Beyond this, the role of occupational therapy in addressing pelvic health issues became a specialised area of advanced practice scope.

In the case study, several occupational therapists worked with women experiencing pelvic organ prolapse following childbirth in the immediate postpartum period. The role of occupational therapists in preparing for birth to reduce the risk of pelvic organ prolapse and pelvic injury is regarded as health promotion, prehabilitation, and key prevention approaches (Baker et al., 2017; Burkhart et al., 2021; Olsén & Anzén, 2012; Woodley et al., 2020). Interventions to adapt occupational performance to comply with lifting restrictions post-injury are consistent with professional practice scope and rehabilitative roles for occupational therapists (Burkhart et al., 2021; Occupational Therapy Australia, 2017; Payne, 2019). The occupational therapists interviewed provided a range of physical, sensory, neurological, functional, and occupational adaptive techniques through perinatal stages, helping women physically, spiritually, and emotionally prepare for childbirth and recover their pelvic function in the postpartum period.

SELF-CONCEPT, BODY IMAGE AND SEXUALITY

The occupational therapists worked with women to address the impact of body image and sexuality issues connected with women's experiences of gestational change, perinatal stages, and significant events. Helping women to work through their relationships with their body during and after birth involved holistically addressing the occupational implications of how pelvic dysfunction, birth injuries, and other physical changes caused emotional or psychosocial distress. Body image issues and pelvic dysfunction impacted women's self-perception, and self-respect, which had implications for their motivations to re-engage in intimate partner relationships and affected their sexual identity and self-concept (American Occupational Therapy Association, 2020).

Occupational therapists have a role in addressing women's altered body image, sexuality and self-concept following perinatal dysfunction or disability (Briltz, 2019; Shearsmith-Farthing, 2001; Vidmar, 2020a; Walker et al., 2020), and supporting women to work through difficult or traumatic experiences of gendered, sexualised and objectified maternal development (Ferigato et al., 2018). Difficulty engaging or participating in meaningful intimate occupations, relationships and sexuality impacted women's wellbeing during perinatal transitions (Walker et al., 2020). The therapeutic process of assessing, validating, and addressing the occupational implications of birth injuries and scars, changing function of sexual and reproductive organs, sexual identity, self-perception, mental wellbeing, and body image was revealed to be a complex and sensitive areas of occupational therapy practice.

The role of occupational therapy in the disability sector to support women with sexuality, sexual activities, expression, function and options are outlined in several textbooks (Adler, 2013; Tipton-Burton et al., 2018), and clarified by the American Occupation Therapy Association as

within scope of practice (MacRae, 2013). Associated approaches to address intimate occupational performance issues predominantly consider sexual positioning and dysfunction for women with injuries and disability are “couched in terms of dysfunction and pathology” (Ralph et al., 2017, p. e310), consistent with the medical model of disability.

Occupational therapists in this study approached intimate occupations from a more holistic occupation-centred approach. Women’s intimate relationships, sexual identity, and sexuality changed during maternal development as they navigated a spectrum of personal changes, processed childbirth experiences, recovered from birth, and came to see themselves as new mothers. This aligns with the WHO’s recommendation that women’s sexuality and reproductive rights should be addressed when providing quality intrapartum care (World Health Organization, 2018), and that sexuality during perinatal stages is an area of unmet need which requires improved understanding and support (Ferigato et al., 2018; Rose & Hughes, 2018; Tully et al., 2017; Verbiest et al., 2018; Vidmar, 2020a).

Occupational therapists addressed the physical, spiritual, psychosocial, mental, emotional, and personal domains of women’s intimate occupations, sexuality, and body-image, noting issues commonly reflected occupational deprivation and disruption during perinatal stages. These practices were in keeping with growing awareness of how sexuality and sexual occupations can be addressed in contemporary occupational therapy practice (Ferigato et al., 2018; Rose & Hughes, 2018; Walker et al., 2020; Young et al., 2020). Opportunities and adaptive strategies to re-engage in and strengthen intimate partner relationships focused on enhancing communication, connectedness, and mindful engagement in mutually meaningful adult co-occupations, which were not dependent on sexual activity.

Participating in intimate occupations was a meaningful interpersonal need often prioritised by occupational therapists supporting women on prolonged hospitalised bedrest, in preventative mental health roles, and working with women struggling to feel intimately connected to their partner. These approaches are consistent with recent literature which highlight how self-perceptions of sexuality and sexual wellbeing influence women's identity, self-concept, and relationships during perinatal stages, and are a fundamental human occupation and wellbeing need (Athan, 2020; Ferigato et al., 2018; Rose & Hughes, 2018; Verbiest et al., 2017; Walker et al., 2020; World Health Organization, 2020).

WORKING THROUGH TRAUMATIC AND RE-TRAUMATISING PERINATAL EXPERIENCES

Working through traumatic and re-traumatising perinatal experiences was a significant, common, and complex issue addressed by occupational therapists in this study. The negative impact of traumatic experiences on people's coping capacities and daily occupational performance and life participation can be supported by occupational therapists (Edgelow & Cramm, 2020). Many of the occupational therapists interviewed were passionate about women's rights, dignity, and empowerment being compromised through traumatic perinatal experiences, and tailored occupation-centred interventions guided by woman-led practice and desire for healing, social justice, and re-empowerment.

Perinatal trauma was regarded by participants as deeply personal and subjective in nature and could be caused and/or triggered by perinatal and maternity care experiences. Occupational therapists in the case study approached perinatal trauma from an intergenerational, neurodevelopmental, biomechanical, social justice, and psychocognitive perspective, recognising trauma as a complex issue that impacts women's self-regulation, coping capacities, resilience,

capacity for trust and occupational wellbeing. When not addressed soon after the traumatising or triggering event, women experienced physical, emotional, psychological, behavioural and neurocognitive issues, which could become highly complex and have significant and chronic impact on their occupational wellbeing (Vidmar, 2020a). Prioritising sensitively timed and occupation-centred practice for interventions informed by trauma research aligns with the Occupational Therapy Trauma Intervention Framework (OTTIF) for best practice (Edgelow & Cramm, 2020). Providing preventative approaches and early intervention services were prioritised by all participants.

The range of trauma-related symptoms and occupational performance issues addressed varied in the multiple case study. Occupational therapists applied rehabilitative and trauma-informed practice approaches to support clients recover from traumatic injuries, usually contextualised by a doing, being, becoming and belonging perspective (Hitch & Pepin, 2021). Coming to terms with traumatic childbirth and newborn experiences were commonly addressed by occupational therapists and are a new area for professional practice emerging in the literature (Baker et al., 2017; Briltz, 2019; Graham, 2021). Occupational therapists worked to acknowledge and validate women's experiences, addressing intergenerational trauma, experiences of discrimination, disrespect and culturally inappropriate care using strategies similar to decolonising Westernised care practices for Indigenous clients (White & Beagan, 2020).

Occupational therapists' intervention approaches to working through the occupational implications of perinatal-PTSD aligned with the OTTIF, addressing painful intercourse, body image embarrassment and shame, and reluctance to actively resume intimate partner relationships following birth (Edgelow & Cramm, 2020; Grabarkewitz & Swanson, 2020;

Torchalla et al., 2019). Intervention strategies to reduce pain, improve comfort and work through emotional distress and trauma associated with pelvic dysfunction and birth scars were consistent with research findings reporting that childbirth injury "symptoms limit parous women's occupational performance, specifically sexual activity and exercise" (Burkhart et al., 2021, p. 108). This included addressing the impact of lumbar-pelvic and pelvic girdle pain during pregnancy and resuming activities following birth (Elkins-Bushnell & Boyle, 2019) and working through women's fear of childbirth during subsequent pregnancies (Jha et al., 2019).

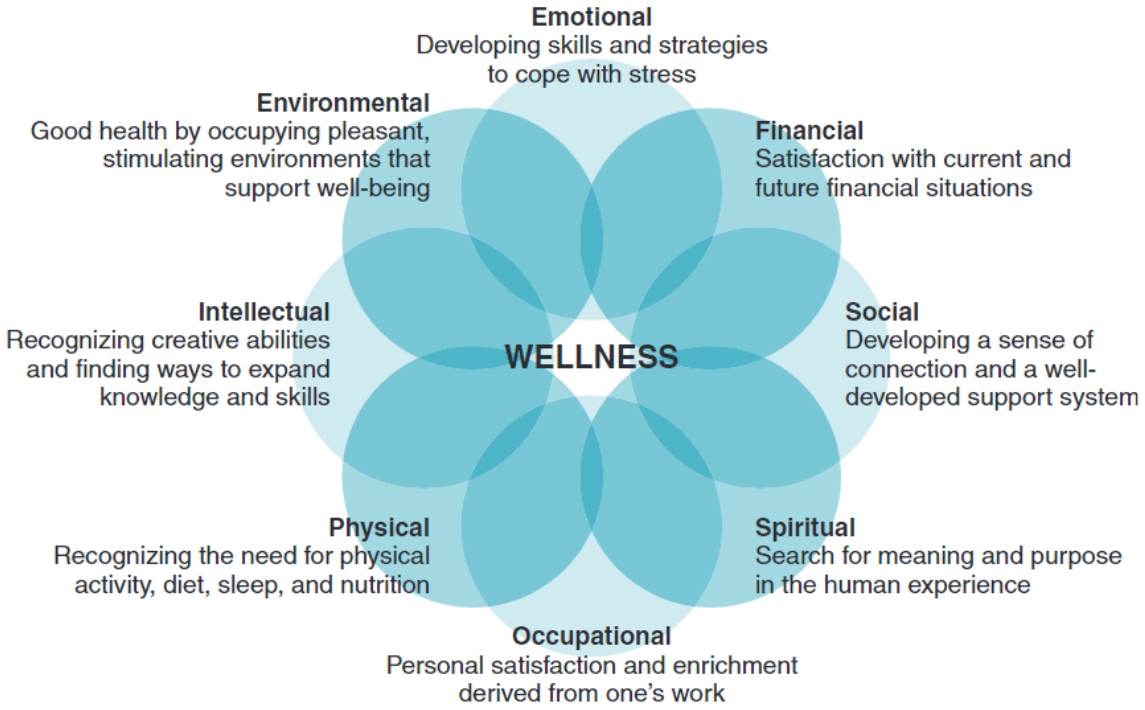
PROMOTING WOMEN'S MENTAL HEALTH AND WELLBEING

All occupational therapists had a role in screening and/or addressing women's mental health and wellbeing needs during perinatal periods. While there are no perinatal mental illnesses or disorders specified in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V), onset of depressive symptoms during perinatal stages are commonly conceptualised as 'perinatal-' or 'postpartum-depression' (Barbic et al., 2021; Stuart-Parrigon & Stuart, 2014). The woman-led and occupation-centred approach to understanding women's perinatal depression described by participants in this study aligned with practice recommendations that "ideas and concepts need to be developed in context and in collaboration with the women themselves" (Worrall, 2018, p. 2). Occupational therapists believed that compromises to women's mental wellbeing during perinatal periods can occur in response to experiences of social injustice, disempowerment and socioculturally gendered occupational performance pressures. This echoes Worrall's (2018) report that women's suffering can reflect macro-level problems relating to power, control, racism, colonisation and sexism.

Women's mental health during perinatal periods was also considered from a strengths-based, co-occupational and wellbeing perspective (Pizur-Barnekow & Pickens, 2019; Swarbrick, 2019). Feeling mentally prepared to deal with the challenges of motherhood was a common woman-led goal, with the occupational therapists in this study addressing wellbeing domains aligning with the "eight dimensions of wellness" (refer Figure 13) in the Wellness Model in Community Mental Health (Swarbrick, 2019, p. 774).

FIGURE 13

The Wellness Model in Community Mental Health



Note: This represents the co-occurring personal, environmental, and occupational elements impacting an individual's lived experiences and participation in meaningful occupations whilst navigating their recovery journey towards mental wellness. Reprinted from *The Wellness Model in Community Mental Health,* in "Wellness", by Swarbrick, M., (2019), in Brown, C., et al (Eds.), in *Occupational Therapy in Mental Health: A Vision for Participation,* (2nd Edition), p. 774.

Awareness of tailored preventative and acute non-pharmaceutical interventions which connect micro- (personal) and macro-level (social, cultural, and political) components to improve women's mental health and wellbeing during perinatal periods is growing (Fahey & Shenassa, 2013; Worrall, 2018). Occupational therapists in the case study addressed holistic components of women's mental wellbeing in relation to changes experienced during motherhood. Interventions were contextualised within meaningful occupational and co-occupational performance, lifestyle redesign, self-regulation and actualisation, cognitive reframing, maternal development, and positive self-efficacy, which are associated with mothing occupations (Esdaile & Olson, 2004).

Occupational therapists role in addressing women's perinatal mental health needs in the context of motherhood through occupation-centred practice aligned with contemporary research (Barbic et al., 2021). Mental wellbeing during perinatal periods was approached from prevention, early intervention, health promotion, wellbeing, psychosocial (including mother-infant dyads), trauma, recovery, rehabilitative and empowerment perspectives (Acharya, 2014; Cardinale et al., 2014; Chiu et al., 2012; Ferigato et al., 2018; Hammell, 2016; Williams & Chard, 2019). Occupation-centred interventions drew from occupational therapists' diverse practice skillset. Perinatal mental wellbeing intervention approaches and outcomes aligned with the seven themes Kirsh et al. (2019) identified to inform evidence-based mental health occupation-centred practice with adults, including: Employment and education; psychoeducation; creative occupations and activity; time use and occupational balance; skills and habit development; group and family approaches; and animal-assisted therapy.

A key role for many occupational therapists in this study was contextualising women's mental health and wellbeing within perinatal stages, maternal developmental needs, and goals.

This involved exploring meaning in occupational histories, making sense of difficult emotions, validating traumatic and difficult experiences, self-reflection, maternal development, self-regulation, and making parenting and occupational choices which aligned with personal values, beliefs, and lifestyle goals.

The therapeutic process of addressing women's mental health through nurturing maternal development and personal growth using reflective and occupation-centred practice is known to be restorative, healing and empowering for women (Brady et al., 2019; Cardinale et al., 2014; Ferigato et al., 2018; Hanish et al., 2019). This aligned with research findings into how occupation engagement supported women to work through feelings of discomfort, grief, loss, failure, shame, and embarrassment, fear and avoidance, which were commonly associated with delayed, disrupted or interrupted maternal development relating to trauma, infertility, miscarriage and perinatal bereavement (Athan et al., 2015; Ferigato et al., 2018; Forhan, 2010; Greenfield et al., 2019; Hanish et al., 2019; Lederman & Weis, 2020a).

RESTORING MATERNAL INSTINCT AND SELF-EFFICACY

Normalising women's issues and challenges during perinatal phases was a common technique applied by maternity care providers and some occupational therapists to ease women's concerns and alleviate unnecessary anxieties and worries. However, some of the occupational therapists interviewed were conscious that normalisation was a strategy that needed to be cautiously and sensitively used in a client-centred way, identifying maternal self-doubt and poor self-esteem as significant practice contraindications. Women's intrinsic attunement, self-awareness skills, and abilities often became compromised when medicalised maternity care was not available to treat or validate symptoms through diagnosis. Risk of poor maternal self-efficacy

was compounded when the instinctual mother-infant attachment bond was slow or difficult to develop. These factors were considered to affect maternal role development, which occupational therapists addressed through promoting women's maternal self-efficacy development (Acharya, 2014; Lederman & Weis, 2009; Lederman & Weis, 2020a).

Occupational therapists worked with women to help them learn to listen to their bodies, tune into their spiritual self, hear and interpret their instinctual responses to mothering and understand their intrinsic values. These practices are consistent with the occupational therapy conceptual domain of spirituality, which is at the core of a person's identity and wellbeing and fundamental for self-efficacy development during motherhood (Humbert, 2015; Jones et al., 2016; Prinds et al., 2014). Working with women to restore their trust in symptoms as indicators of health and wellbeing issues, and learning to listen and interpret their maternal instinct aimed to improve maternal self-efficacy, and were practice approaches aligning with women-led and occupation-centred practice philosophies (Ford et al., 2021; Garcia, 2021; Miah & Adamson, 2015; Moghasemi et al., 2018).

SELF-CARE SKILLS FOR MOTHERHOOD: REGULATION, RESILIENCE, AND SELF-EFFICACY DEVELOPMENT

Women's self-care priorities and needs change during perinatal transitions and motherhood (Barkin & Wisner, 2013; Vidmar, 2020a). Self-care is a fundamental human occupation and essential activity of daily living which was a primary focus of occupational therapy practice in this study. Occupational therapists' observation that women's self-care became compromised, deprioritised, or neglected during motherhood has been documented by other researchers (Barkin & Wisner, 2013; Horne et al., 2005; Nichols et al., 2015). Self-care is a

core component of occupational therapy practice and a known primary factor influencing women's health during motherhood. Evidence clarifying the occupational nature, meaning and implications of women's compromised and changing self-care during motherhood has not been a focus in research or academic literature.

The occupational therapy role in addressing self-care issues and needs during motherhood included working with women to reprioritise caring and feeling motivated to satisfy their own needs, which reflects a strengths-based and self-mastery approach to wellbeing and enablement (Grajo, 2020; Swarbrick, 2019). This was particularly needed when women lost their sense of self as their life paradigm became dominated by the infant's wellbeing in co-occupations, familial roles, and motherhood responsibilities. According to Barkin and Wisner (2013), women who wanted to feel effective as mothers had strongly divided opinions on the importance of self-care. Whilst many women regarded their "self-care was of primary importance" during motherhood, others associated selflessness and "self-sacrifice" were synonymous with effective mothering (Barkin & Wisner, 2013, p. 1050).

Exploring the role of self-care in new motherhood, Barkin and Wisner (2013) identified self-care activities included taking time out for self, engaging in pleasurable activities, delegating infant care tasks at times, and taking care of physical and emotional self. Barriers to practicing effective self-care included time, limited resources and difficulty accepting help and setting boundaries. These themes were expanded in occupational therapy literature, where women's self-care issues related to bathing, personal hygiene, toileting, cooking, and dressing (Burkhart et al., 2021; da Conceição et al., 2020; Fernandes, 2018; Frenchman, 2018), and spiritual life, self-advocacy, and intimacy and sexual expression for mothers with chronic illness (Opacich & Savage, 2004).

The deeper meaning of self-care occupations was noted in research by Vidmar (2020a, p. 38), reporting women identified their self-care became a “luxury” during perinatal transitions which they “pushed on to the back burner” and struggled to find time for. The self-care activities women sacrificed during motherhood included looking after their health needs, eating, physical activity such as running and yoga, which were associated with frustration and a loss of freedom. This more closely aligned with research findings by Barkin and Wisner (2013) and suggests that more needs to be known about women’s self-care occupational issues and needs during perinatal stages.

Women’s self-care routines suffered during the transition to motherhood (Briltz, 2019; Vidmar, 2020a), which occupational therapists in this study associated with occupational overwhelm, imbalance, loss, and deprivation. Occupational therapists roles in supporting women to establish self-care routines have been proposed as a key enabler to promote women’s wellbeing and prevent mental health challenges (Grabarkewitz & Swanson, 2020). In this study, the self-regulation and self-care skills occupational therapists supported women to develop were consistent with aspects of overall wellness identified by Swarbrick (2019). These included “social support, spiritual connections, and taking care of one’s physical health through rest, sleep, healthy food choices, physical activity, and access to timely quality screenings and needed medical care” (Swarbrick, 2019, p. 778).

Occupational therapists in the case studies worked to enhance women’s prioritisation of self-care during perinatal stages, which they identified was a core determinant of women’s wellbeing during motherhood. Participants observed that high levels of stress and anxiety, impaired coping mechanisms and low self-esteem negatively influenced women’s occupational function and performance capacities, relationships, development, and wellbeing during

motherhood, which could be improved through routinely engaging in meaningful self-care occupations.

Ongoing stress, anxiety and low self-esteem had the potential to prolong women's difficulties with self-regulation, resilience, and positive self-efficacy development during perinatal stages, which are known to be critical skills for nurturing self-care, occupational wellbeing and healthy mother-infant attachment (Burbidge, 2015b; Germain, 2018; Hitch et al., 2018; Torchalla et al., 2019). The occupational therapists promoted development of women's self-care skills from a holistic wellbeing perspective through preventative, maintenance, restorative, and rehabilitative approaches which aligned with occupational enablement practices (Barcelos Pontes & Polatajko, 2016). Self-care interventions were contextualised by client- and occupation-centred practice, motherhood, and mother-infant relationship development. These were tailored to be individualised and woman-led, and were in keeping with the wellness, self-mastery, occupational adaptation, and doing, being, becoming and belonging frameworks (Grajo, 2020; Hitch & Pepin, 2021; Potgieter & Adams, 2019; Swarbrick, 2019; Williams & Chard, 2019).

BIOMECHANICAL FRAMEWORK APPROACH TO PROMOTE FUNCTIONAL CAPACITIES

Women's physical and functional performance capacities change during perinatal stages of maternal development for a multitude of reasons (Berglund & Peterman, 2021; Branco et al., 2014). Occupational therapists in the case studies observed how these changes could lead to back and pelvic pain, movement and mobility challenges, and a range of injuries that became causes of occupational performance issues. Many occupational therapists addressed women's motion, movement, strength, and endurance to prevent deterioration, restore functional capacities, and

compensate for movement loss, which is consistent with the biomechanical frame of reference (McMillan, 2014).

Several occupational therapists applied ergonomics and biomechanics frameworks to working with women during pregnancy, preparing for labour and birth, and mothering occupations and co-occupations in the postnatal period. The physiological, morphological, and hormonal system changes women can experience during gestational phases can affect their balance, body stability, postural control (Branco et al., 2014; da Conceição et al., 2020). This can result in musculoskeletal pain, discomfort and dysfunction, leading to altered gait patterns, static or awkward body positioning, difficult transfers, fatigue, and falls during pregnancy (Berglund & Peterman, 2021; Branco et al., 2014). The case studies revealed how this affected women's capacity to work, engage in usual occupations, and perform infant caring duties. Unresolved pain, dysfunction and discomfort during pregnancy were identified by many occupational therapists as commonly a cause of sleep deprivation, depressive mood, and negative body-image for women, which aligns with contemporary research findings (Bergbom et al., 2017; Berglund & Peterman, 2021; Sanders & Morse, 2005).

Several occupational therapists in this study combined biomechanics, cognitive behavioural techniques, sensory regulation, spirituality, and ergonomics to work with women preparing their bodies for the occupation of labour and childbirth. Focusing on musculoskeletal and biomechanical function, postural positioning, systems modulation and motion, occupational therapy recommendations were consistent with contemporary research evidence for positive childbirth experiences, pelvic floor 'prehabilitation', and postpartum recovery (Baker et al., 2017; da Conceição et al., 2020; Desseauve et al., 2017a; Desseauve et al., 2017b; Rogers, 2020). During the first year of motherhood, occupational therapists addressed the ergonomics of

infant care, breastfeeding, and co-occupations, as well as addressing women's functional needs during mobility, transfers, sleep and rest, and postural alignment during occupational performance. These approaches are consistent with research recommending increased care and support of women's ergonomic and biomechanical function in the postnatal phase of motherhood (Berglund & Peterman, 2021; Grabarkewitz & Swanson, 2020; Vincent & Hocking, 2013).

PROMOTING HAND AND UPPER-LIMB FUNCTION

Hand function issues caused by carpal tunnel syndrome and De Quervain's tenosynovitis are relatively common during pregnancy and postpartum and can be assessed and addressed by occupational therapists trained in hand therapy (Fernandes, 2018; Stein et al., 2015). Occupational therapists tailor client-centred hand therapies to address the impact of hand and upper-limb injuries, dysfunction, pain and discomfort contextualised by the occupational demands of motherhood (Fernandes, 2018; Stein et al., 2015). Whilst the need for hand therapy interventions for these issues are known, there is minimal literature outlining how occupational-centred approaches uniquely benefit maternal populations (Watkins, 2019).

The occupational therapists who were trained in hand therapy in this study were able to address women's hand issues, prevent injury, enable occupations, and achieve functional goals within occupational performance contexts of motherhood (Fernandes, 2018). Interventions were predominantly focused on lifting, carrying, transferring, and the ergonomics of infant care, contextualised by environments, the woman's functional capacities, and adaptive aids such as splints.

The occupational therapists also contextualised hand function issues by addressing manual demands of increased home duties. Homemaking occupations are associated with upper

limb repetitive stress injuries (Yang & Cheung, 2016). Home duties and household chores can be regarded as manual labour, requiring occupational therapy recommendations to manage repetitive movements, frequent or heavy lifting, constant hand and upper limb use and body movement, core strength and stability to reduce risk of back pain (Grabarkewitz & Swanson, 2020; Sanders & Morse, 2005; Vincent & Hocking, 2013). Occupation-centred hand therapy interventions in the case studies were adapted to consider the impact of increased exposure to water and detergents for handwashing, infant hygiene, and household item cleaning, which could compromise women's skin integrity over time.

Occupational therapists in this study noted that women's capacity to prevent and self-manage hand injuries during performance of household duties and infant care was often more difficult following caesarean or traumatic deliveries. This was assumed to be reflective of women's need to heal and recover from childbirth experiences, sleep deprivation, manage pain and tenderness, and comply with recovery-related movement precautions and restrictions (Grabarkewitz & Swanson, 2020). Recognising the negative impact of self-care neglect, exhaustion, unresolved pain, occupational overloading and overwhelm on wellbeing, occupational therapists incorporated hand therapy with conversation-based occupational analysis and profiling to screen how the woman was coping during perinatal stages. Functional issues were addressed using adapted or modified hand therapy interventions. These were tailored to accommodate the occupational and ergonomic demands and context of women's daily activities, mothering co-occupations and familial routines, which aligns with women's upper limb functional needs during perinatal periods (Fernandes, 2018; Primeau, 2004; Watkins, 2019).

Occupational therapists in the case studies regarded hand therapy interventions as highly accessible therapeutic avenues for engaging with women. Assessments were used to

preliminarily diagnose, validate, and address many downplayed and normalised physical functional issues hindering women's occupational performance capacities during motherhood. The multiple case study findings suggested that holistic and occupation-centred approaches to hand therapy were unique and important for maternal role performance, self-efficacy development and meaningful co-occupational engagement. This aligns with findings of research exploring psychosocial symptomology in hand therapy (Hardison et al., 2021), the meaning and role of touch during co-occupational engagement (O'Brien & Lynch, 2011; Visser et al., 2016), and suggests more needs to be learnt about the role of hand therapy in occupation-centred practice with maternal clients.

Feeding routines and breastfeeding

Feeding routines and breastfeeding can be a major cause of occupational stress for women in the first year of motherhood (Briltz, 2019). Infant feeding, including breastfeeding, is increasingly considered by occupational therapists (Barrie et al., 2018; Briltz, 2019; Fernandes, 2018; Grabarkewitz & Swanson, 2020; Podvey & Kern, 2018; Sponseller & Foy, 2018; Vidmar, 2020b). In Australia and the USA, participants in the case studies described occupational therapy support for breastfeeding issues after reaching a therapeutic plateau with maternal nurses, midwives, and/or lactation consultants. Occupational therapy interventions to address breastfeeding issues included education, manual therapy to alleviate breast discomfort, milk supply, flow and draining, strategies to improve breastfeeding positioning, and adaptive techniques to reduce pain, discomfort and enhance the quality of meaningful co-occupational engagement (Briltz, 2019; Fernandes, 2018; Pitonyak, 2014; Pitonyak et al., 2015; Vidmar, 2020a; Visser et al., 2016; Watkins, 2019). Many of these approaches were used to support

women to improve performance satisfaction, environmental set-up, comfort, and meaningful engagement through bottle-feeding as a co-occupation.

