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**THE ANALYSIS OF PSYCHO-SOCIAL AND CULTURAL FACTORS
DURING PREGNANCY, CHILDBIRTH AND EARLY MOTHERHOOD
FROM THE WOMAN'S PSYCHOLOGICAL DISEASE
TO THE SUBJECTIVE AND PSYCHOLOGICAL WELL-BEING**

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INTRODUCTION

In a woman's life, childbirth emerges as a crucial event, which involves both biological and psychological changes (Kwee & Mc Bride, 2015; Taubman-Ben-Ari, Shlomo, & Findler, 2012). In recent years, several studies have been undertaken primarily to understand the negative aspects and consequences of the transition to motherhood, investigating the mothers' intra-psychic dynamics and mental disorders, and their role as risk factors for the cognitive, affective and relational development of the child (Ammaniti, Tambelli, & Odorisio, 2013). But a mother play a vital role in the family (Irwin, Beeghly, Rosenblum, & Muzik, 2016) and researchers have gradually extended the focus of their analysis. From the prevention, detection and management of problems to the psycho-social aspects which may promote a family's healthy psychological adjustment (Symon, 2003), to an analysis of the perinatal well-being concept as a subject for more in depth investigation (Allan, Carrick-Sen, & Martin, 2013). The catalyst for this change in the study perspective is traceable to a World Health Organization's statement (2004; 2014) that, extending the definition of health as not merely the absence of disease or infirmity (World Health Organization, 1948), defined the individual's mental health as a state of well-being characterized by the realization of the individual's potential, being able to cope with the normal stresses of life, work productively and fruitfully, and make a contribution to one's community.

The title of the present doctoral thesis refers specifically to this historical change. Moreover, it reflects an analysis of psycho-social and cultural factors that includes both the perspective of psychological disease and that of well-being, with a view to understanding the relationship between health and social aspects (Fassio & De Piccoli, 2010). Before proceeding, it is necessary to clarify the terminology used. Most of the

studies concerning the perinatal period use the term 'psychological well-being' to refer to 'psychological disease', such as depression and distress. Instead, in these pages the term 'well-being' is used to indicate the constructs that in literature are also called the 'positive aspects' of 'psychological well-being', as well as 'disease' which are also called 'negative aspects' of 'psychological well-being'. Precisely, the well-being perspective adopted is that of the positive psychology which uses the word 'well-being' for the constructs included in the more general conceptualizations of 'subjective well-being' and 'psychological well-being'. So, in line with Keyes' conceptualizations of mental illness/health (Keyes, 2007; Keyes & Lopez, 2009), positive and negative psychological aspects are not considered as two opposite poles of a single continuum (De Piccoli, 2014). Finally, in order to refer to a joint analysis of psychological disease and well-being, the term 'psychological health' is used in the sense of the inclusive approach of Alderdice and colleagues (2013), also to avoid overlapping with terms that already have a distinctive usage (e.g. 'mental health').

The need for this double exploration above derives from the fact that far greater evidence has been accumulated over time by quantitative research on women's psychological disease compared to the few limited data on well-being (Study-I): in the study of perinatal well-being it is fundamental to look at statistical relationships between well-being and psychological disease measures (Study-II). Furthermore, by literature analysis it emerged that constructs, which have already been widely explored, such as perinatal depression, have yet to be studied looking at possible effects of mediation (Study-III). Finally, this double perspective allows an investigation of specific constructs which have not previously been analyzed in the perinatal psychological area, for example proactive coping, already widely studied as protective factor of disease and enhancing well-being within other psychology research fields. Although no previous research has explored this type of coping in relation to women's psychological well-being during the perinatal

period, some findings about other coping strategies and women's depression justify the effort to investigate it in relation to disease and well-being, in addition to parental couple dyadic adjustment (Study-III, Study-IV).

As underlined by Held and Rutherford (2012), new motherhood is a highly public and culturally fraught experience, in addition to being intensely personal. Many disciplines investigate the exposing perinatal period including psychology in its various fields. But research questions continue to be formulated because of the cultural complexity and social transformations surrounding the incipient mother.

According to a psycho-social approach, in families there are phases that determine the progression of relationships starting from the formation of the couple until the dissolution of the same (McGoldrick & Carter, 2003). Within the cycle of life paradigm, the transition from one phase to another is identified as characterized by psycho-social stress, since it requires a redefinition and reorganization of family roles. Therefore, transition is a critical event, as it may expose vulnerabilities in the family system and its components. The birth of a child is a transition, as is the parenting project because the emotional involvement due to expectations about roles can generate stress (Cowan & Cowan, 2003). Regarding family roles, in the last century the family has undergone major transformations (Walsh, 2012) that have also changed the modalities and meanings related to being parent. For example, currently having a child does not represent, in most cases, a mandatory phase of the life cycle, and fathers are often more involved in the processes of caring for their children (Migliorini & Rania, 2008). These family transformations, alongside other structural ones, such as a greater precariousness of ties, or the smaller numbers of family members, make parenthood more than ever strongly linked to symbolic, ethical emotional and cultural meanings (Malagoli, Togliatti, & Zavattini, 2000). Among the social aspects capable of making this transition more complex, migration emerges.

In the last few decades, Italy has increasingly become a multicultural Country encompassing 198 nationalities, out of a world total of 232. 52.3% of authorized foreigner residents are women, around 5 million (Caritas e Migrantes, 2017). Generally, migration is a process where various factors make adaptation of the family system difficult, resulting in additional stress during transitions (Bacallao & Smokowsky, 2007; Falicov, 2012). Particularly during transition to motherhood, migrant women may find themselves facing a situation of amplified psycho-social risk (Berlincioni et al., 2014; Collins, Zimmerman, & Howard, 2011), because of the remoteness from the primary networks of social support and from the cultural values and traditional beliefs about pregnancy and childbirth practices (Benza & Liamputtong, 2014; Moro, Neuman & Réal, 2010).

Furthermore, other social changes, such as the medicalization of pregnancy and childbirth make the study of perinatal psychology more significant. Other themes related to this phenomenon, which however are beyond the objectives of this work, should be mentioned for their potential to affect the transition to parenthood these are: medically assisted procreation and obstetric violence. As regards perinatal medicalization, in Italy an over-use of diagnostic services during pregnancy and a rate of caesarean section among the highest in European Countries emerges, with the most recent data showing 35% (CEDAP, 2017). This data reflects a limited control of women on their bodies, which produce anxiety and limits the natural ability of women to give birth (Mansfield, 2008). Researchers talk about a context that charges the concepts of pregnancy and birth with perceived risk, but at the same time provides women with the possibility of choice (Malacrida & Boulton, 2014). The critical goal therefore appears to be not to romanticize natural and pre-technological birth, since this would ignore the benefits in terms of perinatal deaths, but to allow women an effective choice, putting her at the center of the decision-making process (Crossley, 2007; McAra-Couper, Jones, & Smythe, 2012). According to this, and in line with a medical-patient collaborative approach

(Zuccheromaglio, Alby, & Fatigante, 2016), studies have shown that to take part in the decision-making process for the delivery mode is important for women's birth satisfaction (Salmela-Aro et al.,2012).

According to the socio-cultural framework just outlined, the following needs for further study emerge. To analyze the positive and negative aspects of psychological well-being considering migration as a variable (Study-II). To adopt a qualitative methodology in order: to explore through an intercultural perspective the meanings attributed by women to perinatal well-being and their experience and expectations (Study-V); to deepen the theme of women's choice of delivery mode (Study-VI).

This work is the result of, and reflects, the development of a gradual personal interest in the positive aspects of the woman's perinatal psychological well-being. At the beginning of the research doctorate, the study was mainly oriented towards psychological disease and related protection factors. The participation in a perinatal psychology working-group at the Department of Education Sciences of the University of Genoa gave me the opportunity to collaborate in research carried out within the *Optibirth* project (Morano et al., 2018), an international research project to address the increase in caesarean section rates focusing on the practice of routine caesarean after a first caesarean section. At the same time, I participated in the completion of the second wave of the International Survey of Children's Well-being (ISCWeB), a worldwide study of subjective well-being that was developed by the International Society for Child Indicators (ISCI) (Migliorini, Tassara, & Rania, 2018; Migliorini, Tassara, & Rania, in progress). This collaboration increased my knowledge in the field of well-being in general and in particular as conceptualized in the perspective of positive psychology. Similarly to what was reported by Alderdice and colleagues (2013), I recognized the importance of promoting women's perinatal well-being and of their families in addition to the prevention of psychological disease, as it is

in such stark contrast with the majority of the women experience positively the perinatal period.

The overall purpose of this doctoral thesis is therefore to focus on women's perinatal psychological disease/well-being in order to analyze various psycho-social factors, which emerged from an analysis of the literature and of the cultural context.

The thesis is organized into six chapters, each dedicated to a study. The first chapter reports a systematic scoping review of the literature (Study-I) undertaken to identify studies in the perinatal psychology area which used standardized measures of well-being developed within the positive psychology perspective. Results report the instruments utilized and summarize the evidence of the researches identified. The second chapter presents a quantitative study (Study-II) dedicated to exploring women's psychological well-being/disease during pregnancy and after childbirth, by the analysis of the statistical relationship between various measures. The study also provides group comparisons, including an analysis of differences between Italian and migrant women. The third chapter refers to a quantitative study (Study-III) undertaken to analyze relationships between distress, depression and dyadic adjustment during pregnancy and postpartum. The study provides evidence of the mediation role of depression between distress and dyadic adjustment, and investigates social support as a protective factor of depression through dyadic adjustment and proactive coping as mediators. The fourth chapter concerns a quantitative study (Study-IV) aiming to analyze, during pregnancy and motherhood, relationships between perceived social support and measures of women's psychological well-being, analyzing the mediating role of dyadic adjustment and proactive coping. In the fifth chapter a qualitative study (Study-V) is presented aiming to explore, among Italian and migrant pregnant women, the conceptualizations of perinatal well-being as well as the emotional experience, expectations regarding pregnancy, birth and motherhood, and the meaning that birth has from the mothers' perspective. Finally,

in the sixth chapter Italian women's perceptions were investigated regarding the possibility to give birth with a *VBAC*, focusing on their relational and psychological needs (Study-VI). To be precise, the second, third and fourth studies were carried out with the same participants, while the fifth and sixth with different samples. Strengths and limitations are reported in the conclusions section, as well as implications for future research and psychological well-being promotion interventions, both for pregnant woman and for their partners.

CHAPTER ONE

Measurements of Women's Subjective and Psychological Well-Being: A Systematic Scoping Review of the Literature in the Perinatal Area

1. Introduction to Study-I. Perinatal psychology research area: a literature gap between women's well-being and disease studies

The study presented in this chapter represents the foundations for a large part of this doctoral thesis which, as indicated in the introduction, has set itself the goal of exploring women's psychological health (in its broadest sense of mental health, i.e. both positive and negative psychological dimensions) during the perinatal period.

Several studies carried out in the context of perinatal psychology have shown that there is a significant gap between the study of the positive and negative aspects of women's mental health during the transition to maternity but no study has yet systematically reviewed the literature to identify the research that examined well-being, even partially, from the perspective of positive psychology. Reviewing the literature systematically, the present work aims to identify those studies that explored women's psychological health during the perinatal period using at least one standardized measure of subjective or psychological well-being, in other words hedonic or eudemonic.

For the overall purpose of this thesis, the current chapter has a dual goal, establishing the current state of the art as well as identifying and reviewing the tools to be used to further deepen the understanding of the women's well-being during pregnancy and postpartum, as emerges from Study-II and Study-IV.

2. Study-I: background

In recent years, well-being has become an increasingly popular research topic in various subject areas, but much less so in the transition to motherhood, from pregnancy to postpartum (Bassi et al., 2017). In fact, research on well-being in the perinatal period is still biased in favour of measuring the negative aspects of psychological health (Alderdice et al., 2013), as emerged in the review by Morrell, Cantrell, Evans and Carrick-Sen (2013) which focused on identifying the direct pregnancy-specific measures of women's psychological well-being.

2.1. The concept of well-being within the positive psychology perspective

From the positive psychology perspective, well-being is considered both hedonic and eudemonic. With hedonic well-being, researchers mean subjective well-being, which is the assessment people make about their lives and emotional experiences (Diener et al., 2016). Subjective well-being is therefore made-up of cognitive evaluations in terms of life satisfaction, ongoing emotional reactions in terms of both positive and negative feelings and /or affect (Diener & Diener, 2009). Regarding eudemonic well-being, approaches emerge based on the idea of universal human needs and effective functioning; approaches defined as psychological well-being (Diener et al., 2009). In recent decades, a number of scales have been developed to measure these constructs (Diener et al., 2010) and, with the aim of more exhaustive and integrated frameworks, studies have been undertaken to explore correlations between subjective and positive well-being (Delle Fave, Pozzo, Bassi, & Cetin, 2013), as well as with other constructs related to positive aspects of human functioning such as self-esteem, self-efficacy and proactive coping (Lopez & Snyder, 2003; 2009). Moreover, researchers have also considered intercultural perspectives, in order to understand variations in the understanding of the concept of well-

being and cross-cultural differences in the relationships between variables (Diener & Diener, 2009; Diener & Ryan, 2009).

2.2. *The psychological perinatal well-being: a recent definition*

Only recently has the first pregnancy-specific well-being questionnaire been developed (Alderdice, McNeill, Gargan, & Perra, 2017), while pregnancy-specific measures which provide results which are predictive of birth outcomes (Alderdice, Lynn, & Lobel, 2012) are widely available. However, as highlighted by Allan, Carrick-Sen, & Martin (2013), the term perinatal well-being has only recently been developed and further research is needed on the positive aspects of perinatal well-being in order to assess the relationship between them and the negative aspects. Studies about quality of life during the perinatal period have become more numerous as emerges from Symon's review (2003) and the more recent review by Mogos, August, Salinas-Miranda, Sultan and Salihu (2013). Regarding this, positive psychology shares much in common with the field of social indicators and quality of life research, but not all quality of life research can or should be characterized as positive (Keyes, Fredrickson, & Park, 2012) and, although there are similarities, the two terms (quality of life and positive psychology) refer to different constructs (Pinto, Fumincelli, Mazzo, Caldeira, & Martins, 2017). As pointed out by Keyes and colleagues (2012), it would be more correct to define positive psychology as an important model within the quality of life tradition that emphasizes positive indicators (and thereby addresses an imbalance in the historical corpus of research in human well-being) rather than as the absence of the negative. Based on a literature analysis no work has previously been undertaken to systematically review the literature regarding women's psychological health utilizing measurements developed from the positive psychology perspective.

2.3. Aims

Based on this evidence, the research question of the present study was: what is the current situation regarding the use of these measures in the context of the perinatal research? Adopting the definition of the perinatal period as the time span from conception to the first year post-partum (Austin, 2004), the main aim of the present scoping review (Colquhoun et al., 2014) was to make a contribution to the literature by systematically searching, selecting and summarizing existing studies with the goal of providing guidance on carrying out further research on the positive aspects of psychological well-being.

In detail the objectives of this work were:

1. identify in the perinatal well-being literature the research that used standardized measures of well-being, both subjective and psychological, developed in the context of positive psychology;
2. report on these standardized measures of well-being;
3. summarize the conclusions of the research, focusing on the results concerning the above measures.

3. Method

This work was derived from a systematic scoping review of the literature to identify standardized instruments developed within the positive psychology perspective and used to measure women's well-being during the perinatal period.

3.1. Search strategy

The search was performed in February 2018 for the period 'Always – 2018'. Seven databases and a web search engine were searched systematically (see Table I) and the references of articles and reviews which were found were then manually searched to identify additional relevant studies.

3.2. *Inclusion and exclusion criteria*

Studies assessed for eligibility were included in the broad review if they:

- focused on, or were related to, positive aspects of the woman's psychological health during the perinatal period;
- included at least one standardized measure of well-being developed from the positive psychology perspective;
- were research papers where the measurement was completed by women during the perinatal period;
- were peer-reviewed published papers written in English.

Studies were excluded from the review if they:

- did not provide detailed measures of psychological health;
- were systematic reviews, qualitative data, secondary data analysis;
- detailed only measures of negative aspects of psychological well-being;
- detailed only measures of adaptation to pregnancy/childbirth/motherhood (e.g., coping, self-efficacy) or inherent quality of life;
- focused on the development/validation of an instrument.

Table I Search strategy

Step	Actions/Results
A	Electronic database: PsycINFO, Medline, Pubmed, Scopus, SSRN, Sciencedirect, Webofscience. Combined-facets search strategy: - 1 = wellbeing OR well-being OR psychological - 2 = pregnancy OR childbearing OR delivery OR childbirth OR maternity OR motherhood - 1 AND 2
B	Web search engine: Google Scholar Search strategy to locate literature using the terms “maternal psychological well-being”, “perinatal”, “postpartum”, “pregnant woman”
C	Reference search of articles and reviews
D	Detected publications: 1416 after removal of duplicates

3.3. Identification, screening and inclusion of publications

As shown in the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) diagram (Moher, Liberati, Tetzlaff, Altman, & The PRISMA Group (2009) (Figure I), a total of 1416 publications were identified. The titles and abstracts of these publications were imported as an electronic file. After removing duplicates, the abstracts were manually examined to identify well-being measures developed from the positive psychology perspective. Publications that did not meet the inclusion criteria were excluded. The full texts of the remaining publications were retrieved and examined.

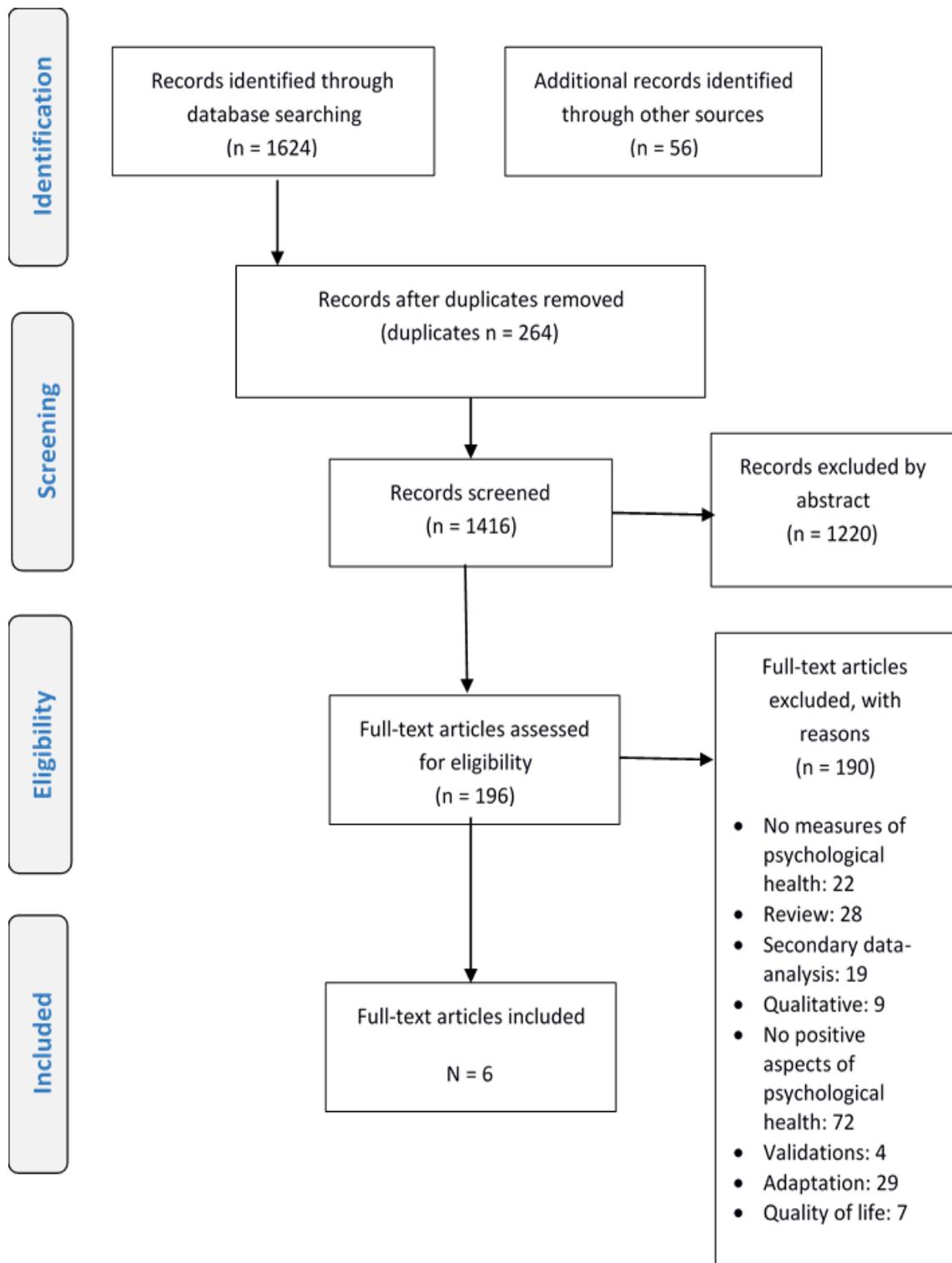


Figure I Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) diagram.

3.4. Data analysis

Two “blind” reviewers examined the publications, resolving by consensus any inconsistencies in reviewers’ assessment. Data from the included publications was extracted.

4. Results

For the aim of the present work, studies focused on measures of well-being developed through the positive psychology perspective were identified. Considering the articles assessed for eligibility, there were 6/196 (3.05%) publications that included at least one standardized measure of well-being developed from the positive psychology perspective. Of these, one was an intervention study while all the others were measurement studies. A summary of the characteristics of the studies is provided in alphabetical order by first author in Table II.

In the following sub-headings, the measurement tools utilized are reported along with a summary of the results of the studies.

4.1. Measurements

The standardized measures developed within the positive psychology perspective and utilized in the identified studies were: the Positive and Negative Affect Schedule (PANAS) (Watson, Clark, & Tellegen, 1988); the Psychological Well-Being Scale (PWBS) (Ryff, 1989); the Satisfaction With Life Scale (SWLS) (Diener, Emmons, Larsen, & Griffin, 1985).

- PANAS measures the individual’s positive and negative affect. It is regarded as a reliable measure for nonclinical populations and has been shown to be highly consistent internally and stable at appropriate levels over a two-month period (Watson et al., 1988). The instrument consists of 20 items asking the participant to rate the extent to which they

experienced a particular feeling over the preceding two weeks. Half of the items concern positive affect (e.g. *“Interested”*, *“Proud”*, *“Active”*), and the other half concern negative affect (e.g. *“Upset”*, *“Irritable”*, *“Afraid”*). The scale ranges from 1 = *“Not at all”* to 5 = *“Very much”*. Two total scores are calculated in order to obtain a positive index and a negative index.

- The PWBS assesses an individual's psychological well-being through 84 scaled items ranging from 1 = *“Strongly disagree”* to 6 = *“Strongly agree”* (Ryff, 1989; Ryff & Singer, 2008). Initially validated on a population of men and women divided into categories of young, middle-aged, and older adults, showed good psychometric properties and has been used in numerous studies (Ryff, 1995; Ryff & Essex, 1992; Ryff & Keyes, 1995; Ryff & Singer, 1996). The instrument consists of 6 subscales of 14 items, each subscale identifies a dimension of psychological well-being: *“Autonomy”* (e.g. *“I have confidence in my opinions even if they are contrary to the general consensus”*), *“Environmental mastery”* (e.g. *“I am quite good in managing the many responsibilities of my daily life”*), *“Positive relations”* (e.g. *“Most people see me as loving and affectionate”*);), *“Personal growth”* (e.g. *“I think it is important to have new experiences that challenge how you think about yourself and the world”*), *“Purpose in life”* (e.g. *“Some people wander aimlessly through life, but I am not one of them”*) and *“Self-acceptance”* (e.g. *“I like most aspects of my personality”*). It is possible to calculate both a global score and that relating to the subscales.

- The SWLS assesses a person's life satisfaction in general. The scale was validated initially with college students and geriatric populations showing acceptable psychometric properties, including high internal consistency and high temporal reliability (Diener et al., 1985). Subsequently, it was validated with various other populations (Pavot & Diener, 2009). It consists of five items on a scale ranging from 1 = *“Strongly disagree”* to 7 =

“*Strongly agree*”. Each statement assesses the individual’s level of overall life satisfaction (e.g. “*The conditions of my life are excellent*”).

4.2. The studies

Aasheim, Waldenström, Rasmussen, Espehaug and Schytt (2014), explored the satisfaction with life during pregnancy, at the 17th and 30th gestational weeks, and in the postpartum, at the 6th month and 3 years after childbirth. Participants were first-time mothers of “advanced” age, defining advanced age as 32-37 years and “very advanced” age as more than 38 years. The comparison group was composed of women aged 25-31. Satisfaction with life was measured with the SWLS. Considering the scores at all points of time when the test was administered, the authors found, in general, a decline in satisfaction with life from around age 28 to age 40 and beyond within the age limits of the participants in the study. By comparison between the three age groups, it emerged that satisfaction with life was slightly reduced in the two older age groups and most severely in women of very advanced age, who reported the lowest scores at all-time points, in particular at three years after birth.

In the study undertaken by Airo and colleagues (2018), the main purpose was to gain a more detailed understanding of the changes in women’s positive and negative emotions during a psycho-educative group therapy intervention for primiparous pregnant women with severe fear of childbirth. Emotions were measured with the PANAS. The intervention consisted of seven sessions from 28 weeks of pregnancy to 6-8 weeks after childbirth, and the participants were surveyed at each session. Focusing on the negative emotions, the authors found that they decreased after the first session and that a significant decline emerged after the fourth. Regarding positive emotions, they started to increase slowly, however the increase was only significant after childbirth.

Table II List of publications identified in the review, which used at least a standardized measure of well-being developed within positive psychology perspective.

First author and year	Country	Context	Main objectives	Study design	Sample description	Positive psychology standardized measures	Perinatal stage of administration
Aasheim et al., 2014	Norway	Norwegian Institute of Public Health. Norwegian Mother and Child Cohort Study (MoBa)	To investigate satisfaction with life at an advanced and very advanced age	Prospective population-based cohort	Primiparous pregnant women N = 18565	SWLS	<ul style="list-style-type: none"> • 17 gwk • 30 gwk • 6 mpp • 3 ypp
Airo et al., 2018	Finland	Helsinki University Hospital maternal clinic. Group intervention for fear of childbirth within a randomized control trial (Nyytti – Control)	To explore the changes in emotions occurring during the group intervention	Cross sectional prospective longitudinal	Primiparous pregnant women with severe fear of childbirth N = 105	PANAS	<ul style="list-style-type: none"> • 11-13 gwk (screening FOC) • 28, 29, 30, 31, 32, 33 gwk (intervention sessions) • 6-8 wpp (intervention session)
Bassi et al., 2017	Italy	Two hospitals In Northern Italy. Obstetrics and gynaecology units	To explore the impact of childbirth and parity on perinatal depression and psychological well-being	Cross sectional prospective longitudinal	Primiparous and multiparous pregnant women N = 81 (primiparous = 39; pluriparous = 42)	PWBS	<ul style="list-style-type: none"> • 22-32 gwk • 3-6 mpp

Table II (Continued)

First author and year	Country	Context	Main objectives	Study design	Sample description	Positive psychology standardized measures	Perinatal stage of administration
Delle Fave et al., 2013	Italy	Hospital in Northern Italy. Obstetrics and gynaecology unit	To investigate before and after childbirth perinatal depression and psychological well-being	Cross sectional prospective longitudinal	Second-time pregnant women N = 19	PWBS SWLS	<ul style="list-style-type: none"> • 20-22 gwk • 6 mpp
Pesonen et al., 2016	Finland	Helsinki University Central Hospital (10 maternity clinics). Prediction and Prevention of Preeclampsia Study (PREDO)	To investigate whether maternal prenatal emotions are associated with birth outcomes	Cross sectional prospective longitudinal	Pregnant women N = 3376	PANAS	From 12/13gwk until delivery/ 38/39 gwk for a total of 14 administrations
Velikonja et al., 2016	Slovenia	Department of Human Reproduction, Division of Obstetrics and Gynaecology, University Medical Centre Ljubljana	To explore differences in psychological well-being and quality of life, between pregnant women conceiving through in vitro fertilization and conceiving spontaneously	Cross sectional	Pregnant women N = 112 (in vitro fertilization = 49; spontaneous conception = 63)	PANAS PWBS	5 – 26 gwk

Note: gwk, gestational week; mpp, month postpartum; PANAS, Positive and Negative Affect Schedule; PWBS, Psychological Well-Being Scales; SWLS, Satisfaction With Life Scale; wpp, week postpartum; ypp, year postpartum.

Bassi and colleagues (2017) undertook a study to explore the role of the event of childbirth in primiparous and pluriparous women on the levels of psychological well-being, measured with the PWBS, and of perinatal depression, measured with the Edinburg Postnatal Depression Scale (EDPS) (Cox, Holden, & Sagovsky, 1987). Assessment time points were during pregnancy between the 22nd and 32nd week and, after childbirth, between the 3rd and 6th month. From the results it emerged that at both assessment times significant positive correlations were observed between depression and psychological well-being. Overall, both during pregnancy and after childbirth, depression was significantly and negatively correlated with the global score of the PWBS. In detail, considering the six dimensions of the PWBS, during pregnancy depression was significantly and negatively correlated with 'Autonomy', 'Environmental mastery', 'Personal growth', 'Positive relations' and 'Self-acceptance'; and in the postpartum with 'Environmental mastery', 'Positive relations' and 'Self-acceptance'. Regarding parity, the authors found that after childbirth, primiparous women reported higher values of 'Environmental mastery' and 'Self-acceptance' when compared with the multiparous women. Moreover, 'Self-acceptance' and 'Personal growth' increased from pregnancy to postpartum only among the primiparous women.

The research undertaken by Delle Fave and colleagues (2013) aimed to investigate, second-time mothers' levels of hedonic and eudemonic well-being, including psychological well-being and satisfaction with life, and the relations between well-being and perinatal depression during pregnancy and after childbirth. Psychological well-being was measured with the PWBS; satisfaction with life with the SWLS and perinatal depression with the EPDS. The surveys were performed during pregnancy between the 20th and 22nd week, and after childbirth at the 6th month. By comparison between pregnancy and after childbirth, women in the postpartum reported significantly lower scores of 'Environmental mastery' and 'Personal growth'. Analyzing correlations

between well-being measures and perinatal depression, no significant differences emerged during pregnancy, while after childbirth EPDS scores were significantly and negatively correlated with 'Environmental mastery'.

Pesonen and colleagues (2016) investigated the correlation between three prenatal emotions and between these and birth outcomes, specifically length of gestation and birth weight. The emotions considered were: positive affect, measured with the PANAS; perinatal depression, measured with the Center for Epidemiologic Studies Depression Scale (CES-D) (Radloff, 1977) and anxiety, measured with the State-Trait Anxiety Inventory (STAI) (Spielberg, Gorsuch, Lushene, & Vagg, 1983). The study consisted of multiple measurement points performed from between the 12th and 13th gestational week, until delivery or the 38th/39th gestational week for a total of 14 times. About correlations, from the results it emerged that positive affect, depression and anxiety were significantly correlated across the three pregnancy trimesters. Specifically, positive emotions correlated negatively with anxiety and depression. Anxiety and depression correlated positively with each other. Moreover, comparing the mean scores among trimesters, no significant changes emerged among PANAS scores, whereas depression and anxiety were significantly higher during the first and third trimesters compared to the second trimester, and significantly higher during the third trimester than during the first. Regarding birth outcomes, authors found statistically significant, but clinically negligible associations between emotions and gestational length, and no significant associations with birth weight. Furthermore, positive emotions were associated with a lower probability of a preterm birth during the third trimester.

The study of Velikonja, Lozej, Leban, Verdenik and Bokal (2016) was undertaken to determine whether pregnant women conceiving through in vitro fertilization differed, in terms of psychological well-being and subjective quality of life from those conceiving spontaneously. The psychological well-being measures used in the research were the

PANAS and the PWBS. For subjective quality of life, the subjective Quality of Life Scale (QLS) was used (Henrich & Herschbach, 2000). Administration occurred between the 5th and 23rd gestational weeks. Authors reported that on the PANAS and PWBS no statistically significant differences emerged between the two groups of participants. Conversely, within group comparisons, women conceiving through in vitro fertilization pregnant up to 20th gestational week showed higher mean scores in ‘Positive affect’ and ‘Purpose in life’ with respect to those (conceiving through in vitro fertilization) pregnant beyond the 20th gestational week. No significant differences were observed in the group of women conceiving spontaneously. Finally, analysis revealed statistically significant relation between conceiving group and weeks of pregnancy on ‘Positive emotions’ and ‘Purpose in life’, with the women conceiving with in vitro fertilization reporting a higher impact of progress in pregnancy.

5. Discussion

This systematic scoping review was undertaken to provide a summary of the studies performed in the perinatal well-being research area utilizing standardized measures developed in the context of positive psychology.

Three tools used to measure woman’s well-being were identified: the PANAS, the PWBS and the SWLS. The first and second were employed in three studies, whereas the SWLS in two. These scales are widely used in other well-being research areas (Diener et al., 2009). Regarding psychometric properties, in particular the SWBS has received extensive testing (Diener et al., 2010; Pavot & Diener, 2009). For PANAS, the main limitations addressed by Diener and colleagues (2009) are that it assesses some states that are not usually considered to be feelings, and that it can fail to measure pleasant and unpleasant feelings considered important in enhancing well-being, as well as emotions that are important in some cultures. Instead, considering Ryff’s PWBS the main limitation

identifiable for its use in a research context is the number of the items included since, besides validity and consistent reliability, in general an instrument requires to be usable, brief and easily & quickly self-completed (Morrel et al., 2013). Moreover, the PWBS does not measure all aspects of psychological well-being (Diener et al., 2010), such as ‘Engagement’, ‘Interest’ and ‘Optimism’ (Csikszentmihalyi, 1990; Peterson & Seligman, 2004; Seligman, 2002).

Regarding the research identified, two studies were undertaken in Finland, two in Italy, one in Norway and one in Slovenia. One study had a sample size of 19 participants, three around 100 participants and two included more than 3000 participants. The studies were published between 2013-2018, which shows the recent rise in research interest in the positive aspects of the woman's psychological well-being during perinatal period. Similarly to what was reported by Morrel and colleagues (2013), all the studies involved pregnant women and four were prospective studies that explored women’s well-being from pregnancy until postpartum. Of these, two utilized multiple measurement points, whereas two performed a single administration during pregnancy and one in the postpartum. None of the research explored psychological well-being during labour and delivery, although in literature these events emerge as rich psychological experiences (Howarth, Swain, & Treharne, 2010; 2011).

Regarding the subject area, four studies explored more in depth relationships between psychological constructs, whereas two studies adopted an interdisciplinary perspective (Kwee & Mc Bride, 2015), also analyzing relationships between psychological constructs and medical aspects. Looking more in depth at the data analysis of the identified studies, none tried to identify psychological mediators or moderators other than core components of well-being (Alderdice et al., 2013), this is in contrast to the research on the negative aspects of the woman's psychological well-being (e.g. Prino et al., 2016; Rollè et al., 2017). However, all the studies highlighted the need not to focus only on the negative

aspects that may characterize pregnancy and postpartum. Rather, they suggest the usefulness of continued research on the positive aspects of woman's psychological well-being exploring relationships between positive and negative aspects (Allan et al., 2013).

6. Conclusion

The present review identified studies assessing women's psychological well-being during the perinatal period using measures developed through the positive psychology perspective. As expected by literature analysis, these measures were not specifically designed for use in pregnancy and postpartum. Considering this aspect, these instruments could be further tested in other research to assess their utility and psychometric properties in measuring women's well-being during the perinatal period. At the same time, recently developed measures by Diener and colleagues (2010) could be used and assessed in order to increase the knowledge of the positive aspects of perinatal well-being, in addition to developing specific pregnancy and postpartum well-being measurement tools.

As to the limits of the research, although a rigorous search strategy was used, some relevant publications may not have been found due to the possibility that studies used key terms not included in the present work. Furthermore, the review indicated the measures utilized by the studies and the main results of the same, but did not have amongst its objectives a review of the quality of the individual studies identified. Nevertheless, reporting on the limited research already carried out using, partially, the perspective of positive psychology, the present review suggests areas to be studied in the perinatal area. With reference to future development of the present work, it would be interesting to undertake a review of the positive aspects of fathers' psychological health before and after childbirth.

CHAPTER TWO

Psychological Disease and Well-Being during Pregnancy and Motherhood:

An exploratory Study with Italian and Migrant Women

1. Introduction to Study-II. To deepen our understanding of the relations between and within negative and positive continua of women's psychological health during the perinatal period.

The previous review was undertaken to systematically search for and select studies that employed at least one standardized measure of well-being developed in the context of positive psychology. In addition to describing the data and instruments of the identified studies, the work highlighted that little research had been done to investigate the relations between negative and positive continua of women's perinatal psychological health that is between psychological disease and hedonic/eudemonic well-being. The aim of the present study was to increase data on this issue. In comparison with previous studies that analyzed depression and anxiety, the present work employed three additional distress measurement tools. Furthermore, compared to studies that jointly examined disease and well-being, new measures of well-being developed through the positive psychology perspective were used, and relations between constructs within the negative and positive continua were analyzed.

2. Study-II: background

Being pregnant and becoming a mother is a challenging transition for women that may be stressful (Stapleton et al., 2012; Wu & Hung, 2016), as well as generating an experience of personal growth (Taubman-Ben-Ari, 2014).

Over recent decades, studies and clinical interventions were devoted mainly to the psychological disease experienced by women during the transition to motherhood, with the major focus on perinatal depression (Howard et al., 2014). Research revealed very similar prevalence rates of depression during pregnancy and postpartum, though tending to be higher in pregnancy, and that postpartum depression can represent the continuation of pre-existing symptoms into the postpartum period, with antepartum depression representing the strongest predictor of depression after childbirth (Austin, 2004; Underwood, Waldie, D'Souza, Peterson, & Morton, 2016). Symptoms of depression can appear at any time during the perinatal period, although usually beginning in the first trimester of pregnancy and in the first month postpartum. It is difficult to indicate a precise percentage of prevalence, since factors linked to the methodology of studies leads to variations in results, but it is estimated that up to 20% of mothers suffer from perinatal mood disorders (Evagorou, Arvaniti, & Samakouri, 2015; Giardinelli et al., 2012; O'Hara & Wisner, 2014; Teixeira, Figueiredo, Conde, Pacheco, & Costa, 2009).

However, during the perinatal period the majority of women are well and it is important to support them in coping with the changes required by enhancing well-being (Alderdice et al., 2013). Furthermore, studies have highlighted that depression and psychological well-being are inversely related during the perinatal period, suggesting the usefulness of steps to promote well-being also in order to decrease psychological disease (Bassi et al., 2017). As stated by Hoffenaar, van Balen and Hermanns (2010), to fully understand the impact of the transition to motherhood on women's mental health it is necessary to consider both negative and positive dimensions.

2.1. Women's psychological health in the perinatal period: from disease to well-being

Women's mood disorders during the perinatal period receives considerable attention because of the impact that they can have on family adjustment and children's development (Goodman et al., 2014; Johnson et al., 2012; Kieffer et al., 2013; Stein et al., 2014; Whisman, Davila, & Goodman, 2011). Perinatal depression appears independent of cultural background, affecting women in all parts of society and socioeconomic background, regardless of cultural identity and beliefs (Banti et al., 2011; Evagorou et al., 2015). Looking more widely at the literature, the main risk factors evidenced are psychosocial aspects such as the lack of social support, the satisfaction of the couple and migration, in addition to clinical aspects of anxiety, fear of childbirth and perinatal stress (Alipour, Lamyian, & Hajizadeh, 2012; Dennis, Merry, Stewart, & Gagnon, 2016; Fenaroli, Saita, Molgora, & Accordini, 2016; Martini et al., 2015; Nordeng, Hansen, Garthus-Niegel, & Eberhard-Gran, 2012; Rubertsson, Hellström, Cross, & Sydsjö, 2014; Yim, Tanner Stapleton, Guardino, Hahn-Holbrook, & Dunkel Schetter, 2015; Zerkowitz et al., 2004; Zerkowitz et al., 2008).

This body of evidence brings out a complex theoretical framework in which all the factors mentioned are interrelated, and suggesting that in order to better understand the psychological disease of women during the perinatal period the concept of stress must be kept separate from those of depression and anxiety, (Rallis, Skouteris, McCabe, & Milgrom, 2014a; 2014b; Schetter & Glynn, 2011). Regarding this, it appears appropriate to adopt a psychosocial approach (Lazarus & Folkman, 1984) in measuring perinatal stress, that is, an aggregate evaluation of stress responses (emotions), stress stimuli (life events or conditions) and stress perception appraisals (Lobel, Hamilton, & Cannella, 2008), revealing what women are anxious about or whether they experience life events/condition as stressful. Moreover, this approach highlights the usefulness to

employing measures of pregnancy specific stress, namely maternal fears and worries related to pregnancy (Alderdice, Lynn, & Lobel, 2012; Guardino et al., 2014; Huizink, Mulder, de Medina, Visser, & Buitelaar, 2004; Lobel et al., 2008; Staneva, Bogossian, Pritchard, & Wittkowski, 2015). Similarly, various research on the postpartum period measured parenting stress, conceptualized as a discrepancy between the resources required for the parental role and the perception of being able to cope with this role (Abidin, 1995), showing consistent associations with increased depression and anxiety and decreased dyadic adjustment (Rollè et al., 2017; Thomason et al., 2014; Vismara et al., 2016).

Shifting the focus of the analysis on studies about the relation between depression and positive dimensions of women's psychological health during the transition to motherhood, as emerged in Study-I excluding research on well-being conceptualized as the absence of psychological disorders evidence is still lacking. However, first findings showed negative correlations between depression and various dimensions of psychological well-being as conceptualized by Ryff (1989), including autonomy, environmental mastery, personal growth, positive relations and self-acceptance (Bassi et al., 2017). Hoffenaar and colleagues (2010), studying the impact of having a baby on women's well-being in first-time mothers, found that during pregnancy depression negatively correlated with life satisfaction, good mood and positive affect, positively with negative affect, while positive and negative affect were inversely correlated. In the postpartum period, anhedonia was negatively correlated to life satisfaction, good mood and positive affect; positive and negative affect inversely correlated, and positive affect was positively correlated to life satisfaction, whereas negative affect was negatively correlated.

Always referring to Study-I, one study explored relations between depression, anxiety and positive affect before childbirth (Pesonen et al., 2016), showing that positive affect,

depression and anxiety were significantly correlated across the three pregnancy trimesters, with positive affect correlated negatively with anxiety and depression, and anxiety and depression correlated positively with each other. Furthermore, comparing trimesters, no significant changes emerged among positive and negative affect scores. Another study focused on fear of childbirth and positive/negative affect (Airo et al., 2018), but it did not examine relations between constructs. Moreover, no single research analyzed perinatal specific stress. By further literature analysis, studies exploring personal growth and meaning in life in first-time mothers were identified but, although devoted to identifying the most influential factors, such as self-esteem, self-efficacy and social support (Noy, Taubman–Ben Ari, & Kuint, 2015; Taubman-Ben-Ari, Shlomo, & Findler, 2012), they did not analyse relations between well-being and depression, anxiety or stress.

Overall, it emerges that research from the joint perspective of women’s psychological disease and well-being during the perinatal period is still lacking, in particular regarding the use of both specific perinatal stress measures and both hedonic and eudemonic well-being measures. With respect to the last aspect it is worth noting that, with the exception of Delle Fave, Pozzo, Bassi, and Cetin (2013), no research using both hedonic and eudemonic well-being constructs emerged. As argued by Huppert and So (2013), a well-being assessment based only on one of the two perspectives can lead to the loss of important data. Moreover, in order to expand the examination of relations between positive and negative continua of women’s psychological health during perinatal period, it would be useful to consider the suggestion to replace two of the most widely used well-being measures, the *Psychological Well-Being Scale* (PWBS) (Ryff, 1989) and the *Positive and Negative Affect Schedule* (PANAS) (Watson, Clark, & Tellegen, 1988) with, respectively, the *Flourishing Scale* (FS) and the *Scale of Positive and Negative*

Experience (SPANE), in order to obtain a more comprehensive measure of both psychological and subjective well-being (Diener et al., 2011).

Finally, with a view to deepening our knowledge from the perspective of steps to promote well-being, starting from findings of other research areas it would be useful to test causal relational models among variables of well-being, specifically life satisfaction, positive/negative experience and flourishing. For example, research indicates that purpose in life, one of the dimensions of psychological well-being, or flourishing, (Diener et al., 2010; Frank, 1959; Ryff, 2014; Seligman, 2002), relates positively to subjective well-being from adolescence to late adulthood, showing it to be an essential part of the concept of a good life (King, Hicks, Krull, & Del Gaiso, 2006). ‘To flourish means to live within an optimal range of human functioning, one that connotes goodness, generativity, growth, and resilience’ (Fredrickson & Losada, 2005, p. 678). Theory suggests meaning in life influencing subjective well-being (Zika & Chamberlain, 1992) and, similarly, publications provide evidence that flourishing may be a consequence of well-being (Ryff, 2014). Specifically, purpose in life emerged positively affecting life satisfaction from adolescence to adulthood (Doğan, Sapmaz, Tel, Sapmaz, & Temizel, 2012; Ho, Cheung & Cheung, 2010; Cotton Bronk, Hill, Lapsley, Talib, & Finch, 2009). Similarly, also emotions were identified as affecting life satisfaction, positive emotions generally indirectly through the increase of personal resources, whereas the negative mostly directly and immediately adaptive (Cohn, Fredrickson, Brown, Mikels, & Conway, 2009; Fredrickson, 2001). Positive emotions can be considered a critical ingredient within flourishing (Fredrickson & Losada, 2005), helping people to create desirable outcomes, leading to positive cognitions and behavior, and increasing cognitive capability (Huppert, 2009; Lyubomirsky, King, & Diener, 2005; Ryan & Deci, 2001). The balance of positive and negative emotions contributes to judgements of life satisfaction (Diener & Larsen, 1993; Fredrickson & Joiner, 2002), and flourishing people demonstrate more positive

emotional reactivity in response to pleasant everyday events when compared to not flourishing people (Catalino & Fredrickson, 2011). Taken together all these findings suggest the utility to analyze the relationship between flourishing and life satisfaction hypothesizing that experienced positive and negative emotions can moderate the effect of flourishing on life satisfaction.

2.2. Aims

Within this theoretical framework, the main goal of this cross-sectional study was to delineate a picture of women's psychological health during pregnancy and after childbirth, adopting an integrated analysis of both psychological disease/well-being, and utilizing specific distress measurements alongside those for depression and anxiety, as well as measures of both hedonic and eudemonic well-being. In order to obtain a more differentiated description, various group comparisons were undertaken (e.g. primiparous vs multiparous, Italian vs migrant).

In detail the objectives were:

- to assess the levels of disease/well-being, hypothesizing overall low levels of disease and high levels of well-being;
- to examine associations between measures (specifically between disease measures, between well-being measures, and between disease and well-being measures) initially assuming that disease and well-being are two independent continua of psychological health;
- to study the effect of flourishing on women's life satisfaction, speculating a direct effect of flourishing and a moderation effect of emotional experience.

3. Methods

3.1. *Participants and procedure*

The study involved two convenience samples for a total of 144 participants: 90 pregnant women and 54 women during the postpartum period.

Women involved in the research were contacted through two institutions located in a medium-sized city in Northern Italy: a private gynecological consulting center and a voluntary association at the service of women and couples during the transition to parenthood (see presentation brochure in Appendix 1). Eligible participants were pregnant women between the 13-36 gestational week, and women during the 2-12 month postpartum period. Exclusion criteria considered by the research team were: presence of psychopathology, fetal development criticality, less than 18 years old and inability to speak, read and understand Italian.

The pregnant women in the sample had an average age of 31.67 ($SD = 5.55$). The majority reported having paid employment (74.3%) and a stable relationship (98.9%). Regarding nationality, 79% were Italian and 21% foreign. The average gestation week was 24.8 ($SD = 6.37$); 46.7% were in the second pregnancy trimester (13-24 gestational week) and 53.3% in the third (25-36 gestational week). 64.4% were primiparous.

The women in the postnatal period had an average age of 34.72 ($SD = 5.40$). The majority reported having paid employment (81.2%) and a stable relationship (98.2%). Regarding nationality, 89% were Italian and 11% foreign. The average postpartum month was 6.37 ($SD = 3.13$); 61.1% women were in the first postpartum semester and 38.9% in the second. 64.8% were primiparous. Of the total, 79.6% gave birth with a vaginal delivery.

Women who agreed to participate signed an informed consent form (Appendix 2) and were not rewarded or paid. Participants completed, independently, a protocol of measurement tools, with the full respect of privacy, anonymity and confidentiality. The data collection procedure fully complied with the Research Ethical Code of the Italian

Association of Psychology and the ethical recommendations of the Declaration of Helsinki, as well as the American Psychological Association (APA) standards for the treatment of human volunteers. The ethics committee of the Department of Education Sciences of the University of Genoa approved the study.

3.2. Instruments

Participants of both samples filled in a suite of surveys consisting of eight self-report measurement tools. Three instruments assessed well-being, one depression and four distress. Only one instrument differed between pregnancy and postpartum and concerned distress. Below is a description of the tools.

- Well-being

- *Satisfaction with Life Scale* (SWLS) (Diener, Emmons, Larsen, & Griffin, 1985) (Italian version available on <https://internal.psychology.illinois.edu/~ediener/SWLS.html>). As illustrated in the Study-I, this scale evaluates a person's overall satisfaction with life. Participants were asked to assess 5 statements (e.g. *"I am satisfied with my life"*, *"So far I have had most of the things I wanted from life"*) on a seven-point Likert scale ranging from 1 = *"Strongly disagree"* to 7 = *"Strongly agree"*, with a possible range of scores from 5 to 35, with higher values indicating more satisfaction with life. In the present study, internal consistence measured by *Cronbach's alphas* was .896 in the pregnancy sample and .903 in the postpartum sample.

- *Flourishing Scale* (FS) (Diener et al., 2010). (Italian version available on <https://internal.psychology.illinois.edu/~ediener/FS.html>). This instrument measures the individual's psychological well-being in terms of overall positive human functioning through the personal evaluation of different domains of life. Participants were asked to assess 8 statements (e.g. *"I lead a purposeful and meaningful life"*, *"My social*

relationships are supportive and rewarding") on a seven-point Likert scale ranging from 1 = "Strongly disagree" to 7 = "Strongly agree", with a possible range of scores from 8 to 56 with higher values indicating more psychological well-being. In the present study *Cronbach's alpha* was .902 in the pregnancy sample and .797 in the postpartum sample.

- *Scale of Positive and Negative Experience* (SPANE) (Diener et al., 2010). (Italian version available on <https://internal.psychology.illinois.edu/~ediener/SPANE.html>). This instrument assesses the person's overall emotional experience in terms of pleasant and unpleasant feelings. Participants were asked to think about what they have done and experienced over the past 4 weeks, assessing 12 items, six of which dedicated to positive experiences (e.g. "Happy", "Good") and six to negative ones (e.g. "Bad", "Angry"). The response scale was a five-point Likert ranging from 1 = "Very rarely or never" to 7 = "Very often or always". The summed positive score (SPANE-P) and negative score (SPANE-N) range from 6 to 30. The balance score (SPANE-B), obtained subtracting SPANE-N from SPANE-P, can range from -24 to + 24, with higher values indicating more positive than negative feelings. In the present study were utilized SPANE-P and SPANE-N. In the pregnancy sample *Cronbach's alphas* were SPANE/P = .89, SPANE/N = .848; in the postpartum sample SPANE/P = .918, SPANE/N = .836

- Depression

To assess depression was used the Edinburgh Depression Scale (EPDS) (Cox et al., 1987) (Italian version Benvenuti, Ferrara, Niccolai, Valoriani, & Cox, 1999). This scale is a widely used screening tool for depression, originally developed for the postpartum period and subsequently validated among childbearing women (Cox, Chapman, Murray, & Jones, 1996). The scale consists of 10 items related to psychological conditions. Participants were asked to answer referring over the past seven days assessing on a four-point Likert response scale ranging from 0 to 3. Following two Item samples. "I looked

joyfully to future things”, with the response format: 0 = “*As I have always done*”, 1 = “*A little less than I was used to doing*”, 2 = “*Definitely less than I was used to doing*”, 3 = “*Almost for nothing*”. “*I was worried or anxious without a valid reason*”, with response format: 0 = “*No, not at all*”, 1 = “*Almost never*”, 2 = “*Yes, sometimes*”, 3 = “*Yes, very often*”. The total score ranges from 0 to 30 with higher values indicating more negative feelings, with clinical depression cut-off > 12 (Banti et al., 2011). In the present study *Cronbach’s alpha* was .813 in the pregnancy sample and .797 in the postpartum sample.

- Distress

- *Form Y-2 of the State-Trait Anxiety Inventory (STAI-Y)* (Spielberg, 1983) (Italian version Pedrabissi & Santinello, 1996). This instrument was developed to detect and measure anxiety. It consists of two 20-item modules: Form Y-1 to measure state anxiety (e.g. “*I feel nervous*”, “*I feel pleasant*”); Form-Y2 to measure trait anxiety (e.g. “*I feel secure*”, “*I feel inadequate*”). In line with previous study (Fenaroli & Saita, 2013; Wijma, Wijma, & Zar, 1998), participants were asked to fill the Form Y-2 referring to the ongoing pregnancy/maternity. Response scale is a four-point Likert from 1 = “*Almost never*” to 4 = “*Almost always*”. The total score ranges from 20 to 80, with higher values indicating greater experienced anxiety, with a clinical anxiety cut-off > 40 (Giardinelli et al., 2012). In the present study *Cronbach’s alpha* was .892 in the pregnancy sample and .905 in the postpartum sample.

- *Revised Prenatal Life Events Scale (PLES)* (Lobel, 1996). The original scale was translated in Italian language with the translation/back-translation technique. The tool consists of 28 items related to life events that the woman may have experienced or that happened to a close family member of friend during pregnancy (e.g. “*Did you move or look for a new home?*”, “*Did anyone close and important to you die?*”). In addition, woman rated each occurred event on how undesirable or negative it was on a four-point

Likert scale from 0 = “*Not at all*” to 3 = “*Very much*”. Two indices can be computed: the number of life events occurred and a mean life event distress score, which can range from 0 to 84, with higher values indicating more distress. In the present study was utilized the distress score. *Cronbach’s alpha* was .532 in the pregnancy sample and .675 in the postpartum sample.

- *Revised Prenatal Distress Questionnaire* (NUPDQ) (Lobel, 1996; Yali & Lobel, 1999).

The original scale was translated in Italian language with the translation/back-translation technique. This instrument was administered only to the sample of pregnant women. The scale measures the level of distress that the woman experiences about a number of different aspects of pregnancy including physical and emotional symptoms, maternity ability, body image, pregnancy outcomes, and relationships. Participants were asked to assess 17 statements indicating whether they currently were feeling bothered, upset or worried about the above different aspects of pregnancy (e.g. “*about taking care of a newborn baby?*”, “*about pain during labor and delivery?*”) on a three-point Likert scale ranging from 0 = “*Not at all*” to 2 = “*Very much*”. The total score ranges from 0 to 34, with higher values indicating more prenatal distress. In the present study *Cronbach’s alpha* was .807

- *Parenting Distress* subscale (PD) of the *Parenting Stress Index-Short Form* (PSI-SF) (Abidin, 1997) (Italian version Guarino, Di Blasio, D’Alessio, Camisasca, & Serantoni, 2008). This instrument was administered only to the women of the post-partum sample. *Parenting Stress Index* measures the total stress that an individual experiences covering the role of parent, is composed of three subscales: 1) parenting distress; 2) dysfunctional parent-child interaction; 3) difficult child. In the present study was employed the *Parenting Distress* subscale, which measures the stress deriving from personal factors directly connected to the parental role. Participants were asked to assess 12 statements (e.g. “*I often feel I cannot cope with situations very well*”, “*Having a child caused more*

problems than I expected in my relationship with my partner”) on five-point Likert scale ranging from 1 = “Strongly disagree” to 5 = “Strongly agree”. The possible scores range from 12 to 60 with higher values indicating more parenting distress. In the present study *Cronbach’s alpha* was .785.

- *Wijma Delivery Expectancy/Experience Questionnaire* (WDEQ) (Wijma, Wijma, & Zar, 1998) (Italian version Fenaroli & Saita, 2013). WDEQ was developed to measure the fear of childbirth in terms of the woman’s cognitive appraisal of childbirth. The tool was designed in two versions: version A, to measure fear of childbirth during pregnancy; version B, to measure fear of childbirth after delivery. Version A asks to respondent to imagining how labor and delivery are going to be, and how they expect to feel (e.g. “How do you imagine it will feel the very moment you deliver the baby?”). Version B asks woman to rethink labor and delivery and how she was feeling (e.g. “How did you experience your labour and delivery as a whole?”). Both versions consist of 33 items on a six-point Likert scale ranging from 0 = “Do not agree” to 5 = “Totally agree”. The total score ranges from 0 to 165. The higher the score, the greater the fear the pregnant women experience, with a severe fear of childbirth cut-off ≥ 85 . In the present study *Cronbach’s alpha* was .873 in the pregnancy sample and .933 in the postpartum sample.