In the case studies, occupational therapists regarded breastfeeding as a deeply personal occupation. Women's engagement and performance in breastfeeding reflected their mental, physical, and relational capacities, and needs, and needed to reflect their rights to make decisions, which aligns with collaborative relationship-focused occupational therapy practice (Restall & Egan, 2021). Occupational therapists tailored client-centred and woman-led interventions which regarded breastfeeding as a complex occupational choice, challenge, and goal for women as individuals and mothers. These approaches align with research exploring the meaning, role, and value of breastfeeding as a maternal occupation and mother-infant co-occupation (Froehlich et al., 2015; Lau, 2018; Pitonyak, 2014; Visser et al., 2016). Many occupational therapists worked with women to develop daily and nocturnal feeding routines, including breastfeeding, expressing, bottle-feeding, weaning, introduction to solids, and family mealtimes. Strategies also included partners and co-parents in family-centred practice, using infant feeding as a meaningful co-occupation to strengthen familial relationships with the infant, and through occupational balance and mutual engagement.

PERINATAL TRANSITIONS: RETURNING TO HOME, DAILY ROUTINES AND WORK

Supporting women to return safely home from hospital following childbirth was a key role for occupational therapists on inpatient acute and maternity wards. This is a common hospital-based role for generalist occupational therapists, and increasingly neonatal intensive care units (NICUs) and mother-baby units (MBUs) (Briltz, 2019; Burbidge, 2015b; Schultz-Krohn & Pendleton, 2013). There is increasing recognition that women can feel stressed, sleep-

deprived, or anxious when they are discharged from hospital too early, without adequate time to process their experience, recover from birth or access health professionals (Finlayson et al., 2020; Forhan, 2010; Parliament of Victoria, 2018). The occupational therapy role in supporting women to return home, addressed their functional capacities as well as their capacity to sustainably care for their infant at home in a safe environment. This aligned with research from Brazil, which discussed how occupational therapists applied "several therapeutic strategies" to promote new mothers' development of self-confidence, self-efficacy, and capacity to perform infant care duties safely on returning home from the hospital (da Conceição et al., 2020, p. 122).

Being a worker is a major component of life for many women, which continues throughout perinatal stages (Frenchman, 2018; Pascoe Leahy, 2021; Vogels-Broeke et al., 2019). Participants in the case study highlighted how the perinatal period is a uniquely disruptive stage of motherhood for women's careers, professional identity, and income earning potential, which often influenced changes to their social identity and partner relationships. This phenomenon is well known (Frenchman, 2018; Lederman & Weis, 2020a; O'Reilly, 2019; Pascoe Leahy, 2021). In contemporary high-incomes societies, expectations about returning to work are often complicated by "intensive mothering norms [which] prescribe women to be perfect mothers", often at the expense of their career ambitions (Meeussen & van Laar, 2018, p. 1). Women's desire and/or need to work during motherhood is a complex sociocultural and socioeconomic occupational performance issue, which occupational therapists addressed using a sensitive and individualised client-centred approach.

Supporting clients returning to work is a common goal in both generalist and specialist occupational therapy practice areas. Recently researchers have called for greater input supporting women returning to work in the postpartum period (Froehlich et al., 2015; Pitonyak et al., 2015;

Rexe et al., 2013). Focus of these studies was generalised towards women as mothers, workers, and income earners. Supporting women to maintain work roles during pregnancy and return to work in the postnatal period were addressed by occupational therapists in Australia, Canada, New Zealand, and the USA. In Australia, occupational therapists identified that planning for return-to-work was often a priority for self-employed and single mothers, including preparing and planning for childcare arrangements, routines, breastfeeding/expressing routines and set-up, work-role advocacy, injury prevention, functional reconditioning, and positive postpartum recovery, enabling them to resume earning an income. Participants identified that work-role related challenges were experienced by women during pregnancy and early postpartum, in hospital-based inpatient, outpatient and community settings.

MATERNAL ROLE DEVELOPMENT AND LIFESTYLE REDESIGN

Maternal role development is increasingly recognised as a key component impacting a woman's perceived competence to care for her infant's multifaceted developmental needs, and fundamental for positive mother-infant bonding and attachment (Emmanuel et al., 2011). Maternal role development refers to the process of identity transformation a woman experiences, when transitioning through seven dimensions of psychosocial adaptation to become a mother (Lederman & Weis, 2020a).

Occupational therapy practices acknowledged the need to support women with preventing and managing maternal stress. In the multiple case study, women's capacity to perform gendered maternal roles, manage changing partner relationships, and meet sociocultural expectations of motherhood emerged as a key source of occupational imbalance, overwhelm, overloading, stress, anxiety, loss of self-efficacy and social isolation. Interventions were designed

to nurture maternal role competence, recognising that a mother's negative perception of her competence to positively care for her child can result in maternal distress, which has been linked to increased incidences of child abuse and neglect (Emmanuel et al., 2011). These primarily included facilitated and scaffolded development of practical parenting and partner communication skills, with tailored client-centred education around meaningful occupational and co-occupation engagement, pacing and activity prioritisation, delegation and adaptation within culturally sensitive co-parenting and familial routines.

Working with women to make conscious, well-educated, and values-based occupational choices whilst adapting activities, roles and routines were general strategies applied by occupational therapists to improve occupational balance. This was usually applied through lifestyle redesign, which is a known occupational therapy intervention aiming to reduce stress and enhance balance, satisfaction, and meaning in occupational routines (Burbidge, 2015b; Doidge, 2012; Frenchman, 2018). In the case study, women and occupational therapists saw lifestyle redesign enabled positive development of maternal self-efficacy, improved self-worth, strengthened partner communication and healthier mother-infant attachment styles. These practices and reported outcomes are consistent with best-practice recommendations for promoting adult, maternal, perinatal, and dyadic mother-infant mental health and wellbeing (Athan et al., 2015; Bochenek et al., 2017; Sepulveda, 2019; Williams & Chard, 2019; World Health Organization, 2020).

THE RELATIONAL NATURE OF PARENTING AND CO-PARENTING OCCUPATIONS

Working with mother-infant dyads was a common role for occupational therapists. Maternal health and wellbeing are often considered mutually in the context of infant

development and attachment (Briltz, 2019; McNamara et al., 2019; Sepulveda & Hanish, 2018). Developing a mutually bonded and healthy attached relationship can be difficult for mother-infant dyads, particularly when women do not feel an intrinsic sense of connection with their child (Eadie, 2016; McNamara et al., 2019; Pitonyak, 2014). Delays in mother-infant bonding and complex attachment styles are linked to poorer mental health and developmental outcomes for both women and children (O'Brien & Lynch, 2011; Potgieter & Adams, 2019; Sepulveda, 2019; Williams & Chard, 2019), and preventing this was a priority for occupational therapists.

Strained or difficult partner relationships were identified as a common and significant occupational performance issue in the multiple case study. Working with spouses, partners, co-parents, and families was another key psychosocial practice approach applied by occupational therapists. Participants acknowledged that women need social support during perinatal stages and motherhood, which aligns with recommendations for maternal satisfaction, mental and emotional wellbeing, and self-efficacy development (Lederman & Weis, 2020b).

Recognising that partners and spouses are often co-parents in contemporary families (Lederman & Weis, 2020b) and that mothering is a relational role (Sethi, 2019), occupational therapists applied a client-centred and culturally sensitive psychosocial approach to improving the mother-infant-family dynamic. Collaborative relationship-focused practices with women often involved working relationally with parents as partnered couples (Restall & Egan, 2021). This approach aimed to improve competent and confident parenting skills and promote communication and positive interpersonal engagement for healthy and sustainable parenting and partner relationships. This aligns with research acknowledging the importance of quality mother-infant-family social interactions (Williams & Chard, 2019), contemporary roles for father's and co-parents (Lederman & Weis, 2020b), and highlights the influence of father-partner

relationships on mothers' and children's wellbeing (Alexander, 2020; Pizur-Barnekow et al., 2017).

Occupational therapists in the case study worked with parents using a range of strategies to improve lifestyle balance, manage the impact of occupational overloading, and improve mother-infant-family relationships. Working relationally to create meaningful family routines and strengthen parent-partner relationships and mother-infant-family triads is in keeping with research recommending improved partner communication to promote mental health and wellbeing for all family members (Ferigato et al., 2018; Ponnet et al., 2013).

PRACTICAL PERFORMANCE SKILLS FOR MOTHERHOOD

Occupational therapists have a primary role in enabling occupation (Barcelos Pontes & Polatajko, 2016; Njelesani et al., 2015). Managing the activity spike, escalated and fluctuating performance demands, and occupational overloading and imbalance during motherhood can be challenging or overwhelming for women (Acharya, 2014; Grabarkewitz & Swanson, 2020; Michelitch, 2009). The negative impact of women feeling incompetent and incapable in mothering roles is increasingly being understood, which is compounded by pressure to be a 'perfect' mother (Burbidge, 2015b; Meeussen & van Laar, 2018; Williams & Chard, 2019). Occupational therapists in the multiple case study tailored client-centred education and adaptive strategies using aids, equipment, and modified techniques to support women develop practical skills for motherhood. Enhancing women's knowledge, self-efficacy and functional capacities were considered critical to perform well in practical parenting activities, self-manage occupational issues causing dysfunction, and prevent injuries. Supporting women to develop practical skills for parenting was addressed through occupational analysis and woman-led

perspectives in the multiple case study. Competence with practical mothering skills was usually determined collaboratively by the woman's sense of sufficient and satisfactory performance, and the occupational therapist's perception of occupational performance safety and sustainability.

CONCLUSION

This chapter outlined the role scope and potential place for occupational therapy in perinatal health teams and maternal care pathways. In the next chapter a conceptual practice model is proposed to better understand the role and practice potential for occupational therapy supporting women through perinatal stages and the developmental process of matrescence.

CHAPTER 11: CONCEPTUALISING THE OCCUPATIONAL NATURE OF MATERNAL DEVELOPMENT

"It is what we know already that often prevents us from learning."

– Claude Bernard

INTRODUCTION

This chapter follows on from the previous chapter outlining the role of occupational therapy in perinatal health. In this chapter, the concept of matrescence is introduced to further explore and understand occupational therapy practices working with women during maternal developmental life phases. The influence of maternalism, perinatal health economics, and social constructs of motherhood contextualise the place, potential, and value of occupational therapy in women's occupational health, wellbeing, and maternal development are considered. A proposed conceptual practice model is introduced to clarify, inform, and guide future development of occupational therapy in perinatal health and maternal development.

CLIENT-CENTRED, PERSON-CENTERED AND WOMAN-LED OCCUPATIONAL THERAPY PRACTICE APPROACHES

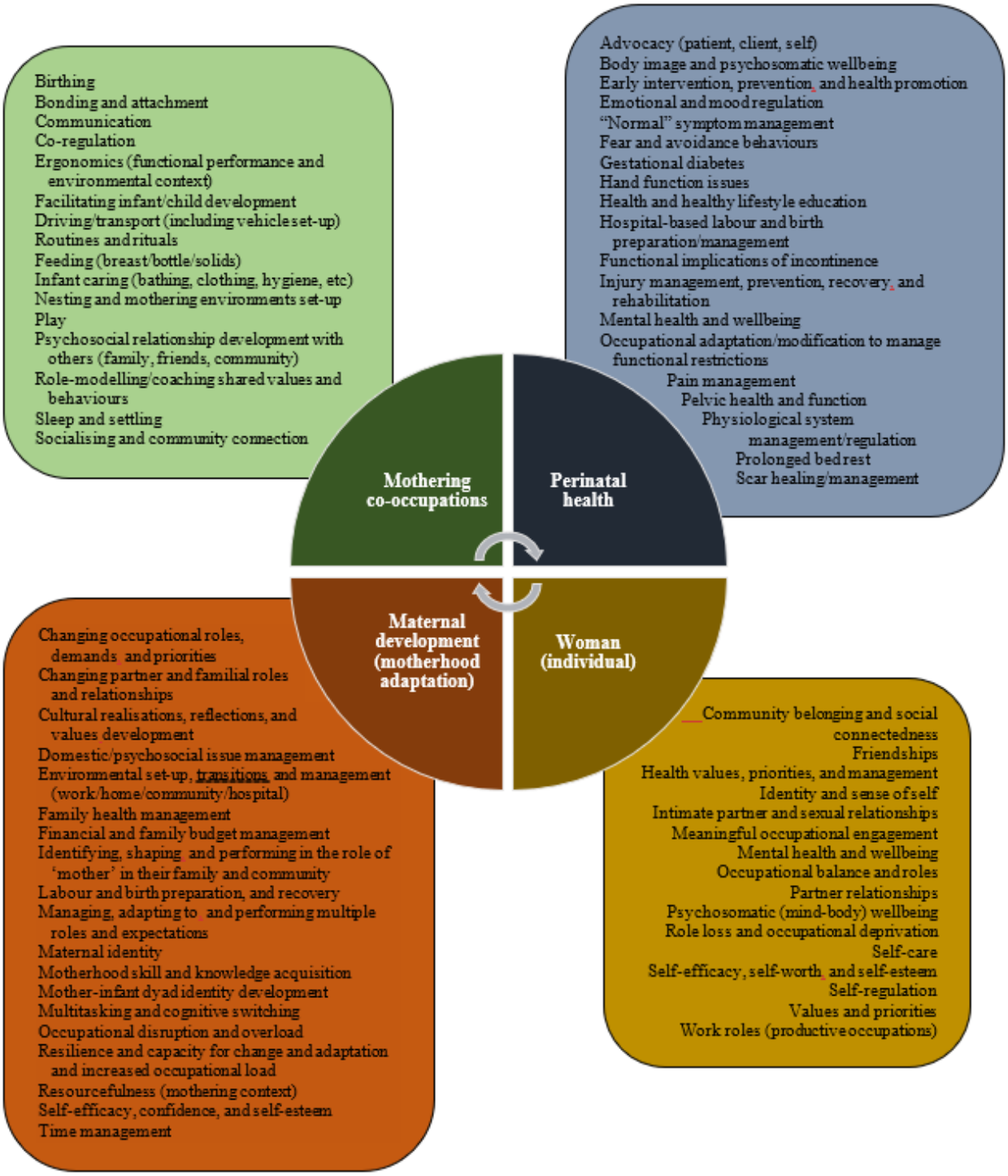
Occupational therapists drew from various theories to work with women during perinatal stages. Reflexively reframing the woman or mother as a person or human being is a unique perspective that occupational therapists contribute to perinatal health and maternity care. The occupational therapists in this study applied client-centred practice to explore how the complex

nature of motherhood as a significant life event, impacted women's entire state of occupational being. In the contexts of modern feminism, identity, self-efficacy, relationships, perinatal transitions, role performance, and co-occupations, this practice approach aligned with Esdaile and Olson's (2004) position that the unique occupational nature and challenges associated with mothering occupations: work, gendered roles, and maternal wellbeing impact women as individuals and mothers.

Exploring and addressing complex, shifting and dynamic components impacting women's maternal development and occupational wellbeing was an approach unique to person-centred occupational therapy practice. By reconceptualising women as occupational beings, occupational therapists addressed a spectrum of factors shaping health and wellbeing during perinatal phases. The approach used by therapist's interpreted how women's occupational performance needs and issues were contextualised by expanding and compartmentalised multiple identities women navigated during motherhood developmental stages and perinatal transitions (refer Figure 14). This perspective added breadth, depth and context not previously known or understood in occupational therapy practice with perinatal populations and revealed an expanded understanding of occupational factors impacting maternal development.

FIGURE 14

Person-centered and multi-identity perspective of the occupational and functional performance issues, wellbeing needs, and goals during motherhood phases



WOMAN-LED OCCUPATIONAL THERAPY PRACTICE

Client- or person-centred occupational therapy interventions involve collaboration with clients, promoting evidence-based practices to optimise adaptive and compensatory strategies, disability prevention and health promotion, and maintaining, establishing, or restoring skills and abilities (Barcelos Pontes & Polatajko, 2016; Schultz-Krohn & Pendleton, 2013). In early intervention, key prevention, or health promotion roles, this approach extends to enhancing development and skills to predict and mitigate the risk of future occupational issues emerging (da Conceição et al., 2020; Hitch et al., 2018; Pizzi & Richards, 2017).

Woman-led practice in maternity services is intended to provide choice for women, improve quality of care, and address gender-based discrimination, social justice, human rights, and obstetric violence in hospital settings (Garcia, 2021; Miah & Adamson, 2015; Moghasemi et al., 2018). In this study, occupational therapists were guided by woman-led practice philosophies in tailoring interventions to support women working through traumatic experiences, disempowerment, and self-doubt related to normalising and downplaying non-medical issues during perinatal phases. Many of the occupational therapists interviewed were motivated by social justice to validate non-medical symptoms as occupational issues, provide accessible care, and deliver client-centred education enabling informed choices for women.

The occupational therapists in this study described adjustment to motherhood as a multifaceted and gendered role that presented challenges for women. Becoming a mother was a highly complex developmental and occupational phenomenon, characterised by occupations, roles, and performance pressures and expectations that were influenced by power, gender, culture, and socioeconomic factors.

FINDING A PERINATAL LANGUAGE FOR OCCUPATIONAL THERAPY

Perinatal or maternal status rarely defines the need for occupational therapy roles. Very few occupational therapists in the multiple case study or literature identify themselves as perinatal specialists, and nearly half of the case study participants were unfamiliar with the term perinatal. Across research and practice, occupational therapists lack consistency with using and applying maternity terminology in practice. The terms '*perinatal'* and '*well'* reflexively emerged as maternity care constructs, and conversational snags in the case study interviews. Whilst some occupational therapists were familiar with the term 'perinatal' and confident in its meaning, many seemed professionally uncomfortable or embarrassed about their unfamiliarity and unsureness, and several rejected the relevance or necessity to apply 'perinatal' to define their practice scope. It was not a term applied by any occupational therapists to describe or define their practice.

The use of occupational language, connecting to occupation and referencing occupational therapy theory is key to strengthening occupation-centred professional practice (Ford et al., 2021). Regardless of whether the occupational therapist's role was situated in maternity care settings, in this study they applied client- and occupation-centred practices to interpret women's health and wellbeing needs during pregnancy, intrapartum and postnatal periods. By using *'client-centred practice'* and '*occupation'* to provide the framework for interpreting motherhood, mothering and parenthood challenges, changes and transitions, case study participants were tasked with translating women's issues and needs into discipline-specific language. This difficulty is echoed by inconsistent terminology in the literature (Barbic et al., 2021; Bochenek et al., 2017; Burbidge, 2015a; Dudley-Bean, 2015; Kaupp & Desrosiers, 2018), suggesting that occupational therapists lack a common professional language and framework to define how they

interpret, understand, and address women's occupational performance issues within the context of medicalised maternity healthcare. The emerging occupation-centred terminology and language participants used to describe a range of factors impacting the health and wellbeing of contemporary maternal populations were unfamiliar and difficult to fit in maternity care contexts.

Finding a common language to describe women's health, wellness, and wellbeing during perinatal stages from an occupational therapy perspective was difficult and reflected practice scope diversity. Discussion to clarify meaning and achieve mutual understanding through shared language and terminology was consistently necessary with both occupational therapy and service user participants. These conversations revealed much of the terminology commonly used in maternity health were interpreted as medicalised and unnecessarily segregating and divisive. It emerged that medicalised maternalism and the politicised institution of perinatal care created a sense of separateness for both occupational therapists and women, who focused on lived experience and occupation-centred health and wellbeing, respectively. In keeping with the social constructivist paradigm, perinatal terminology concepts came to be recognised as maternity care constructs useful for categorising women's gestational progress, maternal status and biophysiological capacity to become pregnant, give birth and recover. Women in these perinatal healthcare settings became socioculturally gendered, socially defined mothers, maternity patients, and perinatal healthcare consumers, which had little relevance to occupational therapy approaches (Alexander, 2020; Dombroski et al., 2016; Ferigato et al., 2018; Pascoe Leahy & Bueskens, 2020a).

LISTENING TO WOMEN: HOW WOMEN'S LANGUAGE DEFINED OCCUPATIONAL THERAPY PRACTICE

The occupational therapists in this study described active listening using storytelling as compassionate and nurturing therapeutic strategies which improved the likelihood of women feeling safe to share difficult or traumatic experiences, depression and anxiety, difficult partner relationships, and infant bereavement (Alexander, 2020; Burbidge, 2015b; Finlayson et al., 2020; Hanish et al., 2019). Listening to mothers voices offered the occupational therapists opportunity to learn about the client's individual experiences, values and goals, separate from gendered, politicised and sociocultural expectations of maternity care, gestational stages, and motherhood (Alexander, 2020; Athan & Miller, 2013).

Occupational therapists described the telling of perinatal and childbirth experiences as stories as a common and basic maternal occupation and need for women. There is a growing call to recognise the need for women to share birth experiences (Jha et al., 2019; Olin & Faxelid, 2003), and support women psychologically and emotionally recovering from traumatic birth experiences (Fontein-Kuipers, 2016; Pizur-Barnekow & Erickson, 2011; Russell et al., 2013). These concepts were identified, prioritised, and addressed by the interviewed occupational therapists in all roles and practice settings.

Reflectively listening to women's experiences was described as especially important as an early intervention approach following traumatic labour, childbirth, or newborn experiences, or to promote positive mindset for women with a history of perinatal trauma approaching subsequent births (Barnett, 2020; Graham, 2021; Greenfield et al., 2019; Vidmar, 2020a). The occupational therapy process of profiling and analysis through listening to women's stories and

then translating their issues and needs into occupational frameworks, defined woman-led goals, and sometimes had benefits as a therapeutic intervention.

The occupational therapists interviewed validated women's issues by interpreting and naming them as disruptive components, categorised under occupational deprivation, disempowerment, complex adaptation during life transitions, and maternal development, which impacted their ability to achieve, perform and enjoy meaningful and essential occupations. The healing process of naming and claiming is known to have therapeutic benefits promoting reconstruction of self through storytelling for women who have survived traumatic experiences and sexual abuse (Rose, 2009). This therapeutic process appeared mutually beneficial for both women and occupational therapists and saw an emerging occupation-centred healthcare language that named and substantiated many of the complex and non-medical challenges issues women experienced that were not commonly addressed within maternity care.

OCCUPATIONAL WELLBEING AND WOMEN'S WELLNESS

How occupational therapists worked with generally '*well'* women throughout perinatal transitional periods had little relevance to understanding practice roles. Being 'well' emerged as a highly polarising concept, refuted by occupational therapy practitioners and the women interviewed for being unnecessarily constrictive, discriminatory, and perpetuating ableist models. Instead, occupational therapists conceptually prioritised client-centred approaches to optimise occupational enablement, function, and wellbeing. Feeling 'well' was a goal of the two women interviewed. Being 'well'; however, was determined by the woman's intrinsically personal sense of wellbeing, and was irrespective of medical or maternal status. From an occupational therapy perspective, being 'well' was synonymous with medical and biomedical models influencing

maternity care approaches (da Conceição et al., 2020; Kundisova et al., 2019), and had little relevance to women's perceived sense of wellness or wellbeing. As allied health professionals, occupational therapists saw their practice scope with women focused on achieving 'well' status through promoting and enabling function, meaningful occupation, engagement, and participation.

'Wellbeing' and 'wellness' emerged as a more appropriate framework to contextualise what 'well' meant. For the occupational therapists interviewed, language diversity to communicate wellness and wellbeing made it difficult to understand how the role of occupational therapy incorporated wellbeing within the context of perinatal healthcare and to understand what occupational wellbeing meant for women. According to Doble and Caron Santha (2008, p. 184), "occupational well-being is enhanced when individuals' occupational needs, including their needs for accomplishment, affirmation, agency, coherence, companionship, pleasure, and renewal are consistently met". In listening to clients, the occupational therapists in this study identified and considered a holistic range of complex and meaningful components influencing women's occupational wellbeing and maternal role development during perinatal phases. The elements of meaningful occupational function and wellbeing occupational therapists incorporated into tailored interventions aiming to resolve women's OPIs and enhance role performance and engagement during motherhood is illustratively represented in a sun-wheel diagram (Figure 15).

FIGURE 15

Elements of meaningful occupational function and wellbeing occupational therapists incorporated into tailored interventions aiming to resolve women's OPIs and enhance role performance and engagement during motherhood

Occupational therapy practices with perinatal clients appeared to be influenced by Wilcock's (1999) doing, being, becoming and belonging framework. The wellbeing and wellness aspects of women's meaningful occupation and goal attainment during the paradoxical event of motherhood were broader and more complex than Wilcock's framework represented, which is a common limitation of contemporary practice models (Reid et al., 2019). Women's development of self-esteem, self-efficacy, and functional performance capacities were shaped by motherhood, and influenced by their personal and psychosocial experiences of doing, preparing, feeling, coping, thinking, developing, connecting, sharing, knowing, being and contributing.

CO-OCCUPATION-CENTRED PRACTICE WITH MOTHER-INFANT DYADS

Many occupational therapists in the multiple case study described applying co-occupations in practice, despite not being familiar with the concept or using the term. Co-occupation has been explored in the mothering context for nearly two decades (Branjerdporn, 2021; Doidge, 2012; Olson, 2004; Pickens & Pizur‐Barnekow, 2009; Pitonyak, 2014; Sethi, 2019). With professional expectations to align clinical reasoning with occupation-centred practice, co-occupations became central to understanding how and why many occupational therapists in this study were addressing a spectrum of holistic and complex factors influencing mother-infant bonding and attachment (Doidge, 2012; Pitonyak, 2014; Teufen, 2016), functional capacities, health, development, and wellbeing. While most occupational therapists in the case study applied the concept of co-occupation in practice, few were familiar with the term or concept.

For occupational therapists, the concept of co-occupation offers a unique and relevant approach to work with mother-infant dyads in maternal and paediatric practice. Similar to

occupations, therapeutic interventions or outcomes can be anchored by co-occupations in evidence-based practice. Co-occupations contextualise mothering as a relational role (Doidge, 2012; Rybski & Israel, 2017; Sethi, 2019), and provide opportunities for meaningful engagement and relationship development during mutually engaging occupations such as infant care and feeding (Froehlich et al., 2015; Maris-Shaw & Gosset, 2017), breastfeeding (Pitonyak, 2014; Vidmar, 2020b), playing (Elkins-Bushnell & Boyle, 2019), sleeping, social awareness, routines and rituals, and engaging with family, friends and peers (Doidge, 2012). Co-occupations are diverse and complex, and facilitate mother-infant communication (Briltz, 2019; Price & Miner, 2009), social interaction (Williams & Chard, 2019), neurodevelopment, sensory interaction and co-regulation (Germain, 2018; O'Brien & Lynch, 2011).

Co-occupation challenges many Westernised constructs of the individual, including dominant models in occupational therapy (Hammell & Iwama, 2012; Iwama, 2003; Yerxa, 1990). While many occupational therapists considered elements from mother-infant psychology and the "Westernised middle-class perspective" of attachment theory (Keller, 2018, p. 11414), research exploring the outcomes of co-occupations tend to be predominantly focused on the infant's needs (Branjerdporn et al., 2020, 2021; Whitcomb, 2012), and guided by Westernised mothering culture (Alexander, 2020). The impact of prioritising the infants needs and outcomes in co-occupation-centred practice, common in paediatric settings, can be likened to that of maternalism; which "emphasises the influence that mothers have on children's wellbeing" (Barnett, 2020, p. 87), and sways EBP decisions toward the child's needs and outcomes.

Drawing on the findings from this study, the concept of co-occupation sees mutual occupational engagement as central to a state of maternal being, requiring an occupation-centred practice approach to understand the mother-infant dyad (Blair, 2000; Ford et al., 2021; Hinojosa

et al., 2020b; Zemke & Clark, 1996). Multiple models of co-occupation have been proposed and appear to have relevance to occupational therapy practice in perinatal health; however, none were known or used by occupational therapists in the multiple case study. When tested in the context of mothering, Doidge (2012) found the majority of co-occupation models were based on expert opinion and literature instead of empirical research.

In the mothering context, co-occupations were found to define relationships "through the co-creation of experience" which "create a link between people are and the essence of relationships" (Doidge, 2012, p. 133). Although implications of the study were limited to occupational therapy in paediatric and maternal mental health practices, Doidge (2012, p. 134) proposed that; as "occupations define a person's identity, co-occupations shape the identity of mother-child relationships and are the essence of being a mother". Existing models fail to convey the complex struggle to find satisfying levels of mutually beneficial function, connection, occupational balance, and co-regulation, or depict the humanness or weight of responsibility, pressure, and expectations that primary caregivers experience in the mother-infant relationship. These elements were at the core of occupational therapists' person-centred approach to working with women during perinatal stages in the multiple case study, and need to be addressed.

Two recently proposed models conceptualising co-occupation for occupational therapy practice with mothers are Branjerdporn's (2021) proposed 'Mother-Baby CARE (Co-occupations, Attachment Relationship before and after birth, Environment) Model' and Sethi's (2019, p. 163) 'Mothering as a relational role' conceptual framework. Offering a model to consider the mother-infant dyad during pregnancy and the postnatal period, the 'Mother-Baby CARE Model' is an adaptation of the PEO model (Law et al., 1996) which reflects the fit between the two persons (mother and infant), environment, and co-occupation to conceptualise

how the "'goodness of fit' between the elements" impacts occupational performance over time (Branjerdporn, 2021, p. 239). Focused on the relational nature of mother-infant attachment connecting the two 'persons' within the PEO Model, the Mother-Baby CARE Model conceptualised how attachment theory enhances understanding of co-occupations for the mother-infant dyad (Branjerdporn, 2021).

The Mother-Baby CARE Model presented the mother and infant as two 'persons' and identified the four elements characterising a mother were; "perinatal loss, adult attachment, mental health, and sensory patterns" (Branjerdporn, 2021, p. 239). Whilst noting that mothers' developed "a sense of 'we-ness'" (Branjerdporn, 2021, p. 35) by psychocognitively investing in the child as an extension of themselves, the model did not appear to conceptualise how engagement in co-occupations influenced a woman's functional capacities, identity, and self-efficacy development. Separating pre- and postnatal periods and using medicalised language such as "maternal-foetal attachment" and "maternal-infant attachment" to describe relationships in the pre- and postnatal periods respectively (Branjerdporn, 2021, p. 238) did not align with occupational therapist's perinatal and matricentric approaches identified in this multiple case study. This model appears useful to consider co-occupations when working with mothers and infants in practice; however, appears to have limited scope for woman-led care or considering the complexity of women's matrescent development.

Beyond the perinatal period, Sethi (2019) conceptualised that co-occupations for mothers with typically developing children aged between two to six years were more transactional in nature, rather than bidirectional, and guided by mothering roles. The relational motherhood roles identified were varied, temporal, and interconnected, and included "caregiver, nurturer, educator, protector, and learner" (Sethi, 2019, p. 162). This perspective differed from research by Doidge

(2012), who tested co-occupation in the mothering context and claimed mother-infant co-occupations were guided by four themes: ‘doing with’, ‘doing alongside’, ‘doing for’, and ‘doing because of’ (including sub-themes of ‘doing to’ and ‘being done to’), in a variety of daily roles and occupations.

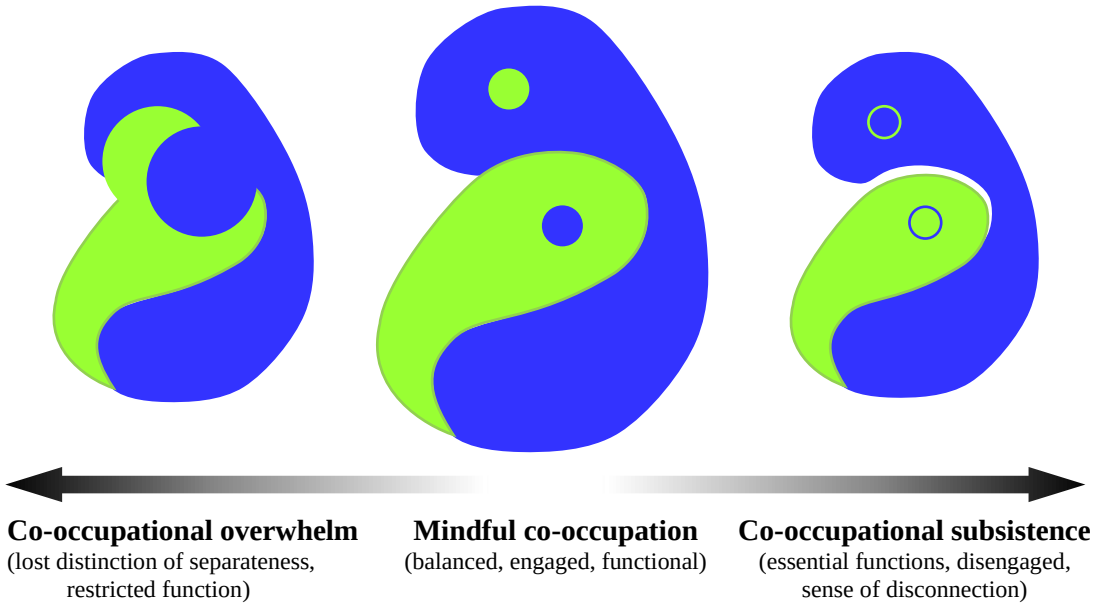
Finding a language to conceptualise how occupational therapists in the multiple case study applied co-occupation-centred practice needs to transcend many of the gendered, Westernised, medicalised, and maternalist constructs influencing occupational therapy and maternity care (Iwama, 2003; Reid et al., 2019). A spectrum of co-occupations exists, and “the degree with which a co-occupation is characterized by shared physicality, shared emotionality, shared communication, and shared intentionality varies and is dependent on the co-occupation, the age and abilities of the individuals engaging in the co-occupation, and sociocultural expectation” (Pizur-Barnekow & Pickens, 2019, pp. 766-767). Applying a reductionist approach, co-occupation was applied to conceptualise the unique way in which occupational therapists understood and addressed the occupational nature and functionality of the mother-infant dyadic relationship in perinatal practice.

In an effort to further develop a framework enabling occupational therapists a culturally sensitive practice approach, the *Spectrum of functional connection and meaningful engagement in mother-infant co-occupations* (refer Figure 16) is intended to illustratively clarify the dynamic relational and occupational nature and meaning of co-occupation in the mother-infant dyad, and how that influences the mothers’ and infants’ attachment, development, functional performance, capacities, and identity. The development of Figure 16 is informed by co-occupation (Doidge, 2012; Pizur-Barnekow & Pickens, 2019), the transactional model of development (Olson, 2004), attachment theory (Germain, 2018; Keller, 2018), parent-child relational psychology (Barlow &

Svanberg, 2009), perinatal neurodevelopment (Alexander, 2020; Lederman & Weis, 2020a), matrescence (Newman, 1975; Raphael, 1975), culturally sensitive and diverse occupational therapy paradigms (Hammell & Iwama, 2012; Iwama, 2003), and occupational engagement, harmony and balance, and the concept of Ying Yan in occupational therapy practice (Liu et al., 2021). The design was inspired by the 'Yin Yang Yuan' symbol (Chwaege, 2008).

FIGURE 16

Spectrum of functional connection and meaningful engagement in mother-infant co-occupations



The *Spectrum of functional connection and meaningful engagement in mother-infant co-occupations* is intended for use as an alternative collectivism lens (Alexander, 2020; Keller, 2018; O′Reilly & Bueskens, 2016b) to extend how the 'person' may be perceived as a dyad. This Figure is proposed as an adjunct to the Person-centred Occupational Model of Matrescence introduced later in this chapter. Informed by the multiple case study findings, Figure 16 conceptualises the dynamic and changing relational nature of the mother-infant dyad, which can

include, be irrespective of, and/or extend beyond perinatal periods. According to Pierce (2009, p. 204), "the essence of co-occupation is simply the degree to which the occupations of two or more individuals are interactively shaping each other". Reflecting this emic quality, the figure represents the role of the dyad in shaping identity, satisfying fundamental human needs, promoting wellbeing, understanding and promoting function, and nurturing meaningful development for both mother and infant (Branjerdporn, 2021; Hitch & Pepin, 2021; Lederman & Weis, 2020a; Max-Neef et al., 1989; Reid et al., 2019; Sethi, 2019).

In Figure 16, each mother-infant dyad is connected in body, mind, and meaningful engagement in co-occupation. The mother is greater in size than the infant, which aligns with recommendations that "the significance of the role of mother must not be overlooked" (Pizur-Barnekow, 2011, p.134) in mother-infant co-occupations, particularly when recovering from perinatal trauma. The optimal functional relationship is depicted as *mindful co-occupation*, which is flanked by bipolar ranges of dysfunction represented as *co-occupational overwhelm*, and *co-occupational subsistence*.

Mindful co-occupations saw the mother and infant emotionally and spiritually bonded, having a healthy, invested, and connected sense of one another that enabled mutual capacities for balanced and functional participation, role performance, engagement, and development (Alkire, 2002; Athan & Miller, 2013; Castro, 2020; Donica, 2008; Keller, 2018). *Co-occupational overwhelm* occurred when the mother and infant lost their sense of separateness, which resulted in separation anxiety, restricted function due to inseparability, and difficulty engaging in wellbeing occupations to nurture individual development (Germain, 2018; Pentland et al., 2018; Sethi, 2019). Disengaged performance of caring occupations is represented by *co-occupational subsistence*, where infant care tasks are performed systematically or mechanically, and the

mother and child are not mindfully connected in sharing a mutually meaningful co-occupation (Grabarkewitz & Swanson, 2020; O'Reilly, 2019; Pizur-Barnekow & Pickens, 2019; World Health Organization, 2018). This is essentially functional on a basic human needs level; however, the disconnect creates a sense of separation between the mother and infant and prohibits capacity for mindful connection and development through co-occupational performance.

In the case study, occupational therapists predominantly addressed co-occupations using, or in conjunction with, psychology theories, spirituality, and maternal development. Improved awareness and practical application of co-occupation sees potential for occupational therapists to strengthen alignment with the contemporary occupational paradigm and professional practice scopes (American Occupational Therapy Association, 2020; Pizur-Barnekow & Pickens, 2019). This spectrum is not intended as a source for judgement about the quality of parenting; however, offers opportunity to contextualise observational screening assessments, intervention, and goal setting to optimise co-occupational engagement, wellbeing, mother-infant relationship development, occupational balance and harmony in dyadic relationships, and maternal self-efficacy and identity development. Co-occupations are common and constant, and not a gendered, maternalist or ageist concept. Although this research has focused on mother-infant dyad co-occupations, occupational therapists can reference co-occupation to inform working with fathers, co-mothers, co-parents, guardians, and older siblings.

MATERNAL DEVELOPMENT

Maternal development was regularly a focus for occupational therapy practice, which was distinct from maternal role development. What constitutes the global concept or domains of

maternal development were not clearly defined by participants, or in occupational therapy literature. Literature addressing maternal development in maternity care is predominantly limited to pregnancy, contextualised by biophysiological maternal-foetal development. Terminology referring to women as ‘gravida’s’ rather than people suggests that maternal development and psychosocial adaption during pregnancy reflects a medicalised maternalism lens (Lederman & Weis, 2020a) that did not align with the occupational therapy practice of those interviewed.

References to maternal development in their occupational therapy practice indicated that the concept was holistic, ambiguous, highly relevant, and fundamental to client-centred and woman-led practices. In the context of maternal development, the occupational therapists in this study flexibly tailored a multi-model practice approach of working holistically towards empowerment, maternal identity and self-efficacy development, and occupational mastery through woman-led care and the process of doing, being, becoming, and belonging (Brady et al., 2019; Grajo, 2020; Hammell, 2016; Hitch, 2017; Hitch & Pepin, 2021).

The multiple case study analysis process reflexively revealed how unintentional use of medicalised, ableist, gendered and maternalism language biased the emic interpretation of participants vicarious experiences throughout the research methodology and methods. Reflecting on what was learned in the multiple case study, definitions, and terminology such as *health promotion, adaptation* and *transitions* seem to nominalise and downplay women’s experiences in becoming mothers, and the role and value of occupational therapists in empowering them through this transformative life journey. The outcome of women experiencing this human developmental process was often personally transformative, more profound, and complex than a single transitional event.

MATRESCENCE: A TRANSFORMATIVE LIFE EVENT AND RITE OF PASSAGE THROUGH MOTHERHOOD

While occupational therapy has a role in perinatal health and maternal care pathways, the full practice scope for occupational therapy can potentially be better understood through the concept of *matrescence*. From a wellbeing and human development perspective, women's occupational choices, behaviours, and capacity to engage in and manage roles and relationships during matrescence offer opportunities to advance occupational therapy roles in maternal care pathways.

Although aligning closely with contemporary occupational science and occupational therapy research, contextualising how transitions across the lifespan and spiritual transcendence shape a person's sense of being (Breen-Franklin, 2018; Hitch, 2017), maternal development and empowerment emerged as transformative concepts (Collins, 2007; Loukas et al., 2015) in the multiple case study. By approaching women's personal transformation in the context of maternal development and empowerment when becoming a mother, occupational therapists reframed women's perinatal transitions from a person-centred occupational wellbeing and human development perspective. Occupational therapists' conceptualisation of maternal development, transformation and empowerment aligned with the developmental process of *matrescence* (Raphael, 1975).

During the last decade, Athan and Reel (2015) proposed reviving the term matrescence, a concept originally coined by an American anthropologist, Dana Raphael (1975). Raphael (1975) conceptualised the maternal transitional journey as a rite of passage; "the time of mother-becoming", when, "changes occur in a woman's physical state, in her status within the group, in her emotional life, in her focus of daily activity, in her own identity, and her relationships with

all those around her" (p. 66). Matrescence is likened conceptually to adolescence as a profoundly transformative developmental process during a human lifespan, "but nested in the niche of mid-life" (Athan & Reel, 2015, p. 319):

> *It is an experience of dis-orientation and re-orientation marked by an acceleration of changes in multiple domains: physical (changes in body, hormonal fluctuations); psychological (e.g., identity, personality, defensive structure, self-esteem); social (e.g., re-evaluation of friendships, forgiveness of loved ones, gains in social status, or loss of professional status), and spiritual (e.g., existential questioning, re-commitment to faith, increased religious/spiritual practices).*

Whilst seemingly a conceptual fit for occupational therapy, matrescence is a newly developing theory emerging in practice and academic research. A rapidly growing body of research considers the dimensions of women's wellbeing and care during perinatal transitions, and satisfaction with experience as perinatal healthcare users (Barnett, 2020; Collins et al., 2017; Finlayson et al., 2020; Parliament of Victoria, 2018; Tully et al., 2017; Vogels-Broeke et al., 2019; World Health Organization, 2018). However, there is little known about women's wellbeing needs in the context of human occupation and matrescence transitions.

FINDING A FIT FOR OCCUPATIONAL THERAPY IN MATERNAL DEVELOPMENT AND PERINATAL CARE PATHWAYS

Global calls and actions to address deficits in woman-centred maternal health service structures have seen an expansion of gestational trimesters and the perinatal period, most rapidly over the last five years (Davis & Lovegrove, 2019; Tully et al., 2017; Verbiest et al., 2018; World

Health Organization, 2018, 2020). This expansion has coincided with occupational therapy roles emerging in maternal care, finding a fit both within and beyond the scope of perinatal and maternity healthcare services. Hospital-based perinatal health and medicalised maternal healthcare service models were perceived by many occupational therapists as barriers prohibiting the discipline from joining multidisciplinary teams. While all occupational therapists expressed interest in working collaboratively within or alongside maternity healthcare teams, professional employment opportunities to achieve this were rare. Being recognised, accepted, included, and valued in maternal healthcare teams was a motivating driver and ambition of many occupational therapists in the case study.

Occupational therapists saw their roles as unique, accessible, and offering holistic services which benefitted women, children, families, and added value to perinatal healthcare teams. Participants saw occupational therapists' potential to work with existing healthcare teams, and bridge the gap between perinatal, mental health, paediatric healthcare, and early childhood education services. Occupational therapists have flexible practice capacity to become accessible to work with women and families who are, who have become, or who are at risk of being vulnerable during matrescence, and who want to avoid or are not eligible for maternal healthcare services (Ferigato et al., 2018; Grabarkewitz & Swanson, 2020; Hanish et al., 2019; Sepulveda, 2019).

STRENGTHENING THE CONNECTION BETWEEN HEALTH, WELLBEING AND OCCUPATION

Whilst many therapists drew from conceptual practice models, most rejected reductionist conceptual frameworks and practice models to understand the person as a complex and evolving being, shaped by a myriad of intergenerational, biological, and sociocultural influences, and lived experience. This issue aligns with research highlighting that many occupational practice

models fail to recognise the humanness of occupation and the relational nature of environments (Reid et al., 2019). Many therapists extended their knowledge base beyond occupational therapy to profile the person as an occupational being whose health, wellbeing, functions, and capacities were contextualised by their lived experience and maternal development during and beyond perinatal stages. The occupational therapy practice scope including and expanding beyond perinatal stages and maternal health can be better understood through person-centred practice during matrescence.

PROPOSED MODEL OF CONCEPTUAL PRACTICE: THE PERSON-CENTRED OCCUPATIONAL MODEL OF MATRESCENCE (POMM)

Becoming a mother is a pivotal and paradoxical life event (Prinds et al., 2014, p. 732), involving a spectrum of transitional and transformative changes across multiple occupational and contextual domains (Barnett, 2020; Grabarkewitz & Swanson, 2020; Pascoe Leahy, 2021). The occupational therapy client-centred and woman-led practice approaches described in the multiple case study align with calls to acknowledge women's concerns about their sense of control, believability, choice, and roles as they sought support for non-medical issues and symptoms from over-medicalised maternity care services (Creedy et al., 2017; Neiterman, 2013; Reid et al., 2019). Examining the relationship dynamic between the person, environment, and occupation are consistent with the occupational paradigm, occupational therapy conceptual practice approaches, and the concepts underpinning person-centred evidence-based practice (EBP) in occupational therapy (Cordier & Wilkes-Gillan, 2017; Pentland et al., 2018). These elements provided the foundations for development of a proposed conceptual practice model: the Person-centred Occupational Model of Matrescence (POMM).

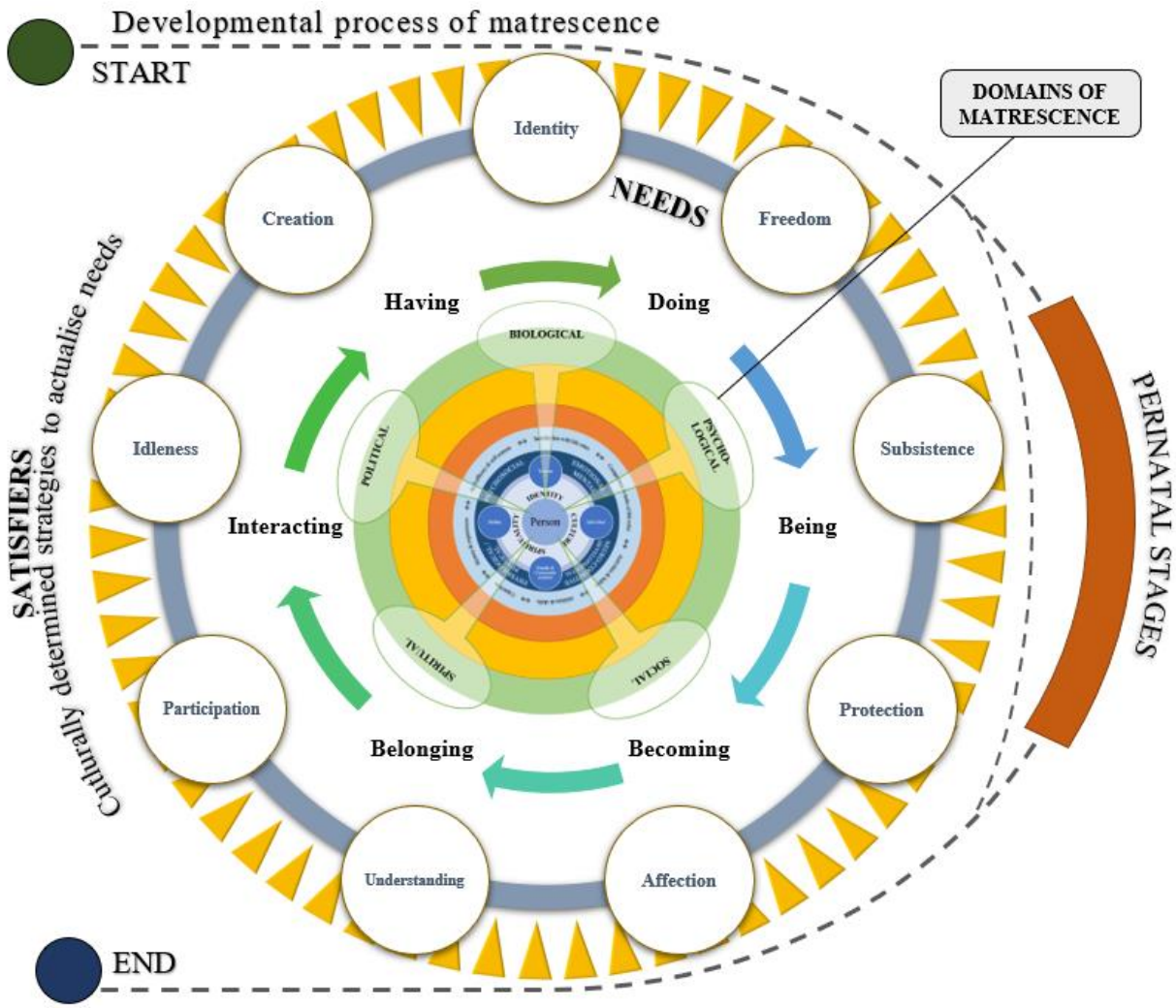
A conceptual model of practice is defined by Duncan (2011, p. 45) as, “occupation-focused theoretical constructs and propositions that have been developed specifically to explain the process and practice of occupational therapy”. While the contemporary occupational paradigm offers therapists “a rich formula for what it means to be an occupational therapist” (Kielhofner, 2009, p. 269), conceptual practice models are a necessary practice tool which therapist use to interpret and explain their client’s issues, needs, and goals, and guide therapy. In response to professional EBP gap identified occupational therapists in the multiple case study, the development of a conceptual practice model was determined to be a meaningful and useful contribution to potentially clarify practice decisions and inform future professional development. The POMM is in the early stage of development, and offers a “thoughtful and theory-based approach” (Kielhofner, 2009, p. 269), to conceptualise the complexity of how occupational therapists work with women during perinatal stages and matrescence. The POMM needs to be tested in practice, with tools developed, the evidence-based increased, and rigorously tested for external verification and usefulness (Duncan, 2011).

The POMM conceptualises how interrelated domains of women's occupational wellbeing needs, and satisfiers facilitate self-efficacy development and empowerment through having, doing, being, becoming, belonging, and interacting, during perinatal stages and the developmental process of matrescence. Occupational therapists’ person-centred practice and woman-led approaches using occupation-centred practice and person-environment-occupation (PEO) principles (Ford et al., 2021; Hinojosa et al., 2020b; Kielhofner, 2009) are contextualised within the domains of matrescence (including perinatal transitions), as a transformative life event. The direction, meaning and value of this approach is clarified when reframed through the lens of occupational wellbeing; with occupational therapists working to support women self-

satisfying their fundamental human needs during a transformative life event. Occupational participation and engagement were used as interventions tailored to mitigate the risk of occupational imbalance, disruption, and deprivation through facilitating the person's development of self-efficacy and empowerment (refer Figure 17). Components of POMM are progressively explored in the remainder of this chapter, commencing with the core PEO aspects.

FIGURE 17

Proposed model of conceptual practice: The Person-centered Occupational Model of Matrescence (POMM)



In the POMM, a woman's experience of matrescence is conceptualised as a complex, transformative and dynamic phenomenon with multiple and interrelated domains, shaped developmental changes, occupations, fundamental human needs, and culturally determined satisfiers over time. Matrescence can be regarded as a rite of passage, examined as a biological fact, culturally constructed life event, and "a series of interaction and changed interrelations with other members of the community" (Raphael, 1975, p. 66). The start and end of matrescence align with this definition. According to Raphael (1975), whilst the "physiological stage of matrescence begins when a female delivers a live infant…, giving birth does not automatically make a mother out of a woman" (p. 66). The moment when a woman is transformed into a mother is a subjective reflection of social, cultural, personal, medical, and politicised definitions of maternal status.

Perinatal stages in the POMM are conceptualised as part of matrescence, represented as a separate experience where women's motherhood journey's become guided and sometimes dominated by medicalised gestational stages and transitions through maternity healthcare services (Alexander, 2020; Benoit et al., 2010; Dombroski et al., 2016; Prinds et al., 2014). Occupational therapists in the case study worked with women during puberty, menstruation, pre-conception, fertility challenges, assisted reproduction, miscarriage, stillbirth, early infant death, adoption, fostering, and beyond the child's first year of life, and menopause. During data collection and analysis it became apparent that these domains of motherhood did not fit within the politicised construct of perinatal health (Alexander, 2020). However, they do fit within the broader spectrum of matrescence, which sees perinatal phases being an optional pathway within a greater rite of passage.

From a human behavioural perspective, Raphael (1975) conceptualised that a person's engagement in mothering roles and maternal behaviours can mark the commencement and conclusion of matrescence. This personal experience "can be extended as far back as when

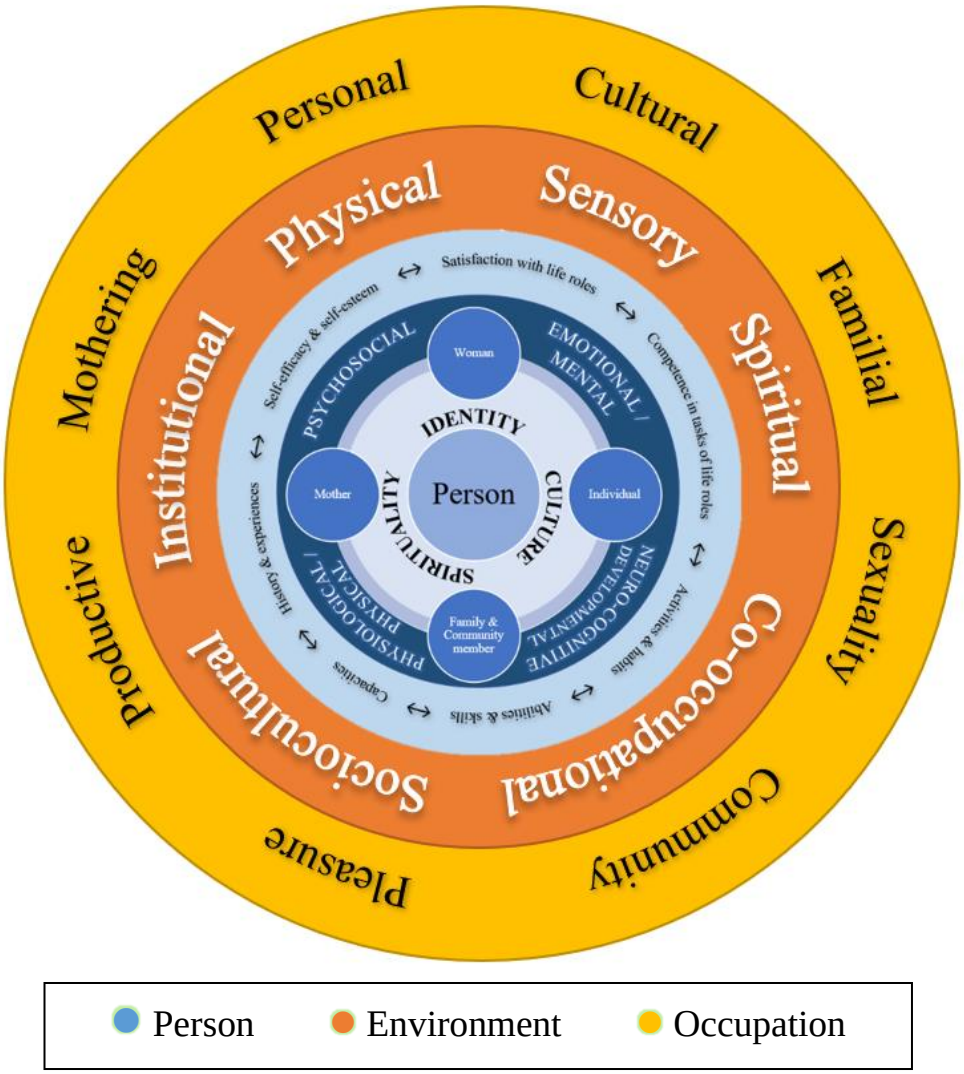
the individual girl/child first mothered a pet, a doll, or another baby", and continue across the lifespan until, "in some instances, full matrescence is not reached until one's own children become parents and one learns a new pattern for mothering grandchildren" (Raphael, 1975, p. 70). By conceptualising that occupations are central to life transitions (Blair, 2000), the POMM has been designed to reflect the occupational nature of matrescence. Women's changing engagement in mothering occupations and co-occupations can be regarded as occupational domains marking maternal developmental milestones during matrescence. The occupational nature of matrescence aligns with the occupational adaptation dimensions of doing, being, becoming and belonging (Hitch & Pepin, 2021; Pentland et al., 2018), mastery (Grajo, 2020), and women's motivation, ability and capacity to satisfy their fundamental human needs (Max-Neef et al., 1989) during motherhood.