3.3. Data analysis

Data analysis was realized using *Statistical Package for Social Science* (SPSS) software. Alongside the descriptive, *Mann Withney/t*-tests were performed to compare several subgroups, including Italian and foreign women. Pearson’s linear correlational analysis were employed to explore associations between disease and well-being measures. Finally, a moderated regression analysis was realized to explore interaction between positive/negative experience (SPANE-P/N) and flourishing (FS) in determining satisfaction with life (SWLS).

4. Results

The results are structured in three parts related both pregnancy and postpartum sample. In the first are illustrated descriptive and group comparisons. The second reports on correlations between measures. The third is about the moderated regression models testing the effect of positive/negative experience (SPANES-P/N) in determining the relation between flourishing (FS) and life satisfaction (SWLS).

- Descriptive and group comparisons

As illustrated by the average values reported in Table I, overall pregnant women reported high levels of well-being and low levels of disease. About depression (EPDS), anxiety (STAI) and fear of childbirth (WDEQ), the majority of women reported a score below the indicated cut-off values: 90% (EPDS), 74.4% (STAI) and 91.1% (WDEQ).

From group comparisons (Table I) it emerged that: the women in the second trimester of pregnancy reported a significant higher level of flourishing (FS) when compared with the women in the third trimester ($t = 2.72, p < .01$); primiparous women reported a higher level of fear of childbirth (WDEQ) when compared with multiparous ($t = 2.61, p < .05$). Considering the migration variable, pregnant foreign women compared with Italian women rated a higher level of depression (EPDS) ($t = -3.29, p < .01$) and of prenatal specific distress (NUPDQ) ($t = -2.65, p < .05$).

Table I Pregnancy sample. Total mean values and group comparisons of well-being, depression and distress measures.

	Total	2 nd trimester	3 rd trimester	Primiparous	Pluriparous	Italian	Foreign
	<i>M</i> (<i>SD</i>)	<i>M</i>	<i>M</i>	<i>M</i>	<i>M</i>	<i>M</i>	<i>M</i>
SWLS	26.96 (5.38)	27.86	26.17	27.10	26.69	27.30	25.68
FS	45.97 (5.98)	47.7**	44.42**	46.24	45.47	46.24	44.95
SPANE-P	26.51 (3,51)	26.76	26.29	26.98	25.66	26.35	27.11
SPANE-N	13.74 (4,27)	13.64	13.83	13.53	14.13	13.51	14.63
EPDS	6.93 (4,49)	6.64	7.19	6.52	7.69	6.17**	9.79**
STAI	36.41 (8,51)	35.69	37.04	35.69	37.72	36.13	37.47
PLES	3.34 (3,65)	3.12	3.53	3.17	3.65	3.11	4.22
NUPDQ	11.52 (5,15)	12.00	11.10	11.67	11.25	10.8*	14.21*
WDEQ	58.74 (18,42)	58.36	59.08	62.40*	52.13*	58.34	60.26

t-tests: * $p < .05$, ** $p < .01$.

As illustrated by the average values reported in Table II, overall postpartum women reported high levels of well-being and low levels of disease. About depression (EPDS), anxiety (STAI) and fear of childbirth (WDEQ), the majority of women reported a score under the cut-off values: 90.7% (EPDS), 77.8% (STAI) and 94.4% (WDEQ).

From group comparisons (Table II and III), only a significant statistical difference emerged, with women who gave birth with a caesarean section reporting higher fear of childbirth when compared with women who gave birth with a vaginal delivery (WDEQ) ($t = -2.388$, $p < .05$).

Table II Postpartum sample. Total mean values and group comparisons of well-being, depression and distress measures.

	Total	1 st semester	2 nd semester	Primiparous	Multiparous
	<i>M (SD)</i>	<i>M</i>	<i>M</i>	<i>M</i>	<i>M</i>
SWLS	27.24 (4.93)	27.42	26.95	27.46	26.84
FS	46.04 (4.87)	46.42	45.43	45.74	46.58
SPANE-P	25.98 (4.08)	26.45	25.24	26.37	25.26
SPANE-N	13.35 (4.20)	13.36	13.33	13.54	13.00
EPDS	6.67 (4.22)	6.27	7.29	6.54	6.89
STAI	35.37 (8.41)	34.67	36.48	35.23	35.63
PLES	4.43 (5.2)	3.55	5.81	4.40	4.47
PS	26.37 (6.47)	25.67	27.48	26.17	26.74
WDEQ	40.06 (23.54)	39.09	41.57	43.63	33.47

Table III Postpartum sample. Total mean values and group comparisons of well-being, depression and distress measures.

	Vaginal	Caesarean	Italian	Foreign
	<i>M</i>	<i>M</i>	<i>M</i>	<i>M</i>
SWLS	27.72	25.36	27.17	27.83
FS	46.33	44.91	45.75	48.33
SPANE-P	26.14	25.36	26.04	25.50
SPANE-N	13.26	13.73	13.21	14.50
EPDS	6.67	6.64	6.58	7.33
STAI	34.88	37.27	35.56	33.83
PLES	4.19	5.36	4.10	7.00
PS	26.16	27.18	26.73	23.50
WDEQ	36.35*	54.55*	40.42	37.17

t-tests: **p* < .05.

- Correlations between measures

During pregnancy, the correlations between depression and distress scales (Table IV) were from low to high, with values ranging from .294 with life events distress (PLES) to .714 with anxiety (STAI). With the exception of relation between fear of childbirth (WDEQ) and life events distress (PLES), all distress measures resulted correlated with each other, with values ranging from .298 between prenatal specific distress (NUPDQ) and life events (PLES) to .432 between prenatal specific distress (NUPDQ) and anxiety (STAI).

Regarding postpartum, also in this case the correlations between depression and distress scales (Table IV) were from low to high, with values ranging from .479 with life events distress (PLES) to .795 with anxiety (STAI). No correlation was found with fear of childbirth (WDEQ). With the exception of relations between life events distress (PLES) and parenting stress (PS), and between life events distress (PLES) and fear of childbirth (WDEQ), the distress measures correlate between them, with values ranging from .428 between anxiety (STAI) and fear of childbirth (WDEQ), to .724 between anxiety (STAI) and parenting stress (PS).

Table IV Correlations between psychological disease measures.

	Pregnancy sample				Postpartum sample				
	STAI	PLES	NUPDQ	WDEQ	STAI	PLES	PS	WDEQ	
EPDS	.714 **	.294 **	.453 **	.306 **	EPDS	.795 **	.479 **	.602 **	.236
STAI	-	.311 **	.432 **	.363 **	STAI	-	.420 **	.724 **	.428 **
PLES	-	-	.298 **	.101	PLES	-	-	.171	.160
NUPDQ	-	-	-	.308 **	PS	-	-	-	.555 **

r-Pearson correlation: ***p* < .01 (2 tailed).

About well-being, during pregnancy all measures correlated with each other in a moderate manner (Table V). Life satisfaction (SWLS), flourishing (FS) and positive experience (SPANE-P) were positively correlated with each other, whereas negative experience (SPANE-N) was negatively correlated with all the other measures. The lower value was -.310 between negative experience (SPANE-N) and flourishing (FS), and the higher was -.495 between negative experience (SPANE-N) and positive experience (SPANE-P).

Also in the postpartum sample all well-being measures correlated with each other, from a moderate to a strong manner (Table V). Life satisfaction (SWLS), flourishing (FS) and positive experience (SPANE-P) correlated positively, whereas negative experience (SPANE-N) correlated negatively with all the other measures. The lower value was -.485 between negative experience (SPANE-N) and life satisfaction (SWLS), and the higher was .702 between life satisfaction (SWLS) and flourishing (FS).

Table V Correlations between subjective and psychological well-being measures.

	Pregnancy sample			Postpartum sample		
	FS	SPANE-P	SPANE-N	FS	SPANE-P	SPANE-N
SWLS	.430 **	.354 **	-.475 **	.702 **	.533 **	-.485 **
FS	-	.325 **	-.310 **	-	.619 **	-.681 **
SPANE-P	-	-	-.495 **	-	-	-.679 **

r-Pearson correlation: ***p* < .01 (2 tailed).

By correlation analysis between well-being and disease measures the following statistical significances emerged.

In the pregnancy sample (Table VI), correlations were from low to moderate. In detail, life satisfaction (SWLS) and flourishing (FS) similarly correlated negatively with depression (EPDS), anxiety (STAI) and with prenatal specific distress (NUPDQ), with

values ranging from -.226 to -.480. Positive experience (SPANE-P) correlated negatively with depression (EPDS), anxiety (STAI) and fear of childbirth (WDEQ), with values from -.212 to -.536. Negative experience (SPANE-N) correlated positively with all the disease measures, with values from .217 to .616.

About postpartum sample (Table VI), correlations were from low to strong. In detail, life satisfaction (SWLS) correlated negatively with depression (EPDS), anxiety (STAI) and life events distress (PLES) with values ranging from -.476 to -.517. Flourishing was correlated negatively with all the disease measures, with values ranging from -.371 to -.712. With the exception of fear of childbirth (WDEQ), positive experience (SPANE-P) was correlated negatively with all the measures, with values from -.414 to -.723. Negative experience (SPANE-N) was positively correlated with all the measures, with values from .298 to .779.

Table VI Correlations between well-being and disease measures.

	Pregnancy sample					Postpartum sample				
	EPDS	STAI	PLES	NUPDQ	WDEQ	EPDS	STAI	PLES	PS	WDEQ
SWLS	-.350 **	-.408 **	-.004	-.297 **	-.167	-.476 **	-.517 **	-.505 **	-.263	-.182
FS	-.348 **	-.480 **	-.146	-.226 *	-.202	-.625 **	-.712 **	-.422 **	-.588 **	-.371 **
SPANE-P	-.330 **	-.536 **	-.131	-.076	-.212 *	-.611 **	-.723 **	-.414 **	-.610 **	-.267
SPANE-N	.465 **	.616 **	.217 *	.313 **	.321 **	.735 **	.779 **	.454 **	.596 **	.298 *

r-Pearson correlation: **p* < .05 (2 tailed); ***p* < .01 (2 tailed).

- Positive and negative experience as moderators

To explore the possible effect of interaction between positive/negative experience (SPANE-P/SPANE-N) and flourishing (FS) on life satisfaction (SWLS), a moderate

regression analyses was performed for pregnancy sample and for postpartum sample, considering positive experience (SPANE-P) and negative experience (SPANE-N) as moderators.

In the regression models, flourishing (FS), positive experience (SPANE-P) and negative experience (SPANE-N) were entered in Step-1, whereas the two-way interaction terms flourishing X positive experience (FS X SPANE-P) and flourishing X negative experience (FS X SPANE-N) were entered in Step-2. Prior to analysis, all the entered variables were standardized. Table VII and VIII show the moderation models, respectively for pregnancy sample and for postpartum sample.

Table VII Pregnancy sample: regression models. The effect of flourishing (FS) on life satisfaction (SWLS) when positive (SPANE-P) and negative experience (SPANE-N) are entered as moderators.

	Step-1				Step-2			
	<i>b</i>	SE	<i>p</i>	95% CI	<i>b</i>	SE	<i>p</i>	95% CI
Intercept	-.009	.09	.921	-	.056	.092	.544	-
FS	.296	.096	.003	.106,.487	.274	.091	.004	.092,.455
SPANE-P	.096	.110	.388	-.123,.315	.002	.110	.985	-.220,.216
SPANE-N	-.336	.103	.002	-.541,-.131	-.336	.099	.001	-.532,-.140
FS X SPANE-P	-	-	-	-	-.269	.096	.006	-.460,-.078
FS X SPANE-N	-	-	-	-	-.073	.145	.616	-.361,.215

In the pregnancy sample, as expected, in Step-1 flourishing (FS) was positively associated with SWLS ($R^2 = .32$; $F = 13.498$, $p < .001$). Moreover, SPANE-N was negatively associated with SWLS, whereas SPANE-P was not. In Step-2 the two-way interaction between flourishing (FS) and positive experience SPANE-P was significant ($R^2 = .402$; $F = 11.316$, $p < .001$).

With regard to this significant interaction (see Figure I), by simple slope analysis it emerged that flourishing (FS) was positively related to life satisfaction (SWLS) for

participants with lower levels (-1SD) of positive experience (SPANE-P) ($b = .546$, $SE = .113$, $p < .001$). Conversely, the relation between flourishing (FS) and life satisfaction (SWLS) was not significant for participants with higher levels (+1SD) of positive experience (SPANE-P) ($b = .100$, $SE = .124$, $p = .419$, 95% CI [-.146, .348]). The Johnson-Neyman (1936) technique (Bauer & Curan, 2005) indicated that the linear effect of flourishing (FS) on life satisfaction (SWLS) was significant at the level of positive experience (SPANE-P) of below .52.

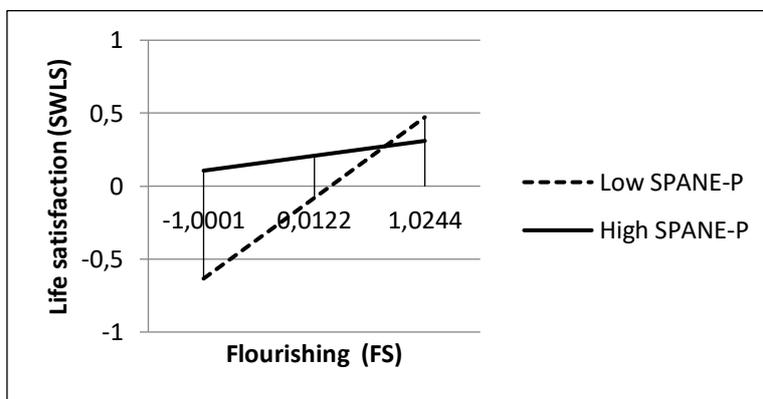


Figure I Pregnancy sample. Interactive effects of flourishing (FS) and positive experience (SPANE-P) on life satisfaction (SWLS).

In the postpartum sample, as expected, in Step-1 flourishing (FS) was positively associated with life satisfaction (SWLS) ($R^2 = .51$; $F = 17.451$, $p < .001$). Neither positive experience (SPANE-P) nor negative experience (SPANE-N) resulted associated with life satisfaction (SWLS). In Step-2, both the two-way interactions were significant ($R^2 = .589$; $F = 13.771$, $p < .001$).

With regard to these significant interactions, by simple slope analysis it emerged as follows.

As regard positive experience (SPANE-P) (see Figure II), flourishing (FS) was positively related to life satisfaction (SWLS) for participants with lower levels (-1SD) of positive experience (SPANE-P) ($b = .619$, $SE = .121$, $p < .001$). Conversely, the relation between flourishing (FS) and life satisfaction (SWLS) was not significant for participants with

higher levels (+1SD) of positive experience (SPANE-P) ($b = .300$, $SE = .187$, $p = .116$, 95% CI [-.077, .677]). The linear effect of flourishing (FS) on life satisfaction (SWLS) was significant at the level of positive experience (SPANE-P) of below .70 (Johnson-Neyman, 1936; Bauer & Curan, 2005).

Table VIII Postpartum sample: regression models. The effect of flourishing (FS) on life satisfaction (SWLS) when positive (SPANE-P) and negative experience (SPANE-N) are entered as moderators.

	Step-1				Step-2			
	<i>b</i>	SE	<i>p</i>	95% CI	<i>b</i>	SE	<i>p</i>	95% CI
Intercept	-.027	.098	.784	-	.044	.103	.674	-
FS	.642	.142	.000	.356,.928	.500	.153	.002	.192,.807
SPANE-P	.188	.137	.178	-.088,.464	.098	.132	.461	-.167,.364
SPANE-N	.078	.148	.600	-.219,.375	.015	.140	.913	-.266,.297
FS X SPANE-P	-	-	-	-	-.390	.133	.005	-.657,-.124
FS X SPANE-N	-	-	-	-	-.257	.122	.040	-.502,-.012

As regard negative experience (SPANE-N) (see Figure III), it emerged that flourishing (FS) was positively related to life satisfaction (SWLS) both for participants with low levels (-1SD) of negative experience (SPANE-N) ($b = .595$, $SE = .202$, $p < .01$), than for participants with high levels (+1SD) negative experience (SPANE-N) ($b = .696$, $SE = .137$, $p < .001$, 95% CI [.419, .973]). However, the effect of flourishing (FS) on life satisfaction (SWLS) was higher for participants with high levels of negative experience (SPANE-N).

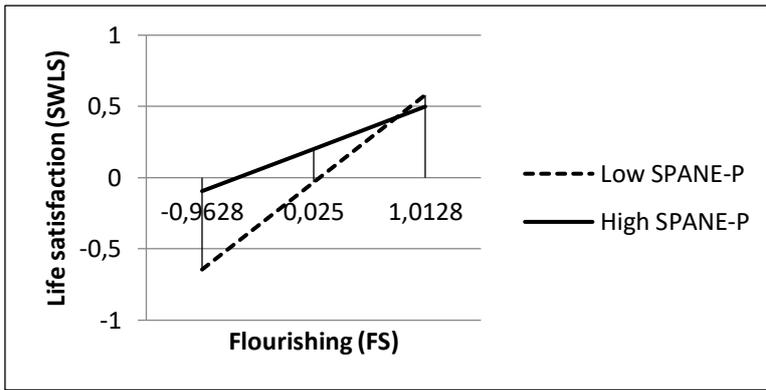


Figure II Postpartum sample. Interactive effects of flourishing (FS) and positive experience (SPANE-P) on life satisfaction (SWLS).

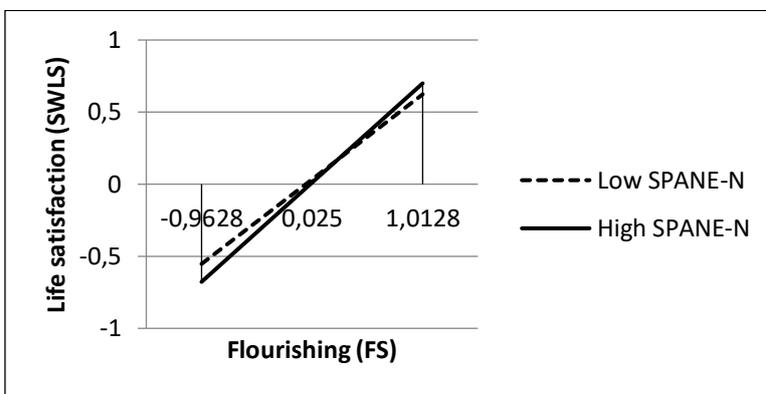


Figure III Postpartum sample. Interactive effects of flourishing (FS) and negative experience (SPANE-N) on life satisfaction (SWLS).

5. Discussion

The general aim of the present work was to delineate a picture of women's psychological health during the perinatal period, through the joint analysis of both positive and negative components (Allan et al., 2013). Two hedonic (SWLS, SPANE-P/N) and one eudemonic well-being measures (FS) were used, as well as one instrument to assess depression (EPDS) and four for distress (STAI, PLES, NUPDQ, PS, WDEQ). Well-being/disease levels were examined and various group comparisons were performed. The aims in more detail: the first was to explore associations between constructs, both within negative and positive continua, and between negative and positive continua; the second, to study the

effect of flourishing (FS) on women's life satisfaction (SWLS), postulating a moderation effect of emotional experience (SPANE-P/N).

Looking at scale ranges, both in the pregnancy sample and in the postpartum sample, overall women reported high levels of subjective and psychological well-being (SWLS, FS, SPANE-P/N) and low levels of disease (Delle Fave et al., 2013; Hoffenaar et al., 2010), with screened depression (EPDS), anxiety (STAI) and fear of childbirth (WDEQ) around, respectively, 10%, 26% and 8.9% in the pregnancy sample, 9.3%, 22% and 5.6% in the postpartum sample, showing rates in line with previous research (Banti et al., 2011; Giardinelli et al., 2012; Salmela-Aro et al., 2012). Altogether, these first results report that the majority of women during the perinatal period are well, underlining the usefulness to support the women in maintaining or increasing their well-being to experience a good transition to motherhood, besides helping women suffering of psychological disease (Alderdice et al., 2013).

At the level of group comparisons, it emerged that during pregnancy women in the third trimester report lower flourishing levels, compared to women in the second trimester. By literature analysis, no study attempts to interpret directly this result. However, research focusing on comparing women conceiving naturally with women conceiving via in vitro fertilization (Veliknovjia, Lozej, Leban, Verdenik, & Bokal 2016) found that purpose in life, a component of flourishing, increased as the pregnancy progresses for in vitro fertilization women but not for the other group. Furthermore, literature about psychological disease and quality of life suggests a possible interpretation that, as the pregnancy progresses, some issues become significant in determining woman's well-being, for example sleep-problems, physical functioning and role limitations due to physical health problems (Da Costa et al., 2010; Fatemeh, Azam, & Nahid, 2010). In line with Bassi and colleagues (2017), no differences emerged between primiparous and pluriparous on the measures of well-being and depression. However, primiparous women

reported higher levels of fear of childbirth compared to multiparous, according to literature addressing this issue it is due to inexperience and the fear of the unknown (Pazzagli et al., 2015; Lukasse, Schei, Ryding, & Bidens Study Group, 2014; Fenwick, Gamble, Nathan, Bayes, & Hauck, 2009; Melender, 2002; Rouhe et al., 2009; Toohill, Creedy, Gamble, & Fenwick, 2015). Finally, by comparison between Italian and migrant women, the latter appeared more at risk of psychological disease, reporting higher levels of depression and prenatal specific distress (Balestrieri et al., 2012; Zelkowitz et al., 2008).

Proceeding with group comparisons, in the postpartum sample only one difference emerged and that regarded the modality of birth: women who delivered vaginally reported lower levels of fear of childbirth when compared with women who delivered with caesarean section. According to other studies, this finding supports the theory that natural birth is able to positively affect women's experience of the birth itself (Nilsson, Lundgren, Karlström, & Hildingsson, 2012; Wiklund, Edman, Ryding, & Andolf, 2008; Waldenström, Hildingsson, & Ryding, 2006). Regarding the lack of differences between first and second semester, it supports the conceptualization of both semesters as crucial phases for women's psychological well-being and disease, that during the first semester family organization challenges may be more significant (Underwood et al., 2016), whereas the return to work tends to characterize the second semester (Hoffenaar et al., 2010). Also in the postpartum sample no differences emerged between multiparous and pluriparous, similarly to the study comparing perceived parental competence in first and second-time mothers (Krieg, 2007). Nevertheless, Bassi and colleagues' research (2017) reported higher levels of environmental mastery and self-acceptance in primiparous women. In both cases, it is worth considering that comparisons with the present study have to be taken with caution, due to different research designs and well-being measures. Finally, in contrast with the majority of studies (Collins, Zimmerman, & Howard, 2011),

no differences emerged between Italian and foreign women. It is very likely that the low number of foreign women in the present sample (6 participants out of a total of 54) makes statistical comparison difficult. However, as suggested by the review of Falah-Hassani, Shiri, Vigod and Dennis, (2015), it is possible that some small/minor studies reporting no or small differences between migrant and native women may have not been published. Such study might provide a confirmation of the interpretation of the current study.

Regarding correlations, as expected (Hoffenaar et al., 2010) in the pregnancy sample all distress measures correlated positively with depression. Similarly in the postpartum sample, where however fear of childbirth did not correlate, suggesting other sources of distress were more significant in this period. Regarding this aspect, both in pregnancy and postpartum, it is notable that, excluding anxiety, the highest correlations of depression were with the measures of period specific distress, that is respectively, prenatal specific distress (NUPDQ) and parenting stress (PS), showing the usefulness of assessing specific stress (Alderdice, & Lynn, 2011; Alderdice et al., 2012; Lobel et al., 2008). About the high correlations between depression (EPDS) and anxiety (STAI), results seem confirm anxiety as a risk factor for depression, although literature suggest to consider also the hypothesis of collinearity between depression and anxiety measures (Brouwers, van Baar, & Pop, 2001). As regards well-being, as expected all measures correlated with each other, in a moderate manner in the pregnancy sample, and from moderate to high manner in the postpartum sample, an overlap indicating that they refer to the overall well-being construct, although the types of well-being are separable and must be assessed separately (Diener et al., 2010). In both samples, correlations between well-being measures and depression were all significant, as was anxiety (Bassi et al., 2016; Pesonen et al., 2016). About the other distress measures, only in the postpartum sample did life events distress show significant correlations with all well-being measures. Considering period specific distress, in the pregnancy sample the major correlation of prenatal specific distress

(NUPDQ) emerged with negative experience (SPANE-N); whereas, in the postpartum sample, parenting stress (PS) showed correlations both with flourishing (FS) and with positive and negative experience (SPANE-P/N). Finally, fear of childbirth (WDEQ), in the pregnancy sample emerged correlated with positive and negative experience (SPANE-P/N), whereas in the postpartum sample with flourishing (FS) and negative experience (SPANE-N).

As regards the second objective of this work, as expected by moderate regression analysis the role of flourishing emerged in determining satisfaction with life, similarly to what emerged in other research areas exploring the effect of purpose in life on life satisfaction (Doğan et al., 2012; Ho et al., 2010; Cotton Bronk et al., 2009). Furthermore, analyses reported emotional experience as influencing the level of subjective well-being (Cohn et al., 2009), showing both during pregnancy and in the postpartum a moderation effect of positive experience, and in the postpartum also a moderation effect of negative experience. Specifically, it emerged that for women with low positive experience high levels of flourishing are important for satisfaction with life. Conversely, about negative experience in the postpartum, it emerged that to have high levels of flourishing is always important for satisfaction with life, but in particular for women with high levels of negative experience. Viewed in another way: positive experience is unrelated to satisfaction with life for women with high flourishing, but is related to increased satisfaction with life for women with low flourishing; negative experience is related to satisfaction with life for women with both low and high flourishing, but the effect on life satisfaction is strongest for women with high level of flourishing.

6. Conclusion

The present study, with respect to previous research, introducing new well-being measures in addition to several psychological disease measures, makes an important

contribution to the research on the women's psychological well-being during the perinatal period, presenting confirmatory and additional evidence, as well as results to be explored with future research. Findings further underline that psychological disease and well-being are not two opposite poles of a single continuum, but are two continua with different psychological effects, in accordance with Keyes' conceptualizations of mental illness/health (Keyes, 2007; Keyes & Lopez, 2009). Overall, it has reinforced the value of a more complex analysis of women's psychological health during the perinatal period, based on a multidimensional perspective of both disease and well-being (Hoffenaar et al., 2010)

Limitations that must be acknowledged include the convenience sampling, which does not allow a generalization of the findings, and the homogeneity of participants, in terms of psychologically healthy women and uncomplicated pregnancy. Furthermore, as mentioned above, it is to note the relatively small postpartum sample size, in particular because it does not facilitate a group comparison between Italian and migrant women. To conclude, the assessment at a single point, both in pregnancy and in postpartum, does not provide any indication of possible fluctuations of well-being during the perinatal period. Despite these limits, the study increases evidence that perinatal depression and distress are significantly and negatively related to subjective and psychological well-being. Positive psychology literature suggests that psychological diseases can be reduced by the presence of high subjective well-being levels and, conversely, that the absence of subjective well-being can be a risk factor for psychological disease (Keyes & Magyar-Moe, 2003; Ryff, 2014). From this point of view, steps to improve well-being could be implemented not only to directly support higher levels of well-being itself, but also to indirectly reduce disease. As regards, the possibility to increase positive experience and reduce negative experience seems applicable in order to increase woman's life satisfaction during perinatal period.

Regarding possible future development, it would be useful to examine from a longitudinal perspective the relations between measures of well-being, depression and distress, starting with pregnancy. With the purpose of an extension, studies illustrated in the next two chapters have been undertaken to deepen our knowledge of the relations between psychological disease/well-being and psychological protective/promotion factors during pregnancy and postpartum.

CHAPTER THREE

Women's Perinatal Psychological Disease and the Relationship of the Couple.

Depression, Dyadic Adjustment and Proactive Coping

From Both Risk and Preventive Perspective

1. Introduction to Study-III. To deepen understanding of maternal depression via mediation models from the perspective of risk and protection

The previous study explored associations within and between the two continua of woman's psychological health before and after childbirth, providing results in line with literature as well as new data related to perinatal specific stress measures. Starting from previous investigations related to parenting stress, the goal of the present work was to explore in more depth the role of pregnancy and postpartum specific stress on dyadic adjustment, analyzing depression as a mediator. Furthermore, considering findings both of perinatal psychology and of other psychological research areas, this work investigated social support as a protective factor of depression through dyadic adjustment and proactive coping as mediators.