PEO COMPONENTS OF THE POMM

Motherhood is a profoundly meaningful, disruptive, and transformative occupation. For women experiencing maternal development or transformation, relationships with themselves and others, their environments and occupations gradually became dominated by their experience of the phenomenon. Analysis of the case study suggested this paradigm shift alters women's personal causation, volition, and perception of meaningful engagement in occupations and environments, which extends from Ferigato et al.'s (2018) research exploring corporality of pregnant women and occupational therapy. Influenced by occupational-centred practice (Ford et al., 2021) and the PEO model (Reid et al., 2019), which all therapists identified as relevant, the POMM reflects how a person's perception of engagement in necessary and meaningful environments and occupations during maternal development can become altered by the phenomenon of matrescence. The proposed PEO components of the POMM are depicted in Figure 18.

FIGURE 18

The person-environment-occupation (PEO) components of meaningful and necessary occupational engagement and performance during motherhood



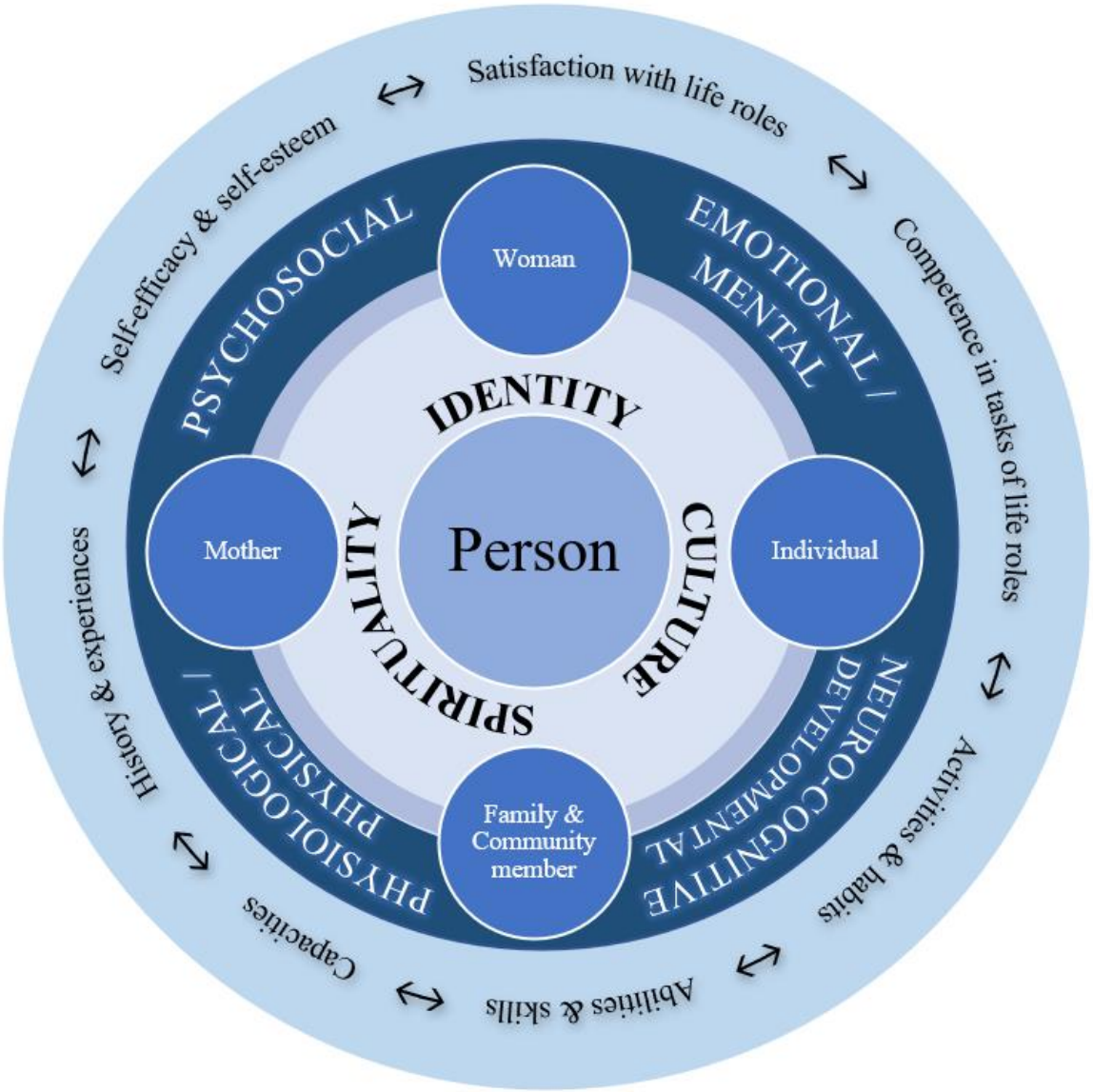
PERSON

Occupational therapists' consistent identification of the woman as a 'person' enabled a client-centred practice framework to be applied. The non-gendered frameworks and compartmentalisation of practice contexts reframed the woman as a 'person' during prenatal, intrapartum, and postnatal phases, and perinatal transitions into components of maternal development. This perspective offered a fresh perspective for exploring women's experiences and needs and highlighted the complex transformation across a spectrum of personal

domains. This is consistent with recommendations for future occupational therapy models to reprioritise the “humanness of the human engaged in occupation”, and the essence of a person’s relational connection with environments (Reid et al., 2019, p. 5). The occupational profiling of a woman as a person engaging in meaningful human occupations in the context of life transition and transformative life events is unique and complex (refer Figure 19).

FIGURE 19

Interrelated intrinsic domains of self-efficacy, personal development, occupational function and wellbeing during matrescence



PERSON

The phenomena of each person living as an individual human occupational being (Reid et al., 2019).

IDENTITY, CULTURE & SPIRITUALITY

A person's sense of identity, cultural connection, and spirituality changes during their lifespan, and is central to their being. This is influenced by how a person processes a myriad of components, life events and experiences over time. These reflect concepts identified in the multiple case study. A person's choice to engage in the world as mother, woman, individual and family or community member shapes their identity and sense of wellbeing.

DOMAINS OF OCCUPATIONAL FUNCTIONING

Women's wellbeing was impacted by how they were able to function in the world. This reflects domains of maternal development and wellbeing occupational therapists addressed with women during perinatal and motherhood transitions.

SELF-EFFICACY DEVELOPMENT THROUGH OCCUPATIONAL FUNCTION & MASTERY

Adapted from Occupational Functioning Model (Trombly Latham, 2014) and Occupational Adaptation Model (Grajo, 2020). Reflects how a person interprets the nature, value and meaning of occupational engagement, participation, and need, which lead to a sense of self-empowerment.

IDENTITY, CULTURE, AND SPIRITUALITY

Occupational therapists regard being a woman, mother, individual, and family or community member as having a deeper meaning than roles to be performed and were intrinsic components of a person. Identifying oneself as a mother, woman, individual and family and community member is deeply personal. A person's sense of identity, connection with culture, and spirituality shapes their lived experience and influences how they perceived themselves, their place and value in the world. Their self-belief, values, and life paradigm shape their expectations of themselves as occupational beings and provides a lens for interpreting lived experiences and occupational engagement opportunities and needs during motherhood.

This perspective allows diversity, compassion and understanding in person-centred care for women during perinatal stages, beyond medicalised, politicised, Colonised, heteronormative, and gendered influences dominating Westernised perinatal maternal healthcare. Occupational therapists in the multiple case study worked with women whose personal sense of identity as a 'mother' differed. This was consistent with Pascoe Leahy's (2021) sociological definition of, "'mother' as someone who takes on significant emotional and practical caring responsibilities for a child and, importantly, self-identifies with a maternal characterization", which includes, "birth-giving mothers, adoptive mothers, relinquishing mothers, stepmothers, and co-mothers" (p. 274).

Occupational therapists' sensitive approach to self-concept aligns with contemporary research exploring women's reproductive and maternal identity development during motherhood (Athan, 2020; Finlayson et al., 2020; Segal, 2004). Understanding maternal identity through woman-led occupation-centred practice revealed that pregnant women preparing to adopt the child immediately following birth may not identify as mothers, whereas foster parents and women with multiple pregnancies and no live births might.

Occupational therapists' interpretation that women's identity as a mother was demonstrated through meaningful occupational choices relating to rituals, integrating intergenerational cultures and traditions into daily activities such as preparing food and family meals aligns with research embedding identity within spiritual and cultural occupations (Acharya, 2014; Hackett & Cook, 2016; Segal, 2004).

The POMM is designed to recognise the impact of complex social issues such as education and poverty, cultural diversity, health, race and class, age, and community on mothers occupational wellbeing (Ferigato et al., 2018; Head & Esdaile, 2004), which aligns with the occupational therapy practice profile in addressing social and occupational justice (Canadian Association of Occupational Therapists, 2012). Occupational therapists worked with women to explore their changing sense of spirituality and identity to develop confidence and work out who they are, as individuals and mothers, during motherhood which is known to often become challenged during motherhood experiences (Athan, 2020; Finlayson et al., 2020).

DOMAINS OF OCCUPATIONAL FUNCTIONING

Occupational functioning in the context of wellbeing was complex due to the transformative nature of maternal development, "normalisation" of common symptoms and issues, women's personal paradigm shifts during motherhood transitions, and the necessity for significant lifestyle redesign when becoming a mother. In the absence of known research into how occupational therapy theoretically conceptualises maternal development, these domains are drawn from the evidence-based occupational therapy practice approaches in the multiple case study. The four domains of occupational functioning include: Emotional/mental; Neuro-cognitive and neurodevelopmental; Physiological and physical; and, Psychosocial.

Emotional/mental wellbeing refers to a person's capacity to recognise, understand, cope with and work through a broad spectrum of personal, environmental, and occupational disruptions and changes, commonly emerging as mental and emotional 'symptoms' such as 'struggling', baby blues, and fear-avoidance behaviours during perinatal motherhood phases. *Neuro-cognitive and neurodevelopmental* recognises normalised maternal symptoms such as 'baby brain' as occupational performance issues impacting women's functional capacities (Connolly, 2018; Davies et al., 2018; Pownall et al., 2021). This component encompasses a range of global functional implications stemming from sleep deprivation, distress, poor nutrition, fatigue, exhaustion, pain, occupational overloading and overwhelm, trauma, and the psychocognitive shift in moving from individual person to bonded mother-infant dyad and mindfully engaging in co-occupations. *Psychosocial* wellbeing recognised the inseparable dynamic between mental wellbeing and social engagement influenced by changing behaviours and meaningful relationships, and sense of connectedness and belonging as individuals and mothers throughout maternal developmental stages. Relationships included mother-infant, partner, co-parents, familial and intergenerational, friendships, community, workplace, and reflects a collaborative relationship-focused occupational therapy approach (Restall & Egan, 2021). This aligns with research recognising the connection between psychosocial relationships and mental health (Røhder et al., 2020), and the importance of strengthening healthy bonded attachment between mother-infant dyads (Alexander, 2020; Pascoe Leahy, 2021), and mother-infant-family triads (da Conceição et al., 2020).

Physiological and physical refers to the structural and physiological system changes and challenges women's bodies undergo during the course of maternal development, which impacts their capacity for biomechanical and occupational function and movement, sensory processing, systems regulation and co-regulation, as individuals and in the mother-infant dyad (Germain, 2018; Kerley, 2022; Lederman & Weis, 2020a; Potticary & Duckworth,

2020). Sensory processing for physiological systems regulations was a strong focus for many therapists, and included body mapping (proprioception), hearing, pain (nociception), sight (perception of colour; sense of light with orientation to time of day), itch (pruriception), smell, taste, temperature (thermoception), touch (pressure, vibration, interpersonal contact), orientation, navigation and balance (vestibular senses), interoception, and gut senses (hunger, thirst and waste, including fullness and osmotic pressure) (Young, 2021). Interoception is considered in many therapeutic approaches to addressing women's self-care occupations (including mindful, nurturing food choices), social connection, emotional wellbeing, self-efficacy development, prevention and recovery from perinatal trauma, and meaningful engagement in co-occupations and co-regulation (Arnold et al., 2019; Kerley, 2022; MacCormack et al., 2020).

SELF-EFFICACY DEVELOPMENT

Self-efficacy development through occupational function and mastery was a primary goal of most occupational therapy interventions in the multiple case study and were described by both occupational therapists and service users. Many participants endeavoured to explore and understand how a person's interpretation of a lived experience impacted their wellbeing. This was a fundamental client-centred practice component that guided how occupational therapists facilitated women's development of self-efficacy and empowerment. Occupational therapists in the case study observed that women's values and beliefs about motherhood were influenced by their experiences with their mothers, family life, and being mothered. This aligned with research exploring diversity in women's identity and relationship changes during motherhood (Pascoe Leahy, 2021), which are connected with empowerment, psychosocial wellbeing and self-efficacy development (Barnett, 2020; Mikolajczak et al., 2018b; Vidmar, 2020a).

There are currently no known occupational therapy models which conceptually frame how practitioners interpreted the complex transgenerational or habitual schematic processes of a person in experiencing the transformative events of mother-becoming and maternal development. Concepts and themes gathered from the multiple case study aligned closely with two practice models identifying empowerment and self-efficacy development as the primary and most significant outcomes for clients: the Occupational Functioning Model (OFM) (Trombly Latham, 2014) and Occupational Adaptation (OAM) model (Grajo, 2020).

The OFM is a collaborative and client-centred model geared towards an outcome of self-fulfilment, self-esteem and self-empowerment through the development of role competence (Trombly Latham, 2014). Whilst limited to physical dysfunction in occupational therapy practice, the OFM conceptually aligns with practitioner focus on promoting competence, satisfaction and empowerment for women accessing occupational therapy during perinatal stages and motherhood. The OFM has further relevance to maternal clients in sharing outcomes pertaining to occupational performance, adaptation, health and wellness, participation, prevention, quality of life, role competence, self-advocacy and occupational justice, as a result of occupational therapy goal-setting, assessment and intervention and evaluation processes (Trombly Latham, 2014).

The OAM is complex and individualised, focused predominantly on how a person adapts to master their occupational environment (Grajo, 2020). It was developed for practical application enabling occupational therapists to conceptually frame how "occupation provides the means by which human beings adapt to changing needs and conditions", when a person's, "normal developmental process… has been disrupted through illness or trauma" (Schkade & Schultz, 1992, p. 829). The primary outcome of the schematic occupational adaptation flow is the dynamic development of mastery through a person's experience of occupational challenges, role expectations and adaptive responses (Schkade & Schultz, 1992; Schultz &

Schkade, 1992). The process of occupational adaptation enables development and achievement of competence, mastery, motivation, and resilience, valuing self-initiated engagement through "doing, active involvement and choice" (Grajo, 2020, p. 288). This conceptually aligned with case study accounts of how occupational therapists support women through experiences of occupational change, disruption and deprivation, dysfunction, overwhelm, traumatic and transformative experiences, in the context of maternal development.

Components of the OAM are adaptively interwoven with OFM components within the person's *Self-efficacy development through occupational function and mastery* domain. This is collectively represented as a continuous cycle of changing self-perceived capacities, abilities and skills, activities and habits, competence in tasks of life role, satisfaction with life roles, self-efficacy and self-esteem, and history and experiences. This represented a lens as to how occupational therapists explore and address a person's schematic approach to interpreting their experience of human occupations, reflecting their adaptation skills and self-efficacy development styles and patterns.

Throughout stages of maternal development and perinatal transitions, occupational adaptation is an ever-present phenomenon that women negotiate at home, work, and across all facets of their daily life routines (Finlayson et al., 2020; Vogels-Broeke et al., 2019). This is consistent with the occupational science concept that people's conscious decisions to engage in an orchestrated and structured daily blend of "occupations… mediate adaptation" (Yerxa, 1990, p. 6). Occupational adaptation and MOHO are commonly referenced in occupational therapy research exploring women's wellbeing and perinatal health (Avrech Bar et al., 2016; Briltz, 2019; Burbidge, 2015b; Michelitch, 2009; Pizur-Barnekow & Erickson, 2011; Watkins, 2019). Whilst some women adapt with varying degrees of disruption through

perinatal transitions, others experience a transformative life event that disrupts and affects every aspect of their occupations, environment, and life paradigms.

ENVIRONMENT

The meaning of environments often changes for women during adaptation to motherhood. The six domains of occupational environments identified in the case study are summarised as: Co-occupational; Institutional; Physical; Sensory; Sociocultural; and Spiritual. Environments such as homes, cars, outdoor spaces, public spaces, shops, restaurants, communities, healthcare clinics, and workplaces transformed as a woman progressively perceived them through the lens of *co-occupation*. As many women grow to become mindful of their child's occupations as much as their own, how they perceive the accessibility, functionality, comfort, and purpose of environments changes. Engaging in environments as a mother-infant dyad to perform co-occupations can be supported by occupational therapists.

The POMM reflects the conceptualisation of women's bodies as a nurturing occupational environment during matrescence in the context of pre-conception, conception, pregnancy, birthing, breastfeeding, and infant caring. The interrelationship between women's mind-body-environment-time influenced wellbeing are complex co-occupational environments for creation, sustaining, birthing, and nurturing infant development during perinatal phases aligns with research (Conrad, 2006; Creek, 2008; Gatrell, 2011). Occupational therapists address women's body's as complex physical co-occupational environments through the lens of hand therapy, pelvic function, biomechanics, epigenetics, sensory processing, and physiological systems regulation. As women's bodies and functional capacities changed during maternal developmental stages and motherhood, their relationship with *physical* environments altered. These changes influenced women's perception of

physical environments as being accessible, comfortable, safe, and functional. This included physical environments for labour, birthing and immediate post-partum, which saw interconnection with co-occupational and sensory environments.

Perinatal healthcare services were typically provided from *institutional* settings, which the woman was required to attend regularly during motherhood transitions. Institutionalised environments delegated the person into the role of perinatal healthcare service patient and consumer (Dombroski et al., 2016), seeing women enter a foreign world governed by medical maternalist language and mandatory procedures. This could be disengaging, disempowering and traumatic for women. Occupational therapists provided a range of services to support women to develop and gain a sense of control and empowerment, self-efficacy, self-advocacy, work through feelings of fear-avoidance, and manage trauma triggers in institutional environments. The impact on women was usually long-lasting, and occupational therapists provided support to women leading up to, during, following, and in-between intrapartum experiences.

Sensory environments during motherhood played a significant role in maternal and mother-infant development and occupational wellbeing. In keeping with occupational therapy approaches to sensory modulation, integration and regulation (American Occupational Therapy Association, 2020; Bochenek et al., 2017; Occupational Therapy Australia, 2017), occupational therapists addressed the impact on women's physiological systems regulation in relation to a spectrum of complex and changing multisensory environments throughout maternal developmental phases. Environmental sensory stimuli were identified through occupational analysis, with efforts made to moderate stressors and relievers influencing women's capacity to self-regulate their emotions, coping and systems response during occupational performance. This was considered in the context of occupational overwhelm

and overloading, reduced thresholds stemming from perinatal trauma and triggering occupations or environments, and mother-infant co-occupations and co-regulation.

The *sociocultural* environments women occupationally engaged with shaped expectations of role performance and capacity for wellbeing and included virtual (online) and real-life communities. These environments played a large role in shaping women's perceived sense of identity, connection, roles, relationships, capacity, potential, belonging, power, acceptance, and worth. Occupational therapists supported women who felt socially isolated to seek connection with other 'like-minded' mothers, finding environments where they felt able to be themselves, and accessing services respectful and flexibly accommodating of their unique sociocultural background and context. Making efforts to understand women's sociocultural contexts for motherhood was in keeping with collaborative relationship-focused occupational therapy practices (Restall & Egan, 2021). This approach allowed occupational therapists to gain insight into women's unique motivations, attachment styles and exposure to parenting role-models, co-parent, partner and familial relationship dynamics, and reaction to intergenerational influences shaping life role expectations.

The *spiritual* nature of environments emerged as a focus for several occupational therapists (Jones et al., 2016). This appeared due to the nature of mothering occupations being deeply rooted in a person's sense of spirituality, and cultural traditions, values, roles, all of which commonly emerged for personal reflection during the paradoxical transformation to motherhood. In the USA, Canada, and Australia, occupational therapists prioritised spiritual environments in practice, often coupled with sensory and physical components. Participants identified that becoming a mother was a deeply spiritual and empowering experience. They individually worked to adjust the flow and energy of spiritual environments to facilitate the development of a sense of peace, wellness, strength, and balance for women

during preconception and during pregnancy in preparation for spiritually empowering and connected intrapartum experiences.

OCCUPATION

Women's occupations during the transformation to motherhood were often shaped, and sometimes defined, by the experience. Occupational engagement and meaning during maternal development phases were individual and multidimensional, which occupational therapists considered reflected the woman's perceived sense of identity, obligations, and intrinsic need. The domains of occupation commonly addressed by therapists in the multiple case study included community; cultural; familial and intergenerational; mothering; personal; pleasure; productive; and sexuality. These concepts aligned with domains of health, wellbeing and maternal development becoming increasingly well-known for women during perinatal stages (Doble & Caron Santha, 2008; Lederman & Weis, 2020a; Tully et al., 2017).

Community occupations included shopping, health and medical appointments, socialising, care and education, and transport for community access. The nature of *cultural* occupations was defined by the woman's values, traditions and background, and engagement in social media, which are increasingly recognised in contemporary occupational therapy practice approaches (Restall & Egan, 2021). These influenced occupational choices about engaging in gendered roles, routines and rituals, informing standards and expectations about working, family, mothering, co-parenting and home duties. *Familial* occupations were those that the woman assumed within the family unit, and included decisions and management of the family's finances, healthcare, routines, nutrition, hygiene, home environment set-up and facilitating meaningful relationships between family members. Several occupational therapists stressed the importance of understanding the pressure on women to perform these tasks and activities, particularly when caring for more than one child.

Mothering occupations included the essential, routine, and necessary tasks and activities required for infant and child wellbeing and sustenance, as well as co-occupations. These did not necessarily include interaction with the child and addressed items and objects required for infant care, such as bottles, nappies, clothes, food, and objects within the home, such as cots, baths, highchairs, carriers, prams, and car seats. Co-occupations were contextualised by the inseparability of the mother-infant dyad. These were interactive opportunities to develop relationship bonds, and included nesting, pregnancy, birthing, bathing, feeding (breast, bottle, nasogastric/PEG tube, introducing solids, weaning), changing, playing, co-sleeping, co-regulation, settling to sleep, and communication.

Personal occupations were those the woman needed to do for herself, and included self-care, engagement in spiritual occupations, enabling healing, investing in recovery, personal growth, self-regulation, identity development, health management, relationship maintenance, prioritising wellbeing, and self-efficacy development. *Pleasurable* occupations were wellbeing activities that brought the woman a sense of leisure, joy and renewal (Doble & Caron Santha, 2008) in the absence of opportunities for leisure, positive identity development, nurturing and self-care; notorious sources of occupational deprivation in motherhood. These included building positive and nurturing relationships, strengthening friendships, creating communities, developing meaningful and healthy routines, a positive sense of identity and self-efficacy and actively working towards future goals.

Productive occupations included work, self-care and nurturing infant development during pregnancy, home duties, nurturing family development across the lifespan, and creation, maintenance, and development of a successful family home environment. For example, Rosalind sought help from an occupational therapist to facilitate maintaining her work role performance during pregnancy, Susie developed strategies for single mothers

returning to work early in the postpartum period, and Pamela and Cath supported pregnant women continuing to work from bed during prolonged hospital admissions.

Occupations relating to *sexuality* included giving and receiving affection, intimacy, engaging in intimate partner activities (not necessarily involving sex activities), engaging/re-engaging in sex activities (independently or with a sexual partner), body image and self-view, pelvic health and function, family planning, and sexual health, sexual identity, interests, motivations and routines (Walker et al., 2020). Identity, self-efficacy and performance relating to sexuality, and sexual intimacy are meaningful occupations (Michelitch, 2009) and within occupational therapy scope of practice (MacRae, 2013; Ralph et al., 2017; Tipton-Burton et al., 2018; Young et al., 2020). Expression through sexuality is a primary occupational domain influencing health and wellbeing, which impacts relationships (MacRae, 2013; Young et al., 2020). Bortolami et al. (2015) explain "the ability to express one's sexuality and engage in sexual activity requires multisystemic coordination involving many psychological functions as well as the integrity of the nervous, hormonal, vascular, immune, and neuromuscular body structures and functions" (p. 1233).

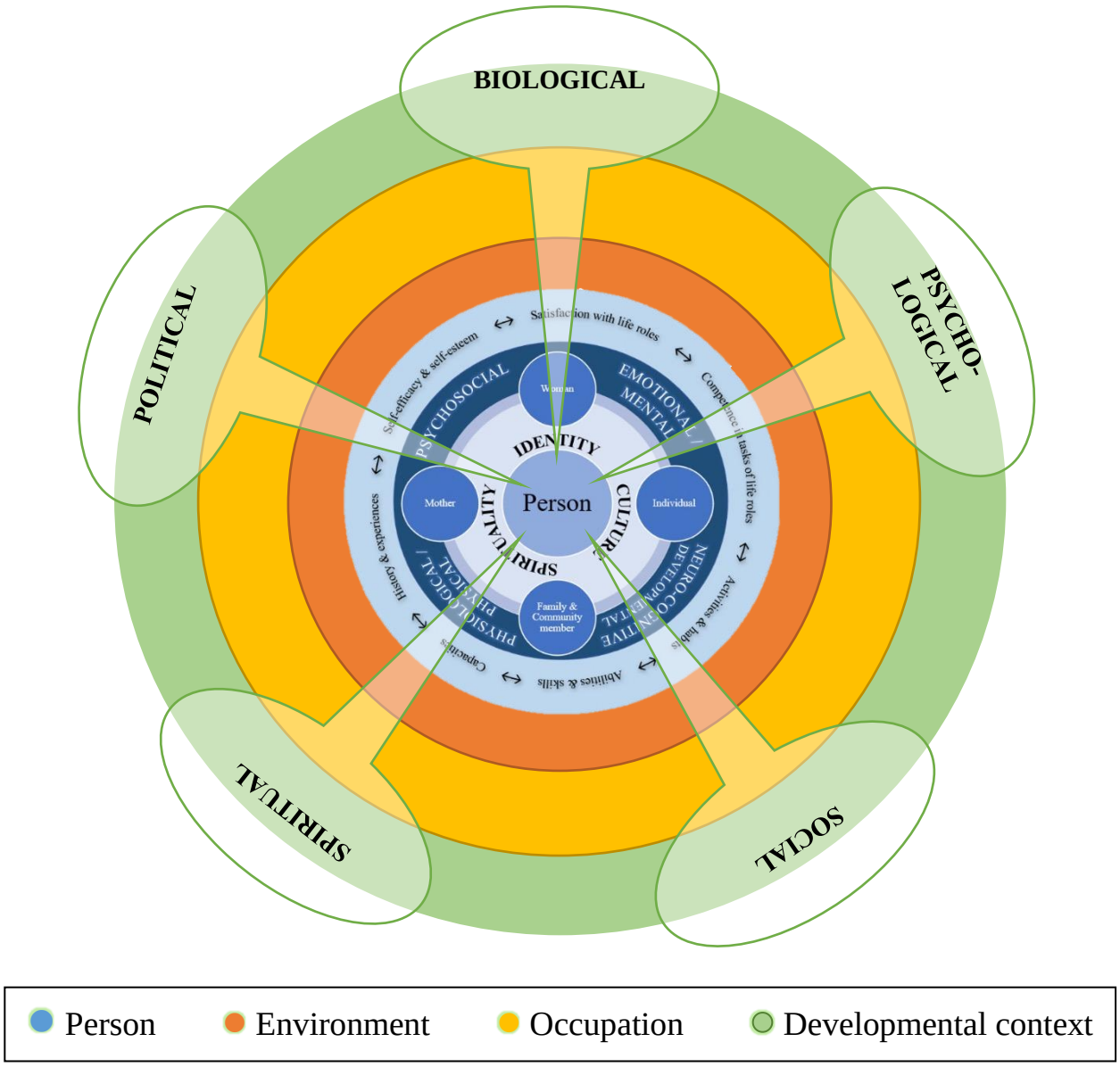
EXTENDING THE PERINATAL PARADIGM: THE DEVELOPMENTAL CONTEXT OF MATRESCENCE

Maternal development and matrescence are fields of contemporary study and emerging knowledge that are in their infancy (Athan & Reel, 2015; Lederman & Weis, 2020a). The domains of matrescence are defined in maternal psychology as bio-psycho-social-spiritual-political (Athan & Reel, 2015) aligned with the physical, psychological, social, spiritual and gendered, cultural and social justice elements influencing occupational therapy client-centred practice, as reported throughout this thesis. These elements appear to

align with the context of maternal development occupational therapists referred to throughout the multiple case study and are assumed to permeate all domains of human occupation (refer Figure 20).