2. Study-III: background

The birth of a child can be considered one of the most critical life transitions of adulthood (Cowan & Cowan, 2012; Schulz, Cowan, & Cowan, 2006), in which individual, relational and contextual factors are associated in the adaptation process (Dulude, Belanger, Wright, & Sabourin, 2002).

Because of the changes of roles that this major transition entails, in addition to physical and biological impact, pregnancy and childbirth can be stressful life phases for women,

as well as for the relationship of the couple (Cigoli & Scabini, 2007; Kingston, Tough, & Whitfield, 2012; Lawrence, Rothman, Cobb, Rothman, & Bradbury, 2008; Martini, Knappe, Beesdo-Baum, Lieb, & Wittchen, 2010; Molgora, Acquati, Fenaroli, & Saita, 2018). Extensive data confirms that maternal stress negatively affects women's psychological adaptation, in particular with regard depression (Naveed & Naz, 2015), and that also the quality of the relationship of the couple is related to maternal stress and depression (Jonsdottir et al., 2017; Kershaw et al., 2013; Whisman, Davila, & Goddman, 2011).

Literature widely reports measures of relationship quality conceptualized as couple satisfaction or through the multidimensional construct of dyadic adjustment (Kluwer, 2010; Lawrence, Nylén, & Cobb, 2007). Dyadic adjustment is characterized by dyadic satisfaction, dyadic cohesion, affective expression, and consensus on important aspects related to dyadic functioning, and refers to the adaptation of couples to everyday life and changing conditions in life (Spanier, 1976).

Most of the research in the perinatal area has highlighted that after childbirth a decline in dyadic adjustment occurs related to parental role stress (Camisasca, Miragoli, & Di Blasio, 2014; Krieg, 2007; Lawrence et al., 2008; Luhmann, Hofmann, Eid, & Lucas, 2012; Twenge, Campbell, & Foster, 2003). Research has consistently shown that stress associated with the parental role is related to maternal depressive symptoms (Gray, Edwards, O'Callaghan, & Cuskelly, 2012; Hildingsson & Thomas, 2014; Prino et al., 2016; Thomason et al., 2014; Vismara et al., 2016). In particular, Rollè and colleagues (2017) found in mothers and fathers parenting stress indirectly influenced dyadic adjustment in terms of mental health conceptualized as both depression and anxiety. However, apart from this study and that of Gray and colleagues (2012), no other research has emerged that analyzed simultaneously relations between these three constructs, and no research was found that analyzed perinatal specific stress separately from parenting

stress (Cf., Study-II). Furthermore, some findings showed the usefulness of extending these examinations to pregnancy, which already represents a stressful phase for the couple (Molgora, Acquati, Fenaroli, & Saita, 2018). For example, Whisman and colleagues (2011) found antenatal depression predictive of dyadic adjustment, and in the study of Trillingsgaard, Baucom and Heyman (2014) both anxiety and depression predict declines in relationship satisfaction from pregnancy to 30-months postpartum.

2.1. Social support toward dyadic adjustment during the transition to parenthood

Studies also reported that maternal psychological adjustment can be impacted by the couple's relationship (Figueiredo et al., 2008; Rini, Schetter, Hobel, Glynn, & Sandman, 2006). In particular, literature points to a strong bidirectional association between dyadic adjustment and depression (Mamun et al., 2009), suggesting a potential role for the couple's relationship, since a high-quality and supportive partner relationship contributes to maternal and infant mental health (Cheng et al., 2016; Gambrel & Piercy, 2015; Stapleton et al., 2012; Yargawa & Leonardi-Bee, 2015).

Within this context, social support emerges as a protective factor for maternal depression, especially if characterized by being provided from a variety of sources (Elsenbruch et al., 2006; Reid & Taylor, 2015), and evidence tends to indicate the error of considering the couple's adaptation as a closed system in which first the partners and then the children are included (Mert, 2018).

For many years, research on family dynamics has claimed social support has a protective role towards the quality of a couple's relationship (Dehle, Larsen, & Landers, 2001; Dehle & Weiss, 2002; Graham, Fischer, Crawford, Fitzpatrick, & Bina, 2000; Sprecher, 1988; Sprecher & Felmlee, 1992), but to date few studies have analyzed the relations between social support, quality of couple's relationship and woman's psychological disease. As regards, considering a wide range of support providers, Qadir, Khalid, Haqqani and

Medhin (2013) found that: perceived higher social support reduces the likelihood of depression and anxiety by enhancing positive relationships; perceived higher social support is positively associated, both directly and indirectly, with marital adjustment through relationship dynamics which is associated with reduced risk of depression through the increased level of reported marital satisfaction. However, about women during perinatal period, by literature analysis only the study of Wu and Hung (2016) was found. Furthermore, the authors explored joint social support by partner/medical staff, quality of couple relationship and depression in first-time mothers, but the goal was to examine changes during transition to motherhood and not to explore associations between the above constructs. Similarly, no study examining social support in affecting depression through proactive coping was found, neither in pregnancy nor during postpartum, although an established theoretical model exists suggesting that social support directly affects proactive coping and that both social support and proactive coping synergistically contribute to decrease depression and increase well-being (Greenglass, 2002; Greenglass & Fiksenbaum, 2009). As stated by Dunkel Schetter (2011), maternal coping processes in pregnancy are an open area of opportunity, but theoretical models driving research are needed, in order to identify causality for skills-based social support interventions (Guardino & Dunkel Schetter, 2014).

2.2. Linking social support and coping in a positive perspective: the construct of proactive coping

In the past, coping was viewed as an adaptive reaction, a strategy to use in the case of experienced stress (Greenglass & Fiksenbaum, 2009). However, in the context of the positive psychology movement the conceptualization of coping now includes also self-regulated goal attainment strategies and personal goals (Schwarzer & Knoll, 2011).

Reactive coping refers to the transactional stress theory of Lazarus and Folkman (1984), who distinguished between problem focus and emotion focus coping, leading to the identification of instrumental/attentive coping and avoidance/palliative and emotional coping. Lazarus (1966) defined stress as a relationship between the person and the environment, appraised as personally significant and exceeding resources for coping. This framework emphasizes appraisal and coping as mediators of the ongoing relationship between the person and the environment (Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986; Folkman, 2013). In this perspective, coping is a distress regulator, a process that the individual initiates as a response to a situation identified as significant and in which important goals are lost or threatened (Greenglass & Fiksenbaum, 2009).

Social support is a key concept in stress and coping theory, because it represents one resource factor influencing the cognitive appraisal of stressful encounters: the more social support is available and the more coping is facilitated (Schwarzer and Knoll, 2007). Social support refers to the degree to which individuals are socially embedded and have a sense of belonging, in particular to the function and quality of social relationship, including perceived availability of help or actually received support. The cognitive appraisal of stress depends partly on the perceived availability of social support; coping also depends on such resources. Social support and coping are therefore intertwined also because coping, especially via mobilization of social resources, can generate different levels of support provision (Schwarzer & Knoll, 2007). Despite this, social support and coping have long been studied separately (Greenglass & Fiksenbaum, 2009).

Social support research has been directed primarily to understanding if social support has a main effect on mental health or, rather, has a stress buffer effect. Main effect occurs when individuals with high social support levels have better mental health in comparison to those with low levels of social support. Conversely, stress buffering occurs when the link between life stress and poor mental health is stronger for people with low social

support, but in the absence of stress social support is not linked to mental health (Lakey & Orehek, 2011). About coping, research was focused on exploring multiple aspects of the coping processes, such as the nature and structure, actual processes and the variables that influence them, and their relation to the outcomes of the stressful encounters people experience including the physiological and psychological health implications of coping (cf., Folkman et al., 1986; Penley, Tomaka, & Wiebe, 2002; Skinner, Edge, Altman, & Sherwood, 2003; Stroebe, 2011). In line with this, most perinatal research studied both the direct (main) and the indirect (buffer) effect of social support on birth outcomes or psychological disease, obtaining favorable results for both perspectives, although evidence points more towards a buffer effect of maternal stress on birth outcomes (cf., Collins, Dunkel-Schetter, Lobel, & Scrimshaw, 1993; Dunkel Schetter, 2011; Lobel, Hamilton, & Cannella, 2008; Razurel, Kaiser, Sellenet, & Epiney, 2013). Consequently, researchers have tried to understand how women cope with perinatal stress (e.g., Aneja et al., 2018; Dunkel Schetter & Lobel, 2012; Goletzke et al., 2017; Lau et al., 2016; Lobel et al., 2008; Shamsaei et al., 2018) and overall research has shown that avoidance strategies or styles and poor coping skills in general are dysfunctional and associated with postpartum depression, preterm birth and infant development (Guardino & Dunkel Schetter, 2014; Razurel et al., 2013; Gutiérrez-Zotes et al., 2016).

Schwarzer and Knoll (2003) theorized that coping strategies include, in addition to reactive, also positive ones, and the prototype of positive coping is proactive coping. The focus on positive coping is important because it places the focus on a broader range of risk and goal management that include active construction of opportunities and the positive experience of stress, instead of mere responding to negative events (Schwarzer & Knoll, 2011). Proactive coping is defined as a set of efforts aimed at building up general resources that facilitate the achievement of challenging goals and promote personal growth (Greenglass, 2002). Proactive coping is a multidimensional, forward-looking

strategy differing from traditional conceptions of coping (Schwarzer & Taubert, 2002). Traditional forms of coping tend to be reactive to stressful events, which have already occurred, in order to compensate for past harm or loss, whereas proactive coping is more future-oriented. Proactive coping is a form of goal management, because people perceive difficult situations as challenges. Finally, the motivation for proactive coping is more positive. In proactive coping, individuals have a vision, they see risks, demands and opportunities in the distant future and perceive demanding situations as personal challenges (Schwarzer & Knoll, 2003). The proactive individual accumulates resources, takes steps to prevent resource depletion, and can mobilize resources when needed. This approach recognizes the importance of resources that can be incorporated into the individual's coping repertoire.

About research findings on proactive coping, they point to significant and negative correlation between proactive coping and depression, and social support associated with greater proactive coping (cf., Greenglass, Fiksenbaum, & Eaton, 2006). Specifically, Greenglass and colleagues (2006), in a cross-sectional study of community-dwelling seniors, found proactive coping associated with less functional disability, less depression, and greater perceived social support and, in particular, that social support was indirectly related to depression through proactive coping. As noted previously, this mediation model has never been examined in the perinatal psychology area, but a study (Haslam, Pakenham, & Smith, 2006) found parental support reduces women's postnatal depression by the enhancement of maternal self-efficacy. As argued by Greenglass and colleagues (2006) proactive coping and self-efficacy are related moderately and positively suggesting that self-regulation is one dimension of proactive coping. Linking social support to coping allows us to theoretically link areas that have been previously viewed as conceptually distinct, and is useful in order to elaborate traditional constructs using theoretical developments in another area. Furthermore, the conceptualization of social

support as coping broadens the concept of coping as it is then defined to include interpersonal and relational skills. Finally, this approach recognizes the importance of the resources of others' that can be adopted into the individual's coping repertoire (Greenglass & Fiksenbaum, 2009).

Razurel and colleagues (2013) showed that perinatal literature does not match social support with coping strategies, but research is needed in this crucial issue in order to understand if coping can be influenced or encouraged (cf., Razurel, Bruchon-Schweitzer, Dupanloup, Irion, & Epiney, 2011). Further research should investigate the relation between maternal health, perceived social support and coping strategies in a transactional and complex logic with more specific tools.

2.3. Aims

Within this theoretical framework, and in line with the suggestion to adopt a perinatal specific stress approach (Lobel et al., 2008; cf., Study-II), the general purpose of the present work was to deepen knowledge regarding risk factors of perinatal depression and dyadic adjustment, and preventive factors of perinatal depression during pregnancy and after childbirth. About the risk factors considered, they were prenatal and postpartum specific stress. About protective factors, they were perceived social support, dyadic adjustment and proactive coping.

In addition to examining the links between disease and risk/protective factors, in detail the objectives were:

- to explore the relations between maternal stress, depression and dyadic adjustment, assuming the role of depression as mediator;
- to explore the relations between social support, dyadic adjustment, proactive coping and maternal depression, assuming the role of dyadic adjustment and proactive coping as possible parallel mediators.

Based on literature it was hypothesized that:

- stress measures positively related to depression;
- both distress measures and depression negatively related with dyadic adjustment;
- perceived social support positively related to dyadic adjustment and proactive coping;
- both dyadic adjustment and proactive coping negatively related to depression;
- stress negatively affects dyadic adjustment through depression;
- social support positively affects depression through dyadic adjustment and proactive coping.

Regarding the penultimate hypothesis, according to findings regarding the stress related to the parental role (Rollé et al., 2017), it was assumed that this postpartum specific stress affects also directly dyadic adjustment.

Regarding the last hypothesis, considering that perinatal literature predominantly points to a stress buffering effect of social support, in particular during pregnancy, it was assumed that perceived social support does not directly affect depression.

The Hayes's approach to statistical mediation analysis was adopted (Hayes, 2009; Hayes, 2013; Rucker, Preacher, Tormala, & Petty, 2011).

3. Methods

3.1. *Participants and procedure*

The present study was undertaken with the same samples as Study-II; for a complete description of participants and procedure please refer to Study-II.

3.2. *Instruments*

The following measures of depression and stress employed in Study-II were used:

- *Edinburgh Depression Scale (EPDS)*;

- *Revised Prenatal Life Events Scale* (PLES);
- *Revised Prenatal Distress Questionnaire* (NUPDQ) (pregnancy sample);
- *Parenting Distress* subscale (PD) of the *Parenting Stress Inventory-Short Form* (PSI-SF) (post-partum sample).

Furthermore, participants filled-in the *Multidimensional Scale of Perceived Social Support* (MSPSS) (Zimet, Dahlem, Zimet, & Farley, 1988) (Italian version Prezza & Principato, 2002), the *Dyadic Adjustment Scale* (DAS) (Spanier, 1976) (Italian version Gentili, Contreras, Cassaniti, & D'arista, 2002) and the *Proactive Coping* subscale (PC) of the *Proactive Coping Inventory* (PCI) (Greenglass, Schwarzer, Jakubiec, Fiksenbaum, & Taubert, 1999) (Italian version Comunian, Greenglass, & Schwarzer, 2003).

- *Multidimensional Scale of Perceived Social Support* (MSPSS) is a 12-item self-report tool devoted to assess the level of social support perceived, consisting of three subscales of 4 items each one: family (e.g. “*My family really tries to help me*”); friends (e.g. “*I have friends with whom I can share joys and sorrows*”); significant others (e.g. “*There is a special person who is near me when I need to*”). Participants were asked to answer on a seven-point Likert scale ranging from 1 = “*Completely disagree*” to 7 = “*Completely agree*”. The total score can range from 12 to 84 with higher values indicating higher levels of perceived social support. In the present study *Cronbach's alpha* was .883 in the pregnancy sample and .896 the postpartum sample.

- *Dyadic Adjustment Scale* (DAS) is a 32-item self-report tool for assessing dyadic adjustment in couple relationship, consisting of four sub-scales. Dyadic consensus (13 items) that assesses the level of agreement about aspects considered important for the relationships (e.g. “*Management of family resources*”). Affectional expression (4 items) that measures the level of affective expression and sexual relationships (e.g. “*Do not show love*”). Dyadic satisfaction (10 items) that evaluates the level of satisfaction about the

relationship (e.g. “*You have ever regretted getting married?*”). Dyadic cohesion (5 items) that estimates closeness and shared activity level between the partners (e.g. “*As much as you and your partner share interests outside the home?*”). Participants were asked to answer on eight different point-scales overall ranging from 0 to 6 with a total score between 0 and to 151, with higher values indicating more dyadic adjustment. *Cronbach’s alpha* was .894 in the pregnancy sample and .933 in the postpartum sample.

- *Proactive Coping Inventory* (PCI) is a self-report tool consisting of seven subscales (*Proactive Coping Scale, Reflective Coping Scale, Strategic Planning, Preventive Coping, Instrumental Support Seeking, Emotional Support Seeking, and Avoidance Coping*) for a total of 55 items implementing the way of coping based on resourcefulness, responsibility, and vision (Greenglass et al., 1999). In the present study, was administered the 14-items *Proactive Coping* subscale (PC) that assesses the level of proactive coping combining autonomous goal setting with self-regulatory goal attainment cognitions and behavior (e.g. “*I always try to find a way to work around obstacles; nothing really stops me*”; “*I clearly visualize my dreams and I try to realize them*”). Participants were asked to indicate their degree of agreement on a four-point Likert scale ranging from 1 = “*Not at all true*” to 4 = “*Completely true*”. The total score can range from 14 to 56 with higher values indicating higher levels of proactive coping. *Cronbach’s alpha* was .847 in the pregnancy sample and .826 in the postpartum sample.

3.3. Data Analysis

Data analysis were performed using *Statistical Package for Social Science (SPSS) software*. Alongside *r-Pearson’s* linear correlational, by using Hayes’ (2012) *PROCESS* macro, mediation models were realized to explore: depression (EPDS) as mediator between distress measures (PLES, NUPDQ, PD) and dyadic adjustment (DAS); dyadic

adjustment (DAS) and proactive coping (PC) as mediators between perceived social support (MSPSS) and depression (EPDS).

4. Results

Results are organized in two parts. In the first are reported analysis regarding pregnancy sample, and in the second the analysis regarding postpartum sample.

- Pregnancy sample

In Table I are illustrated the correlations between depression, distress measures, dyadic adjustment, perceived social support and proactive coping.

By analysis, it emerged that both distress measures (PLES, NUPDQ) are positively related to depression (EPDS) (cf., Study-II). Dyadic adjustment (DAS) was negatively correlated both with the measures of distress (PLES, NUPDQ), that with depression (EPDS). Perceived social support (MSPSS) was negatively correlated with all the distress measures (PLES, NUPDQ) but not with depression (EPDS), and was positively correlated both with dyadic adjustment (DAS) that with proactive coping (PC). About proactive coping, it was negatively correlated with depression (EPDS), and positively with dyadic adjustment (DAS) in addition to perceived social support (MSPSS).

Table I Pregnancy sample. Correlations between disease measures, dyadic adjustment, perceived social support and proactive coping.

	PLES	NUPDQ	DAS	MSPSS	PC
EPDS	.294 **	.453 **	-.412 **	-.191	-.349 **
PLES	-	.298 **	-.233 *	-.210 *	-.002
NUPDQ	-	-	-.306 *	-.028	-.110
DAS	-	-	-	.470 **	.221 *
MSPSS	-	-	-	-	.255 *

r-Pearson: * $p < .05$ (2 tailed); ** $p < .01$ (2 tailed).

Pursuing the first objective of exploring the possible effect of mediation of depression (EPDS) two mediation models were tested. As regards independent variables, these were life events distress (PLES), and prenatal specific distress (NUPDQ). In all models, dyadic adjustment (DAS) was entered as dependent variable, and depression (EPDS) was entered as mediation variable. Prior to analysis, all the variables were standardized. Because it emerged that participants' nationality was significantly correlated with depression (EPDS; *r-Pearson* = .331, $p < .01$) and prenatal specific distress (NUPDQ; *r-Pearson* = .272, $p < .01$), it was dummy coded (- 1 = Italian vs +1 = Foreign) and entered as covariate. Life events distress (PLES) and prenatal specific distress (NUPDQ) were positively associated with depression (EPDS) (PLES: $b = .24$, $SE = .09$, $t = 2.62$, $p < .05$; NUPDQ: $b = .39$, $SE = .09$, $t = 4.06$, $p < .001$). Moreover, mediation effects of depression (EPDS) between distress measures and dyadic adjustment emerged, as follows.

When depression (EPDS) was entered into the regression model together with life events distress (PLES) it was negatively associated with dyadic adjustment (DAS) ($b = -.25$, $SE = .10$, $t = -2.5$, $p < .05$); the relation between life events distress (PLES) and dyadic adjustment (DAS) was not significant ($b = -.13$, $SE = .09$, $t = -1.4$, $p = .16$); instead the

indirect path from life events distress (PLES) to dyadic adjustment (DAS) through depression (EPDS) was significant ($a*b = -.07$, Bootstrap 95% CI [-.212, -.009]) (Figure I).

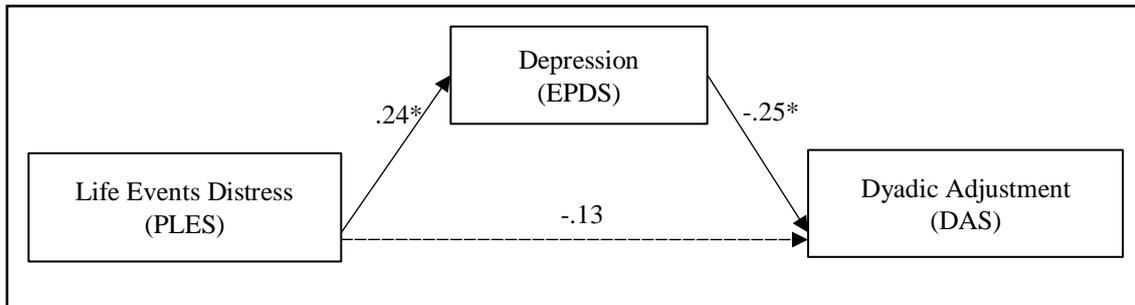


Figure I Pregnancy sample: depression as mediator between life events distress and dyadic adjustment. Path coefficients. $*p < .05$.

When depression (EPDS) was entered into the regression model together with prenatal specific distress (NUPDQ) it was negatively associated with dyadic adjustment (DAS) ($b = -.32$, $SE = .10$, $t = -2.95$, $p < .01$); the relation between prenatal specific distress (NUPDQ) and dyadic adjustment (DAS) was not significant ($b = -.13$, $SE = .10$, $t = -1.3$, $p = .19$); instead the indirect path from prenatal specific distress (NUPDQ) to dyadic adjustment (DAS) through depression (EPDS) was significant ($a*b = -.12$, Bootstrap 95% CI [-.266, -.039]) (Figure II).

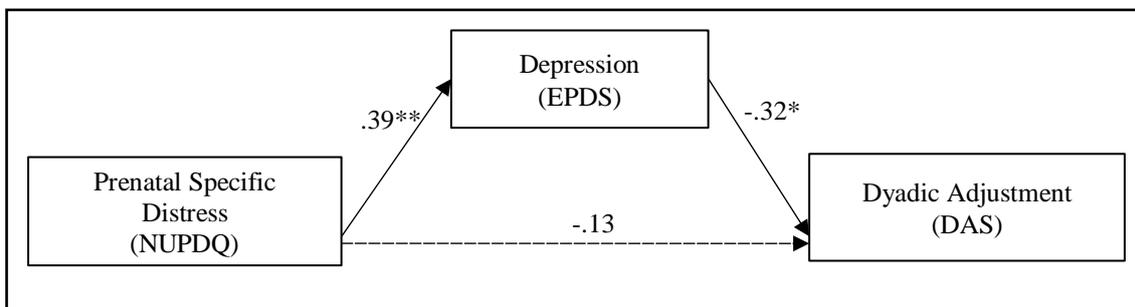


Figure II Pregnancy sample: depression as mediator between prenatal specific distress and dyadic adjustment. Path coefficients. $*p < .01$, $**p < .001$.

Pursuing the second objective of exploring the possible effect of mediation of dyadic adjustment (DAS) and proactive coping (PC) one mediation model was tested. As regards independent variable, it was perceived social support (MSPSS). Depression (EPDS) was entered as dependent variable, whereas dyadic adjustment (DAS) and proactive coping (PC) were entered as parallel mediation variables. Prior to analysis, all the variables were standardized. Participants' nationality was dummy coded (-1 = Italian vs +1 = Foreign) and entered as covariate.

Perceived social support (MSPSS) was positively associated both with dyadic adjustment (DAS) ($b = .45, SE = .08, t = 5.02, p < .001$) that with proactive coping (PC) ($b = .25, SE = .10, t = 2.47, p < .05$). Moreover, mediation effects of dyadic adjustment (DAS) and proactive coping (PC) between perceived social support (MSPSS) and depression (EPDS) emerged as follows.

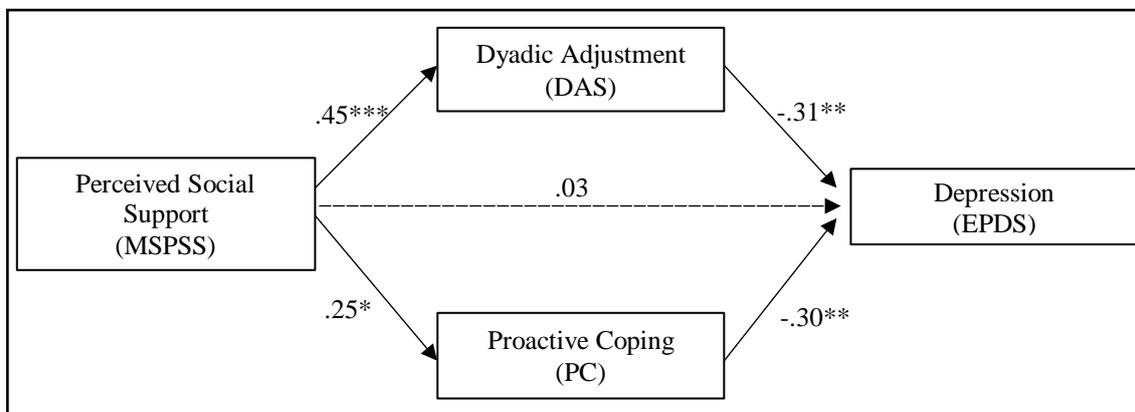


Figure III Pregnancy sample: dyadic adjustment and proactive coping as mediators between perceived social support and depression. Path coefficients. $*p < .05$, $**p < .01$, $***p < .001$.

When dyadic adjustment (DAS) and proactive coping (PC) were entered into the regression model together with perceived social support (MSPSS) they were negatively associated with depression (EPDS) (DAS: $b = -.31, SE = .10, t = -2.93, p < .01$; PC: $b = -.30, SE = .09, t = -3.27, p < .01$); the relation between perceived social support (MSPSS) and depression (EPDS) was not significant ($b = .03, SE = .10, t = .37, p = .70$); instead,

the indirect paths from perceived social support (MSPSS) to depression (EPDS) through dyadic adjustment (DAS) and proactive coping (PC) were significant (DAS: $a*b = -.15$, Bootstrap 95% CI [-.286, -.024]; PC: $a*b = -.08$, Bootstrap 95% CI [-.197, -.011]) (Figure III).

- Postpartum sample

In Table II are illustrated the correlations between depression, distress measures, dyadic adjustment, perceived social support and proactive coping. By analysis, it emerged that both distress measures (PLES, PS) are positively related to depression (EPDS) (cf., Study-II). Dyadic adjustment (DAS) was negatively correlated both with the measures of distress (PLES, PS) and of depression (EPDS). Perceived social support (MSPSS) was negatively correlated with depression (EPDS) and with all the distress measures (PLES, PS), and was positively correlated with dyadic adjustment (DAS) but not with proactive coping (PC). About proactive coping, it was negatively correlated with depression (EPDS) and parenting stress (PS), and positively with dyadic adjustment (DAS).

Table II Postpartum sample. Correlations between disease measures, dyadic adjustment, perceived social support and proactive coping.

	PLES	PS	DAS	MSPSS	PC
EPDS	.479 **	.602 **	-.571 **	-.474 **	-.443 **
PLES	-	.171	-.344 *	-.350 **	-.078
PS	-	-	-.608 **	-.373 **	-.440 **
DAS	-	-	-	.511 **	.284 *
MSPSS	-	-	-	-	.258

r-Pearson: * $p < .05$ (2 tailed); ** $p < .01$ (2 tailed).

Pursuing the first objective of exploring the possible effect of mediation of depression (EPDS) three mediation models were tested. As regards independent variables, these were life events distress (PLES) and parenting stress (PS). In all models, dyadic adjustment (DAS) was entered as dependent variable, and depression (EPDS) as mediation variable. Prior to analysis, all the variables were standardized.

Life events distress (PLES) and parenting stress (PS) were positively associated with depression (EPDS) (PLES: $b = .39$, $SE = .13$, $t = 2.9$, $p < .01$; PS: $b = .55$, $SE = .10$, $t = 5.36$, $p < .001$). Moreover, two mediation effects of depression (EPDS) between distress measures (PLES, PS) and dyadic adjustment (DAS) emerged, as follows.