FIGURE 20

Components of human occupation contextualised by the developmental process of becoming a mother, and the domains of matrescence



Defining the bio-psycho-social-spiritual-political domains of matrescence is beyond the scope of this thesis. The occupational nature of matrescence has been introduced and

conceptualised with relevance to the POMM; however, require further research and development to enhance understanding and meaningful relevance. The theoretical potential for domains of matrescence to be developed in relation to occupational therapy can be hypothetically considered within the concept of *matricentric feminism*.

MATRICENTRIC FEMINISM

From an academic perspective, matricentric feminism has been rapidly developing in the last five years (Barnett, 2020; O'Reilly, 2019; O′Reilly, 2016; O′Reilly & Bueskens, 2016a, 2016b; Pascoe Leahy, 2021; Pascoe Leahy & Bueskens, 2020a, 2020b). These emerging concepts have arisen and evolved in response to social movements and perceived conflict and incompatibility between feminism and motherhood in popular culture during the early twenty-first Century (Pascoe Leahy & Bueskens, 2020b).

Matricentric feminism was introduced by O'Reilly (2019) as “a mother-centred model of feminism” (p. 13), which, “seeks to make motherhood the business of feminism by positioning mothers’ needs and concerns as the starting point for a theory and politics on and for women’s empowerment” (p. 14). The application of a matricentric feminist lens in place of standpoint feminism shifted my perception and understanding of occupational therapist’s roles in perinatal health and maternal development. This re-focus enabled instant clarity of how the emic qualities of the occupational paradigm conceptually aligned with the theoretical position of matricentric feminism:

> *It is to emphasize that the category of mother is distinct from the category of woman and that many of the problems mothers face—social, economic, political, cultural, psychological, and so forth—are specific to women’s role and identity as mothers (O'Reilly, 2019, p. 15).*

Matricentric feminism has featured in occupational therapy research (Barnett, 2020); however, matrescence has not yet been considered in occupational therapy research. These conceptually align with theories of meaningful occupation, occupational science, occupational behaviour and choice (Creek, 2008), rights-based self-determination (Restall & Egan, 2021), and occupational justice (American Occupational Therapy Association, 2020).

WOMEN'S HUMAN OCCUPATIONAL NEEDS AND SATISFIERS DURING MATRESCENCE

Based on the position that the experience of matrescence is a paradoxical life event which leads to changing personal values in response to existential questions about life meaning and purpose (Prinds et al., 2014), we see that "in many cultures and for most women becoming a mother is their most dramatic life crisis" (Newman, 1975, p. 9). Whilst occupational therapists in the multiple case study offered interventions to promote functional capacities and occupational performance, they also supported women's identity development and occupational wellbeing. This can be interpreted from a fundamental human needs perspective (Max-Neef et al., 1989), with occupational therapists providing services to facilitate and enable women to understand and self-satisfy their needs during a transformative life event.

Max-Neef et al. (1989) conceptualised fundamental human needs as a system from a deprivation and potential perspective, framing inter-related and interactive axiological and existential needs within a non-hierarchical (excepting subsistence) matrix (refer Table 23). Unlike human needs, satisfiers are culturally determined and influenced by a person's choices about quantity and quality. Satisfiers are contextualised with regards to the person, social group and environment, and vary according to rhythm of history, culture and circumstance (Max-Neef et al., 1989). This paradigm for human development was reflexively developed by a collaborative multicultural transdisciplinary team to be more organic, dynamic, and humane

than previous models. By interweaving development and human needs, an individual's capabilities and functions become determinants or domains of potential for attainment of the satisfiers necessary for quality of life and self-actualisation (Alkire, 2002; Max-Neef et al., 1989; Pelenc, 2017).

TABLE 23

Matrix of fundamental human needs and satisfiers

Matrix of needs and satisfiers[6]		Needs according to existential categories			
		Being	**Having**	**Doing**	**Interacting**
Needs according to axiological categories	**Subsistence**	1/ Physical health, mental health, equilibrium, sense of humour, adaptability	2/ Food, shelter, work	3/ Feed, procreate, rest, work	4/ Living environment, social setting
	Protection	5/ Care, adaptability, autonomy, equilibrium, solidarity	6/ Insurance systems, savings, social security, health systems, rights, family, work	7/ Co-operate, prevent, plan, take care of, cure, help	8/ Living space, social environment, dwelling
	Affection	9/ Self-esteem, solidarity, respect, tolerance, generosity, receptiveness, passion, determination, sensuality, sense of humour	10/ Friendships, family, partnerships, relationships with nature	11/ Make love, caress, express emotions, share, take care of, cultivate, appreciate	12/ Privacy, intimacy, home, space of togetherness
	Understanding	13/ Critical conscience, receptiveness, curiosity, astonishment, discipline, intuition, rationality	14/ Literature, teachers, method, educational policies, communication policies	15/ Investigate, study, experiment, educate, analyse, meditate	16/ Settings of formative interaction, schools, universities, academies, groups, communities, family
	Participation	17/ Adaptability, receptiveness, solidarity, willingness, determination, dedication, respect, passion, sense of humour	18/ Rights, responsibilities, duties, privileges, work	19/ Become affiliated, cooperate, propose, share, dissent, obey, interact, agree on, express opinions	20/ Settings of participative interaction, parties, associations, churches, communities, neighbourhoods, family
	Idleness	21/ Curiosity, receptiveness, imagination, recklessness, sense of humour, tranquillity, sensuality	22/ Games, spectacles, clubs, parties, peace of mind	23/ Daydream, brood, dream, recall old times, give way to fantasies, remember, relax, have fun, play	24/ Privacy, intimacy, spaces of closeness, free time, surroundings, landscapes
	Creation	25/ Passion, determination, intuition, imagination, boldness, rationality, autonomy, inventiveness, curiosity	26/ Abilities, skills, method, work	27/ Work, invent, build, design, compose, interpret	28/ Productive and feedback settings, workshops, cultural groups, audiences, spaces for expression, temporal freedom
	Identity	29/ Sense of belonging, consistency, differentiation, self-esteem, assertiveness	30/ Symbols, language, religion, habits, customs, reference groups, sexuality, values, norms, historical memory, work	31/ Commit oneself, integrate oneself, confront, decide on, get to know oneself, recognize oneself, actualize oneself, grow	32/ Social rhythms, everyday settings, settings which one belongs to, maturation stages
	Freedom	33/ Autonomy, self-esteem, determination, passion, assertive-ness, open-mindedness, boldness, rebelliousness, tolerance	34/ Equal rights	35/Dissent, choose, be different from, run risks, develop awareness, commit oneself, disobey	36/ Temporal/spatial plasticity

Note: Adapted from "Table 1: Matrix of Needs and Satisfiers" by Max-Neef et al. (1989, p. 33), in, *Foundations for a possible systemisation* of "Human scale development: An option for the future", *Development Dialogue*, 1, 7-80. www.researchgate.net/publication/285755287

[6] "The column of BEING registers attributes, personal or collective, that are expressed as nouns. The column of HAVING registers institutions, norms, mechanisms, tools (not in a material sense), laws, etc. that can be expressed in one or more words. The column of DOING registers actions, personal or collective, that can be expressed as verbs. The column of INTERACTING registers locations and milieus (as times and spaces). It stands for the Spanish ESTAR or the German BEFINDEN, in the sense of time and space. Since there is no corresponding word in English, INTERACTING was chosen 'a faut de mieux'". Taken from Max-Neef, M., Hevia, A., & Hopenhayn, M. (1989). Human scale development: An option for the future. *Development Dialogue*, *1*, 7-80. https://www.researchgate.net/publication/285755287, p. 33.

In the POMM, conceptualisation of satisfiers as forms of having, doing, being and interacting (Max-Neef et al., 1989) is likened to the occupational therapy framework of 'doing, being, becoming and belonging', developed in response to the broadening perspective of the complex relationship between occupation with health and wellbeing (Wilcock, 1999). Wilcock's (1999) framework combined occupational therapy and science to enable a holistic understanding of "occupational dysfunction and occupational wellness that is not constrained by a medical view of disorder" (p. 1). This had a likeness to Max-Neef et al. (1989) conceptualisation of changes that influence the capacity to satisfy human needs being structural, episodic and evolutionary, influenced by paces and rhythms of time.

The collective professional approach of occupational therapists in the multiple case study appears to have amalgamated these paradigms, by inadvertently demonstrating the practical application of "a framework for people to transform their lives through enabling them to do and to be and through the process of becoming… [including] transformation and self-actualization (Wilcock, 1999, p. 1). The relevance of Max-Neef et al. (1989) axiological human needs (refer Table 23) was also reminiscent of occupational therapists' perception of women's wellbeing needs during perinatal phases as reported earlier in this chapter, and offers an opportunity to further explore the emerging role of occupational therapy in matrescence.

The relationships between development, wellness, and wellbeing with satisfying human needs have been conceptualised a few times (Gasper, 2007; Pelenc, 2017); however, not in the context of human occupation or matrescence. In 2012, the World Federation of Occupational Therapy affirmed a professional commitment to ensuring equitable, inclusive and innovative "occupational opportunities necessary to meet human needs, access human rights and maintain health" (Hammell, 2019, p. 21). This professional commitment was demonstrated in occupational therapy practice accounts explored in the multiple case study.

SUMMARY

The POMM conceptual practice model reflects the complex human and occupational nature of perinatal transitions, maternal development, personal paradigm shifts (Duncan, 2011). It has been reflexively developed by loosening the obligation to conceptually fit within existing reductionist models (Reid et al., 2019). Acknowledging that many of the 'common-sense' issues women struggle with during perinatal stages have long been normalised, downplayed, and nominalised in medicalised healthcare, this approach sought to avoid oversimplifying the phenomenon (Barnett, 2020; Neiterman, 2013; Pascoe Leahy, 2021). Occupational therapists in the case study acknowledged the social expectations of women to adapt and transition during perinatal transitions, who then made conscientious efforts to respectfully withhold judgement about personal choices and mothering performance expectations.

The POMM has been progressively and reflexively developed in accordance with the model of conceptual practice development recommendations (Duncan, 2011; Kielhofner, 2009). As a proposed model, the POMM requires critical appraisal, debate and future refinement of conceptual ideas and understandings with the occupational therapy community, clinicians, clients, and academics (Duncan, 2011). Testing in practice will be required to determine and progressively establish validity, and develop protocols and practice tools, which can then be rigorously tested to verify the POMM and practice tools (Duncan, 2011; Kielhofner, 2009).

CONCLUSION

The theoretical components of how occupational therapists approached and interpreted women's maternal development and occupational issues, needs and wellbeing

were discussed. Key terms to guide the development of a professional language for occupational therapists in perinatal health and matrescence were suggested, and a proposed model of conceptual practice, the Person-centred Occupational Model of Matrescence (POMM) was presented and discussed. The following chapter concludes this thesis, and includes a statement of limitation, recommendations, and concluding remarks.

CHAPTER 12: CONCLUSIONS, LIMITATIONS, AND RECOMMENDATIONS

"If you don't like something, change it. If you can't change it,

change the way you think about it."

– Mary Engelbreit

In this final chapter, my research exploring the role of occupational therapists working to support the needs of women during perinatal transitional periods is reflexively considered. Strengths and limitations of this study that have influenced the quality and comprehensiveness of the findings are reported. Finally, directions for further research and implications for practice are recommended.

REFLEXIVE INTRODUCTION

One of my favourite sayings is, '*a comfort zone is a beautiful place, but nothing ever grows there'* (Unknown author, 2022). This doctoral experience has truly drawn me far beyond many of my comfort zone boundaries. I commenced this research motivated to compile an evidence base that could be used to improve maternity healthcare teams. Someone joked with me recently that hindsight might be one of humankind's greatest afflictions. Before this PhD commenced, my understanding of occupational therapy was culturally biased and limited to my professional practice experience and education. It has become a running witticism with my colleagues that I never found any concrete evidence in my research stating that occupational therapists can and should prescribe over-toilet aids and shower-chairs to new mothers following caesarean delivery. What I did find, instead, was a community of like-minded occupational therapists in a broad spectrum of roles around the world. They

were driven by a shared desire to make a difference and enhance EBP for occupational therapists within and aligning with maternity healthcare services. I did not expect the diversity, complexity and breadth of findings that emerged during this doctoral research. I did not anticipate that I would experience a sense of privilege in hearing the bravery of pioneering occupational therapists sharing their clinical reasoning processes to meet women's needs. Nor did I expect to hear women's stories about their motherhood journeys and thoughts about the impact occupational therapists had made on their lives. The participant's voices and stories will stay with me for many years to come.

While my perception of the world and perspective shaped this doctoral research, my views, ideas, and expectations have been challenged many times during the experience and have changed – and no doubt will continue to evolve – over time. Whilst learning more about how occupational therapists were practicing around the world to support their clients' needs when becoming mothers, I was surprised on multiple occasions, realising my limited understanding of many practices that were unfamiliar. In endeavouring to respectfully explore and honour the emic 'truth' of the findings and answer the research question as objectively as possible, I came to embrace this doctoral journey as a unique and privileged opportunity for indulging my intellectual curiosities, exploring learning directions I never could have imagined, and imagining future professional goals I had never previously considered. It has become an academic and personal rite of passage that has altered my life ambitions and made me a more open-minded person, occupational therapist, mum, daughter, co-parent, and friend.

Through the lenses of occupational therapy, occupational science, matrescence, and matricentric feminism, this doctoral journey has vastly expanded and refined my understanding of feminist research, women's place in society as mothers, maternity care services, and the potential for occupational therapy practice development into the future. I

hope that this thesis might offer a platform to consider, debate and prompt further research and practice developments in perinatal health, matrescence, and occupational therapy.

STUDY OUTCOMES

The purpose of this doctoral research was to explore and document how occupational therapists worked with women during perinatal stages. My aims were:

1) To identify how the occupational performance needs of women are being addressed during perinatal transitional phases by occupational therapists;
2) To explore how literature, practice models and health outcome measures inform and influence the practice of perinatal occupational therapists; and,
3) To explore the perceived scope, capacity, and barriers for a potential perinatal occupational therapy role to address the occupational performance needs of 'well' women accessing primary health services.

The first section of the thesis reports on what is known in the literature about contemporary occupational therapy roles in perinatal health. My research approach was informed by my personal and professional expectations, experiences, and assumptions, reflexively balanced by applying research methodology guidelines and guidance from the supervision team. It became gradually and increasingly apparent during the literature review and multiple case study analysis that the roles of occupational therapists in perinatal health were more complex than originally anticipated, which is reflected in the mid-section of this thesis.

KEY RESEARCH QUESTIONS AND MAIN STUDY FINDINGS

1) *What are the occupational performance issues experienced by women during the pre and postnatal (perinatal) transitional periods?*

Women experienced a spectrum of occupational performance issues stemming from impaired function and occupational wellbeing capacities during perinatal transitions. These were categorised according to the basic occupational therapy PEO domains of person (identity, individuality, functional capacities); environment (co-occupational; institutional; physical; sensory; sociocultural; and spiritual) and occupations (community; cultural; familial and intergenerational; mothering; personal; pleasure; productive; and sexuality). Women's experience of occupational imbalance, disruption and deprivation were often triggered by their fundamental human needs not being satisfied during maternal developmental experiences. These were conceptually regarded from the transformative bio-psycho-social-spiritual-political domains of matrescence, and experience of accessing and transitioning through prenatal, intrapartum, and postnatal phases as a perinatal healthcare services consumer. Development of the mother-infant relationship and bonded attachment were conceptually reframed as mindful co-occupations through engagement and participation in meaningful mothering occupations.

2) *What is known about the role of occupational therapists supporting well women during perinatal transitional periods?*

Roles for occupational therapy were primarily situated as members in multidisciplinary maternity and perinatal healthcare teams. There was strong evidence that occupational therapy roles in perinatal health were best understood through the lenses of client-centred practice, and matrescence. Being 'well' emerged as a term associated with

medicalised healthcare which had little relevance to understanding occupational therapy roles in perinatal health. Except for significant illness or untreated mental disorders, occupational therapists worked with women during perinatal stages with and without medical and disability histories. By focusing on maternal development, functional performance and occupational wellbeing, occupational therapists tailored services to support women during perinatal transitional periods and matrescence. They were guided by client-centred practice and woman-led care rather than their maternal, medical, health or ability status, which emerged as a unique approach unfamiliar in maternity care practice models.

Difficulty analysing occupational therapy roles using maternity care terminology and gestational stages revealed that ‘perinatal’ and ‘transitional periods’ were constrictive constructs for understanding occupational therapy practice. Instead, it was considered that occupational therapists applied client-centred and woman-led care to help clients prevent and work through occupational performance issues. While a few occupational therapists considered women’s perinatal health, nearly all promoted and addressed ‘maternal development’ in practice, which can be better understood through the concept of ‘matrescence’. Through the lens of matrescence, occupational therapists had a role in supporting women during perinatal transitional periods as maternity care service users and hospital inpatients or outpatients. These roles were consistent with generalist occupational therapy roles applying restorative and rehabilitative frameworks. Outside of maternity healthcare settings, the scope for occupational therapy roles expanded to focus more on early intervention, health promotion, prevention, enablement, group function, and empowerment. The primary role of occupational therapy in perinatal health is to assess, address, and promote women’s goal attainment, self-efficacy development, occupational function, and wellbeing needs, guided by EBP, client-centred and woman-led care, throughout various maternal developmental stages. This often involved working with partners and families.

3) *What are the current professional service gaps in supporting women's health needs during the perinatal transitional periods, which could be met by occupational therapists?*

The flexibility of occupational therapists to work in and beyond primary and maternal healthcare settings enabled roles to be situated in maternity healthcare, early childhood education centres, community, and online forums. In the UK and Australia, occupational therapists were employed in preventative and early intervention mental health roles to bridge the gap between maternal healthcare and perinatal mental health services. In mental health and psychosocial roles, the ambiguity of occupational therapy promoted accessibility for women who were reluctant to access psychological or maternal healthcare specialists. These initiatives enabled improved accessibility for women who were identified as vulnerable, due to their difficulty or reluctance to attend mainstream perinatal health appointments.

In hospital settings, the focus of occupational therapists on occupational function and wellbeing expanded the scope of traditional maternity care teams. Client-centred interventions were tailored to alleviate or manage the functional implications of trauma, birth-related injuries, caesarean deliveries, dysfunction, hand injuries, pain, sensory processing difficulties, and physiological systems dysregulation. These were contextualised by women's occupational performance capacities and ease of adaptation into mothering and life tasks, activities, roles, and routines, and returning home from hospital with their new baby. Occupational therapists saw their roles complementing obstetric and midwifery teams by expanding healthcare services scope and improving early detection, intervention and referral pathways for women struggling with complex occupational performance issues.

SUMMARY OF KEY FINDINGS

The research findings demonstrate that contemporary occupational therapy roles are emerging to address the phenomenon of complex adjustment, growth, and transformation women experience during perinatal transitions. Aspects of perinatal transitions, maternal development, and personal transformation were often relational in nature, and strongly influenced by women's occupational roles. Perception of women's issues and needs were typically informed by the practice settings, and occupational therapists were able to apply a full scope of core, advanced and extended practice skillset through client-centred practices and woman-led care. The myriad of functional issues and occupational wellbeing needs women experienced during perinatal transitions can be interpreted from a maternal development perspective, which can be better understood through the concept of matrescence. Many complex and maternal developmental issues and needs required occupational therapists to upskill and expand their knowledge base to better understand and clinically reason their professional capacity to address these within practice scope.

Occupational therapists all prioritised evidence-based practice decisions, which were limited by a lack of accessible and highly relevant discipline-specific resources. The person-environment-occupation (PEO) conceptual practice approach was referenced by all therapists as a starting point; however, relied on their personal knowledge and experiences to flexibly adapt practice approaches. This complex adaptation was necessary to contextualise the woman's issues and needs within maternal development and perinatal transitions. Whilst some formal outcome measures were used to monitor changes in symptom severity, women's personal satisfaction with maternal self-efficacy development, empowerment, goal attainment and symptom relief were primary outcomes, as well as perceived success with functional, safe, and sustainable discharge home from hospital. Additionally, as therapists prioritised enablement and empowerment approaches, observationally assessments of women's

development of self-efficacy and discontinuation of services as successful outcomes measures.

The subtlety, transience, diversity and complexity of women's functional challenges and occupational wellbeing issues and needs during perinatal transitions called for application of the fullest scope of occupational therapy practice skills. Women were not always motivated to access primary health services and subsequently consulted with occupational therapists in a broad range of settings including private practice, children's educational centres and online. The capacity of occupational therapists to address women's occupational performance needs was extensive; however, may have been limited by employment opportunities, public health funding, practitioner expertise and lack of maternal healthcare services and public awareness of what occupational therapy is.

STRENGTHS AND LIMITATIONS

A key strength of this research is that it explores complex and multidimensional areas of professional need, by producing information that describes the perceived values, barriers and benefits of maternal health occupational therapy roles, and potential future scope for professional expansion. The findings can inform health policy reforms to either encourage or refute proposals for increased occupational therapy presence on dynamic interdisciplinary perinatal health teams, to optimise holistic health outcomes for women.

A limitation of the study is that results were impacted by the population sampling process. In defining the exclusion and inclusion criteria for 'well' women during the perinatal phases from pregnancy through to one-year postpartum, potential participants receiving or offering highly relevant occupational therapy services were omitted from the study. An expanded research focus exploring the role of occupational therapists working with all women in society becoming mothers might have produced different findings. Additionally,

with the historical culture of occupational therapy services having a defensive protectiveness around professional integrity, potential participants may have declined the recruitment invitation based on fear of revealing a lack of evidence base in clinical practices. Every effort was taken to establish and maintain rapport and trustworthiness to reduce this risk, which resulted in some findings not being reported at participants' request for the omission of some recorded information (consent, conversational reflection).

The intention of this research was to document and explore the role of occupational therapists in perinatal health. While Stake's (1995) case study methodology chosen was appropriate for this aim; the flexibility of this approach was often time consuming because unpredictable developments emerged and pursued, particularly during data analysis. Grounded theory or situational analysis methods could have been used to improve sensitivity to feminist theories (Hesse-Biber, 2012) in the development of a new theory or conceptual framework (Charmaz, 2014), which may have streamlined and strengthened research approaches.

A paradoxical limitation of this study is owing to the underdevelopment of matricentric feminism as an academic theory (O′Reilly & Bueskens, 2016b). At the time this research was designed, matricentric feminism was not recognised in "the field of academic feminism" (O′Reilly & Bueskens, 2016a, p. 185), and a feminist standpoint epistemology (Devault, 1990; Hartsock, 1983; Hesse-Biber & Leckenby, 2004) was deemed the best fit. Intuitively exploring the emic value of research findings (Stake, 1995) through a matricentric feminist lens (O'Reilly, 2019; Pascoe Leahy & Bueskens, 2020b) had a transformative and liberating impact on interpreting the data. The same depth of qualitative research analysis in this study would not have been facilitated or guided if a feminist standpoint was used.

RECRUITMENT

The recruitment process sought to balance the sampling numbers between the two participant groups, women, and occupational therapists; however, this was not possible due to significant difficulty reaching and recruiting women who had accessed perinatal occupational therapy services. Failure to recruit women resulted in a lack of sample breadth, voice, and representation in multiple case B, which limited the interpretation of findings for that cohort and potential for cross-case analysis between multiple cases A and B. Recruitment difficulties were due to several factors, including occupational therapists expressing various degrees of reluctance to invite women to participate who had accessed their services. Several occupational therapists expressed concern that the invitation might make women feel pressured to advocate for their services and might alter the therapist-client relationship. Several others felt uncomfortable singling clients out as potential participants for reasons not disclosed. In a hospital-based setting, the hospital ethics application and approval process required to advertise the research invitation exceeded the timeframe of the recruitment and data collection phases of this research, and thus was deemed unrealistic for this study.

The recruitment process relied on established formal, informal, and professional networks, and access to communication platforms (such as the internet) for social media. Whilst this method is expected to have reached a high percentage of the targeted population, many occupational therapists reported that they were working as pioneers in professional isolation. Additionally, there are known occupational therapists working in countries such as Brazil, Namibia and Israel using primary languages other than English who have not been able to be contacted due to language barriers. There may be occupational therapists working with well maternal health clients who did not see an invitation to participate in the research, or who may not identify themselves as perinatal occupational therapists.

Efforts to recruit an occupational therapist specialising in pelvic health and function was particularly disappointing. New learning attained during a lengthy informal conversation with a highly experienced American pelvic function occupational therapist midway through the data collection phase was not recorded or described in this study, at their request. From social media and closed special interest groups on Facebook, it is evident that this specialist role is rapidly growing in prevalence and popularity, especially in the USA, and is not fully represented in this research.

At the time this case study research was conducted, the field of occupational therapy in perinatal health was very much 'emerging', with role confidence and professional networks in the early stages of development. Currently, there is evidence that occupational therapy roles in perinatal healthcare, maternal health, and wellbeing, and matrescence are rapidly emerging and expanding. Several potential participants were not recruited due to exclusion criteria or failure to complete the recruitment process in accordance with ethics approval. Whilst these participant cases are not reported, their unique positions offer a glimpse to further understand the breadth and practice context of this emerging specialist occupational therapy field. Several are briefly described to acknowledge this and to illustrate the limitations of this study.

Three additional occupational therapists working in France and the USA who were specialists in women's perinatal pelvic health and function withdrew during the early recruitment phase of this research process for personal reasons. One of these occupational therapists agreed to and participated in a 60-minute informal telephone conversation about their role on the condition that it was not audio-recorded and with the understanding that they did not wish to be recruited as a participant for this study. An Australian occupational therapist who had worked extensively in community/home-based perinatal health and was now a lecturer at a major university did not meet the recency of practice criteria. Four

occupational therapists working in perinatal mental health settings in Australia and England expressed interest in participating in this research; however, were excluded based on most of their work being provided to clients who had a medically diagnosed mental illness as the reason for occupational therapy services, which is recognised as a separate area of specialist practice.