When depression (EPDS) was entered into the regression model together with life events distress (PLES) it was negatively associated with dyadic adjustment (DAS) ($b = -.55$, $SE = .13$, $t = -4.16$, $p < .001$); the relation between life events distress (PLES) and dyadic adjustment (DAS) was not significant ($b = .16$, $SE = .13$, $t = -1.21$, $p = .23$), instead the indirect path from life events distress (PLES) to dyadic adjustment (DAS) through depression (EPDS) was significant ($a*b = -.19$, Bootstrap 95% CI [-.392, -.054]) (Figure IV).

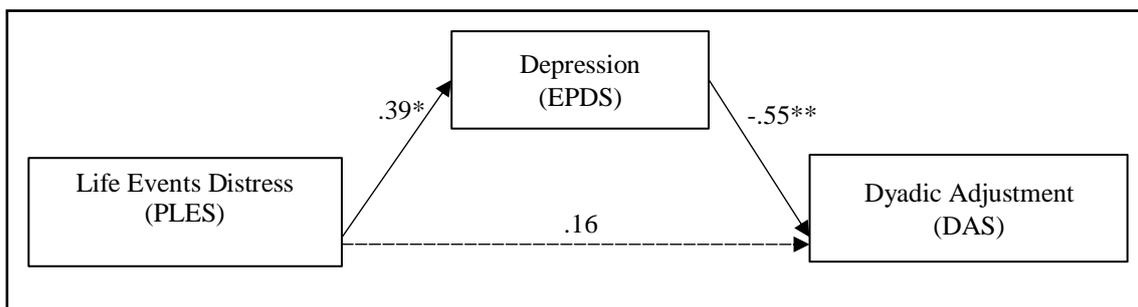


Figure IV Postpartum sample: depression as mediator between life events distress and dyadic adjustment. Path coefficients. * $p < .01$, ** $p < .001$.

When depression (EPDS) was entered into the regression model together with parenting stress (PS) it was negatively associated with dyadic adjustment (DAS) ($b = -.34$, $SE = .14$,

$t = -2.42, p < .05$); the relation between parenting stress (PS) and dyadic adjustment (DAS) was significant ($b = -.41, SE = .13, t = -3.12, p < .01$), as well as the indirect path from parenting stress (PS) to dyadic adjustment (DAS) through depression (EPDS) ($a*b = -.19, \text{Bootstrap } 95\% \text{ CI } [-.412, -.033]$) (Figure V).

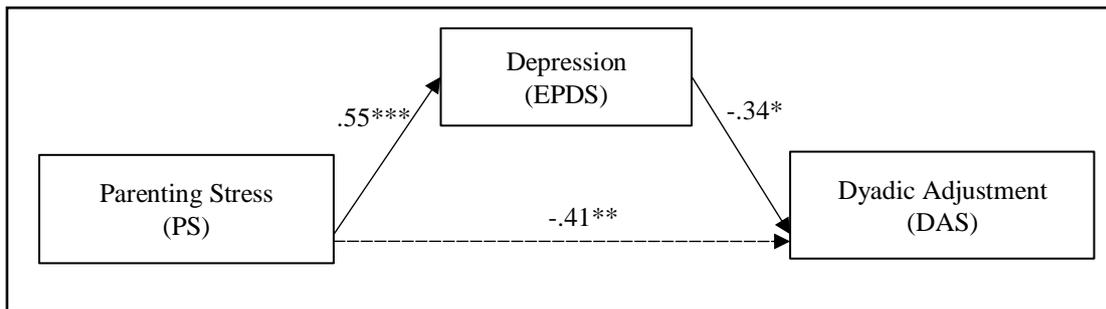


Figure V Postpartum sample: depression as mediator between parenting stress and dyadic adjustment. Path coefficients. * $p < .05$, ** $p < .01$, *** $p < .001$.

Pursuing the second objective one mediation model was tested. As regards independent variable, this was social support (MSPSS). Depression (EPDS) was entered as dependent variable, whereas dyadic adjustment (DAS) and proactive coping (PC) were entered as parallel mediation variables. Prior to analysis, all the variables were standardized.

Perceived social support (MSPSS) was positively associated with dyadic adjustment (DAS) ($b = .59, SE = .13, t = 4.24, p < .001$), but not with proactive coping (PC) ($b = .19, SE = .14, t = 1.37, p = .17$), in line with correlational analysis (Table II). Mediation effect of dyadic adjustment (DAS) between perceived social support (MSPSS) and depression (EPDS) emerged as follows.

When dyadic adjustment (DAS) and proactive coping (PC) were entered into the regression model together with perceived social support (MSPSS), dyadic adjustment (DAS) was negatively associated with depression (EPDS) ($b = -.39, SE = .12, t = -3.18, p < .01$). Neither proactive coping (PC), nor perceived social support (MSPSS) were significantly associated with depression (EPDS) (PC: $b = -.22, SE = .12, t = 1.88, p =$

.06; MSPSS: $b = -.18$, $SE = .14$, $t = 1.30$, $p = .19$). The indirect path from perceived social support (MSPSS) to depression (EPDS) through dyadic adjustment (DAS) was significant ($a*b = -.21$, Bootstrap 95% CI [-.430, -.064]). Instead, as expected, the indirect path through proactive coping (PC) was not significant ($a*b = -.04$, Bootstrap 95% CI [-.155, -.010]) (Figure VI).

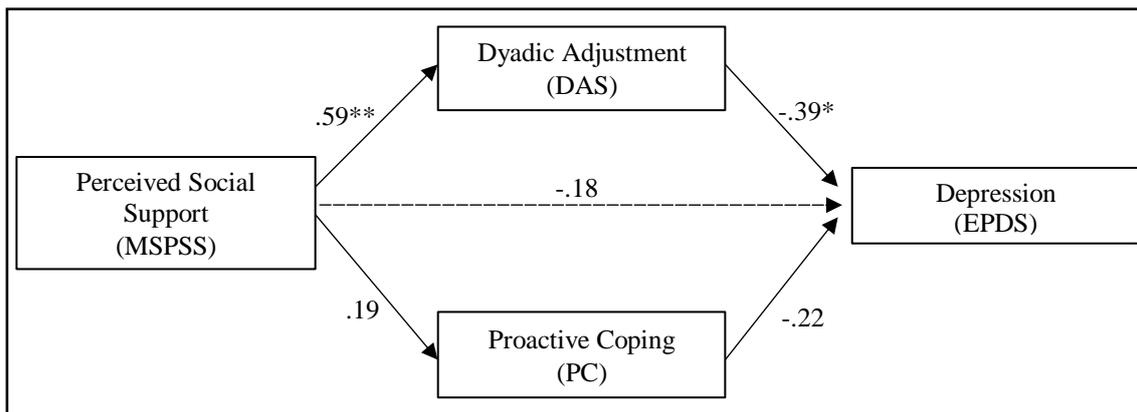


Figure VI Postpartum sample: dyadic adjustment and proactive coping as mediators between perceived social support and depression. Path coefficients. * $p < .01$, ** $p < .001$.

5. Discussion

The general purpose of the present work was twofold. From a risk perspective, to deepen knowledge about the relationship between perinatal stress, depression and dyadic adjustment during pregnancy and postpartum. From a preventive perspective, to deepen knowledge about the relationship between social support, dyadic adjustment, proactive coping and depression, during pregnancy and postpartum. In particular, two mediation models were tested: the effect of specific stress on dyadic adjustment through depression; and the effect of social support on depression through dyadic adjustment and proactive coping. A psychosocial and perinatal specific stress approach was adopted (Lobel et al., 2008; cf., Study-II), including in the analysis the woman's cognitive evaluation of life events, a measure of pregnancy related stress and a measure of parenting related stress.

Two convenience samples of participants were involved: one of pregnant women and one of women during the postpartum period.

As regards the disease and risk/protective factors considered, in both samples all the stress measures considered (PLES and NUPDQ or PS) positively correlated with depression (EPDS) (cf., Study-II), confirming the link between stress and depression (e.g. Hoffenaar, van Balen, & Hermanns, 2010; Rallis, Skouteris, McCabe, & Milgrom, 2014), with particular attention to perinatal specific stress (Alderdice, Lynn, & Lobel, 2012; Lobel et al., 2008). About protective factors, in both samples perceived social support (MSPSS) related positively with dyadic adjustment (DAS), showing the connection between this external resource and the adaptation of the couple's relationship (Dehle et al., 2001; Dehle & Weiss, 2002; Graham et al., 2000); whereas it was related positively to proactive coping (PC) only in the pregnancy sample, suggesting that during postpartum different paths exist for the construction of internal resources (Greenglass, 2002). In line with previous research (Cheng et al., 2016; Greenglass et al., 2006), in both samples dyadic adjustment (DAS) and proactive coping (PC) negatively correlated with depression (EPDS), indicating that both can have a protective role against maternal depression. Finally, it is noteworthy that only in the postpartum perceived social support (MSPSS) and depression (EPDS) correlated negatively and significantly (EPDS). Overall, comparing pregnancy and postpartum about the strength of relationships, correlations emerged stronger in the postpartum sample, underlining the criticality of transition to maternity and the need for adaptation (Cowan & Cowan, 2012; Held & Rutherford, 2012; Velotti, Castellano, & Zavattini, 2011)

Focusing on the first objective, as hypothesized, it emerged that both during pregnancy and in the postpartum, life events stress (PLES) as well as perinatal specific stress (NUPDQ or PS) determined an increasing in the level of depression (EPDS), with a strongest effect of specific stress in line with correlational analysis. Furthermore, in all

models depression (EPDS) predicted a decrease in the levels of dyadic adjustment (DAS) (Trillingsgaard et al., 2014; Whisman et al., 2011). Regarding depression as mediator, analysis confirmed what had previously emerged by literature, namely that maternal stress can influence dyadic adjustment through maternal depression (Rollé et al., 2017). Regarding the direct effect of stress on dyadic adjustment (DAS), the findings confirm what was hypothesized, since only in the postpartum and only with regard to parental stress (PS) there was a significant relation (Rollé et al., 2017; Vismara et al., 2016). Considering the other stress measures, no assumption was formulated due to the absence of indications in the relevant literature. However, about possible interpretations of the absence of direct effect, it is possible that the other stress types are not able to directly influence the adjustment in the couple's relationship, considering the absence of a conjunction with the major redefinition of roles that the birth of a child provokes (Cowan & Cowan, 2012; Molgora et al., 2018).

Considering the second objective, by mediation models it emerged that, both during pregnancy and in the postpartum, perceived social support (MSPSS) was positively related to dyadic adjustment (DAS) (Qadir et al., 2013). While, only during pregnancy was perceived social support (MSPSS) positively related to proactive coping (PC). As regards the other analyzed relationships, in line with literature (Cheng et al., 2016; Gambrel & Piercy, 2015; Stapleton et al., 2012; Yargawa & Leonardi-Bee, 2015) both during pregnancy and in the postpartum dyadic adjustment (DAS) predicts a decrease in depression (EPDS). While, on the other hand, only during pregnancy does proactive coping (PC) predict a decrease in depression (EDPS). Finally, regarding the hypothesis of mediation, it emerged that perceived social support (MSPSS) positively affects depression (EPDS) through dyadic adjustment (DAS) during pregnancy as well as during postpartum (Qadir et al., 2013). Instead, perceived social support (MSPSS) resulted as positively affecting depression (EDPS) through proactive coping (PC) only during

pregnancy. About the absence of a direct effect of perceived social support (MSPSS) on depression (EPDS), the results are in line with literature reporting no main effect of social support towards depression (Dunkel Shetter, 2011; Lakey & Orehek, 2011; Lobel, Hamilton, & Cannella, 2008; Razurel, Kaiser, Sellenet, & Epiney, 2013). Starting with the absence of perceived social support (MSPSS) effect on proactive coping (PC), the present results only partially confirmed the initial assumptions. Differently from the findings of Greenglass and colleagues (2006), this relationship was not confirmed by the postpartum sample analysis, and in turn, an indirect effect of perceived social support (MSPSS) to depression (EPDS) through proactive coping (PC) did not emerge, contrary to the theoretical model of Greenglass (2002). It is probable that other constructs, not considered in this study, can better support the role of proactive coping as a protective factor against depression, for example the self-efficacy and the optimism (cf., Stanojević, Krstić, Jaredić, & Dimitrijević, 2014). Moreover, as noted by Greenglass and Fiksenbaum (2009), evidence regarding proactive coping has mainly used effective social support measures and it may be that the perception of social support provides different results, also considering that most research found perceived social support to be a better predictor of psychological status than objectively measured social support (Zimet, Dahlem, Zimet, & Farley, 1988). Furthermore, it is also possible that postpartum represents a unique period in a woman's life, full of changes, and that proactive coping may not have the role of resource catalyst that it would have in other contexts. As regard this speculation, Stanojević and colleagues (2014) in a sample of high school graduates, found that proactive coping was not a significant predictor of depression. From a relational/contextual perspective (Cigoli & Scabini, 2007; Dulude et al., 2002; Mert, 2018) it may be that during postpartum external resources and adjustments within the couple's relationship play a greater role than the mother's personal characteristics (Letourneau et al., 2012; Misri, Kostaras, Fox, & Kostaras, 2000; Pilkington, Whelan, &

Milne, 2015), as previously suggested by the correlational comparisons between pregnancy and postpartum.

6. Conclusion

In perinatal psychology literature, various evidence has been produced about the relations between maternal stress and depression, but only recently an interest in the relationships that these factors have with dyadic adjustment has developed (Gray et al., 2012; Rollé et al., 2017). Furthermore, researchers have extensively explored the role of social support as a preventive factor of depression, as well as dyadic adjustment. Nevertheless, research has not jointly analyzed these factors to study any mediation effects. Finally, although other psychology research areas are analyzing the role of proactive coping as a preventive factor of depression, no perinatal psychology study has yet focused on this construct, although there is some evidence that tends to suggest a maladaptive effect of negative coping style (Guardino & Dunkel Schetter, 2014; Razurel et al., 2013; Gutiérrez-Zotes et al., 2016).

The literature reports that the transition to parenting can have a negative effect on the couple's relationship during both pregnancy and postpartum (Molgora et al., 2018). The present study makes an important contribution to understanding what factors can determine this, for the first time extending to pregnancy, and utilizing various stress measures. Previous studies have shown that prenatal maternal stress influences depression, and that depression affects the quality of the couple's relationship, but the present study shows that maternal depression could be a mediator between stress and couple adjustment also during pregnancy.

Moreover, the research, assuming the bi-directionality of the relationship between dyadic adjustment and depression (Mamun et al., 2009), indicates that the couple's relationship can have a protective role for maternal depression, also as a mediator of social support.

About proactive coping, the pregnancy results open new perspectives of coping research during the perinatal period. Although no effect emerged during the postpartum, being a first attempt it would be useful to deepen the study of this type of coping during perinatal period, perhaps with a qualitative methodology.

About limits, alongside those already indicated in Study-II, the relatively small size of the postpartum sample casts some doubt on the statistical significance of the effects. Another limitation which emerges, and which suggests a future development of research, is the lack of involvement of fathers in the research.

Despite these limits, this study increases the understanding of the mechanisms that may underlie the relationships between stress and dyadic adjustment and between social support and depression, highlighting the relational complexity between variables. Steps to improve parenting starting at pregnancy (e.g., Albritton, Angley, Gibson, Sipsma, & Kershaw, 2015; Brock, O'Hara, & Segre, 2017) could benefit from an approach that takes into account the strengthening of the quality of the couple's relationship, as well as proactive coping in order to reduce depression and with a view to increasing the skills both of the women and their partners in seeking social support.

CHAPTER FOUR

Perceived Social Support, Dyadic Adjustment and Proactive Coping: Their Role in Maternal Psychological Well-Being during Pregnancy and Postpartum

1. Introduction to Study-IV. To deepen our understanding of how best to promote maternal subjective and psychological well-being via mediation models

Given that the current study was aimed at promoting well-being within the positive continua of woman's perinatal psychological health, it can be considered an extension of the previous one. Study-III, in addition to examining the role of stress and depression in determining dyadic adjustment, explored, from a preventive perspective, the relationship between social support and depression assuming mediation effect of dyadic adjustment and proactive coping. Study-IV explored the relationship between social support and various indicators of well-being, always assuming dyadic adjustment and proactive coping as mediators. A conceptual framework associating social support to well-being through relationships and an extension of the theory that links social support to proactive coping guided the work.

2. Study-IV: background

The birth of a child plays a central role in human life and entails both positive and negative changes in various dimensions of parents' well-being (Hansen, 2012; Kohler, Behrman, & Skytthe, 2005; Lyubomirsky & Boehm, 2010; Nelson, Kushlev, English, Dunn, &

Lyubomirsky, 2013) that, in turn, can affect parent-child relationships (Malinen et al., 2010).

The highly complex relationship between parenthood and well-being has become a relevant topic among family and mental health scholars, as well as to a broader audience outside academia (Nelson, Kushlev, & Lyubomirsky, 2014; Nomaguchi, 2012). A large body of research in the positive aspects of mental health supports the theory that deep and meaningful close relationships, as well as social support, are important in promoting well-being (Carr, Freedman, Cornman, & Schwarz, 2014; Diener, 2012; Feeney & Collins, 2015; Garbarino, Gerino, Marino, Rollé, & Brustia, 2014). Nevertheless, despite several studies have been undertaken to compare the costs and rewards of childbirth (Nomaguchi & Brown, 2011; Nomaguchi & Milkie, 2003; Pollmann-Schult, 2014; Umberson, Pudrovska, & Reczek, 2010), research analyzing parenthood and well-being is not very extensive, with the major focus being on the couple's satisfaction in relation to maternal psychological disease rather than broader measures of well-being (Dyrdal & Lucas, 2013; cf., Study-III).

The relatively few studies exploring the quality of the couple's relationship and well-being found that, in general, dyadic adjustment and life satisfaction are positively and significantly correlated (Arshad, Mohsin, & Mahmood, 2014; Carr et al., 2014; Scorsolini-Comin & dos Santos, 2012). Focusing on the transition to parenthood, a recent meta-analysis (Luhmann, Hofmann, Eid, & Lucas, 2012) reported that both life satisfaction and relationship satisfaction tend to decrease after childbirth, and that the decreased relationship satisfaction has some negative effects on life satisfaction. In particular, Dyrdal and Lucas (2013) found that, during pregnancy and after childbirth, women's relationship satisfaction was better at predicting life satisfaction than women's life satisfaction was at predicting changes in relationship satisfaction.

However, while being happy and finding life meaningful overlap, there are important differences (Baumeister, Vohs, Aaker, & Garbinsky, 2013), and it is possible that the reduction in parent's life satisfaction is compensated by satisfaction in other areas, or by an increase in other aspects related to psychological well-being (Dyrdal & Lucas, 2013; Luhmann et al., 2012; Nelson et al., 2013). In this regard, an analysis of the perinatal psychology literature found no research that explored the quality of the couple's relationship in relation to other well-being measures, such as emotions or psychological well-being. Furthermore, no research was found that explored dyadic adjustment in relation to maternal well-being considering also social support. Although the concepts of well-being and quality of life do not totally overlap (Keyes, Fredrickson, & Park, 2012; Pinto, Fumincelli, Mazzo, Caldeira, & Martins, 2017; cf., Study-I), studies have identified social support as contributing significantly to the mother's quality of life during the perinatal period (Emmanuel, St John, & Sun, 2012; Gul, Riaz, Batool, Yasmin, & Riaz, 2018; Liu, Setse, Grogan, Powe, & Nicholson, 2013; Pires, Araújo-Pedrosa, & Canavarro, 2014).

2.1. Linking social support and dyadic adjustment to well-being

As reported by Feeney and Collins (2015, p.113), in general, people who experience more supportive and rewarding relationships report better mental health in terms of well-being, but 'Unfortunately, the mechanisms linking relationships to health, and the specific features of relationships that should be cultivated, are not well-understood', while it would be useful to understand the mediators through which relational support affects the positive dimensions of mental health.

Considering the possible reasons for this literature gap, the authors illustrated that most of the empirical work linking relationships to health and well-being conceptualizes social relations in terms of individuals' general reports of their marital status, social networks,

social integration, and perceived social support, not considering specific dyadic behavior or interaction patterns that underlie the effects of social relations on health and well-being. Secondly, research on relationships and health has focused almost exclusively on the importance of supportive relationships in the context of stress or adversity but, despite the importance of stress-buffering, there is also evidence indicating that close relationships are tied to well-being even in the absence of specific stressors. Third, the research on social support, since it has not generally considered the positive dimensions of well-being, has conceptualized health primarily in terms of the presence or absence of negative outcomes, limiting our understanding of the many ways in which social relationships can promote positive health.

Feeney and Collin (2015) offered a model that allows us to understand how relationships affect well-being, describing specific interpersonal processes that have implications for human thriving. Within this framework, thriving is an umbrella concept including subjective and psychological well-being, as well as social and physical. The model highlights two life contexts through which an individual may potentially thrive: coping successfully with life's adversities and actively pursuing life's opportunities for growth and development. In the first life context, people thrive when they are able to emerge from an experience as a stronger or more knowledgeable person, in ways that enable them to grow from the experience. In the second context, individuals thrive when they are able to fully participate in fulfilling and growth opportunities viewed as positive challenges, because often involving striving to achieve goals. Social support is one of the resources that enables people to thrive, a source of strength, fortifying and protecting in times of adversity, and promoting engagement in life opportunities in non-adverse times as a relational catalyst.

For both support functions, the mediation mechanisms that allows thriving are organized into eight broad categories reflecting immediate changes in the recipient's social support.

For the purpose of the present work, the category emerging as salient is that of relational outcomes, as it allows us to hypothesize that the perception of social support by women has an effect on the perception of the quality of the couple's relationship and, in turn, on well-being. As argued by the authors, in fact, receiving support increases feelings of closeness within the relationship and should result in other immediate relational outcomes, including feelings of being valued and respected, consistent with research showing that responsive support predicts relationship mood/satisfaction.

2.2. Linking social support and proactive coping to well-being

Looking at the reasons for the literature gap highlighted by Feeney and Collin (2015), it is possible to identify a conjunction with the theoretical framework of proactive coping, illustrated in Study-III. Furthermore, proactive coping incorporates a confirmatory and positive approach to dealing with stress that can predict positive outcomes important to the promotion of well-being (Greenglass & Fiksenbaum, 2009). In fact, the Greenglass' theoretical model (2002) proposes proactive coping mediating the relationship between resource and outcomes. About this aspect, resources can be internal and external, for example respectively self-efficacy and social support; and outcomes can be negative as well as positive, such as respectively depression (cf., Study-III) and life satisfaction or positive affect.

As argued by Folkman and Moskowitz (2000a; 2000b; 2004) the broadening of models of stress and coping by the inclusion of positive outcomes allows us to change the kinds of questions psychologists ask about coping. With reference to related evidence, besides the association with social support and depression already illustrated in Study-III, proactive coping was found to be associated with life satisfaction (Greenglass, 2000; Uskul & Greenglass, 2005) and positive affect (Greenglass, Stokes, & Fiksenbaum, 2005). In particular, the research of Greenglass and Fiksenbaum (2009) showed that

proactive coping mediates between social support and positive affect, and that positive affect is associated with better psychological functioning. Recently, Stanojević, Krstić, Jaredić and Dimitrijević (2014) reported that proactive coping mediates between social support and satisfaction with life.

2.3. Aims

Overall, the perspectives just described highlight the importance of social support in determining well-being through two mediation variables: relational outcomes and proactive coping. No research adopting these perspectives was previously undertaken to explore women's subjective and psychological well-being during the perinatal period. Within this theoretical framework, the general goal of the present work was to deepen knowledge regarding promotion factors of women's subjective and psychological well-being (Diener et al., 2010; cf., Study-II) during pregnancy and childbirth.

In detail, besides examining the associations between promotion factors and subjective and psychological well-being, the main objective was to explore the relations between social support, dyadic adjustment, proactive coping and subjective and psychological well-being, assuming the role of dyadic adjustment and proactive coping as possible parallel mediators.

Based on the literature the hypotheses were the following:

- perceived social support is positively associated to dyadic adjustment and proactive coping;
- both dyadic adjustment and proactive coping are positively associated to subjective and psychological well-being;
- social support positively affects subjective and psychological well-being through dyadic adjustment and proactive coping.

However, considering the findings of previous Study-III, it cannot be hypothesized that during postpartum social support affects proactive coping, and consequently the same applies to the effect of social support on well-being through proactive coping. Nevertheless, proactive coping was inserted into the mediation models in order to study its relations with subjective and psychological well-being.

Related to mediation hypothesis, as in Study-III, the Hayes's approach to statistical mediation analysis was adopted (Hayes, 2009; Hayes, 2013; Rucker, Preacher, Tormala, & Petty, 2011).

3. Methods

3.1. *Participants and procedure*

The present study was realized with the same samples of the Study-II, to refer to for a complete description of participants and procedure.

3.2 *Instruments*

The following measures employed in Study-II and Study-III were used:

- *Satisfaction with Life Scale (SWLS)*;
- *Flourishing Scale (FS)*;
- *Scale of Positive and Negative Experience (SPANE)*;
- *Multidimensional Scale of Perceived Social Support (MSPSS)*;
- *Dyadic Adjustment Scale (DAS)*;
- *Proactive Coping subscale (PC) of the Proactive Coping Inventory (PCI)*.

3.3. Data Analysis

Data analysis were performed using *Statistical Package for Social Science (SPSS)* software. Alongside *r-Pearson's* linear correlational, by using Hayes' (2012) PROCESS macro models were realized to explore the role of dyadic adjustment (DAS) and proactive coping (PC) as mediators between perceived social support (MSPSS) and well-being measure (SWLS, FS, SPANE-B).

4. Results

Similarly to Study-III, results are organized in two parts. In the first are reported the analysis regarding pregnancy-sample, and in the second the analysis regarding postpartum-sample.

- Pregnancy sample

In Table I are illustrated the correlations between perceived social support (MSPSS), dyadic adjustment (DAS), proactive coping (PC), satisfaction with life (SWLS), flourishing (FS) and balance experience (SPANE-B). By analysis, first it emerged that perceived social support (MSPSS), dyadic adjustment (DAS) and proactive coping (PC) are positively correlated with each other. Considering well-being: perceived social support (MSPSS) was positively correlated with balance experience (SPANE-B); dyadic adjustment (DAS) and proactive coping (PC) were positively correlated with all the measures (SWLS, FS, SPANE-B).

Pursuing the objective of exploring the possible effect of mediation of dyadic adjustment (DAS) and proactive coping (PC), three mediation models were tested. In all models, perceived social support (MSPSS) was entered as independent variable, and dyadic adjustment (DAS) and proactive coping (PC) were entered as parallel mediation variables. As regard dependent variables, in the first model it was satisfaction with life

(SWLS), in the second flourishing (FS), in the third balance experience (SPANE-B). Prior to analysis, all the inserted variables were standardized.

Table I Pregnancy sample. Correlations between perceived social support, dyadic adjustment, proactive coping and well-being measures.

	DAS	PC	SWLS	FS	SPANE-B
MSPSS	.470 **	.255 *	.166	.197	.261 *
DAS	-	.221 *	.373 **	.348 **	.364 **
PC	-	-	.234 *	.501 **	.397 **

r-Pearson correlation: * $p < .05$ (2-tailed); ** $p < .01$ (2-tailed).

As expected by correlational analysis, perceived social support (MSPSS) was positively associated with dyadic adjustment (DAS) ($b = .45$, $SE = .09$, $t = 4.99$, $p < .001$) and with proactive coping (PC) ($b = .25$, $SE = .10$, $t = 2.47$, $p < .05$). Moreover, mediation effects of dyadic adjustment (DAS) and of proactive coping (PC) between perceived social support (MSPSS) and well-being measures (SWLS, FS, SPANE-B) emerged as follows.

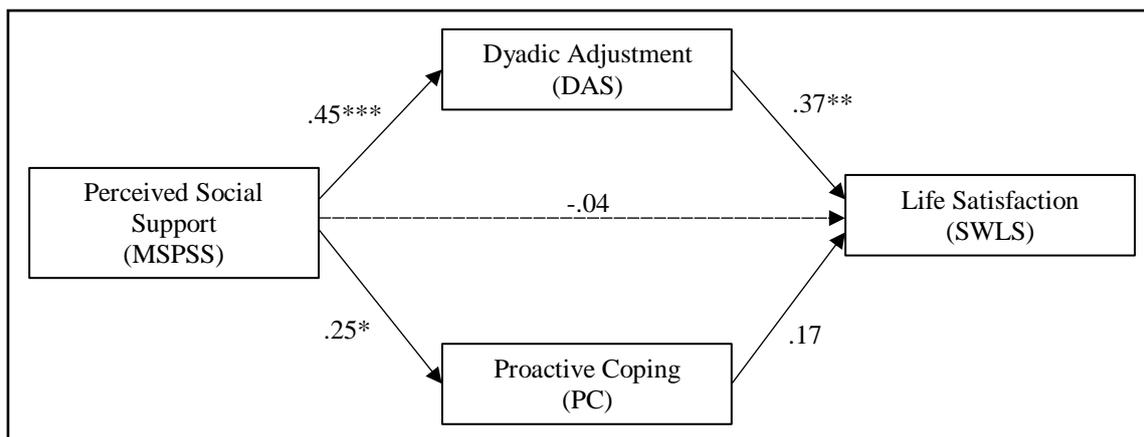


Figure I Pregnancy sample: dyadic adjustment and proactive coping as mediators between perceived social support and life satisfaction. Path coefficients. * $p < .05$, ** $p < .01$, *** $p < .001$.

Satisfaction with life (SWLS) as dependent variable. When dyadic adjustment (DAS) and proactive coping (PC) were entered into the regression model together with perceived

social support (MSPSS), dyadic adjustment (DAS) was positively associated with satisfaction with life (SWLS) ($b = .37, SE = .11, t = 3.17, p < .01$), while no significant association emerged between proactive coping (PC) and satisfaction with life (SWLS) ($b = .17, SE = .10, t = 1.62, p = .09$). The relation between perceived social support (MSPSS) and satisfaction with life (SWLS) was not significant ($b = -.04, SE = .11, t = -.38, p = .69$). The indirect paths from perceived social support (MSPSS) to satisfaction with life (SWLS) through dyadic adjustment (DAS) was significant ($a*b = .16$, Bootstrap 95% CI [.078, .308]) (Figure I). Instead, as expected, the indirect path through proactive coping (PC) was not significant ($a*b = .04$, Bootstrap 95% CI [-.011, .173]) (Figure I).

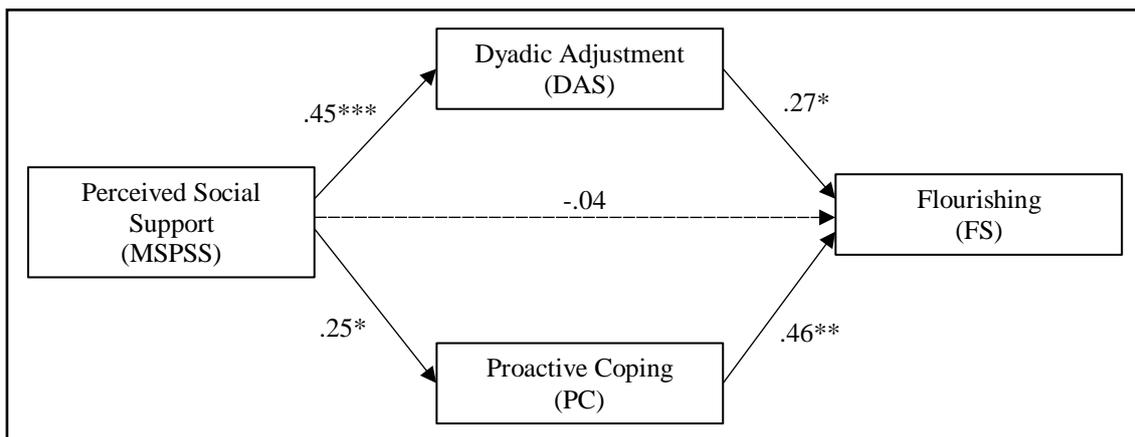


Figure II Pregnancy sample: dyadic adjustment and proactive coping as mediators between perceived social support and flourishing. Path coefficients. * $p < .05$, ** $p < .01$, *** $p < .001$.

Flourishing (FS) as dependent variable. When dyadic adjustment (DAS) and proactive coping (PC) were entered into the regression model together with perceived social support (MSPSS) they were positively associated with flourishing (FS) (DAS: $b = .27, SE = .10, t = 2.63, p < .05$; PC: $b = .46, SE = .09, t = 4.86, p < .001$). The relation between perceived social support (MSPSS) and balance experience (SPANE-B) was not significant ($b = -.04, SE = .10, t = -.43, p = .66$), instead the indirect paths from specific perceived social support (MSPSS) to flourishing (FS) through dyadic adjustment (DAS) and proactive

coping (PC) were significant (DAS: $a*b = .12$, Bootstrap 95% CI [.046, .258]; PC: $a*b = .11$, Bootstrap 95% CI [.014, .256]) (Figure II).

Balance experience (SPANE-B) as dependent variable. When dyadic adjustment (DAS) and proactive coping (PC) were entered into the regression model together with perceived social support (MSPSS) they were positively associated with balance experience (SPANE-B) (DAS: $b = .27$, $SE = .11$, $t = 2.49$, $p < .05$; PC: $b = .33$, $SE = .09$, $t = 3.31$, $p < .01$). The relation between perceived social support (MSPSS) and balance experience (SPANE-B) was not significant ($b = .05$, $SE = .10$, $t = .48$, $p = .62$), instead the indirect paths from specific perceived social support (MSPSS) to balance experience (SPANE-B) through dyadic adjustment (DAS) and proactive coping (PC) were significant (DAS: $a*b = .12$, Bootstrap 95% CI [.042, .241]; PC: $a*b = .08$, Bootstrap 95% CI [.015, .196]) (Figure III).

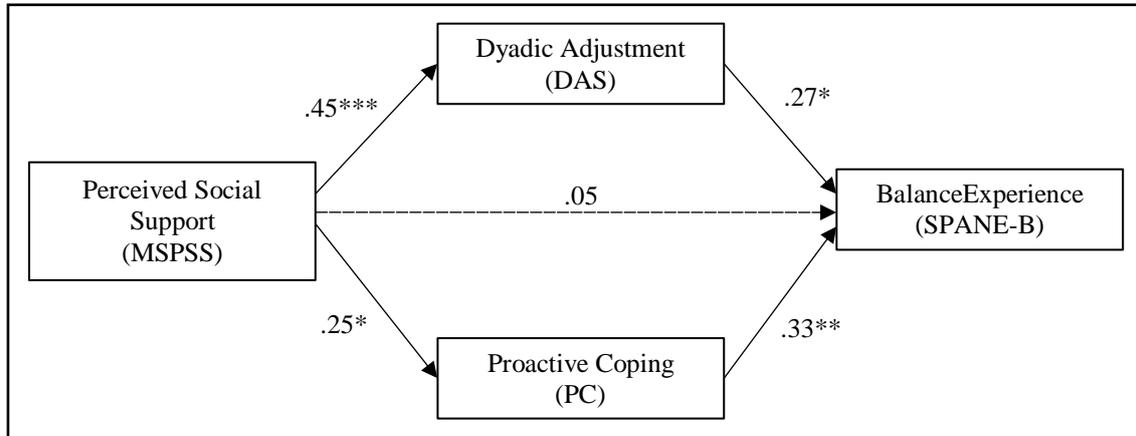


Figure III Pregnancy sample: dyadic adjustment and proactive coping as mediators between perceived social support and balance experience. Path coefficients. * $p < .05$, ** $p < .01$, *** $p < .001$.

- Postpartum sample

In Table II are illustrated the correlations between perceived social support (MSPSS), dyadic adjustment (DAS), proactive coping (PC), satisfaction with life (SWLS), flourishing (FS) and balance experience (SPANE-B). By analysis, first it emerged that perceived social support (MSPSS) is positively correlated with dyadic adjustment (DAS), but not with proactive coping (PC) that, instead, is positively correlated with dyadic adjustment (DAS). Considering well-being, perceived social support (MSPSS) dyadic adjustment (DAS) and proactive coping (PC) were positively correlated with all the measures (SWLS, FS, SPANE-B).

Table II Postpartum sample. Correlations between perceived social support, dyadic adjustment, proactive coping and well-being measures

	DAS	PC	SWLS	FS	SPANE-B
MSPSS	.511 **	.258	.399 **	.534 **	.462 **
DAS	-	.284 *	.464**	.604 **	.543 **
PC	-	-	.348 **	.564 **	.489 **

r-Pearson correlation: * $p < .05$ (2 tailed); ** $p < .01$ (2 tailed).

Pursuing the objective of exploring the possible effect of mediation of dyadic adjustment (DAS) and proactive coping (PC), three mediation models were tested. In all models, perceived social support (MSPSS) was entered as independent variable, and dyadic adjustment (DAS) and proactive coping (PC) were entered as parallel mediation variables. As regard dependent variables, in the first model it was satisfaction with life (SWLS), in the second flourishing (FS), in the third balance experience (SPANE-B). Prior to analysis, all the inserted variables were standardized.

As expected by correlational analysis, perceived social support (MSPSS) was positively associated with dyadic adjustment (DAS) ($b = .59$, $SE = .13$, $t = 4.24$, $p < .001$), but not

with proactive coping (PC) ($b = .19$, $SE = .14$, $t = 1.37$, $p = .17$). Moreover, mediation effects of dyadic adjustment (DAS) between perceived social support (MSPSS) and well-being measures (SWLS, FS, SPANE-B) emerged as follows.

Satisfaction with life (SWLS) as dependent variable. When dyadic adjustment (DAS) and proactive coping (PC) were entered into the regression model together with perceived social support (MSPSS), dyadic adjustment was positively associated with satisfaction with life (SWLS) (DAS: $b = .32$, $SE = .12$, $t = 2.61$, $p < .05$), instead the relation between proactive coping (PC) and satisfaction with life (SWLS) was not significant (PC: $b = .05$, $SE = .11$, $t = .45$, $p = .64$). The relation between perceived social support (MSPSS) and satisfaction with life (SWLS) was not significant ($b = .10$, $SE = .13$, $t = .72$, $p = .47$), as well as the indirect path from perceived social support (MSPSS) to satisfaction with life (SWLS) through dyadic adjustment (DAS) ($a*b = .20$, Bootstrap 95% CI [-.004, .511]). Furthermore, as expected, proactive coping (PC) did not mediate the relation between perceived social support (MSPSS) and satisfaction with life (SWLS) ($a*b = .01$, Bootstrap 95% CI [-.039, .128] (Figure IV).

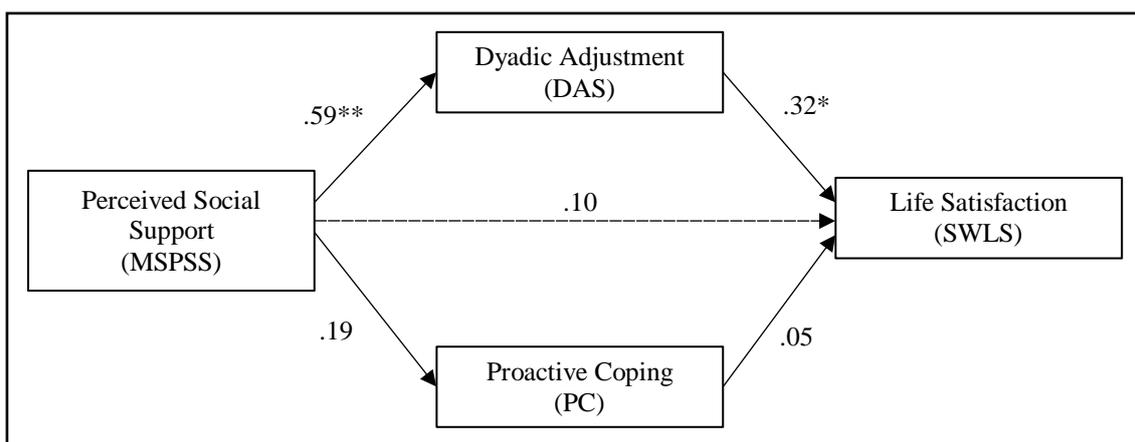


Figure IV Postpartum sample: dyadic adjustment and proactive coping as mediators between perceived social support and life satisfaction. Path coefficients. * $p < .05$, ** $p < .001$.

Flourishing (FS) as dependent variable. When dyadic adjustment (DAS) and proactive coping (PC) were entered into the regression model together with perceived social support (MSPSS) they were positively associated with flourishing (FS) (DAS: $b = .33$, $SE = .10$, $t = 3.32$, $p < .01$; PC: $b = .30$, $SE = .09$, $t = 3.09$, $p < .01$). The relation between perceived social support (MSPSS) and flourishing (FS) was not significant ($b = .21$, $SE = .11$, $t = 1.89$, $p = .06$). About the indirect paths from specific perceived social support (MSPSS) to flourishing (FS), dyadic adjustment (DAS) mediated the relation ($a*b = .20$, Bootstrap 95% CI [.058, .425]); as expected, proactive coping (PC) did not mediate ($a*b = .06$, Bootstrap 95% CI [-.022, .188]) (Figure V).

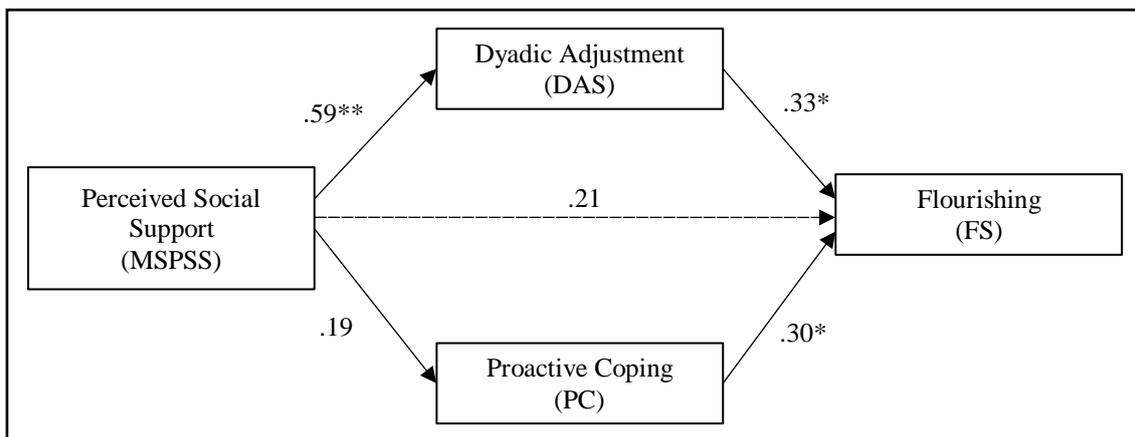


Figure V Postpartum sample: dyadic adjustment and proactive coping as mediators between perceived social support and flourishing. Path coefficients. * $p < .01$, ** $p < .001$.

Balance experience (SPANE-B) as dependent variable. When dyadic adjustment (DAS) and proactive coping (PC) were entered into the regression model together with perceived social support (MSPSS) they were positively associated with balance experience (SPANE-B) (DAS: $b = .36$, $SE = .12$, $t = 2.87$, $p < .01$; PC: $b = .28$, $SE = .12$, $t = 2.31$, $p < .05$). The relation between perceived social support (MSPSS) and balance experience (SPANE-B) was not significant ($b = .17$, $SE = .14$, $t = 1.22$, $p = .22$). About the indirect paths from specific perceived social support (MSPSS) to balance experience (SPANE-

B), dyadic adjustment (DAS) mediated the relation ($a*b = .19$, Bootstrap 95% CI [.016, .448]); as expected, proactive coping (PC) did not mediate ($a*b = .05$, Bootstrap 95% CI [-.012, .194]) (Figure VI).

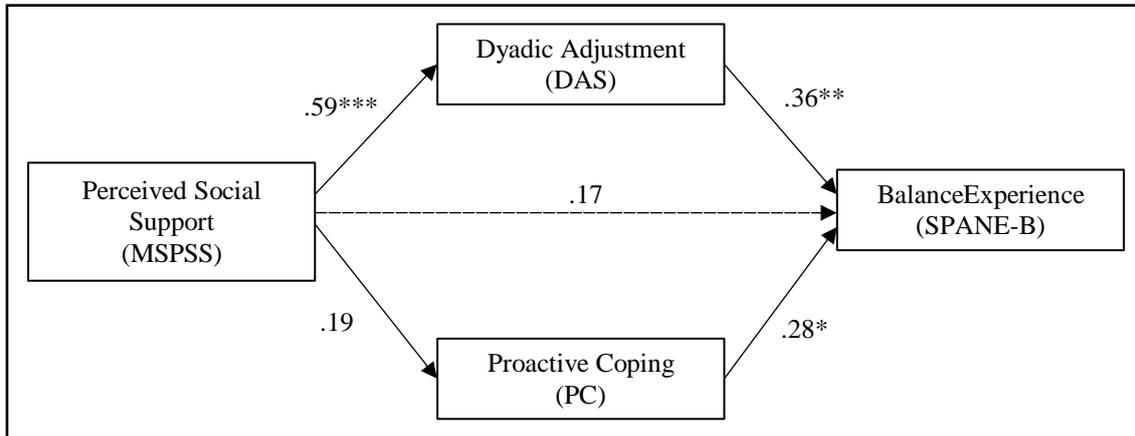


Figure VI Postpartum sample: dyadic adjustment and proactive coping as mediators between perceived social support and balance experience. Path coefficients. * $p < .05$, ** $p < .01$, *** $p < .001$.

5. Discussion

The general purpose of the present work was to deepen knowledge about relations between social support (MSPSS), dyadic adjustment (DAS), proactive coping (PC) and well-being (SWLS, FS, SPANE/B) during pregnancy and postpartum. Both hedonic and eudemonic well-being measures were employed. Two convenience samples of participants were involved: one of pregnant women and one of women during the postpartum period. In particular, the hypothesis that social support can affect well-being through dyadic adjustment and proactive coping was tested. In detail, for both perinatal periods three mediation models were analyzed, one for each well-being measure.

As regards correlations between promotion factors and subjective and psychological well-being, reporting from Study-III, in both samples perceived social support (MSPSS) related positively with dyadic adjustment (DAS), showing the connection between this

external resource for the adaptation of the couple's relationship. Conversely, only in the pregnancy sample perceived social support (MSPSS) was positively related to proactive coping (PC), suggesting that during postpartum different paths for the construction of internal resource are active. Furthermore, both during pregnancy and postpartum, dyadic adjustment (DAS) and proactive coping positively correlated with all well-being measures (SWLS, FS, SPANE-B), confirming the link between dyadic adjustment and woman's subjective and psychological well-being, and suggesting the potential role of proactive coping in increasing women's well-being during the perinatal period (Dyrdal & Lucas, 2013; Greenglass & Fiksenbaum, 2009).

Looking at mediation analysis, in line with literature on quality of life (Emmanuel et al., 2012; Gul et al., 2018; Liu et al., 2013; Pires et al., 2014), both during pregnancy and in the postpartum, dyadic adjustment (DAS) predicted an increase in the level of all the well-being measures. As regards proactive coping (PC), in both samples it predicted an increase in the levels of flourishing (FS) and of balance experience (SPANE-B), but not in the level of life satisfaction (SWLS), only partly confirming literature that found proactive coping positively influencing both life satisfaction and positive affect (Greenglass & Fiksenbaum, 2009; Stanojević et al., 2014). Regarding the hypothesis of mediation, it therefore emerged that during pregnancy perceived social support (MSPSS) positively affects all the measures of well-being (SWLS, FS, SPANE-B) through dyadic adjustment (DAS), while during postpartum affects flourishing (FS) and balance experience (SPANE-B). Instead, only during pregnancy did perceived social support (MSPSS) result as positively affecting flourishing (FS) and balance experience (SPANE-B) through proactive coping (PC). About the absence of a direct effect of perceived social support (MSPSS) on well-being, as argued by Feeney and Collins (2015), findings show that a connection exists between the perception of social support and the outcomes mechanisms linking relationships to health.

As commented in Study-III, the present results only partially confirmed what was assumed. In particular, in contrast to the literature (Greenglass & Fiksenbaum, 2009; Stanojević et al., 2014), in the postpartum sample proactive coping did not mediate the relationship between social support and well-being. However, the role of proactive coping (PC) in determining flourishing (FS) and balance experience (SPANB-B) emerged, suggesting a need for further study.

6. Conclusion

In perinatal psychology literature, no study was previously undertaken to explore, through mediation models, the relations between perceived social support, dyadic adjustment, proactive coping and hedonic/eudemonic well-being. Adopting two perspectives linking external resources to positive psychological outcomes (Feeney & Collins, 2015; Greenglass, 2002), this study can be considered an important contribution to increase knowledge about the mechanisms that may underlie the relationships between social support and subjective and psychological well-being. About limits, beside those illustrated in previous Study-III, the theoretical framework of the present work in large part does not belong to the perinatal psychology area. For this reason, the results must be considered with caution, although they deserve further attention in new research paths. However, overall the research highlights that steps to promote well-being could benefit from an approach considering contextual, relational and individual aspects.

CHAPTER FIVE

Italian and Migrant Pregnant Women's Point of View about Perinatal Well-Being: Emotions, Expectations and Meanings

1. Introduction to Study-V. What further to study about perinatal psychological health?

Adopting a quantitative methodology, the studies in the previous chapters have contributed to knowledge about women's psychological health during the perinatal period in both positive and negative continua. However, as already highlighted, the conceptualization of perinatal well-being is very recent and there is a need for further research.

The present study aimed to explore, from a qualitative perspective, pregnant women's points of view regarding perinatal psychological health, analyzing their narratives about feeling well/unwell, emotional experiences, as well as expectations about childbirth. In order to consider the salience of migration during the transition to parenthood, an intercultural perspective was adopted comparing the representations of Italian and migrant women.

2. Study-V: background

Pregnancy, birth and motherhood are crucial life stages for a woman's identity, in which her experience and psychological health are closely entwined (Howarth, Swain, & Treharne, 2011; Kwee & Mc Bride, 2015; Slade, Cohen, Sadler, & Miller, 2009; Spinelli et al., 2016).

As argued by Demuth (2015), psychological researchers have become increasingly aware of the usefulness of qualitative methods in understanding the phenomena from the point of view of those who experience the situation. Due to this, in the last few decades a growing number of qualitative studies have been undertaken to explore the psychological aspects of women's experience during the perinatal period, focusing on postpartum distress and fear or experience of childbirth (e.g., Cipolletta, 2016; Coates, Ayers, & de Visser, 2014; Fisher, Hauck, & Fenwick, 2006; Hight, Stevenson, Purtell, & Coe, 2014; Karlström, Nystedt, & Hildingsson, 2015; Razurel, Bruchon-Schweitzer, Dupanloup, Irion, & Epiney, 2011). Recent studies have also been conducted from a more socio-cultural perspective to analyze the experience related to the perceived treatment (Megnin-Viggars, Symington, Howard, & Pilling, 2015; Novick, 2009; O'Mahen & Flynn, 2008), especially the experiences of migrant women (Balaam et al., 2013; Benza & Liamputtong, 2014; Hennegan, Redshaw, & Kruske, 2015; Hildingsson & Rådestad, 2005; McKeary & Newbold, 2010; Cheung & Pan, 2012).

However, by literature analysis there emerged a lack of studies exploring the psychological aspects of foreign women's experience (Russo, Lewis, Joyce, Crockett, & Luchters, 2015; Wittkowski, Patel, & Fox, 2017). In general, the majority of psychological contributions analyzed postpartum experience, and the few studies found involving pregnant women explored antenatal depression (Bennett, Boon, Romans, & Grootendorst, 2007; Staneva, Bogossian, Morawska, & Wittkowski, 2017) or changes in mood associated with bodily changes (Clark, Skouteris, Wertheim, Paxton, & Milgrom, 2009). In particular, no research was found examining the overall emotional experience, the positive aspects of psychological health or the representations of pregnant women about their psychological health. This is in contrast to other research areas where the representations of health have been studied, although mainly concerning disease (Åsbring, 2012; Flick & Foster, 2007; Lu, Chauhan, Campbell, 2015; Maurya, 2009). In

regard of this last issue, the social representations of health do not always correspond to the scientific definition, with consequences in terms of behavior, action and social practices, as well as expectations regarding medical care (De Piccoli, 2014).

The adoption of an intercultural perspective could be useful to fill this gap, since, as mentioned in the introduction of the thesis, migration introduces a further element of criticity in the transition to motherhood. The possible lack of a family support network and cultural references (Benza & Liamputtong, 2014; Moro, Neuman & Réal, 2010), and the difficulty in accessing maternity care (Bollini, Pampallona, Wanner, & Kupelnick, 2009; Small et al., 2014) have possible consequences on the physical and psychological health of foreign pregnant women (Balestrieri et al., 2012). The increase in immigration to Italy requires a deeper knowledge of the aspects that may characterize a fruitful process of psycho-social integration, particularly when the discourse concerns the condition of migrant women (Gozzoli & Regalia, 2005; Regalia & Giuliani, 2012).

2.1 Aims

Within this theoretical context, the present research analyzed pregnant women's perspectives, both Italian and migrant, of psychological health. The objective was to obtain information useful in advancing research on perinatal well-being as well as in developing projects to promote health centered on women. The intercultural perspective was adopted to examine the impact of migration.

Specifically, the objectives were to explore:

the overall emotional experience;

the women's representation of well-being and ill-being;

the aspects that can help women to being or feeling well during pregnancy, as well as during and after birth;

the differences between Italian and migrant women's points of view.

3. Methods

A qualitative research approach, using grounded theory methodology, was employed to collect and analyze data (Glaser & Strauss, 1967). This methodology is particularly useful in new fields in which there is little theory available to describe a phenomenon that researchers want to investigate. As stated by Glaser (1996), grounded theory is extremely useful in allowing the identification of relevant concepts and assessing social interactions and processes in a dynamic way. Grounded theory is aimed at the production of knowledge based on processes which emerge from the data, through a collection of data as extensive and accurate as possible, and their codification into non-predefined or mutually exclusive categories (Mantovani, 2003; Willing, 2001). At the beginning of the data analysis process, categories are identified by means of a codification that is largely descriptive. As the theory emerges from the data, the researcher produces codifications of categories with increasing generality but always anchored to data and context and not borrowed from pre-existing theories. Another fundamental characteristic of this methodology is the comparative analysis, continuously passing from the data to the categories and vice versa (Dey, 1999).

The study used the qualitative research method of face-to-face interview in order to collect rich data around the meaning of psychological health during the perinatal period, as suggested by research on social representation (Galli, 2006). In particular, a semi-structured interview was employed, since this method is useful to explore and understand conditions and life events (Serranò & Fasulo, 2011) such as pregnancy and the prospect of childbirth. The strength of the semi-structured interview is to have a thematic reference frame that guides the conduct of the interview by ensuring that the research topics are covered without preventing the free flow of speech.

3.1. Participants and setting

The study involved a total of 22 pregnant women, 13 Italian and 9 foreign.

Women involved in the research were contacted through the two institutions indicated in Study-I. Eligible participants were pregnant women between 24-36 gestational weeks. Exclusion criteria considered by the research team were: presence of psychopathology, fetal development criticality, less than 18 years old and inability to speak, read and understand Italian.

Overall participants had an average age of 30.55 ($SD = 4.79$). Regarding work, 11 Italian women and 3 foreign women reported having paid employment. All had stable relationships. The average gestation week was 28 ($SD = 4.43$). There were 6 secondiparous women, of whom 4 Italian and 2 foreign. The average length of residence in Italy for migrant women was 5.11 ($SD 4.01$). Regarding nationality, foreign women were from: Equatorial Africa (1 Burundi, 2 Cameroon); Europe (1 Albania, 1 Spain, 1 Ukraine); South-America (2 Peru, 1 Ecuador).

Participants were administered a semi-structured interview with the full respect of privacy, anonymity, confidentiality. Women who agreed to participate, signed an informed consent form (Appendix 2), and any further request for clarification of the procedure and the research was provided (Alby, Zucchermaglio, & Fatigante, 2014). No reward or payment was made to the participants.

The data collection procedure fully complied with the Research Ethical Code of the Italian Association of Psychology and the ethical recommendations of the Declaration of Helsinki, as well as the American Psychological Association (APA) standards for the treatment of human volunteers.

The ethics committee of the Department of Education Sciences of the University of Genoa approved the study.

3.2. Data collection and analysis

A total of 22 interviews were conducted using a semi-structured question guide (Appendix 3), developed based on three areas identified by literature analysis: positive and negative aspects of perinatal psychological health; the dimensions of perinatal well-being; expectations and representations of childbirth. Regarding the duration of the interview, on average these lasted an hour, ranging from about 40 minutes to up to an hour and a half. In general, the interviews of Italian women were longer: the knowledge of the language certainly affecting the duration of the interview.

Each interview was audiotaped and transcribed verbatim. In order to protect participants' anonymity, an alpha-numeric code was assigned to each woman, the first two letters of which were used in reporting the quotations in the section of findings.