A private occupational therapist from Israel who responded to the research invitation was considered. This occupational therapist had extensive experience practicing in fertility, pregnancy, maternity health, and mother and wife life roles, and had written a textbook about their experience. As this person's participation was conditional upon them being identified and recognised in the research for intellectual property and promotion purposes, the research team ultimately agreed this met the exclusion criteria in accordance with ethics requirements specifying participant anonymity. Two Brazilian occupational therapists were not able to be recruited due to language barriers, lack of clarity about whether their practice met inclusion criteria, and the status of being in a low or middle-income country. On reflection, limiting this research to high-income countries likely resulted in the omission of potentially highly relevant data which may have added depth, meaning, and transferability of findings.

An additional two service providers in Australia and the USA were excluded because their occupational therapy professional registration and accreditation had lapsed. Both individuals were occupational therapists whose practices with women during perinatal phases aligned with their training as occupational therapists; however, they felt restricted by accreditation registration criteria, and were now working as women's health specialists rather than occupational therapists. One of these providers worked with mothers through the

transitions of miscarriage, stillbirth, and early infant loss, and the other provided a 'red tent'[7] style community group service for women through female reproductive and motherhood phases (Castro, 2020).

RECOMMENDATIONS AND IMPLICATIONS FOR PRACTICE

RECOMMENDATIONS FOR POLICY

Policy, maternity care models, and perinatal practices are often driven by women's rights, safety, access, and choice within a medicalised healthcare service, which can be inherently disempowering for women (Alexander, 2020; Jenkinson, 2017; Kundisova et al., 2019). Strategic directions for woman-centred care are typically contained within the perinatal period when women access maternity care services (Brady et al., 2019; Council of Australian Governments, 2019; Payne, 2019). The perinatal period construct contextualises healthcare to promote safe, low-risk and successful events and transitions through pregnancy, birth and postpartum periods (Alexander, 2020). Many of the functional and wellbeing issues and needs influencing women's health and wellbeing during maternal experiences occur outside the perinatal period.

RECOMMENDATION 1: Raise awareness and develop policy to promote women's health, development, and wellbeing during matrescence
Many women have complex developmental, health and wellbeing needs that could be addressed by a collaborative team of maternity care providers and allied health professionals, including occupational therapists. It is recommended that a policy should be developed with a new model of coordinated and collaborative care which contextualises

[7] Taken from the historical/anthropological concept of the red tent as fictionally depicted in Diamant, A. (1997). *The red tent*. St. Martin's Press. "Red Tents (RTs) are women's circles that have increased in popularity in recent years… [and] are an under-researched movement". Castro, M. (2020). Introducing the red tent: A discursive and critically hopeful exploration of women's circles in a neoliberal postfeminist context. *Sociological Research Online, 25*(3), 386-404. https://doi.org/10.1177/1360780419889973

perinatal stages within the human developmental experience of matrescence. This would approach women's perinatal health from health promotion, key prevention, and wellness approaches during matrescence, prioritising the functional domains of wellbeing as determinants of health. This should be irrespective of maternal status or gender and in accordance with the International Classification of Functioning (ICF) (World Health Organization, 2002) and recommendations for positive perinatal experiences (World Health Organization, 2018, 2020).

Women's wellness, human needs, and occupational wellbeing throughout the developmental stages of matrescence should be prioritised in an empowerment context which promotes self-efficacy, enablement, and nurturing positive self-esteem (Athan & Reel, 2015; Athan, 2020; Pascoe Leahy, 2021; Raphael, 1975; Sacks, 2018). It is recommended that policy includes mother-infant dyads, family-centred approaches to maternal development (Barlow & Svanberg, 2009), and co-occupations (Doidge, 2012; Sethi, 2019). This policy could guide a complementary approach to women's wellbeing and wellness through health promotion, prevention, and early intervention.

This recommendation is made to promote the development of policy and strategies by the World Health Organization (WHO) and the World Federation of Occupational Therapists (WFOT) to address the non-medical challenges impacting women's function and wellbeing during matrescence. The development of alternative policy aims to offer a complementary avenue for women to access healthcare funding at any stage of matrescence, irrespective of their maternal or gestational status.

RECOMMENDATION 2: Develop an alternative care model to address and promote women's and family's functional health and wellbeing during matrescence
The non-medical issues impacting women's wellbeing during matrescence outside of the maternalist and medicalised perinatal period should be recognised with an alternative practice model, sitting parallel and complementary to existing maternity care models. Aligning with woman-centred care values and priorities (Council of Australian Governments, 2019), this model should acknowledge the diversity and relational nature of parenthood, the influence of culture, the changing nature of family structures and dynamics in contemporary society, and the approaches for working with fathers, guardians and co-parents. This complementary model should also address partner's needs during patrescence (Raphael, 1975), mother-partner co-parenthood, and mother-infant-family triads (da Conceição et al., 2020; Lederman & Weis, 2020b; Mikolajczak et al., 2018b; O'Reilly, 2019). Women's health and wellbeing during matrescence should include preconception care and advice, infertility and assisted conception, miscarriage, infant death and loss, adoption, surrogacy, and fostering. Working through psychosocial, sociocultural and occupational wellbeing aspects of childlessness, by choice and/or involuntarily, should be included (Fieldsend & Smith, 2020; Miettinen & Szalma, 2014).

This model should be developed by the Council of Australian Governments (COAG), and is recommended to consider the POMM to recognise women and their families with issues and needs impacting on their health and wellbeing, who are not currently eligible for maternity care services.

Recommendations For Occupational Therapy

Occupational therapists can address a spectrum of occupational performance issues impacting women's function, health, and wellbeing during matrescence (Baker et al., 2017; da Conceição et al., 2020; Davis & Lovegrove, 2019; Fernandes, 2018; Hanish et al., 2019; Yeager, 2019). The findings of this research highlighted how many of the complex issues women struggle with during perinatal stages can be addressed by occupational therapists; however, the profession lacks cohesiveness and clarity in how women's occupational health and wellbeing needs can be addressed in practice.

RECOMMENDATION 3: A consistent professional language for occupational therapy in perinatal health and matrescence should be curated and clarified
Variations in the language and terminology to describe occupational therapy approaches in practice and research created a sense of ambiguity about how and why occupational therapists were working with women during perinatal stages. It is recommended that an unified occupational therapy language for practice in women's perinatal health and matrescence should be clarified and refined, with efforts made to ensure terminology is conceptually occupation-centred and promoted in practice and research. This should maintain core practice alignment with the contemporary occupational paradigm (Kielhofner, 2009) and use occupation-centred terminology to promote translation of issues and therapeutic outcomes into an occupational performance context (Ford et al., 2021).

Using consistent terminology and practicing in an occupation-centred manner strengthens professional identity in occupational therapy practice (Ford et al., 2021). Imposter syndrome was a common issue compromising the professional confidence, integrity, and place of occupational therapists in perinatal health roles, which could be improved with a consistent practice language. It is recommended that this professional language should be developed in consultation with key stakeholders such as occupational therapy practitioners,

matrescence and perinatal occupational therapy researchers, and professional occupational therapy associations. This should be endorsed and promoted by the WFOT, with national support from individual Associations such as the American Occupational Therapy Association (AOTA), the Royal College of Occupational Therapists (RCOT), and Occupational Therapy Australia (OTA).

RECOMMENDATION 4: A position statement clarifying the role of occupational therapy in perinatal health and matrescence
Occupational therapy roles in perinatal health and matrescence are emerging in practice and research around the world. There is a lack of guidance and accountability in practice as the role and scope of occupational therapy in addressing maternal health, wellbeing and development are not well known or understood. It is recommended that a position statement on the role of occupational therapy in women's health during perinatal stages and matrescence should be developed for the World Federation of Occupational Therapists (WFOT).

A position statement developed for and promoted by the WFOT would validate and raise awareness of occupational therapy roles and may inform the development of specific practice guidelines in various countries, contexts, and settings.

RECOMMENDATION 5: Recognition of occupational therapy practitioners with specialist knowledge in women's health, maternal health, and matrescence
To raise the profile of occupational therapists with specialist knowledge in women's health, maternal health, and matrescence, it is recommended that special interest groups are developed. In perinatal health, occupational therapists provide hand therapy services (Hardison et al., 2021), and are increasingly specialising in mental health (Burbidge, 2015b; Hanish et al., 2019; Williams & Chard, 2019), pelvic function and rehabilitation

(Baker et al., 2017; Burkhart et al., 2021), mother-infant dyads (Sepulveda, 2019; Sethi, 2019), and hospital-based inpatient and outpatient roles (Briltz, 2019; Yeager, 2019). Although an increasing number and variety of occupational therapy services are available to women in public and private practice settings, they are difficult to locate and access. It is recommended that occupational therapists with additional qualifications and specialist knowledge in the fields of women's health, perinatal health, and matrescence be mentored in special interest groups and recognised in professional networks and conference events.

In a competitive and consumer-driven market, many women in high-income countries have and want control and choice to access specialist maternity and perinatal services (Dombroski et al., 2016). Listings on public domains or professional association websites such as AOTA, RCOT, and OTA, would promote accessibility and awareness of occupational therapy roles, and practitioner skillset and availability, in the emerging specialist fields of perinatal health and matrescence.

Recommendations For Practice

The following recommendations are made proposing how occupational therapy roles can be utilised to enhance the capacity of maternity care services to address the heightened needs and demands of contemporary mothers and families (Odendaal et al., 2018; Seefat-van Teeffelen et al., 2011; Verbiest et al., 2018; White Ribbon Alliance, 2019; World Health Organization, 2018).

RECOMMENDATION 6: Future multidisciplinary maternal care pathway teams should include occupational therapists and allied health professionals

Occupational therapists and allied health professionals routinely work collaboratively within multidisciplinary teams in a range of healthcare and practice settings (Pentland,

Kantartzis, Clausen, & Witemyr, 2018; Rexe, McGibbon Lammi, & von Zweck, 2013). Occupational therapists have the potential to address many of the complex and subtle issues impacting women's functional capacities, health, and wellbeing during perinatal stages, and improve outcomes for women, children, and families. It is recommended that occupational therapists join inpatient, outpatient, and community-based maternity care teams in *perinatal continuing care roles*, to proactively and collaboratively promote and address women's health and wellbeing needs during perinatal stages and transitions. Inclusion of other allied health professionals, such as physiotherapists and speech therapists, is also strongly recommended.

The recommendation for alternative clinical practice guidelines by government departments such as the Department of Health (Australia), Health Workforce Australia (HWA), and individual health services providers such as hospitals and primary care facilities, is intended to enhance the scope of practice for maternity care services and expand the potential benefits for women and their families accessing these services.

Maternity care services have a critical role in supporting mother's and infant's perinatal health and medical needs. The findings of this research found that many of the more complex and subtle issues impacting women's function, health, and wellbeing, can be addressed outside of maternity healthcare settings.

RECOMMENDATION 7: Development and pilot trial of matrescence programs to complement perinatal healthcare services

It is recommended that the development and pilot-trial of a matrescence wellbeing program should be considered to promote maternal development, as a complement to perinatal health services, offering continuity of care for women which is extended to their partners and families. Offering access to a full maternal multidisciplinary team, including allied

health professionals, this program should be flexible, location-independent, woman-led, culturally sensitive, and not determined by the health or living status of their infant. The program should offer a holistic approach to health and wellbeing, and should include preventative mental health, education, and bridge gaps between vocational, education, social, health, maternity, and paediatric services. It is further recommended that those leading this client-led program should work collaboratively with key health, maternity, and paediatric care providers, community and family services, early childhood educators, and employers/workplaces, likened to an expanded transition-care program (Department of Health, 2015).

This recommended program aligns with the values and aims outlined in the *Woman-centred care: Strategic directions for Australian maternity services* by the Council of Australian Governments (2019) in prioritising safety, respect, choice and access, in a continuity of care model. This should be co-led by a tertiary hospital and community midwifery and maternal and child health services, such as the Mater Mother's Hospital in Australia, and should include medical and allied health providers addressing women's and maternity health, neonatal intensive care units, hand therapy clinics, and family services. Early childhood education or day care settings and women's workplaces and employers should also be included.

RECOMMENDATIONS FOR EDUCATION

RECOMMENDATION 8: Graduate diploma for occupational therapy in women's perinatal health and matrescence
The development of a graduate diploma for occupational therapy in women's perinatal health and matrescence is recommended. This should include an occupation-centred curriculum relating to perinatal health, wellbeing, and wellness, matrescence,

biomechanics and hand therapy, human development (reproductive, mother-infant, paediatric), patrescence, co-occupations, and culturally sensitive woman-led practice. Practice skills and approaches should align with the Person-centred Occupational Model of Matrescence (POMM).

The tertiary curriculum for undergraduate occupational therapy courses is comprehensive, incorporating a broad range of foundational practice skills for graduate-entry-level roles and professional accreditation. The occupational therapy roles in women's perinatal health and matrescence require skills, experience, and training beyond an undergraduate level. This graduate diploma should be developed by an matrescent and perinatal health expert and provided by a university, such as La Trobe University, in consultation with professional associations, such as OTA, and include placement opportunities in workplaces such as the Mater Mothers Hospital. Individual units from this graduate diploma should be available and endorsed as accredited CPD points by professional associations such as the OTA.

RECOMMENDATION 9: Education about human developmental stages to include matrescence and patrescence
Respecting the humanness and developmental nature of matrescence, it is recommended that both matrescence and patrescence be included in the educational curriculum about human developmental stages, at all levels of early childhood, primary, secondary, and tertiary education. It is recommended that primary and secondary schools nest sexual education within matrescence and patrescence to contextualise and expand current curricula and focus on the complex relational nature of sexuality, sexual identity, and intimate occupations (Athan, 2020; Rose & Hughes, 2018; Walker et al., 2020).

This recommendation is made as an early and ongoing intervention strategy aiming to raise awareness of respect for bodies and sexuality, establish a consistent bridge closing the

gap between health and education (Hayman, 2014; Pelenc, 2017). This should be a collaborative project by co-led and co-directed by the Department of Health and the Department of Education.

Recommendations For Research

Most research exploring the place of occupational therapy in women's perinatal health is theoretical and discusses proposed roles for the future.

RECOMMENDATION 10: Further research into occupational therapy roles in women's perinatal health and matrescence
Further research evaluating the benefits and outcomes of existing occupational therapy practice approaches, resources, and interventions for working with women in perinatal settings and matrescence is recommended, from service-delivery and consumer perspectives. As this study produced limited evidence on women's lived experiences and occupational needs during perinatal periods and matrescence, further qualitative research is needed to understand the occupational pressures impacting contemporary women and mothers. More needs to be learned about the scope, impact, and value of private practice and independent occupational therapy roles for service users and maternity healthcare service outcomes. From a health economics perspective, research exploring if and how occupational therapy roles add value to maternity care teams is needed. This should explore how occupational therapy roles could be best positioned within primary health and maternity care teams, and independent or alternative practice settings (Alexander, 2020; Fox et al., 2019; Rexe et al., 2013).

Since being coined nearly 50-years ago (Raphael, 1975), the anthropological concept of matrescence has only recently been revived in the context of psychology (Athan & Reel,

2015; Athan, 2020; Sacks, 2018), and has scarcely been further explored or expanded in human developmental research (Pascoe Leahy, 2021).

RECOMMENDATION 11: Matrescence to be developed and clarified in academia
A primary recommendation of this doctoral study is that further research is conducted to explore, develop, and clarify matrescence from anthropological, health, and human developmental perspectives. Research into if and how matrescence has relevance to practice in obstetrics/gynaecology, midwifery and maternal-child health nursing, mental health, and allied health disciplines with an interest in perinatal health (including occupational therapy and physiotherapy) is highly recommended. It is further recommended that a non-gendered model of parental development be explored for parents and co-parents who experience a major life transformation in 'becoming' (Newman, 1975; Raphael, 1975), and do not identify with the highly gendered cultural and emotional experiences of motherhood or fatherhood (Pascoe Leahy, 2021).

RECOMMENDATION 12: Maternal and matricentric feminism to be developed for application in academic research
Further development of maternal and matricentric feminism academic theories are needed (O'Reilly, 2019; Pascoe Leahy & Bueskens, 2020b), to elevate their eligibility for use in the field of academic research. It is highly recommended that future research in women's reproductive and developmental health consider the relevance and influence of maternal and matricentric feminism, particularly in the emerging field of occupational therapy specialising in matrescence and perinatal health.

These recommendations are made to encourage consideration of culturally sensitive, socially relevant, and contemporary research directions in future.

A social media article I read recently opened with the line, “Geriatric mother is the hard-hitting term that the medical profession have used” to describe pregnant women over 35 years old (Lowe, 2019). Common use of highly medicalised terminology, like ‘geriatric’, to describe women’s maternal health status during perinatal stages are known to have “a detrimental impact on some mother’s sense of self-worth, wellbeing and mattering” (Barnett, 2020, p. 150), and misalign with contemporary woman-centred care values (Council of Australian Governments, 2019).

RECOMMENDATION 13: The impact of gendered and medicalised language used in maternity care should be reviewed
A review to evaluate the impact, value, cultural appropriateness, and issues with using highly maternalist, medicalised, ageist, and gendered language in maternity healthcare (Barnett, 2020; Shepard & Walker, 2008) is recommended. This should sensitively explore how frequent application of the medicalised and maternalist terminology dominating perinatal healthcare impacts women’s personal and maternal experiences and development of identity and self-efficacy during motherhood transitions. It is recommended that this review is in collaboration with key stakeholders, including allied health professionals, and to be considered with the potential development of future maternity care models.

This research should led by the WHO or White Ribbon Alliance on a global scale, and on national scale by individual agencies such as the COAG, in collaboration with university researchers.

The term ‘perinatal’ is associated with maternal health governance (Alexander, 2020), and repeatedly hindered understanding the full scope or role for occupational therapists in client-centred and woman-led practice (Council of Australian Governments, 2019; Njelesani et al., 2015) in this doctoral research.

RECOMMENDATION 14: Development of a textbook clarifying the occupational nature of women's health and matrescence for application in occupational therapy practice
Although this doctoral research related to the perinatal period, participants also reported their experiences working with women during the broader developmental passage of matrescence. This included working with clients throughout developmental stages of childhood, adolescence, adulthood, advanced- and older-adulthood. Occupational therapists addressed matricentric rites of passage and complex change relating to menses, stages of menopause, and preventative and conservative management of women's health and medical issues and symptoms. With growing numbers of therapists practicing moving into these areas, an occupational therapy textbook addressing the discipline-specific approach and scope of practice to inform and guide practice in matrescence and perinatal health is needed. This should reflect findings from this doctoral research and incorporate the POMM and mother-infant co-occupational functional spectrum (Figure 16).

An expert specialising in occupational therapy practices in perinatal health and matrescence should author this textbook in collaboration with other specialist researchers and practitioners.

Occupational therapists' position that women's functional needs during perinatal periods are not defined by disability, medical or health status requires acknowledgement.

RECOMMENDATION 15: Further development and evaluation of the Person-centred Occupational Model of Matrescence (POMM), including relevant tools and resources
To promote development and establishment in this emerging practice field, occupational therapy practice models and conceptual frameworks for matrescence, co-occupation and perinatal health need to be developed, tested and reviewed. This could be tested through further development and practice-based testing of the proposed Person-centred Occupational Model of Matrescence (POMM). In conjunction with this, it is

recommended that the relevance and usefulness of tools to occupational therapy practice be explored and evaluated. This should include the tools identified in this thesis (Table 18), the Barkin's Index of Maternal Function (Barkin & Wisner, 2013), and PRISM (PRISM Brain Mapping Int. Ltd., 2018) for neurobehavioural mapping, goal-setting, and integration with mindfulness, attachment theory, cognitive behavioural therapy, and neurodevelopmental theory informed occupational therapy interventions. Further research needs to be conducted to test the relevance and applicability of polyvagal theory to analyse and address occupational behaviours and performance in the context of multisensory processing and self-regulation, mother-infant attachment, co-occupations, and co-regulation (Althaver, 2020; Hadiprodjo, 2018; Scherf & Bye, 2017) during matrescence and perinatal stages.

It is recommended that this involves a number of university and Industry PhD research projects connected with leading women's health research institutions such as Jean Hailes, healthcare providers such as the Brigham and Women's Hospital (BWH), collaborating with local, regional, national, and international key stakeholders from practice and research.

CONCLUDING COMMENTS

Occupational therapists can provide services in a spectrum of roles, which are diverse, flexible and have the potential to benefit women and add value to maternal healthcare teams. Globally, a growing number of occupational therapists are building on their core skillset to work with women during the perinatal period and the human developmental phenomena of matrescence. Many of the common or normal challenges women struggle with during motherhood can be interpreted and validated as functional or occupational performance issues. Occupational therapists have the potential to offer a spectrum of flexible client-centred interventions which enhance women's sense of wellbeing, self-efficacy and competence through managing and performing life and mothering roles during matrescence.

The transition to motherhood is often transformative for women and their families. Women's occupational wellbeing needs during motherhood are complex, multidimensional, and valid, and require interdisciplinary solutions before, during, and following perinatal stages. By addressing women's occupational performance issues during motherhood through the lenses of perinatal health and matrescence, occupation therapists have a unique role in maternal healthcare. The full, advanced, and expanded scopes of occupational therapy practice (Occupational Therapy Australia, 2017) complement and enhance maternal healthcare multidisciplinary teams and support the development of alternative care pathways to improve accessibility for women, children, families, and communities. Including occupational therapists on maternal healthcare teams could enhance the quality-of-care women receive from perinatal healthcare services. The limited employment opportunities for occupational therapists to join perinatal healthcare teams, complete discipline specific CPD, and limited awareness of this specialist field, hinder occupational therapists' capacity for professional development in maternal health, which needs to be addressed.

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APPENDICES

LIST OF APPENDICES

APPENDIX A: OCCUPATIONAL THERAPY IN PERINATAL HEALTH: CASE STUDY PRELIMINARY FINDINGS [EPOSTER] (2017)

Occupational Therapy Australia | 27th National Conference and Exhibition 2017

Occupational therapy in maternal health: **Case study**

What is known about occupational therapists working in maternal health?

Occupational therapists are working around the world in women's health, supporting clients through maternal transitional phases, addressing issues during pre-conception, pregnancy, birth, and postnatal recovery and motherhood. Known occupational therapists are practicing in the UK, Australia, Canada, USA, Brazil, the Middle East, and numbers are steadily growing.

Pregnancy is a "productive occupation", and mothers engage in "co-occupations"

Using conceptual practice models, including the PEO, KAWA, MOHO, COPM-E offers occupational therapists a lens to view the occupational performance challenges influencing maternal health outcomes. Co-occupation acknowledges the inseparability of a mother and infant in maternal and child health.

Case study

15 occupational therapists and 2 consumers from around the world were interviewed about the perceived need, benefit, barriers, potential and future for occupational therapy in maternal health.

Traditional maternal health services are different all around the world. Globally, many occupational therapists in various countries are identifying a range of unique maternal health needs slipping through service delivery gaps which require occupational therapy support. Full scope of practice principals sees these services, although incredibly diverse at times, are linked in the therapeutic approach of being client-centered, goal-focussed and oriented towards achieving optimal maternal self-efficacy and infant wellbeing via mothering and self-care occupations.

Education programs are being developed and provided to support further growth and strengthening of this emerging practice area.

OCCUPATIONAL THERAPY TEXTBOOK: *Mothering Occupations: Challenge, Agency and Participation* (2004)

Participants	Australia	Canada	USA
OT's	10	2	3
Consumers	1	1	-

Hannah Slootjes, Dr Carol McKinstry, Prof Amanda Kenny, Dr Leesa Hooker | La Trobe Rural Health School | Bendigo, VIC
PhD candidate @hannahslootjes hlslootjes@students.latrobe.edu.au https://hannahslootjes.wordpress.com

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Appendix B: Poster presentation: Occupational therapy in perinatal health: Case study preliminary findings (2018)

WFOT Congress | Cape Town, South Africa (21-25 May 2018)
Abstract no. 1166

Hannah Slootjes, Dr Carol McKinstry, Prof Amanda Kenny, Dr Leesa Hooker | La Trobe Rural Health School | Bendigo, VIC
PhD candidate @hannahslootjes hlslootjes@students.latrobe.edu.au https://hannahslootjes.wordpress.com

Occupational therapy in maternal health: **A case study**

Introduction/rationale: The transition to motherhood is a significant, stressful life event which can be supported by occupational therapists. New models of maternal healthcare are being considered worldwide (Tully, Stuebe & Verbiest, 2017). Despite limited research to inform practice, occupational therapists can make valuable contributions to the wellbeing of women throughout pregnancy, birth and postnatal transitions (the **perinatal** period) (Slootjes, McKinstry & Kenny, 2015). The uniquely complex psychological, social and physical issues faced by women during the perinatal period require interdisciplinary solutions (AHMAC, 2008). Occupational therapists are practicing in the UK, Australia, Canada, USA, Brazil, the Middle East, and numbers are steadily growing.

Objectives: The aim of this research was to explore the contemporary role of occupational therapists in maternal health during pregnancy, childbirth and postnatal periods, and identify the barriers and supports influencing future growth of this role in healthcare systems.

Research question: How are occupational therapists working with women during perinatal periods?

Method: A case study methodology. Data collection using semi-structured interviews with occupational therapists (n=13), and two women accessing their services.

Participant recruitment strategies:

- Snowballing recruitment, and public invitation: Social media connections/networks, professional association networks, networks of participants, and direct contact with known occupational therapists working in this field of practice.
- Women who had received perinatal occupational therapy services were invited to participate by their occupational therapists.

The fourth trimester:
Interrelated health domains influencing maternal wellbeing in the postnatal period, as reported by Tully, Stuebe & Verbiest (2017):

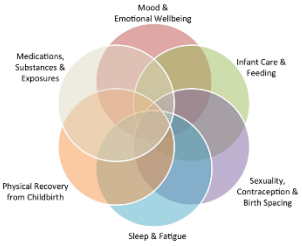


Figure. Interrelated health domains in the fourth trimester. Adapted [reprinted] from Tully, K. P., Stuebe, A. M., & Verbiest, S. B. (2017). The fourth trimester: A critical transition period with unmet maternal health needs. *American Journal of Obstetrics and Gynecology, 217*(1), p.39. © 4th Trimester Project 2017.

Results (preliminary findings):

Perinatal occupational therapists – Professional practice context

Pregnancy is a **productive occupation,** and mothers engage in **co-occupations**

Occupational therapists are using conceptual practice models, including the PEO, KAWA, MOHO, COPM-E, and emerging practice models (such as the Fourth Trimester), as a lens to view the occupational performance challenges influencing maternal health outcomes.

Co-occupation is "a dyadic interplay between the occupations of the mother and those of the infant…. Thus, the mother's occupations require and affect the child's occupations" (Pierce, 2009, p. 204).

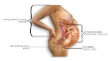
Occupational therapists are providing a range of services, addressing:

- Attachment and bonding (mother-baby)
- Back pain and back care
- Bedrest (complex occupational review)
- Core strength/function/stability
- Family dynamics and relationships
- Fatigue management and time use
- Functional movement
- Hand therapy (including splinting)
- Infant mental health
- Maternal mental health (including prevention, recovery and trauma)
- Pelvic health and function
- Psychosocial wellbeing
- Restorative exercise (biomechanics, movement)
- Return to work/maintaining work roles
- Sensory motor processing
- Sleep (infant routines, maternal sleep)
- Stress/anxiety management (including coping)
- Therapeutic touch
- Modified task performance
- Transition to home

Practice implications:

- The broad range of maternal health occupational therapy services are influenced by funding, professional networks, identified maternal needs, and therapist's confidence and perceived competence to meet these needs.
- Occupational therapists are evolving and expanding their practice scope to meet identified service gaps.
- Many therapists are upskilling with complimentary training to enhance their capacity to offer client-centered services.
- Occupational therapy practice is limited by a lack of clear practice guidelines, practice frameworks relevant to maternal health, evidence to guide clinical decisions and measurement outcomes, professional education and connectedness with peer practitioners (for supervision and professional growth).
- Co-occupation is integral to offering client-centered services to support achievement of maternal and infant health outcomes.






Conclusion: Traditional maternal health services are different all around the world. Globally, many occupational therapists are identifying a range of unique maternal health needs slipping through service delivery gaps which require occupational therapy expertise.

Perinatal occupational therapy services, although diverse, are linked in the therapeutic approach of being:

- Client-centered
- Goal-focused
- Oriented towards achieving optimal maternal self-efficacy and infant wellbeing
- Incorporate mothering and self-care occupations

References:
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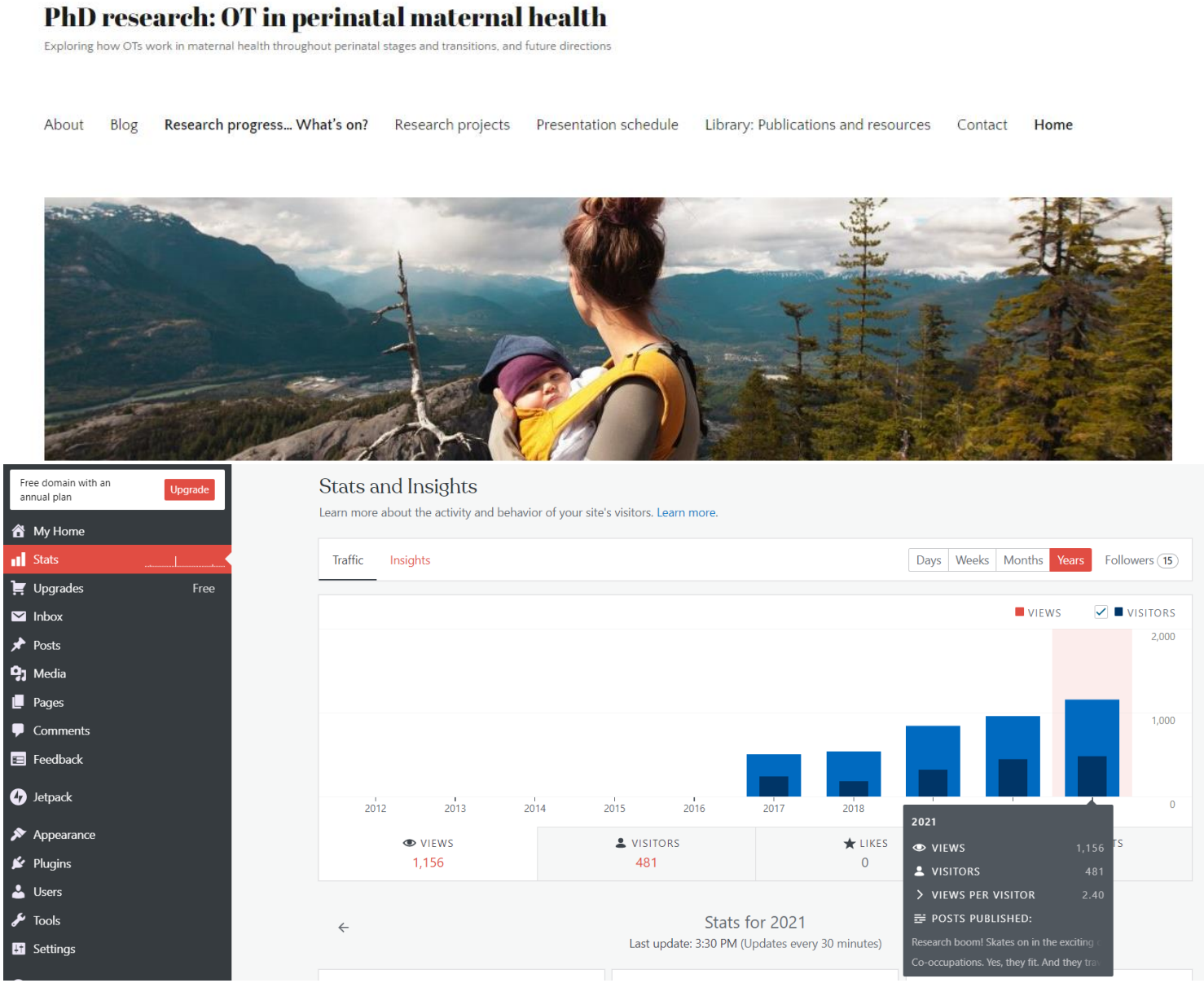
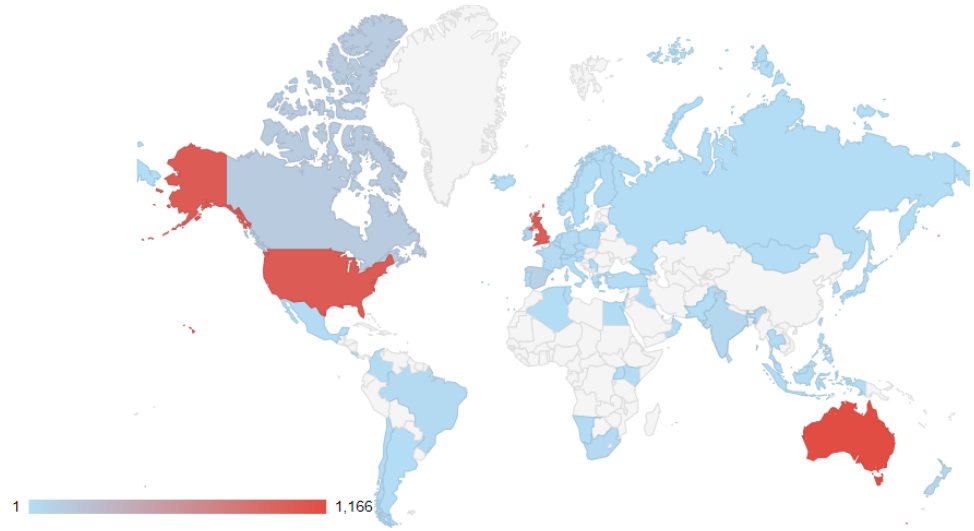
APPENDIX C: RESEARCH BLOG STATISTICS (2017-2021)



APPENDIX D: RESEARCH BLOG STATISTICS SAMPLE, BY COUNTRY (2017-2021)



Country	Views
Australia	1,166
United States	1,051
United Kingdom	1,031
Canada	148
Spain	91
Ireland	65
New Zealand	45
India	39
South Africa	34
France	33
Singapore	24
Brazil	22
Germany	18
Netherlands	17
Switzerland	13
Indonesia	12
Namibia	11
Kenya	11
Portugal	10
Poland	9
Norway	9
Chile	8
Thailand	8
Egypt	8
Belgium	7
Malaysia	7

APPENDIX E: PUBLIC INVITATION TO PARTICIPATE IN CASE STUDY RESEARCH

LA TROBE UNIVERSITY

LA TROBE RURAL HEALTH SCHOOL
College of Science, Health and Engineering

How are occupational therapists working with well women in maternal health?

SEEKING CASE STUDY PARTICIPANTS

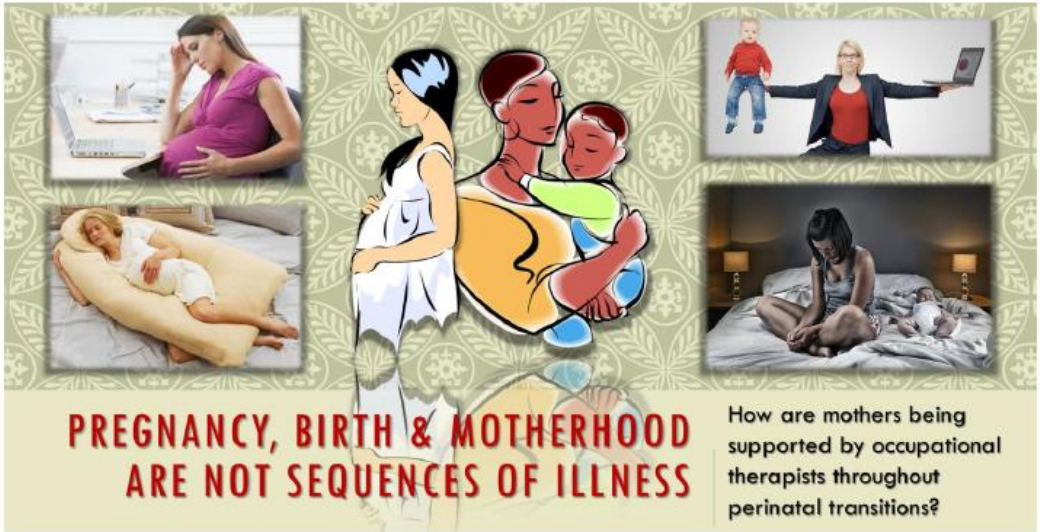
• occupational therapists • well pregnant women who have seen an OT • generally well new mums who have seen an OT •

We would like to invite you to talk about your experience as an occupational therapist, healthy/well mother or pregnant woman, for a study at La Trobe University.

Interested in participating? Want more information?

Please contact Hannah Slootjes at
hlslootjes@students.latrobe.edu.au

Hannah Slootjes is a PhD candidate at La Trobe Rural Health School, La Trobe University (PO Box 199, Bendigo, Victoria, Australia 3552). All correspondence will be confidential.



APPENDIX F: DIRECT EMAIL INVITATION TO PARTICIPATE IN CASE STUDY RESEARCH

Email invitation to occupational therapist working with maternal health clients

Invitation to participate in case study about the OT role in maternal health

Dear …….,

I hope this email finds you well. You may remember from our previous communication (although it was some time ago!), that I am currently completing a PhD at La Trobe University researching the occupational therapy role in maternal health.

I have just been granted ethical approval through La Trobe University to start collecting data through interviewing.

I would like to invite you to participate in this study, and request that you extend this invitation to anyone you know of who also would meet inclusion criteria.

I am looking for participants to be in either of two groups:

1) **Occupational therapists** who currently (or have within the last 12-months) worked with maternal health clients, for issues directly relating to maternal health status/roles.
2) **Women** who have accessed occupational therapy services during and after pregnancy and birth (up until 12-months postpartum), for issues directly relating to their maternal health status/roles.

I'm looking for participants to share their experience and expertise to help us explore the current role(s) of occupational therapists working with maternal health clients, during and after pregnancy and birth. The research is focussed on women who are generally well, and experiencing issues during their maternal health journey which has resulted in need for contact with an occupational therapist.

Attached is the Participant Information Sheet with more details about the project.

Please do forward this email to extend the invitation to any maternal health clients and occupational therapists – even if their experiences are brief.

Kind regards and many thanks

Hannah

Hannah Slootjes
PhD Candidate, La Trobe Rural Health School, La Trobe University
Bendigo, VIC, Australia
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APPENDIX G: MAPPING OF RESEARCH AIMS AND QUESTIONS TO INTERVIEW SCHEDULE ITEMS

Key research aim	Key research question	INTERVIEW SCHEDULES	
		Group one: Occupational therapists	**Group two: Well women, who had accessed occupational therapy services perinatally**
To identify how the occupational performance needs of well women are being addressed during perinatal transitional phases by occupational therapists.	What are the occupational performance issues experienced by well pregnant women during the pre and postnatal (perinatal) transitional periods?	**As an occupational therapist, can you tell me about the occupational performance issues you have noticed *well* women experience during perinatal periods? How have you been able to consider or address these in your practice?** 1) How do you assess occupational performance issues in your role? 2) What models/conceptual frameworks do you consider? 3) What evidence/research/literature informs/guides your practice?	**Can you tell me about what changed for you during pregnancy, birth and postnatal stages? What impacted on your ability to get through your normal daily routines and roles?** 1) What did you want to get help for, but had trouble with [eg. Services available]? 2) Who did you ask for support from (professional services/personal supports)? 3) Where else did you look for information or advice to help you understand how to deal with the issues or challenges you were dealing with?
To explore how literature, practice models and health outcome measures inform and influence the practice of perinatal occupational therapists.	What is the role of occupational therapy for supporting well women during perinatal transitional periods?	**Can you tell me how you see your role as an occupational therapist in supporting maternal health clients?** 1) Who do you receive referrals from, generally? 2) What are some of the reasons women have been referred to you? 3) What interventions have you provided for women accessing the service? 4) How have/do you measure the health outcomes for women?	**How did the occupational therapist support you? When did you find this most useful?** 1) How did it improve your health and general wellbeing?
To explore the perceived scope, capacity and barriers for a potential perinatal occupational therapy role to address the occupational performance needs of well women accessing primary health services.	What are the current professional service gaps in supporting women's health needs during the perinatal transitional periods, which could be met by occupational therapists?	**What do you see as the main service gaps in maternal health services, which could be met by occupational therapists?** 1) What do you think the main role for occupational therapists is in maternal health for well women, across perinatal periods? 2) What do you think are the main benefits for clients who access perinatal occupational therapists? 3) What are the main challenges you face in your role? 4) What CPD opportunities do you need to help you meet client's needs in your role? 5) Where do you see the most value for occupational therapy to help women in future health services?	**From what you've experienced or know, how do you think occupational therapist could improve maternal health services for women?** 1) What do you think the main role for occupational therapists is in maternal health for well women, during and/or after birth? 2) What do you think are the main benefits for women who get support from perinatal occupational therapists? 3) What do you see as the main challenges occupational therapists have to deal with, in working in this role? 4) What do you think the three most important things an occupational therapist needs to know about well women's journey through perinatal transitions? 5) Where do you see the most value or benefit for occupational therapy to help women in health services of the future?

APPENDIX H: DEMOGRAPHIC QUESTIONNAIRE ITEMS FOR DATA COLLECTION

DEMOGRAPHIC QUESTIONNAIRE COMPONENTS FOR PERINATAL OCCUPATIONAL THERAPISTS

Demographic questionnaire items for data collection			
	Context	**Focus**	**Questionnaire items**
Perinatal occupational therapists	Participant background	Personal information	Gender
		Professional training and expertise	Professional title; place of work, Qualifications; Place of qualification; Professional registrations; Further training, education or professional development undertaken
		Professional experience	Years of practice as an OT and/or in maternal health, other fields or professions, and as a maternal health OT.
	Current practice setting	Professional service setting and mode of service delivery	Workplace setting (eg. Inpatient, outpatient, community); Practice focus/setting (eg. International, national, metro, regional, rural); Workplace funding (eg. Public, private, self-employed); Service delivery style (eg. In person, one-to-one, group, telehealth).
		Role sustainability and accessibility	Position status (eg. Employee, self-employed, contracted, part-time)
			How do clients fund access to utilise your services (eg. Public, user-pays, insurance)
	Characteristics of maternal clients receiving OT services	Client caseload; Confirming eligibility for study	Average number of clients per month; Number of contacts per client; Waiting time for service; Age of clients; Age of client's children.
	Position in maternal healthcare system	OT practice context and networks	OT connection with an interdisciplinary team (eg. GP, OB-GYN, physiotherapist, midwife, etc); Connection with referral networks (eg. Profession, regularity of shared-care with other health professional, referrals [to/from]).
	Reflexivity for participant voice	Participant to educate researcher	Other comments/notes (open-ended)

DEMOGRAPHIC QUESTIONNAIRE COMPONENTS FOR WOMEN WHO ACCESSED PERINATAL OCCUPATIONAL THERAPY SERVICES

Demographic questionnaire items for data collection			
	Context	**Focus**	**Questionnaire items**
Women who accessed perinatal occupational therapy services	Participant background	Personal information	Age (now, when became a mother); Number of children and ages; Current maternal status
	Need for OT support during maternal stages and perinatal transitions	Accessibility of perinatal OT services; Confirming eligibility for study	Are you currently seeing an OT for support as a mother; Number of referrals to perinatal OT; Date of initial referral, maternal status (time of referral, and time of first contact with OT); Age of youngest child when discharged from OT
	Accessibility of OT within traditional maternal healthcare systems	OT practice context and networks	Other maternal health professions seen during and after pregnancy and birth; Which health professional suggested/initiated referral to OT
		Health and community understanding of OT role in perinatal health	Multiple choice items of occupational performance issues women were referred for/offered/received or wanted from OT's, including: Carer duties (infant care roles); Enforced bed rest; Ergonomics (seating, sleep position, home); Fatigue management, sleep deprivation; Hand-therapy; Maternal depression / anxiety; Mood management, psychosocial needs; Mother-infant bonding; Pain management; Stress management; Work role (during pregnancy/return to work); Cognitive; Emotional; Mental or psychological; Physical; or other (please specify)
	Engagement with OT services during perinatal phases	Service accessibility	Length of time between referral and service commencement, and perceived appropriateness; How the OT appointment was funded (eg. Public, self-funded, insurance).
		Professional service setting and mode of service delivery	Service delivery place (eg. Inpatient, outpatient, home) and setting (eg. Metro, regional, rural); Service delivery style (eg. In person, one-to-one, group, telehealth)
	Reflexivity for participant voice	Participant to educate researcher	Other comments/notes (open-ended)

APPENDIX I: DEMOGRAPHIC QUESTIONNAIRE (OCCUPATIONAL THERAPISTS)

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MELBOURNE CAMPUSES
Bundoora
Collins Street CBD
Franklin Street CBD

REGIONAL CAMPUSES
Bendigo
Albury-Wodonga
Mildura
Shepparton

CASE STUDY: Occupational therapy in maternal health

Participant questionnaire (perinatal occupational therapists)

Thank you for agreeing to participate in this case study, exploring the role and health outcomes of occupational therapy in maternal health. Please take a few minutes to fill out this questionnaire about your professional and personal details. Your answers will be included as demographic data in this study.

Professional training and experience

Professional title (current)	Place of work	Gender	Qualification(s)
	☐ AHPRA ☐ Medicare ☐ Other:		
Place of qualification (occupational therapy)	Professional registrations	State/County	Country

Years of professional practice history *(relevant to your practice in maternal health)*:

☐ Occupational therapist (years of practice): _____ ☐ Maternal health (years of practice): _____

☐ In other fields/professions (years of practice): _____ ☐ Maternal health OT (years of practice): _____

Further training, education, professional development undertaken *(relevant to your practice in maternal health)*:

How did you come to work in perinatal maternal health as an occupational therapist *(recruitment, training/education)*:

Professional service setting (current)

Which of these defines your current practice setting? *Please select as many as appropriate*

☐ Inpatient ☐ Outpatient (individual, clinic) ☐ Outpatient (group)

☐ Online (including telehealth) ☐ Community ☐ Other: _____

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Professional service setting (current) - *continued*

How would you define your current practice focus/setting?

☐ International ☐ National ☐ Metropolitan ☐ Regional ☐ Rural

Town/city: _____ State/province: _____ Country: _____

How is your current workplace/practice employment funded?

☐ Public (government organisation) ☐ Non-government organisation ☐ Private
☐ Combination (public and private) ☐ N/A ☐ Other: _____

What is your current position status? *Please select any which apply*

☐ Self-employed ☐ Employee ☐ Part-time ☐ Full-time ☐ Casual
☐ Contract ☐ Fixed-term ☐ Permanent ☐ Other: _____

How do clients fund visitation to access your services?

☐ Public (Medicare) ☐ Self-funded (user pays) ☐ Private health insurance
☐ Public (Enhanced Primary Care) ☐ Other: _____

Maternal health occupational therapy role: Client caseload

Please describe your current caseload:

	Number	Notes/comments
Client caseload (average, monthly)		
Number of contacts with each client (average)		
Waiting time for service (from date of referral)		
Length of appointment/contact		
Age of clients (youngest, oldest, average, mean)		
Age of clients' children (youngest, oldest, average, mean)		

Do you work with an interdisciplinary team? *Please tick all which apply*

☐ General practitioner ☐ Lactation consultant ☐ Maternal and child health nurse
☐ Mental health professional ☐ Midwife ☐ Obstetrician ☐ Physiotherapist
☐ Speech pathologist ☐ Social worker ☐ Other: _____

Please describe the interdisciplinary professional referrals / care-coordination in your workplace:

Profession	Regularity of client contact with healthcare professional	No. of clients shared with OT	No. of referrals (per month)	
			To OT	*By OT*
Eg. Midwife	*Daily*	*16*	*4*	*0*

Additional information

Please share any additional comments (optional):

Would you like someone to contact you regarding your responses on this survey?

☐ Yes | ☐ No

Thank you for taking the time to fill out this questionnaire.

Chief investigator: Dr Carol McKinstry, La Trobe Rural Health School, La Trobe University, Bendigo; Phone: (03) 5448 9111, email: c.mckinstry@latrobe.edu.au.

Researchers: Professor Amanda Kenny, La Trobe Rural Health School, La Trobe University, Bendigo; Phone: (03) 5444 7545, email: a.kenny@latrobe.edu.au.

Hannah Slootjes, La Trobe Rural Health School, La Trobe University, Bendigo; Email: hlslootjes@students.latrobe.edu.au

APPENDIX J: DEMOGRAPHIC QUESTIONNAIRE (SERVICE USERS)

LA TROBE UNIVERSITY

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College of Science, Health and Engineering

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REGIONAL CAMPUSES
Bendigo
Albury-Wodonga
Mildura
Shepparton

CASE STUDY: Occupational therapy in maternal health

Participant questionnaire: Women who have accessed perinatal occupational therapists during pregnancy and/or up until one-year postpartum

Thank you for agreeing to participate in this case study, exploring the role and health outcomes of occupational therapy in maternal health. Please take a few minutes to fill out this questionnaire about your personal details and experiences. Your answers will be included as demographic data in this study.

Personal information – Maternal health status

Personal information

Your age:

Age when you first became a mother:

No. of children, and ages:

Age of youngest child when referred to OT:

Current maternal status: *Tick any which apply*

☐ Pre-conception (planning, but not yet pregnant)
☐ Pregnant
☐ Early postnatal (youngest child <12 months)
☐ Postnatal (youngest child 13-18 months)

Are you currently seeing an occupational therapist for support as a mother?

☐ Yes ☐ No ☐ Awaiting new referral

Number of referrals to see OT (as a mother):

Referral to perinatal occupational therapy (OT)

Date of initial referral to occupational therapist: DD/MM/YY

Maternal status at time of referral: *Tick any which apply*

☐ Pre-conception (planning, but not yet pregnant)
☐ Pregnant
☐ Early postnatal (youngest child <12 months)
☐ Postnatal (youngest child 13-18 months)

Maternal status at time of first contact with OT: *Tick any which apply*

☐ Pre-conception (planning, but not yet pregnant)
☐ Pregnant
☐ Early postnatal (youngest child <12 months)
☐ Postnatal (youngest child 13-18 months)

Age of youngest child when discharged from OT:

Maternal health referral and care coordination history

Which maternal health professionals did you see during/after pregnancy and birth? *Please tick all which apply*

☐ General practitioner ☐ Lactation consultant ☐ Maternal and child health nurse
☐ Mental health professional ☐ Midwife ☐ Obstetrician ☐ Occupational therapist
☐ Physiotherapist ☐ Speech pathologist ☐ Social worker ☐ Other: _____

Which health professional(s) suggested a referral to occupational therapy for your needs? *For was reason/s?*

Referral source: _____ Reason for referral: _____

Had you heard of occupational therapy prior to this referral? ☐ Yes ☐ No ☐ I am an occupational therapist

Had you accessed OT services prior to this referral? ☐ Yes (non-maternal) ☐ Yes (maternal) ☐ No

Page 1 of 3

Perinatal maternal health: Occupational therapy – Services received for your needs

Which of these describes the occupational therapy services you have received?

Please indicate the number of times you saw an occupational therapist (for any which apply)

	Referred for	Offered	Offered, but not wanted	Received	Wanted, but not accessed/available
Carer duties (infant care roles)					
Enforced bed rest					
Ergonomics (seating, sleep position, home)					
Fatigue management, sleep deprivation					
Hand-therapy					
Maternal depression / anxiety					
Mood management, psychosocial needs					
Mother-infant bonding					
Pain management					
Stress management					
Work role (during pregnancy/return to work)					
Cognitive – eg. thoughts (other): *please specify*					
Emotional (other): *please specify*					
Mental or psychological (other): *please specify*					
Physical (other): *please specify*					
Other: *please specify*					

Additional comments (*if needed*):

_____

_____

_____

_____

_____

Perinatal maternal health: Occupational therapy – Service time information

From the time you were referred, how long was it until you saw an occupational therapist?

☐ 1-3 days ☐ 3-5 days ☐ 5-7 days ☐ 7-14 days ☐ 14-21 days ☐ 21-28 days ☐ Other: _____

Did this feel like an appropriate amount of time to wait? ☐ Yes ☐ No Comment/s: _____

_____

_____

Perinatal maternal health: Occupational therapy – Professional service setting

Where did you access maternal health occupational therapy services? ☐ Metro ☐ Regional ☐ Rural

Town/city: _____ State/province: _____ Country: _____

☐ In person (group) ☐ In person (one to one) ☐ Online ☐ Telehealth ☐ Other: _____

In which setting have you received occupational therapy services? *Please indicate how many for each, as apply*

☐ Inpatient (public): _____ ☐ Inpatient (private): _____ ☐ At home: _____ ☐ At work: _____

☐ Outpatient (public): _____ ☐ Outpatient (private): _____ ☐ Community/other: _____

How was your appointment with occupational therapy funded?

☐ Public (Medicare) ☐ Self-funded (user pays) ☐ Private health insurance

☐ Public (Enhanced Primary Care) ☐ Other: _____

Additional information

Please share any additional comments (optional):

_____

_____

_____

_____

_____

_____

Would you like someone to contact you regarding your responses on this survey?

☐ Yes | ☐ No

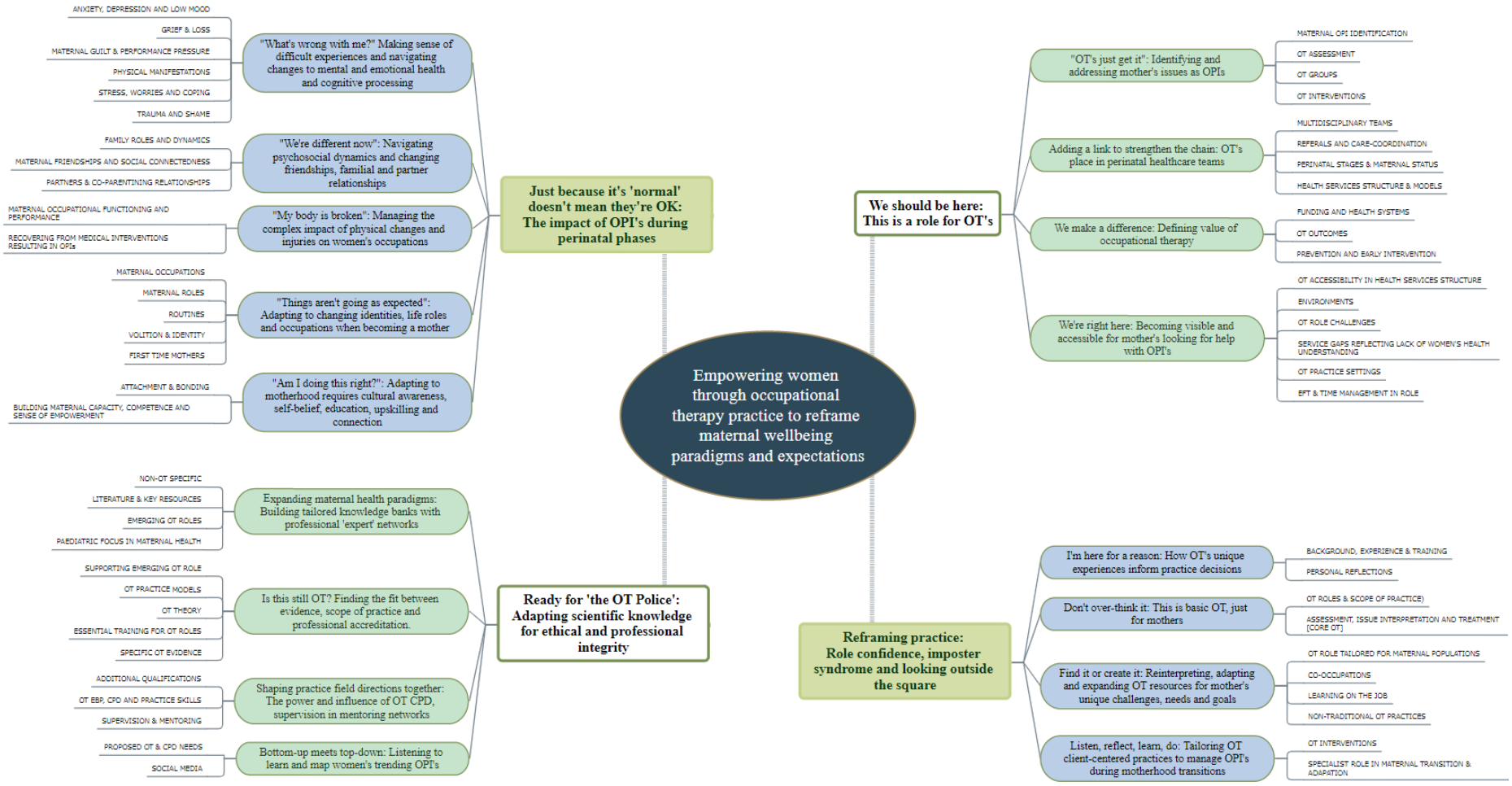
Thank you for taking the time to fill out this questionnaire.