A thematic analysis (Braun, Clarke, & Terry, 2014) of the transcripts was conducted using the *NVivo-11* software, according to a three-stage inductive theoretical framework of grounded theory, a multi-step process that integrated procedures suggested by Strauss and Corbin (1998). A coding scheme was developed inductively from initial readings of the transcripts; this coding scheme guided the systematic review of the qualitative data and organisation into analytical categories (Lofland & Lofland, 1996; Rossman & Rallis, 1998). With the goal of increasing reliability of the findings, the thematic analysis was undertaken independently by two researchers in a recursive process characterized by recapitulation, reformulation and re-summarizing of the emerging findings, to be confident of their basis in the data. In detail of the three-stages, the first consisted of a line-by-line coding of transcripts. In the second stage, the researchers looked for emerging descriptive themes across the interviews by examining the codes generated for similarities and differences in meanings. In the third stage, the researchers used a high level of

interpretation analysing descriptive themes, and inferring the analytical themes. Finally, they met to complete a comparison and obtain a result on the findings.

In detail, after the line-by-line coding, the researchers identified the following thematic levels: sub-themes, main themes and areas. The degree of abstraction in the contents gradually increased, proceeding from the sub-themes to the areas. The sub-themes correspond to the contents expressed by the participants and are the different declinations of the main themes. The main themes have a more abstract level denomination, in order to represent all the sub-themes included in them. Finally, the areas emerge as the highest level of abstraction, and their titles correspond to areas of meaning established by the researchers.

4. Findings

From data analysis, different themes emerged attributable to three large areas: 1) ‘To be pregnant: individuality and context in women’s experiences’; 2) ‘Well-being and ill-being during pregnancy: representations and needs’; 3) ‘Expectations and meanings of childbirth’.

As follows, these areas will serve as key sub-headings. In each sub-heading are reported findings related to both Italian and foreign women, in order to allow an immediate comparison. For clarity, for each main theme and related sub-themes that emerged a graphic representation was produced: in the case of correspondence between the two groups of participants, only one figure; in the case of non-correspondence, two figures. Finally, about the quotations, in order to respect the quality of the words chosen by the participants, and to allow the reader a more immediate verification of the relevance of the themes identified, a basic literal translation was done from the Italian to the English language. Clarifications of the

meaning placed between brackets were reported only when necessary from a cultural point of view.

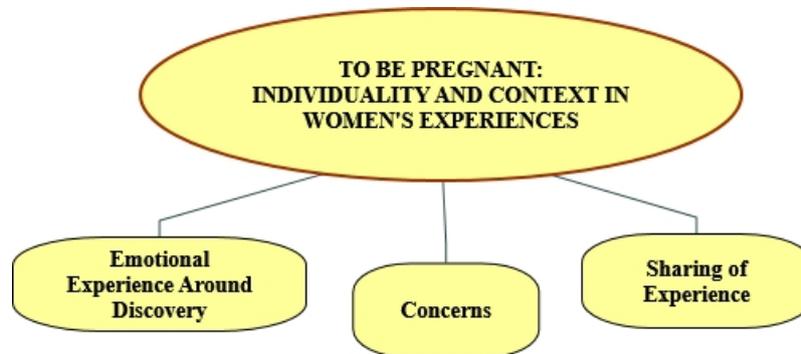


Figure I Area-1. 'To be pregnant: individuality and context in women's experiences' and related main themes.

Area-1. To be pregnant: individuality and context in women's experiences

The first area consists of three main themes: 1) 'Emotional experience around discovery'; 2) 'Concerns'; 3) 'Sharing of experience' (Figure I).

1) The first main theme 'Emotional experience around discovery' refers to the analysis of the women's emotional experiences in relation to discovering they were pregnant, discovery intended in a broad sense including, beyond the day of the pregnancy test, also discovering oneself pregnant and revealing it to significant people. As illustrated in Figure II, three sub-themes emerged.

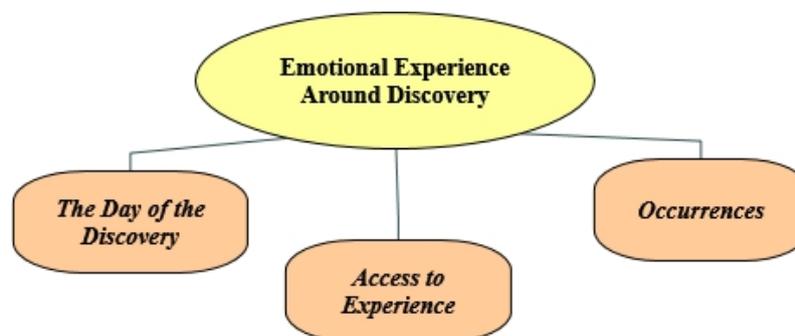


Figure II 'Emotional experience around discovery' and related sub-themes.

Regarding the sub-theme 'The day of the discovery' it emerged that only two Italian participants talked about the discovery of a wanted pregnancy without referring to emotional experiences. About the emotional manifestations, always in the case of wanted pregnancy, happiness emerged. In addition, the narratives of Italian women also reported surprise and the need to mentally process the experience if the pregnancy began at the first attempts.

I did not expect to be pregnant because I had some problems and I was expecting to get pregnant in two or three years...instead at the first...so it was a bit surprising [...] then my husband arrived, he also did not believe it very much... and nothing we were happy, a bit surprised, let's say. (IS, Italian).

When we then decided to take, after a few days, the test was a mix of emotions, in the sense from happiness and contentment for something that I already knew in my heart [...] in short, the effort to process it mentally. (MM, Italian).

Other Italian women, referring to the changes in life that being pregnant involves, reported feelings of upheaval, panic, even though the pregnancy was desired.

I was shocked only a little moment, but for the question of work, just for that, because I knew where I were going ... and so, I was not hesitant, but a bit shocked for that reason. (FE, Italian).

I remember I was in a total panic [...] I was in a panic because I suffer a lot the changes, physical limitations, so I started thinking about everything that I would have to renounce from that moment. (SS, Italian).

For women who had been trying to get pregnant for a long time, feelings of fear of disappointment also emerged. Furthermore, the feeling of suspension, the tendency to hope alongside the repressing of joy emerged in the testimonies of two Italian women who went through a process of medical assisted procreation.

I did not believe it anymore, I say to my husband, 'look', I tell him, 'now it's a year that we expect to have this son and he does not get there', I say 'it's useless to delude ourselves with a test. (MD, foreign).

I was happy, I was happy, even if they actually tell you that you are in pregnancy, that you are pregnant, but you are still a bit suspended because you have to wait. If I'm not mistaken, two weeks before saying if it can actually go well [...] the moment of the test does not coincide with the moment of the enthusiasm, you postpone it a bit. (VM, Italian).

I did the test and they gave us the positive result. We were going to exult but the nurse told us: "Oh, the path is still long" [...] basically we gave ourselves a bit of joy after about a month when, after the check of first weeks, we had not lost it [...] we gave ourselves a bit of joy after about a month in reality, the first month was a lot of hope, but there is always that little voice 'ok, let it go because then if it goes wrong again'. (MR, Italian).

If the pregnancy was not sought, feelings of disbelief and disorientation emerged. Furthermore, foreign women also talked about ambivalence caused by economic problems.

The period was not coming, it was not coming and after fifty days of delay I said 'oh well, I do a pregnancy test'. I see it and it was positive, and I did not believe it. I said 'oh well, it's wrong', then I said 'I go', but where do I go?' I thought [...] and tells me [the gynecologist] 'Something has grafted' and I was there saying 'Mah, it's impossible'. (PV, Italian).

She told me [the gynecologist] 'but you are pregnant', me 'no'. Immediately it was a beautiful feeling, too beautiful, but for five minutes, but then I had to go back to reflect, to say 'God, what's going on?' [...] I went out, I did not even take the bus, nothing, to walk and think what was happening 'it's a dream' or it seemed like an incredible thing 'it's not true' or 'it's true'. (CH, foreign).

We were already a bit better [economically] so I said 'it would be selfish, selfish, selfish, selfish to try maybe to get to something more when we are already in the conditions, more or less'. In my head I did not really have the concept of doing it again [voluntary interruption of pregnancy], I knew that inside of me I would not have made it to do it again, even if I took into consideration the fact of doing it again [...] I felt also anger towards myself, I felt a bit guilty because I said 'it was enough that you were more careful, and that's it! (EP, foreign).

For me it was devastating, because I'm still a student, I have a scholarship, and I'm alone here in Italy, I have no family [...] because I saw the finances, I do not have a house, I have nobody to help me, I have nothing. So for me it was really a day...I spent the whole day thinking, thinking, thinking...then the parents who count on me here, how I had to announce that I'm pregnant and everything, it was just a terrible

day [...] at the beginning I thought 'maybe, maybe I do a pregnancy interruption, it would be the easiest choice' or something like that. (DN, foreign).

The sub-theme 'Access to experience' refers to the process of reflection on the emotions, feelings and sensations experienced. Women reported the perception of bodily/physiological changes accompanied by changes in emotion, in the self where the state of pregnancy appears as an emotional catalyst.

In pregnancy, since it is a moment of change, of transformation, both in the body, in the most visible things, and inside, precisely a very rich, intense moment, perhaps everything is brought to the umpteenth power, for which emotions feel even stronger, and those of course if they are positive more positive [...] also the fragility can be in certain moments amplified. (MM, Italian).

I am in a relaxed setting, as if it had become physiological, that is almost as if it had become natural. (ME, Italian).

There is also an aspect of the need to metabolize the thing [...] in the first months there are so many doubts that surface. There is however a bit of confusion, a bit of fear and malaise, which in fact the first few days you feel a bit of a need to hatch the thing. However, it is a very intimate relationship between you, your body and this person, little person who is coming. (NF, Italian).

On the emotional level I feel in a sort... it has never been happened before... in a moment of grace, a bit more special than others, in the sense that life flows to you the same but you look at it perhaps with different eyes. (VM, Italian).

For me it has been really a progression, so at a certain point I understood that in short, that it was just a matter of, it was a change in life as so many other things [...] so in this period it's really a learning, like saying learn about own limits [...] I'm taking it as something almost funny, I do not know how to say, as if you recognize yourself every day. (SS, Italian).

There is no day that I get up sad, and there is no one that can ruin me the happiness that I feel in these moments [...] people can tell me of everything [...] it enters here and it get out of here. In these moments there is no one apart from my family [...] the most beautiful period of my life. (MD, foreign).

Especially in this period that you're very much at the end, you're focused on the arrival of the child, in my opinion or are you physically ill or have some very big problem, I think you are focused on this thing that other things really do not affect [...] at the beginning yes, because you see it all very far away, I've lived long the first trimester [...] the second trimester was great, because the nausea ended, I had not taken almost weight, you're normal but you still see it all very far away, instead the third trimester you begin to see everything, that the date is approaching and you focus on that. (PS, Italian).

I think that all this makes you grow as a person, that is, become a mother and you are almost complete. It makes you become, I do not know, it's that something more, that is, you can, that is, you must strive to learn to do other things because that is what you have to do. It's not like before, that is, I do not have any options now, but now you have to prepare yourself for the new adventure. (CH, foreign)

About the sub-theme 'Occurrences', it refers to the events referred to by women as emotionally charged. From the analysis of the interviews emerged ultrasound checks, the discovery of the child's sex, or the first time women felt the baby moving. In general, women reported as experiences rich in emotion the physical perception of the child's presence, a bodily perception that triggers the awareness of waiting for a child.

It's in there, it grows with you, but then I realized that day after day...it's something that grows slowly and I find it emotional. (VM, Italian).

When he started moving, when I heard the baby moving the first time, ah, I was very happy, but really because I felt, at first you know you're pregnant, you know there's a baby growing up, but when you feel that he moves, that after a caress moves to make you feel that 'I'm here, mum I'm here'. (DN, foreign).

The participants of both groups reported how the involvement of “significant others” generates emotions. However, there was a difference: while Italian women referred to the emotional involvement of their partner or of their first-born, foreign women reported the communication to their parents.

I started to feel some taps, I looked at my belly and my belly was moving [...] after twenty minutes my husband arrived and I immediately said "Come here, come and see" because he could not feel it, but he could see it. And it was also emotionally charged to be able to share that moment together, because not only I had heard it, but being able to see why the belly had risen, he had seen it too and I remember it as very emotional. (MM, Italian).

When we explained to XXX that in the belly there was a baby that would come then to play with her and then so, and she started to give me the caresses, to make kisses. (EF, Italian).

I do not have a good relationship with my dad, but my dad started crying and I had never seen him cry, so both when I told it to my mom that when I told it to my dad me, it created a beautiful emotion. (EP, foreign).

When I told my parents about pregnancy. They did not know it yet [...] they were happy. Mom had a little bit understood from my face when I spoke to her, that they did not know anything yet. She was happy, he was happy. (GA, foreign).

2) The Main theme 'Concerns' refers to several recurring worries that women reported experiencing. Five sub-themes emerged for both groups of participants, which in part differ as illustrated in Figures III and IV.

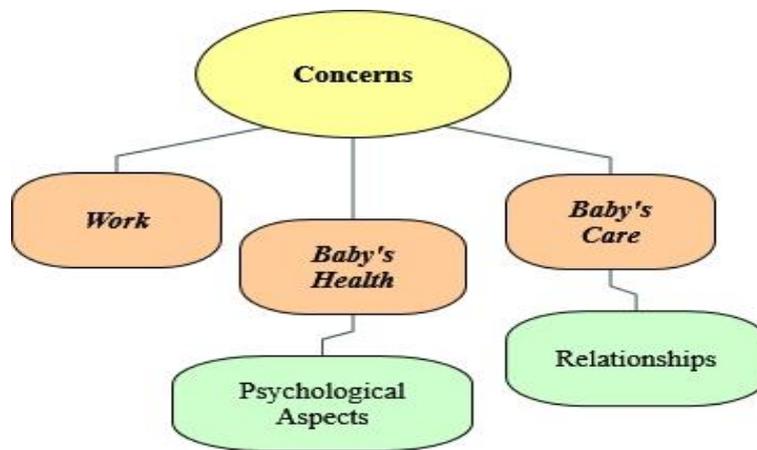


Figure III 'Concerns' and related sub-themes. Italian women.

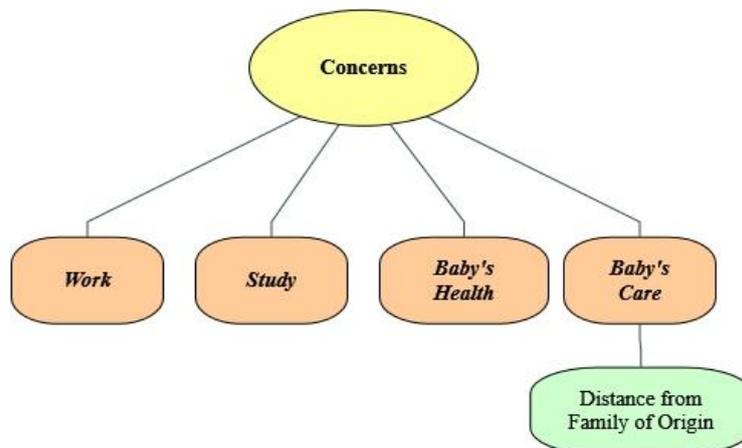


Figure IV 'Concerns' and related sub-themes. Foreign women.

The sub-theme 'Work' refers to the concerns inherent in the job search during postpartum. Foreign women highlighted economic concerns and also the organizational issues that will arise with the new born.

It expired [the employment contract] it) in September, at the end of September and they did not renew it, they told me 'Quiet, when you come back there is always need', I know that there is always need, I was always well, they have always behaved well with me, but there is no written anywhere. (FE, Italian).

I stay jobless, so the main concern first of all is to be able to economically keep us [...] so my fear is to stay without work and have to survive, having to get to that point. Because then we remain with a only salary, if I do not find work already I see it hard, I see it really hard, yes! (EP, Italian).

Who will care the baby when I'm looking for another job? and to find another one, because having another job I solve almost the whole situation, by having a contract I also look for another house [...] that is, with the contract in hand you can find another house, with a contract in hand you can have money, a salary at the end of the month, so you can buy, you can buy milk and what you need. (VI, foreign).

The sub-theme 'Study', emerged only from the interviews of foreign women, referring to the concerns that women show regarding the continuation of studies in the immigration country. As illustrated below, a woman reported a current concern, namely being able to study during pregnancy; for another woman the concern refers to organizational aspects in the postpartum.

Even with the university I was worried. At the beginning I said 'now how do I do it? I go, I leave the university or continue?' [...] then I feel anxiety, I say 'cabbage! [exclamation] so I cannot study, I have to prepare the exams'. (CH, foreign).

I'm doing the third year of nursing, so I have to do internship, I have to think about when I need to do internships. How will I do with the baby? Who's, who will care the baby?'. (DN, Foreign).

About the sub-theme 'Baby's health', in both groups of participants worries emerged about the risk of discovering baby's health problems after birth, even though the medical checks during pregnancy had not highlighted any illness.

The diseases of which I speak are not the Down syndrome, which anyway also gives anxiety, but they are diseases that are not somatic, I do not know how to say, they are noticed later. Of the autism I am afraid to die, I am not afraid of a physical illness, I do not know why, I am not afraid that he has a heart disease, I am afraid of cognitive problems. Or just he is born and...I do not know...he does not cry, he does not breathe...or that they escape, those movie scenes in which they run away with the child because there is something wrong. (FE, Italian).

Maybe that he will come out, I do not know, with a deformation, or a lack of a ... no, it is true that the last ultrasounds that I did have reassured me that he has all its members, so already a positive point, but maybe a morphological alteration. I do not know, I do not know what will happen, but I think about it, but I tell myself 'no, do not think about things like that'. (DN, foreign).

Among the foreign women, fears of a spontaneous abortion and the risk of the child being strangled by the umbilical cord also emerged. Instead, concerns about preterm birth emerged in both groups of participants.

I was a bit worried about the fact that, how to say, if he had decided to be born before then there is not that you say 'ok, he is he is being born', because you have to run fast enough, because in short they have to put a patch in some way. (SS, Italian).

On Facebook I'm part of a group where there are other pregnant mothers, and now a baby was born in the seventh month, so it was premature and now therefore, this thing here a bit, that is, I am, I do not know, I'm obsessed, I'm scared and then I'm careful walking slowly then so [...] we're already in the seventh month so I said 'oh my God, it could be born now' and a little bit this thing keeps me anxious, so I'm careful, I'm careful walking slowly, I try to rest when I feel that it starts to weigh me, then I sit down and then I'm trying to be more calm so I say nothing happens. (CH, foreign).

From the interviews of Italian women, a further sub-theme 'Psychological aspects' emerged, which refers to the women's concerns about the child's health but in emotional aspects. Women reported the fear that their emotions may harm the child.

There are moments of anger linked to the situation with my mother-in-law, so when I mount the anger linked to that aspect there. At the beginning of pregnancy, I felt sorry because I thought to give this to him. (ZD, Italian).

At the beginning for several reasons, one because living a conflict with my partner, I often felt emotions like anger, the disappointment, the sense of being trapped in the relationship that I do not want, and the child feel all this. So I felt guilty that I was transmitting negative emotions to her. (NF, Italian).

A secondiparous woman, making a comparison with the pregnancy of the firstborn, expressed the worry of not having enough time to connect emotionally with the new baby.

There is, a bit, the fear of dedicating little, to have just a little time to establish a relationship with XXX [the baby to be born]. I still work, I manage my schedule, I have my flexibility but I'm very busy anyway. And so, I actually have little time to, how to say, to stop, to talk to her, to pamper her, and so on [...] While with YYY [the firstborn] I read the stories, that is, it was a continuous, with her less. (NF, Italian).

The sub-theme 'Baby's care', refers to the concerns related to taking care of the newborn. The content that emerged differed between Italian and foreign women. Specifically, Italian women reported, in particular, concerns about breastfeeding. Talking about a social context that strongly supports the choice of breastfeeding, two Italian women referred to both the fatigue and difficulties that breastfeeding entails and the concern to be negatively judged should they choose not to breastfeed.

The fact of being judged for the milk thing, because unfortunately now there is this thing that if you do not breastfeed you are an alien. Yes, because I've heard of all the colors. Yes, because they even make you sign a sheet that is your responsibility ... it's not that I give her the morphine I give her the artificial milk! They make you sign the sheet and unfortunately they also look at you a bit 'ah, not breastfeeding'. No, I do not think I am less mother than a breastfeeding mother, but knowing what it can bring, because it takes me of head, I want to avoid it because I have another child to look after at home, it's not that my head can start [freak out] because I have to keep up with milk. (FA, Italian).

I do not want to breastfeed because, in fact, I still want to remain woman, not just mom, I do not know, the thing of breastfeeding that I cannot take mine, a little bit my spaces, it scares me. That is, perhaps I have seen friends who not breastfeed less in difficulty, much less, while on an emotional leveled I have seen breastfeeding women really destroyed. Now they are very extreme about breastfeeding. (IS, Italian).

Also from the interviews of foreign women emerged the concern of not having enough energy to care for the baby, but without specific reference to breastfeeding which instead emerged primarily as a concern related to inexperience.

I do not know if I will have enough calm, enough patience and strength more than anything else for...I will have to have it for force, more than anything else because I stay home alone...but so, the fear to say 'will I die of sleep?' 'Will I endure his tears?' , so yes, that thought I had it from the beginning. (EP, foreign).

The eating, the changing a diaper, I am able to do these things. I'm a little more afraid of breastfeeding because [...] I don't know, I'm afraid it will hurt me, I do not know. (MD, foreign).

It should be noted that, contrary to the above, an Italian woman, referring to her medically assisted procreation path, spoke of the desire to breastfeed because she saw it as a natural thing. Related to this, the worry of feeling a failed mother. In addition, the woman talked about her concern about the risk of depression.

[breastfeeding] it's something that I care so much...I would really hope, it worries me a lot, I think very often [...] because it's natural, because nothing was natural until now, at least this... I would like to keep the most natural possible and then because I know it's good, much better than artificial crap, and because I know how I'm made I would start immediately to feel unsuccessful as a mother if I could not breastfeed and then I do not need negative things I think at that time [...] another big worry that I have on the following is the risk of depression, that worries me, I'm afraid to get in touch with it, so boh? Hopefully well: I was depressed in the past, I have been under treatment and therefore I feel a little more at risk, respect, apart from the fact that it happens regardless, unfortunately the statistics are those. (MR, Italian).

With regard to child care, for both groups of participants emerged a sub-theme: 'Relationships' for Italian women; 'Distance from family of origin' for foreign women. 'Relationships' refers to relational aspects with relatives, first-born and concerning the couple relationship. About the relatives, the women expressed widespread

concern about the management of possible intrusions regarding the pedagogic and child care choices.

With the mother-in-law, the only thing that worries me, since it is a person a bit 'intrusive, not to know how to manage with serenity the intrusion of the mother-in-law. In fact, I'm trying to have pawns to defend myself, because I do not want to find myself telling an adult person some unkind words. (VM, Italian).

One thing that worries me a lot is to manage the various tips in the post, the fact that all have to tell you their experience [...]so my concern is to be able to say this thing in a way educated, without being aggressive. (ZD, Italian).

I would like to say no to what will bothered me, in the sense, I would not want the house full of people [...] then my mother-in-law, who is a very exquisite person and indeed very nice, is not intrusive, however, is not absent either, so I cannot tell her anything, but when she gifts me twenty suits all zero months I do not have the courage to say 'look, if you give them all very small, I cannot use them, in my opinion', just as I do not have the courage to say this thing, I probably will not even have the courage to say 'do not come every day to my house'. (FE, Italian).

Among the relational concerns, Italian women reported also the inability to understand the child's needs or not to dedicate enough time to the child. In particular, secondiparous talked about the fear of jealousy by the firstborn or the ability to love the second child as they did the first.

There is also the fear of XXX's jealousy, who for five years has always been alone. (FA, Italian).

Because I always knew, I wanted more children, but my big question was 'But would I ever love a second child as I love the first?' Because it seems impossible to me, that is, it is so overflowing that I wonder, maybe, that is, all people say yes, absolutely. (NF, Italian).

Finally, an Italian woman referred to the relational changes that the birth of the child involves for the couple.

How will our life change from being two of us to being three, how will it be, what kind of upheaval will be this transition from being two, from being a couple, to being three with all that a little baby can involve. (MM, Italian).

Regarding the sub-theme 'Distance from family of origin', which emerged from interviews with the foreign women and related to child care, it refers to the feeling of loneliness, as well as the fear of caring for the child without reference points for any doubts and concrete help.

And a bit I feel a bit alone, and then I say 'oh God!', maybe being alone here in a different country I will not be able to, that is, I don't know, if I get any doubt, I don't know who to ask, that is, there is not, I don't have mom, grandmother. That scares me a bit, but then I say, my partner tells me 'but do not worry, you will have the mom's instinct and you will resolve everything', I say 'yes' and hopefully. Yes, yes, it feels a little lonely. (CH, foreign).

What worries me the most is the fact of being alone, in the sense that there are no relatives, there are relatives of my husband but it is still always nice to have the mother or close friends who can help you, or simply to go out to do two steps. (PS, foreign).

especially for a young mother like me, I expected when I have my first child to have my mother next to me, to have maybe my sisters and all but, when I realize that all this, I will be here just by myself. No mother, nothing, no one to help me, all this. No family to welcome the child with me and everything, because not even the boyfriend has the family here, he is alone here, so we'll be just like that, in two, waiting for the child. This entails that I miss the family and I also often cry because I miss the family a lot. (DN, foreign).

Having a child here or down is the same. The question is more related to those who help you, because if you are down from me [country of origin] when you give birth there is the mother, there is the grandmother, there is the aunt, there are many people who give you a hand that in the end you do nothing, for three four months you do anything, but here, here you have to move alone, you have to do everything. (VI, foreign).

3) The main theme 'Sharing of experience' emerged from the discourse about people with whom women share, or do not share, the experience of pregnancy and refers to the motivations that underlie this sharing. In general, women mentioned various people with whom they talked about their emotional and physiological experience,

including their partner, mother, sisters and friends. Both for Italian and foreign women, two sub-themes emerged, as illustrated in Figure V.

Although the contents of the two sub-themes may appear to overlap, the sub-theme 'Assumptions' concerns the evaluations that women made about the possibility of sharing the experience or, in other words, the reasons for choosing the people to talk to about their pregnancy. Instead, the sub-theme 'Aims' refers to what the woman expects from sharing.

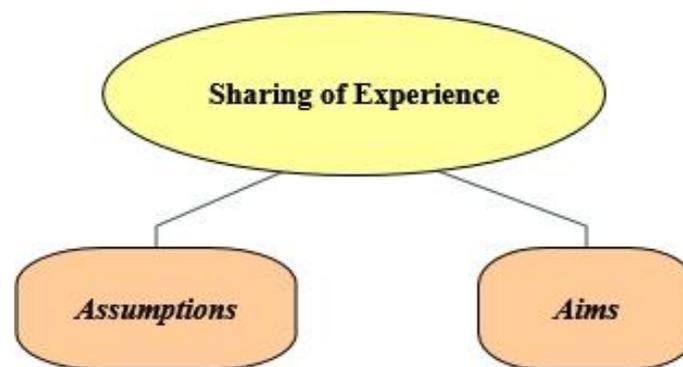


Figure V 'Sharing of experience' and related sub-themes.

Regarding the sub-theme 'Assumptions' it emerged that women, both Italian and foreign, share the experience if they judge the person able to understand their point of view, their experience.

Nothing is shared as when it is shared with my partner that is a kind of other, but that is, there is not a thought that I do that I do not feel I can share with him. (MR, Italian).

Then my sister is eight years older than me, so she's already there, and then [...] she is helping me. (FE, Italian).

While I feel a little less supported, but I think because they simply do not understand me, from some of my friends, because maybe they are still my age, they think of other things and I feel less supported by them, and it does not come to me to tell them some things. (PV, Italian).

My mother, because it's something that only a mother and daughter can understand, that is a mother can understand 100% what you're going through at the moment. (MD, foreign).

With my mother so much. Because anyway I ask her 'tell me what happened to you' and she tells me. With my husband a bit less, because I think men until they see the child do not realize it. (PS, foreign).

Furthermore, it emerged that women share if they perceive the person as reliable, that is, available to listen in time of need. In this regard, both an Italian woman and a foreign woman talked about how geographical distances can hinder this feeling of being able to rely on someone. The foreign woman highlighted also the sense of isolation, the general difficulty of finding someone to share with.

Above all with my mother-in-law, because I have a wonderful relationship with her [...] and with her so I share so many moments, I know that she is there: here, anything I can tell her, I can tell her about it. (FA, Italian).

A little my sister, but my sister is so far, my sister lives in Malawi, so in the sense, she will come in January for the birth, I'm glad to see her but if there is a bad day is the last person that comes to mind to call, I know I cannot count on her, I tend to tell her beautiful things. (MR, Italian).