Chief investigator: Dr Carol McKinstry, La Trobe Rural Health School, La Trobe University, Bendigo; Phone: (03) 5448 9111, email: c.mckinstry@latrobe.edu.au.

Researchers: Professor Amanda Kenny, La Trobe Rural Health School, La Trobe University, Bendigo; Phone: (03) 5444 7545, email: a.kenny@latrobe.edu.au.

Hannah Slootjes, La Trobe Rural Health School, La Trobe University, Bendigo; Email: hlslootjes@students.latrobe.edu.au

APPENDIX K: MINDMAP OF CODED DATA



APPENDIX L: ETHICS APPROVAL

Application HEC16-107 (Pending - UHEC) - Application finalised as Approved

Reply | Reply All | Forward

R ResearchMasterEthics@latrobe.edu.au

To Carol McKinstry; ResearchMasterEthics

Cc HANNAH LE SLOOTJES; Amanda Kenny; Leesa Hooker

Fri 2/12/2016 9:59 AM

We removed extra line breaks from this message.

Dear Carol McKinstry,

The following project has been assessed as complying with the National Statement on Ethical Conduct in Human Research. I am pleased to advise that your project has been granted ethics approval and you may commence the study.

Application ID: HEC16-107
Application Status/Committee: Pending - UHEC

Project Title: The role of occupational therapy in maternal health Chief Investigator: Carol Mckinstry Other Investigators: Amanda Kenny, Hannah Le Slootjes, Leesa Hooker

Date of Approval: 02/12/2016
Date of Ethics Approval Expiry: 31/12/2017

The following standard conditions apply to your project:

- Limit of Approval. Approval is limited strictly to the research proposal as submitted in your application.

- Variation to Project. Any subsequent variations or modifications you wish to make to your project must be formally notified for approval in advance of these modifications being introduced into the project.

- Adverse Events. If any unforeseen or adverse events occur the Chief Investigator must immediately notify the UHEC immediately. Any complaints about the project received by the researchers must also be referred immediately to the UHEC.

- Withdrawal of Project. If you decide to discontinue your research before its planned completion, you must inform the relevant committee and complete a Final Report form.

- Monitoring. All projects are subject to monitoring at any time by the University Human Ethics Committee.

- Annual Progress Reports. If your project continues for more than 12 months, you are required to submit a Progress Report annually, on or just prior to 12 February. The form is available on the Research Office website. Failure to submit a Progress Report will mean approval for this project will lapse.

- Auditing. An audit of the project may be conducted by members of the UHEC.

- Final Report. A Final Report (see above address) is required within six months of the completion of the project.

You may log in to ResearchMaster (https://rmenet.latrobe.edu.au) to view your application.

If you have any further questions, please contact the:
UHEC at humanethics@latrobe.edu.au
SHE College Human Ethics Sub-Committee at chesc.she@latrobe.edu.au ASSC College Human Ethics Sub-Committee at chesc.assc@latrobe.edu.au

APPENDIX M: ETHICS EXTENSION APPROVAL TO 2019

Review by University Human Ethics Committee for Modification to Application HEC16-107 mod 1

HE Human Ethics
To Carol McKinstry
Cc HANNAH LE SLOOTJES

Reply | Reply All | Forward

Thu 18/01/2018 4:36 PM

LA TROBE UNIVERSITY

ETHICS, BIOSAFETY AND INTEGRITY – RESEARCH OFFICE

MEMORANDUM

To: Dr Carol McKinstry, Community and Allied Health Bendigo
Student: Hannah Slootjes, Community and Allied Health Bendigo
From: Human Ethics Officer, University Human Ethics Committee (UHEC)
Reference: HEC16- 107 - Ethics application for modification to project - approved mod 1
Title: The role of occupational therapy in maternal health
Date: 18/01/2018 Project End Date: 30/06/2019

Thank you for submitting your modification request for ethics approval to the University Human Ethics Committee (UHEC) for the project referred to above. The UHEC has reviewed and approved the following modification/s which may commence now:

- **Extension of ethics approval until 30 June 2019.**

Please note that your request has been reviewed by a sub-committee of the UHEC to facilitate a decision before the next Committee meeting. This decision will require ratification by the UHEC and it reserves the right to alter conditions of approval or withdraw approval at that time. However, you may commence prior to ratification and you will be notified if the approval status of your project changes.

The following standard conditions apply to your project:

- **Limit of Approval.** Approval is limited strictly to the research proposal as submitted in your application while taking into account any additional conditions advised by the UHEC.
- **Variation to Project.** Any subsequent variations or modifications you wish to make to your project must be formally notified to the UHEC for approval in advance of these modifications being introduced into the project. This can be done using the appropriate form: *Ethics - Application for Modification to Project* which is available on the Research Services website at http://www.latrobe.edu.au/researchers/starting-your- research/human-ethics. If the UHEC considers that the proposed changes are significant, you may be required to submit a new application form for approval of the revisedproject.
- **Adverse Events.** If any unforeseen or adverse events occur, including adverse effects on participants, during the course of the project which may affect the ethical acceptability of the project, the Chief Investigator must immediately notify the Senior Human Ethics Officer humanethics@latrobe.edu.au. Any complaints about the project received by the researchers must also be referred immediately to the Senior Human Ethics Officer.
- **Withdrawal of Project.** If you decide to discontinue your research before its planned completion, you must advise the UHEC and clarify the circumstances.
- **Monitoring.** All projects are subject to monitoring at any time by the UHEC.
- **Annual Progress Reports.** If your project continues for more than 12 months, you are required to submit an *Ethics - Progress/Final Report Form* annually, **on or just prior to 12 February**. The form is available on the Research Services website (see above address). Failure to submit a Progress Report will mean approval for this project will lapse.
- **Auditing**. An audit of the project may be conducted by members of the UHEC.
- **Final Report.** A Final Report (see above address) is required within six months of the completion of the project.

If you have any queries on the information above or require further clarification please contact me at humanethics@latrobe.edu.au.

Warm regards,
Ellen Munro,

On behalf of
Ms Sara Paradowski
Senior Human Ethics Officer
Executive Officer, University Human Ethics Committee
Ethics and Integrity | Research Office | La Trobe University | Victoria 3086 Australia
T: +61 3 9479 1443 | **E:** humanethics@latrobe.edu.au | **W:** http://www.latrobe.edu.au/researchers/research-office/ethics/human-ethics
Research Office Reception +61 3 9479 1144

APPENDIX N: ETHICS EXTENSION APPROVAL TO 2021

LA TROBE UNIVERSITY

Research Office

To	Carol McKinstry
From	University Human Ethics Committee
HEC Number	HEC16-107
Project title	The role of occupational therapy in maternal health
Subject	Modification request dated 02.05.2019 received from Carol McKinstry re: 1) Extension of ethics expiry date to 02.12.2021
Date	7 May 2019

The modification to this project submitted above was **approved** by the **University Human Ethics Committee**.

If this project is a multicentre project you must forward a copy of this letter to all Investigators at other sites for their records.

Please note that all requirements and conditions of the original ethical approval for this project still apply.

Should you require any further information, please contact the Human Research Ethics Team on:
T: +61 3 9479 1443| E: humanethics@latrobe.edu.au.

La Trobe University wishes you every continued success in your research.

Warm regards,

David Finlay
Chair, University Human Ethics Committee

Modification - Approved letter version dated 21 February 2018 Page 1 of 1

APPENDIX O: PARTICIPATION CONSENT FORM

LA TROBE UNIVERSITY

LA TROBE RURAL HEALTH SCHOOL
College of Science, Health and Engineering

Mailing address
PO Box 199
Bendigo Victoria 3552
Australia

T +61 3 5444 7411
F +61 3 5444 7977
E health@latrobe.edu.au
latrobe.edu.au/health

MELBOURNE CAMPUSES
Bundoora
Collins Street CBD
Franklin Street CBD

REGIONAL CAMPUSES
Bendigo
Albury-Wodonga
Mildura
Shepparton

CONSENT FORM

CASE STUDY

Occupational therapy in maternal health

Chief investigator: Dr Carol McKinstry, La Trobe Rural Health School, La Trobe University, Bendigo; Phone: (03) 5448 9111, email: c.mckinstry@latrobe.edu.au.

Researchers: Professor Amanda Kenny, La Trobe Rural Health School, La Trobe University, Bendigo; Phone: (03) 5444 7545, email: a.kenny@latrobe.edu.au.

Hannah Slootjes, La Trobe Rural Health School, La Trobe University, Bendigo; Email: hlslootjes@students.latrobe.edu.au

Dr Leesa Hooker, La Trobe Rural Health School, La Trobe University, Bendigo; Phone: (03) 5444 7984, email: l.hooker@latrobe.edu.au.

ABN 64 804 735 113
CRICOS Provider 00115M

LA TROBE UNIVERSITY

LA TROBE RURAL HEALTH SCHOOL
Faculty of Health Sciences

Consent Form

I (the participant) have read (or, where appropriate, have had read to me) and understood the participant information statement and consent form, and any questions I have asked have been answered to my satisfaction. I understand that even though I agree to be involved in this project, I can withdraw from the study at any time, and can withdraw my data up to four weeks following the completion of my participation in the research. Further, in withdrawing from the study, I can request that no information from my involvement be used. I agree that research data provided by me or with my permission during the project may be included in a thesis, presented at conferences and published in journals on the condition that neither my name nor any other identifying information is used.

I (the participant) consent to having my interview responses audio recorded (please tick):

☐ Yes ☐ No

Name of Participant (block letters):

Signature: **Date:** _____

***Name of Authorised Representative (block letters):**

Signature: **Date:** _____

Name of Investigator (block letters):

Signature: **Date:** _____

****Name of Student Supervisor (block letters):**

Signature: **Date:** _____

*Use this signature block only in such cases where the participant is not capable of providing his/her own informed consent.
**To be used when the researcher is either an undergraduate or postgraduate student.

APPENDIX P: WITHDRAWAL OF CONSENT FORM

LA TROBE UNIVERSITY

LA TROBE RURAL HEALTH SCHOOL
College of Science, Health and Engineering

Mailing address
PO Box 199
Bendigo Victoria 3552
Australia

T +61 3 5444 7411
F +61 3 5444 7977
E health@latrobe.edu.au
latrobe.edu.au/health

MELBOURNE CAMPUSES
Bundoora
Collins Street CBD
Franklin Street CBD

REGIONAL CAMPUSES
Bendigo
Albury-Wodonga
Mildura
Shepparton

La Trobe University

University Human Ethics Committee

Withdrawal of Consent for Use of Data Form

Project title – Occupational therapy in maternal health: Case study

I, (the participant), wish to WITHDRAW my consent to the use of data arising from my participation. Data arising from my participation must NOT be used in this research project as described in the Information and Consent Form. I understand that data arising from my participation will be destroyed provided this request is received within four weeks of the completion of my participation in this project. I understand that this notification will be retained together with my consent form as evidence of the withdrawal of my consent to use the data I have provided specifically for this research project.

Participant's name (printed):

.....

Signature:

.....

Date:

.....

ABN 64 804 735 113
CRICOS Provider 00115M

APPENDIX Q: PARTICIPANT INFORMATION SUMMARY (OCCUPATIONAL THERAPISTS)

LA TROBE UNIVERSITY

LA TROBE RURAL HEALTH SCHOOL
College of Science, Health and Engineering

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latrobe.edu.au/health

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Franklin Street CBD

REGIONAL CAMPUSES
Bendigo
Albury-Wodonga
Mildura
Shepparton

PARTICIPANT INFORMATION FORM

CASE STUDY

Occupational therapy in maternal health

Chief investigator: Dr Carol McKinstry, La Trobe Rural Health School, La Trobe University, Bendigo; Phone: (03) 5448 9111, email: c.mckinstry@latrobe.edu.au.

Researchers: Professor Amanda Kenny, La Trobe Rural Health School, La Trobe University, Bendigo; Phone: (03) 5444 7545, email: a.kenny@latrobe.edu.au.

Hannah Slootjes, La Trobe Rural Health School, La Trobe University, Bendigo; Email: hlslootjes@students.latrobe.edu.au

Dr Leesa Hooker, La Trobe Rural Health School, La Trobe University, Bendigo; Phone: (03) 5444 7984, email: l.hooker@latrobe.edu.au.

Project aims

This research project aims to explore and document the perceived aims, benefits and barriers of occupational therapy services for well women during perinatal transitions. The term perinatal refers to pregnancy, birth and postnatal periods. At the moment, there is very little evidence-based information published about the role of occupational therapists working with the many women who are generally healthy and well, during pregnancy and after giving birth. Maternal healthcare service models in developed countries are currently being reviewed, with potential for allied health professionals to be included in future interdisciplinary maternal health teams. It is important for research into maternal health occupational therapy services be completed so that the role is clarified and potential outcomes better understood. Occupational therapists are more regularly being encouraged to be entrepreneurial and consider non-traditional roles to practice in, to support future growth of the profession. Without research report documentation, it will be difficult to determine what maternal health occupational therapy services involve. This research aims to provide robust data on if/how occupational therapy might compliment future interdisciplinary maternal health teams.

As the majority of women in developed countries are generally healthy and well prior to becoming pregnant, there is cause to consider how professional health services can best support women's wellbeing and quality of life needs during and after pregnancy. Several occupational therapists have developed specialist professional skills to work with women

ABN 64 804 735 113
CRICOS Provider 00115M

during and after pregnancy, but little is currently known about the role or services they offer, or the health outcomes for women.

This research is focussed on exploring why generally well women would access occupational therapy services during and after pregnancy, and what the benefits/outcomes are. The term "generally well" in this research means that the woman did not have any life-impacting long-term illness or disability which required occupational therapy services before becoming pregnant. The concept underlying the research acknowledges that pregnancy, birth and recovery are life transitions for a woman, which require unique supports in addition to traditional healthcare services.

Participants

In order to participate in this study, you will be:

1. Aged 18 years or older; and
2. A qualified and professionally registered occupational therapist currently working with maternal health population (from conception until one-year postpartum).

Funding / sponsorship

The research is supported by La Trobe Rural Health School, La Trobe University, Bendigo. The research project is not supported by funding or sponsorship.

Interviews

You will be invited to have a one-to-one interview with a researcher, who will ask a series of closed (demographic) and open-ended questions about the benefits, barriers, experience and outcomes of providing occupational therapy services to maternal health clients. It is expected that these interviews will take between 30 to 60 minutes to complete. You will be requested to attend interviews in person, or over the telephone/videocall (such as Skype). Responses will be audiotaped at the time of interview, and the interviewer/research may take brief notes as well. The interviews will be transcribed verbatim at a later time, by researchers.

Risks and support

There are not expected to be any significant risks, discomforts or harms to you which may result from participation in this project. There may be a minor risk that you may feel uncomfortable or upset if a traumatic memory is recalled. In this instance, the interviewer will offer you an opportunity to debrief. Interviews can and will be stopped at any stage, with support from researchers present. If you need a break, you will be offered the opportunity to talk/debrief informally with the interviewer. The researcher is an experienced occupational therapist with training in therapeutic conversation, counselling skills and mediation. A referral will be offered and can be made to formal counselling

services, if you need/want it. Contact details for counselling services will be offered to you at this time.

How data will be used, and stored securely
Your interview responses will be de-identified, coded and analysed to find common/key themes and responses which answer the research questions and aims. This process aims to report your responses anonymously, without being traceable to you personally. Pseudonyms (false names) will be used when needed, in place of your true name. Workplaces will be referred to only by key characteristics (such as "a major rural hospital in country Victoria, Australia"). There may be circumstances under which your confidentiality cannot be guaranteed, for example, as authorised or required by law or where the investigators believe that disclosure is necessary to lessen or prevent a serious threat to public health or public safety.

Hard copy information will be scanned to electronic files. All information and data recorded will be stored electronically on the La Trobe University's password protected research drive. All electronic data will be maintained and used for reporting and publications in the La Trobe University password protected research drive, including publication of interview transcripts. You may request a copy of your personal data collected in the course of the research. When the project is completed, this will remain stored in the research drive as an archive for 5 years. After this 5 year period, all data will then be permanently cleared/deleted from the research drive. Data will not be preserved for possible future use in another project.

You will be provided with an opportunity to review transcript(s) of your interview(s) prior to submission of a thesis or publication of reports or papers. A summary of the results of the research will be provided to you via email.

There is potential for this research to not have any benefits for you personally. However, there may be benefits for you to have an opportunity to be within a forum where you can express your thoughts and opinions about challenges and needs, with a sense that it will be respectfully heard, recorded and reported. Professionally, this data could potentially benefit the development of the occupational therapy profession in indicating whether maternal health is a practice area worth considering for future professional occupational therapy contribution.

Choosing to not participate, or withdraw from the research
Your decision to decline invitation to participate will be wholly respected by researchers, including if you choose to withdraw from participating in the research after initially agreeing. There are no disadvantages, penalties or adverse consequences for not participating or for withdrawing from the research.

Any questions regarding this project may be directed to the Investigator(s) (Hannah Slootjes), of the La Trobe Rural Health School's College of Science, Health and Engineering on telephone number (03 5444 7421).

If you have any complaints or concerns about your participation in the study that the researcher has not been able to answer to your satisfaction, you may contact the Senior Human Ethics Officer, Ethics and Integrity, Research Office, La Trobe University, Victoria, 3086 (P: 03 9479 1443, E: humanethics@latrobe.edu.au). Please quote the application reference number HEC16107.

Withdrawal from research

You have the right to withdraw from active participation in this project at any time. You may also request that data arising from your participation are not used in the research project provided that this right is exercised within four weeks of the completion of your participation in the project. *You are asked to complete the "Withdrawal of Consent Form" or to notify the researcher by email or telephone that you wish to withdraw your consent for your data to be used in this research project.*

APPENDIX R: PARTICIPANT INFORMATION SUMMARY (SERVICE USERS)

LA TROBE UNIVERSITY

LA TROBE RURAL HEALTH SCHOOL
College of Science, Health and Engineering

Mailing address
PO Box 199
Bendigo Victoria 3552
Australia

T +61 3 5444 7411
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REGIONAL CAMPUSES
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Mildura
Shepparton

PARTICIPANT INFORMATION FORM

CASE STUDY

Occupational therapy in maternal health

Chief investigator: Dr Carol McKinstry, La Trobe Rural Health School, La Trobe University, Bendigo; Phone: (03) 5448 9111, email: c.mckinstry@latrobe.edu.au.

Researchers: Professor Amanda Kenny, La Trobe Rural Health School, La Trobe University, Bendigo; Phone: (03) 5444 7545, email: a.kenny@latrobe.edu.au.

Hannah Slootjes, La Trobe Rural Health School, La Trobe University, Bendigo; Email: hlslootjes@students.latrobe.edu.au.

Dr Leesa Hooker, La Trobe Rural Health School, La Trobe University, Bendigo; Phone: (03) 5444 7984, email: l.hooker@latrobe.edu.au.

Project aims

This research project aims to explore and document the perceived aims, benefits and barriers of occupational therapy services for well women during perinatal transitions. The term perinatal refers to pregnancy, birth and postnatal periods. At the moment, there is very little evidence-based information published about the role of occupational therapists working with the many women who are generally healthy and well, during pregnancy and after giving birth. Maternal healthcare service models in developed countries are currently being reviewed, with potential for allied health professionals to be included in future interdisciplinary maternal health teams. It is important for research into maternal health occupational therapy services be completed so that the role is clarified and potential outcomes better understood. Occupational therapists are more regularly being encouraged to be entrepreneurial and consider non-traditional roles to practice in, to support future growth of the profession. Without research report documentation, it will be difficult to determine what maternal health occupational therapy services involve. This research aims to provide robust data on if/how occupational therapy might compliment future interdisciplinary maternal health teams.

As the majority of women in developed countries are generally healthy and well prior to becoming pregnant, there is cause to consider how professional health services can best support women's wellbeing and quality of life needs during and after pregnancy. Several occupational therapists have developed specialist professional skills to work with women

ABN 64 804 735 113
CRICOS Provider 00115M

during and after pregnancy, but little is currently known about the role or services they offer, or the health outcomes for women.

This research is focussed on exploring why generally well women would access occupational therapy services during and after pregnancy, and what the benefits/outcomes are. The term "generally well" in this research means that the woman did not have any life-impacting long-term illness or disability which required occupational therapy services before becoming pregnant. The concept underlying the research acknowledges that pregnancy, birth and recovery are life transitions for a woman, which require unique supports in addition to traditional healthcare services.

Participants

In order to participate in this study, you will be:

1) Aged 18 years or older; and
2) A generally well woman who has accessed occupational therapy services during or after your pregnancy (from conception up until one-year post-birth), for needs related to motherhood.

Funding / sponsorship

The research is supported by La Trobe Rural Health School, La Trobe University, Bendigo. The research project is not supported by funding or sponsorship.

Interviews

You will be invited to have a one-to-one interview with a researcher, who will ask a series of closed (demographic) and open-ended questions about the benefits, barriers, experience and outcomes of received occupational therapy services during your transition to becoming a mother. It is expected that these interviews will take between 30 to 60 minutes to complete. You will be requested to attend interviews in person, or over the telephone/videocall (such as Skype). Responses will be audiotaped at the time of interview, and the interviewer/research may take brief notes as well. The interviews will be transcribed verbatim at a later time, by researchers.

Risks and support

There are not expected to be any significant risks, discomforts or harms to you which may result from participation in this project. There may be a minor risk that you may feel uncomfortable or upset if a traumatic memory is recalled. In this instance, the interviewer will offer you an opportunity to debrief. Interviews can and will be stopped at any stage, with support from researchers present. If you need a break, you will be offered the opportunity to talk/debrief informally with the interviewer. The researcher is an experienced occupational therapist with training in therapeutic conversation, counselling skills and mediation. A referral will be offered and can be made to formal counselling

services, if you need/want it. Contact details for counselling services will be offered to you at this time.

How data will be used, and stored securely
Your interview responses will be de-identified, coded and analysed to find common/key themes and responses which answer the research questions and aims. This process aims to report your responses anonymously, without being traceable to you personally. Pseudonyms (false names) will be used when needed, in place of your true name. Workplaces will be referred to only by key characteristics (such as "a major rural hospital in country Victoria, Australia"). There may be circumstances under which your confidentiality cannot be guaranteed, for example, as authorised or required by law or where the investigators believe that disclosure is necessary to lessen or prevent a serious threat to public health or public safety.

Hard copy information will be scanned to electronic files. All information and data recorded will be stored electronically on the La Trobe University's password protected research drive. All electronic data will be maintained and used for reporting and publications in the La Trobe University password protected research drive, including publication of interview transcripts. You may request a copy of your personal data collected in the course of the research. When the project is completed, this will remain stored in the research drive as an archive for 5 years. After this 5 year period, all data will then be permanently cleared/deleted from the research drive. Data will not be preserved for possible future use in another project.

You will be provided with an opportunity to review transcript(s) of your interview(s) prior to submission of a thesis or publication of reports or papers. A summary of the results of the research will be provided to you via email.

There is potential for this research to not have any benefits for you personally. However, there may be benefits for you to have an opportunity to be within a forum where you can express your thoughts and opinions about challenges and needs, with a sense that it will be respectfully heard, recorded and reported. Professionally, this data could potentially benefit the development of the occupational therapy profession in indicating whether maternal health is a practice area worth considering for future professional occupational therapy contribution.

Choosing to not participate, or withdraw from the research
Your decision to decline invitation to participate will be wholly respected by researchers, including if you choose to withdraw from participating in the research after initially agreeing. There are no disadvantages, penalties or adverse consequences for not participating or for withdrawing from the research.

Any questions regarding this project may be directed to the Investigator(s) (Hannah Slootjes), of the La Trobe Rural Health School's College of Science, Health and Engineering on telephone number (03 5444 7421).

If you have any complaints or concerns about your participation in the study that the researcher has not been able to answer to your satisfaction, you may contact the Senior Human Ethics Officer, Ethics and Integrity, Research Office, La Trobe University, Victoria, 3086 (P: 03 9479 1443, E: humanethics@latrobe.edu.au). Please quote the application reference number HEC16107.

Withdrawal from research

You have the right to withdraw from active participation in this project at any time. You may also request that data arising from your participation are not used in the research project provided that this right is exercised within four weeks of the completion of your participation in the project. *You are asked to complete the "Withdrawal of Consent Form" or to notify the researcher by email or telephone that you wish to withdraw your consent for your data to be used in this research project.*

APPENDIX S: CODEBOOK SAMPLE (MULTIPLE CASE STUDY, CROSS-CASE ANALYSIS CODED DATA

Case study (OT participants)

Nodes

Name	Description	Files	Refs
Good quotes		15	41
Perinatal OT practice		0	0
Macro practice issues influencing perinatal OT	How health services are structured to contextualise OT practice and service delivery to perinatal clients	0	0
Funding influences and outcome measures	How funding influences the OT role and dictates which outcome measures are considered and reported by POT's	11	26
EXCL Indirectly relevant to OT - secondary influences	Parallel services, which influence the structure and place for POT, but not directly relevant.	6	7
Health services structure and models	How the health service structures influence POT roles. Includes medical model, etc	11	39
OT accessibility in health services structure	What, why and how OT's are accessible to perinatal populations (beyond traditional referral pathways)	18	63
OT's prevalence and place within health services	Where, why and how many OT's are working in health services to address perinatal populations	10	16
Prevention and EI (services)	Services influenced by health promotion, prevention, and early intervention, which have resulted in OT being employed	18	42
Referrals and care coordination	How OT services are being offered, coordinated and connected for perinatal populations	10	33
Beyond scope - Service connections for maternal clients	How and who OT's reach out to so that they can help women find the services they need	3	3
MDT and referral networks	The MDT and referral networks OT's use to help women find the services they need	24	76
Reasons for referral to OT	Reasons for referral to perinatal OT	16	61
Referral pathways (to OT)	How referrals are coming into OT's (via referral networks)	15	65
Service gaps reflecting a lack of women's health understanding	OT perception of service gaps which highlight current health services not understanding the needs fo perinatal populations	11	23
OPI's; OT lens on maternal wellbeing, life stages, adaptation and transitions	How OT's recognise OPI's for maternal populations throughout perinatal transitions	0	0
Adaptation to new roles (including first-time mums)	Expectations versus reality; Maternal responsibility, identity and shifting sense of self	11	36
Co-occupation engagement for mother-infant dyad	Shared occupations (mother-infant), including meaningful engagement and participation	24	81
Maternal capacity, empowerment, competence	The ability to perform an act, based on capacity, self-worth, self-efficacy	11	13
Intuition, self-esteem, self-worth and self-efficacy	Women's ability to tune into their intuition and build self-esteem, etc.	14	17
Maternal self-care, wellbeing and priorities	What constitutes 'wellbeing' for women during perinatal stages	17	44
Power, control, accomplishment and contibutions	Feelings of disempowerment and sources (including loss of control, feelings of not accomplishing anything, and not making contributions. Or the other way (positive)	12	24
Maternal occupational function and performance	Occupations and functional considerations performance during perinatal maternal activities	20	94