My mum, then the other people, you know how it is "Yes, beautiful, you're pregnant, you're pregnant!", But the mother is the one that anyway ... My sisters too, however they have their life, have their children, so I cannot expect so much from them. (EP, foreign).

We do not have many friends everywhere and then also the family because then, I do not know, my country is a bit also far, even communicating is not easy because even communicating with the family is not easy [...] we are only two, the others often call, the family calls and only to take the news but, apart from that, nothing, no direct person or things like that, we do everything in two and we only help ourselves. (DN, foreign).

Among Italian women, it also emerged that in order to share the woman needs to perceive participation, involvement.

Mostly with my husband and that's it. Ok, I have a lot of friends with whom I go out often but I do not want to talk about pregnancy, and I do not want to talk

about pregnancy with my parents and her parents; we love with each other, but neither mine nor hers are so involved, I only want to share it with him. (IS, Italian).

They do not do anything [the friends], in the sense that I see them little, they make themselves heard little, even a message "how are you?" sometimes could be synonymous with participation, they are not participating much. (FE, Italian).

There are a lot of girls I know so I feel much protected, they make me little thoughts, and they already talk about this child so much joy. Then, even the grandparents are happy anyway. I share it with many people even with friends [...] they told me 'wow, but fortunate that you have been to achieve this goal of the family' that many of them for a series of reasons have abandoned it. This was a surprise, I did not expect, then share it with them seems to me to give a child to them too, and this is very nice. (VM, Italian).

About the sub-theme 'Aims', women reported the usefulness of comparing their experience with that of other pregnant women or women who are already mothers, and of information support, that is, receiving advice and suggestions.

We all say how valuable and important the comparison is, from the banality of the baby bonus to changes, fatigue, heartburn, to not sleep, these things here [...] I also I have friends already mothers who are very close to me, they give advice with respect to those that have been their experiences. (ZD, Italian).

My friends, that is, yes, for heaven's sake, they listen to me, they support me, but it's not that they are, that is, they rightly have a life more normal life in quotes for our age, and so it is normal that yes they are interested but they do not know, maybe not even in practice, maybe to advise me [...] there is need to compare with who has already had the experience, or is experiencing it. (EF, Italian).

Some girls from my country, who have had children here, often tell me about their experience. They tell me something that has happened to them, and it is a piece of advice that helps me a little to prevent situations [...] my sister who is in Cameroon is also pregnant, we have only one month of pregnancy difference, so we try to communicate, to exchange the experiences of pregnancy, especially that she is her third child, so she already knows something about it. She tells me things, tells me what will happen, morphological changes and everything, so I have some news about pregnancy, experience, and it helps me a lot. (DN, foreign).

Among the goals of sharing, the need to receive emotional support also emerged, in particular, and more explicitly, from the interviews of foreign women, who also refer to the staff of the territorial social services.

I have always supported her and she has always supported me, especially in the last few years several things have happened, so we are closer, and therefore she is helping me. (EF, Italian).

She is all, that is, when I feel down, when I have some problem, I just feel that she tells me 'look I am here, whatever I am here', even if it is far away it is a very support [...] I can tell her anything, 'mom look I feel like this', if one day I want to cry and I call her I can tell her and I know that I can vent myself. (MD, foreign).

At the listening center I speak a little in general, sometimes you talk, you give vent to a bit, and talking you receive reassurance[...] at the listening center, or with the social assistant I have, she tells you 'you'll see that it will be good', that is, I share not only with my boyfriend, but also with the social assistant. It helps me emotionally, yes because sometimes you say 'boh, what will happen?', then she shows you that however things will go for the better. (VI foreign).

Area-2. Well-being and ill-being during pregnancy: representations and needs

The second area consists of four main themes: 1) Well-being and ill-being; 2) Feelings of satisfaction; 3) In order to achieve well-being; 4) Medical care: evaluations and needs (Figure VI).

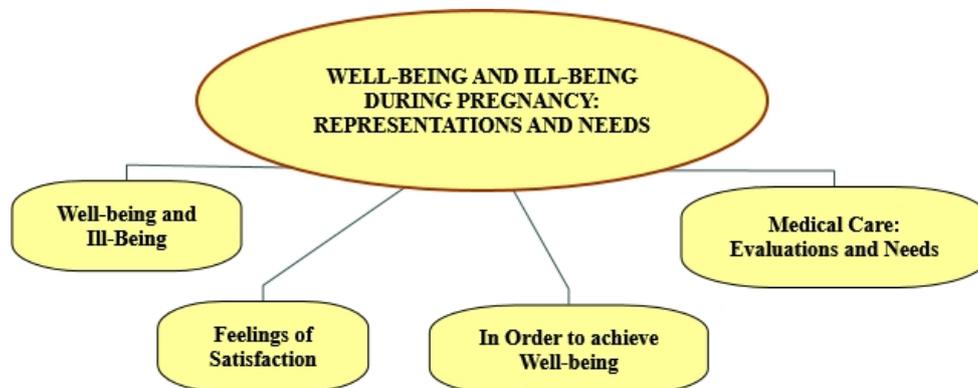


Figure VI Area-2. ‘Well-being and ill-being during pregnancy: representations and needs’ and related main themes.

1) The main theme ‘Well-being and ill-being’ refers to the women’s representations of well-being and ill-being during pregnancy. From the analysis, it emerged that talking about being well and being ill during pregnancy, women reported both in terms of physical and psychological attributes and they described also possible relations between these attributes. Therefore, three sub-themes emerged for both groups, as shown in Figure VII.

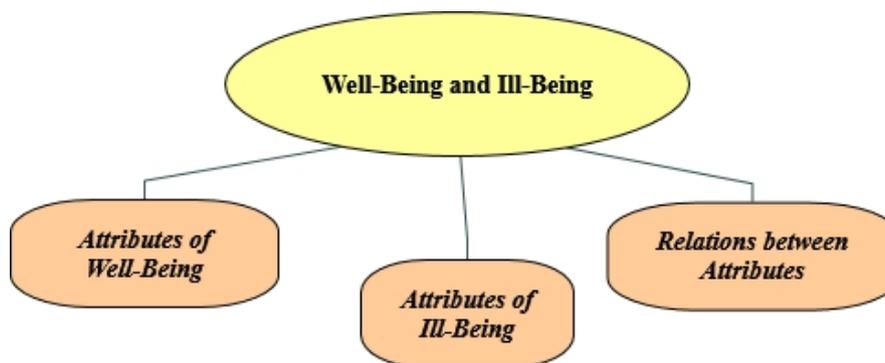


Figure VII ‘Well-being and ill-being’ and related sub-themes.

About the sub-theme 'Attributes of well-being', analyzing the discourse on ‘feeling good’ it emerged that, although with individual differences, in general this is represented both as physical and psychological. Both types are described in terms of the presence of positive aspects and absence of negative aspects, by both Italian and foreign women. Some women showed the tendency to refer only to the physical or only the psychological, as well as only to the presence or only the absence, while others referred to both.

To be physically well, that is, having no one symptom. (ME, Italian).

I'm very energetic, I do, maybe, let's say that three, four days I do a lot and one I sleep, but in general I'm almost always well. (IS, Italian).

I'm well, I'm calm, I cannot want more. (FA, Italian).

I'm very calm, I'm not agitated, the anxiety of the beginning has gradually passed. (SS, Italian).

I was lucky to have, during all these months, a pregnancy, in the sense that I was well physically, I felt a lot of strength, a lot of energy [...] also mental energy. (MM, Italian).

I'm fine, in the sense that I'm not tired, apart from a week of cold I feel healthy [...] I have had so many beautiful moments, both when I was alone, and when I was in the company of other people. There have been not mood swings, I was fine. (VM Italian).

I have been well on the physical level, I never had any kind of problem except the first months, I was sleepy, I felt a lot of tiredness, but I have always been well, both physically and emotionally, and it is something that comes a lot because they make me notice in many that you see that I am more serene more relaxed [...] I do not have big fears, worries, anxieties, so for me to being well is this to be very light in the head. (ZD, Italian).

Yes, yes, I feel good, calm. (CH, foreign).

Many are anemic, all these things here, so on this aspect I feel very lucky, because I have not had anything like that, I can eat everything [...] you know, when you get up really good, full of life, just with the desire to do a thousand things and you do not feel tired. (MD, foreign).

It means no more nausea than I have had so many at the beginning; do not have back pain that I see that many complain about this thing here. About sleeping I sleep well even if sometimes I get up to go to the bathroom, but mentally [...] actually almost all the pregnancy. I do not remember moments of melancholy, malaise, sadness, in reality I think it was a continuous well-being. (PS, foreign).

When I resolved all the problems, even mentally I was freer, when I said everything at work, yes I was fine. Let's say I recovered, I told everyone, I was fine, I was fine, I was also psychologically calm. (EP, foreign).

About the sub-theme 'Attributes of ill-being', analyzing the discourses on feeling ill it emerged that this is conceived more as physical than psychological, and only as the presence of negative aspects and not as the absence of positive aspects.

I would like to do everything, with my head I feel I can do everything, physically instead I start to feel that I have to slow down a little. (ZD, Italian).

Physically when I had renal colic. I was really destructive. You cannot find any position, then you cannot take drugs, it's just devastating. So that on a physical level. On the mental level, on the other hand, the morphological [...] the moment of the morphology I experienced it really badly, because I thought back to the experience [experience with the first daughter] and so it was just a moment when I said 'Today I'm right down. (FA, Italian).

I often have a few episodes of back pain, but apart from that there is nothing at all, so I would say that for me its ok [...] I've had nausea, vomiting until the fifth month. Before that, days of well-being were not there because I could not eat, even sleeping was difficult. (DN, foreign).

The last ailments are coming to me now, two weeks ago, because I have so many gastric acids and it's terrible. And then when I'm tired because I continue to walk, to do my things, I feel the pain in the back. (EP, foreign).

One day when, that is, I was thinking about the difficulties related to after birth. (VI, foreign).

Regarding the last sub-theme 'Relations between attributes', reference is made to reflections by women regarding the relationship between attributes of well-being and ill-being. Two types of relationships emerged. The first concerns the relationships between physical and psychological. Some women said that it is possible to feel mentally well even in the presence of physical disease, while others said that the physical disease can cause psychological distress. The second type of relationship concerns the fact that an individual can feel well psychologically even in the presence of concerns.

It is obvious, as in everyday life, that there are times when one feels ill about something, but like 'I'm annoyed because I broke my leg, but I'm fine because I watch a movie', so it can happen [...] you face a beautiful thing that is having a child, so even if on the other side there are some things that make you feel bad, things are not that are irreconcilable. (PV, Italian).

Even if I was nauseous, I had to throw up, I was sick, I also tried to be well, because I knew that it would not have been my life so forever, I knew that after the third month, the doctor told to me 'after the third month you'll be feeling better, so be quiet, try to relax' and that's how I tried to be. (MD, foreign).

Sometimes I'm sick physically, because then you get to the end of the day that you're tired, But you're well as mental well-being [...] When the negative state starts from the head, you put a little more to recover in my opinion. If then the negative state is the body, at the end then you say 'well, we roll up our sleeves and let's go'. (FA, Italian).

The first three months of constant nausea. However, when one is not well physically [...] instead, now I feel perfectly fit, serene. Yes, I can do, I have the energy, and I can work, to do yoga better than before. In the sense ... this also helps me to relate well with pregnancy. (NF, Italian).

These acids for example make me feel so bad because I have them constantly, even if I take the Maalox that makes them go away, but I drink a glass of juice and they come back immediately, so it's like a stomach ache that hurts you, it hurts you, you keep it, you keep it, but let's say that mentally it creates, also a stomach ache mentally tires you. (EP, foreign).

You can be calm and have worries, as you can have a bad period but have some glimpses of happiness. (IS, Italian).

We live in a society therefore, there can be any influence from the external point of view unrelated to pregnancy, and that in pregnancy we can live better or worse, but in general as in everyday life one can feel good in general and then have the days no. (VC, Italian).

I'm well, but however I would like someone of my family closer, so you feel a little well but also feel ill at the same time [...] more than anything else it causes you a bit of sadness, nostalgia. (CH, foreign).

I think so, that you can be both well and ill because anyway maybe there is just a problem that makes you feel ill, but I feel well. For example, it was my birthday on Saturday, I don't have a good relationship with my dad, he did not call me to say "Congratulations!", I'm the only ..., he did not call me, I'm the only daughter...I feel ill, see I say it to you crying, but then is not that this morning I woke up sad because he did not call me, I'm well, I'm well, yes. (EP, foreign).

An Italian woman reflecting on the psychological fragility of the person, combines both the first and second type of relationship, saying that one can feel well mentally even if one is physically ill; instead, if the malaise is mental it depends on how strong the person is psychologically.

So, let's say that rationally it is what I try to do, and then rationally I would say that if you have a strong enough personality, if you have a strong enough character, I think you can feel well despite elements that make you feel ill, and vice versa. When you are not strong, I don't believe it's possible. (MR, Italian).

2) The main theme 'Feelings of satisfaction' refers to the women's satisfaction about life and self. As illustrated in Figure VIII, two sub-themes emerged.



Figure VIII 'Feelings of satisfaction' and related sub-themes.

About the sub-theme 'Meanings', it emerged that for women life satisfaction corresponds to not wanting anything else or, in other words, to perceiving the positive aspects of one's life.

Living positively daily life, so wake up in the morning without saying 'what balls [exclamation]: today what should I do?'. (EF, Italian).

However, we are all healthy, I'm well, I have a job, I'm healthy, soon another child arrives, so I would say that now the satisfactions are not lacking. (VC, Italian).

Well, just simply when you are well, let's say when you do not want more else. (PS, foreign).

Feeling like this, that is, waking up in the morning and knowing that in the little that I have I'm happy. (MD, foreign).

Regarding the sub-theme 'Sources', women reported that three aspects can affect feelings of satisfaction: objectives, family relationships and physical changes.

About the objectives, the women said that the achievement of their goals is important to be satisfied with themselves and their lives, and that different life contexts have to be considered in order to evaluate the level of satisfaction. A further aspect, which emerged above all among foreign women who had to review their migratory project because of

pregnancy, concerns the usefulness to be able to accept life program changes and recalibrate one's objectives according to contingencies.

I think I'm a person who always engages, it is difficult for me not to be satisfied. If in the long period some things are not achieved, I do not know, the life is strange, in the sense that maybe you find yourself at 40 years doing things that you did not even think about, is the path day after day that I live fully. Then I learned to accept the things of life, to take the changes so [...] I learned that perhaps to be satisfied and happy you have to have many areas so that, if by chance there is one that is not so good [...] I see the satisfaction in the affections, in the work, in the study, in the friendships. (VM, Italian).

Before getting pregnant I had to finish the university [...] take this degree with your own efforts, that is, then I'm here alone, so doing it by myself seemed like a thing, that I felt proud of myself, and so, it was this. Then now, if I have the baby and I can manage in a right way, that I hope, I think it is something that can be satisfactory [...] I think if I will have the baby I will be even more complete as a person, as a woman, then if I finish the degree even better. (CH, foreign).

Before getting pregnant, maybe I started more or less saying 'I'm succeeding'...before, then I got pregnant and you feel stuck anyway, you feel stuck because, for a while, I already imagine when the baby will be one year, it's not that I'll be like before [...] let's say that I feel I could choose a better moment but I feel that I will succeed. (EP, foreign).

Regarding family relationships, women referred both to their partners and to their family of origin. About partners, women talked about the satisfaction deriving from a functional and supportive relationship

My husband, sometimes when I talk to my friends 'does he actually shop? But does he wash the dishes?' I say 'yes, it's true, it's not fake', so I'm really happy with what we've built. (FA, Italian).

I'm also grateful to have the husband I have, because he is very good, very affectionate, he always tries to do his best. (MD, foreign).

Regarding the family of origin, it emerged that life satisfaction derives from feeling the support of one's family in terms of approval of the pregnancy. It should be noted that this

aspect is very present among foreign women, while it was reported only by one Italian woman in terms of dissatisfaction resulting from lack of perceived support.

Especially with my parents because I still go to university [...] they told us things that we hoped would not tell us [...] It was enough, a bit heavy because anyway also, we are living it in serenity and we are glad and all, but they were very 'but why? But then you are not able', so yes, the relationship more than anything with them. (EF, Italian).

Let's say at the family level, because at the beginning they did not accept pregnancy just as I expected. But now that is better with parents, with the family, so I would say that I feel good, that all is well. (DN, foreign).

I thank my mother, I thank my family and all...that at least I became pregnant and I will live it serene even after the birth and everything, yes, yes. (EP, foreign).

Finally, bodily changes refer to the feeling of self-dissatisfaction that can result from changes in one's physical appearance. In this regard, an Italian woman and a foreign woman expressed the difficulty of accepting changes in their bodies. Although from the Italian woman's story emerges a greater emotional difficulty in accepting these changes, both refer to the fact that it is something that one thinks about but which one should not think in order not to appear inappropriate.

I have the anxiety of the physical aspect, of gaining weight, that is, the thing that interests me most in pregnancy, if I see a few extra pounds [...] it is difficult to talk about this thing, because I have many friends and people I know that instead they let go themselves, maybe it's not their main concern, so I say 'boh, maybe I'm strange'. (IS, Italian).

Sometimes when I get up and I see that I cannot wear anything: and I say 'oh God, oh my God but from a size 36 I went to a 40', and you say 'cabbage!' but then you say 'oh well, remember that you have a baby in your lap, so do not worry it will switch', and so it goes away me, but some mornings I get up and say 'cabbage!' [exclamation], I don't know what to put on' and you say 'cabbage!'...You think, even if you don't want to think about it, you think. (MD, foreign).

3) The main theme 'In order to achieve well-being' refers to several aspects that women reported as important to being well during pregnancy, and some, even in the postpartum. Five sub-themes emerged as illustrated in Figures IX.

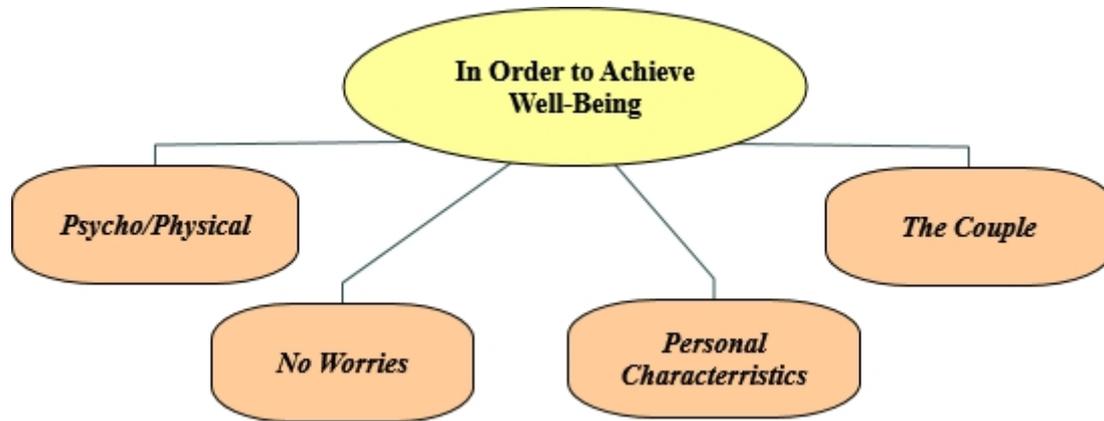


Figure IX 'In order to achieve well-being' and related sub-themes.

Regarding the sub-theme 'Psycho/Physical', it refers to the physical activities women reported doing in order to feel good at the body level. Moreover, it includes the link between mind and body, that is, the need to perform physical activity, or more generally to be able to do something physical, in order to feel good psychologically.

When women were asked about what activities they do in order to be well during pregnancy, Italian women reported swimming and yoga as well as walking, while foreign women reported only walking because of the lack of money. Moreover, it emerged that physical movement is useful also in order to feel good psychologically. In particular, two Italian women who practiced a lot of sports before pregnancy, talked about the need of physical alternatives. From their discourses, it emerges also that pregnancy entails significant sacrifices for them.

I've always been a sportswoman. I realized that, I used to ride a bike but I could not do it anymore, and there I felt a bit ill, I almost started crying [...] I do not hide that among my recurring dreams of when I'm well, I'm hanging on a wall of ice, the moment will come when I return [...] now I walk. I wanted to replace the physical

activity with the fact of going to the pool but it is not my environment, I went there twice then, then I prefer walking. (VM, Italian).

Up to a month or so ago I was a fairly sporty person, so all that is sport, physical challenges, even the fact of testing me to say 'okay, it's not really over my life, I can still do things'. So I looked for physical cues because I like it from this point of view here, so I went a lot in the pool, I went to 3000 meters, I did a lot of things. (SS, Italian).

Besides sports, being able to physically do what they want, or what they did before becoming pregnant, emerged as another important aspect of feeling good psychologically.

To be able to do everything I did before, in the sense of having my rhythms, going out, in this sense here, more physically. (IS, Italian).

To be able to lead a life as before, to make a life like I did it before. (PV, Italian).

I was at home (from work) from the middle of the third month, it was a bit heavy [...] it's just a bore, a practical act is boredom because if I had another child, I [...] gave me a lot of satisfaction to do what I did, and I did not do it any more from one moment to the other, so I cannot find the same satisfaction in cleaning the house, for example [...] I'm quiet, I'm not bad, but being happy maybe it's another thing, maybe I'll be more later, I do not know [...] I would have liked to work a little more. (FE, Italian).

Being able to do all things, not being tired [...] I lost the desire to do everything. Because I embroider, I make clothes and everything. But now it's not there, because it's tiring, I feel nauseated. (KM, foreign).

Everyone was talking about illness, not being able to move or something, but I anyway, to take weight, to be unable to do anything, but now I go to school, I do what I want. (DN, foreign).

there are days when you are sleepy, a lot sleepy, and then I'm there to study, but no, I cannot study because I've sleepy to fall asleep, and then you cannot do anything that then maybe you say 'ok, I do something else '. Maybe you go to clean something, but then you get tired right away because you cannot do anything, you get tired right away, then you say 'ah ', that is what a little makes me feel a bit ill. (CH, foreign).

From the interviews of foreign women, food emerged as a way to feel good psychologically. Specifically, women talked of the possibility to eat the food of their country of origin.

A friend of mine who comes from my country brought me the food of my country and so I was very well [...] I was happy, very happy. (NM, foreign).

There are things that I would like to eat that I cannot find here. We have also salty cucumbers, so much vinegar, even sweets we have them different. I do not know well, in pregnancy I would never like sweets, but maybe I think about when I'm in Ukraine, I would like something that my body knows. (KM, foreign).

Regarding the sub-theme 'No worries' it refers to the fact that not having concerns about the baby's health is important in order to be well during pregnancy.

Being calm, not having bad thoughts because then ... it's normal to have them 'will be well? Will it be born well? How much will he weigh or will not weigh? How long will he be? '. But also this is feeling well in my opinion, to being well of head, do not have unnecessary worries. (FA, Italian).

For me it's important to be calm, calm, do not overload me with worries, I would say that it is the most important thing in order to face well, also, especially this last period. (VC, Italian).

That the child comes out healthy and everything goes well, first of all! Let's say that now the main thought is that: that everything goes well. (EP, foreign).

The important thing is that the child remains healthy, even me and then ... after she grows well. This is important to me, but she must be well as first, because if she is ill ... no ... I already die (VI, foreign).

The sub-theme 'Personal characteristics' refers to the aspects of themselves that women consider important to feel good during pregnancy and postpartum. Various characteristics emerged that can indicatively be grouped as follows: practical and psychological independence; determination and the perception of being strong, capable of doing things also on the basis of the empowerment derived from previous experience; mental rationality and tranquility, including positive thinking, the acceptance of the unexpected and trust in others.

I've always been quite an independent person, so surely the fact of not having much help does not weigh on me [...] the judgment of others does not weigh on me, in the sense that it really slips on me. (EF, Italian).

I listen to the advice of others [...] but I'm the mother [...] but I take the decision. Maybe wrong, but if I wrong, I'm the mother and so I choose [...] with many things helped me, how to say, this determination. (FA, Italian).

I'm a person who does not care enough about things, people tell you what you have to do, you do not have to do, so I do not care so much, and this has helped me so much in life in general and now even more. (SS, Italian).

I'm a person a bit strong [...] I often say to myself that however up to this point I could handle the thing alone without the help of anyone [...] So I would say this character of knowing how to do things a little alone, without always waiting for someone's help, it helps me to manage a little better the situation. (DN, foreign).

Having passed many before makes me feel a little stronger, maybe, I do not know, a little more strength, I seem to have also acquired from the fact of being passed through the experience that many people do but many others do not, and you think that this can help you. (MR, Italian).

I've to say strong, but it is not the word, and not even effective is the word, because effective you say it of an object. I consider myself able to do everything. (PV, Italian).

Grit, determination and then I'm quite calm and serene, and that helps you anyway. (IS, Italian).

I say that I have always been effective, even when I went to live with my boyfriend I did not work a lot, but then I got busy, I found a job and slowly I earned the right to live alone, so I say 'I was effective!' ... certainly with the child will be more difficult, but I'll do the same, I do not think I'll be lying in bed without doing anything or looking for a job, I think there will be to do, so you have to roll up your sleeves and go on. (EP, foreign).

I'm a person, let's say, strong by nature [...] I'm always gritty, 'Oh well, I can do it' even if I see that there are difficulties I say 'Oh well, I can do it!' if I commit myself, I learn to do, maybe I can do ... and therefore that being gritty. (VI, foreign).

I'm a very well balanced person, so this is helping me [...] when there will be a problem then I face it, but if now I have to make anxieties for a problem that is not there. (FE, Italian).

I tend to be rather ... perhaps rational in the ideas that I have, that is in the sense not ... until I clash with something that goes wrong I do not think something could go wrong. (ME, Italian).

The fact that I'm not an anxious person and that I am enough, I do not know if the term is right but, fatalist in the sense that I take what comes, in the sense I am not making myself so many, many assumptions, castles on how be, on how it can be, what can happen. (VC, Italian).

I do not know, maybe because I'm always quiet. (KM, foreign).

I'm a very quiet person and this is already very positive because you transmit everything to the child. (PS, foreign).

The fact of having a very positive approach, in the sense that I'm of the idea that everything can happen, I put it into account [...] when the unexpected happens I put it into account, I face it, but I am convinced that it is winning have so many worries 'this will happen, it will happen that', so this my characteristic of starting always positive helps me and have helped me during pregnancy. (ZD, Italian).

The patience ... yes, I am very patient so I think that ... then that's all right, for example my partner is very pessimistic but I'm more optimistic, I'm more positive, I try to think positively. (CH, foreign).

In this period the fact of having a lot of trust in others for which, I also see when in the hospital tell me some things, when they try to understand if I'm fine, if I'm worried. In short, I trust what they tell me, I'm not going to investigate if they are doing well, if I should do other things, because I hear about of so many people reading, informing. (VM, Italian).

As long as there is life there is hope, so I always carry that phrase and say 'oh well whatever happens there will always be solutions even if they do not come immediately there will always be' so as long as there is life there is hope [...] if there is life I can do things, there will always be something that will come out. If I managed to go to work at XXX having a child of one year and then, that is, I can always be effective. (VI, foreign).

Regarding the sub-theme 'The couple', both Italian and foreign women reported that their partner's support influences well-being as does the perception that he is a responsible and reliable person.

It is important for him to give me support, but even before that he was like that [...] He has always been a very reliable person and he also knows how to deal with it in many things, and this has always given me security. (FE, Italian).

Perceiving the sense of responsibility in the other ... that is, support in the other. (ME, Italian).

It's important that there is, that gives me a hand at home with things ... he says 'no, do not make efforts, I do this rather than do it' ... and from that ... but more than anything else the presence, not being alone makes me feel much better, it makes me feel good [...] from the beginning he has supported me, even when I told him that I was pregnant and I was afraid that maybe he would say 'no look, I have other children, I cannot ', but he told me he told me so' the choice is yours, you choose, what you will choose I will be with you 'and this thing has made me, made me feel much better. (CH, foreign).

About well-being in the couple, women also referred to the need to be heard from the partner, to perceive an attempt at understanding.

Now, maybe a little more patience on his part [...] more fragility than before I was not used to show, to show, the fact that he can understand them, that he can be near me, support, pull me up, accept them this is certainly important. (MM, Italian).

It's obviously important that if I tell him something that he listens me, even if he does not understand me at least that he listens to me. (PS, foreign).

Reflecting more on the well-being of the couple, compared to the well-being of the woman in the couple, the importance for women to feel that their partner is happy and feels well emerged. It is also important, for Italian women, that their partner is emotionally involved.

The fact of sharing what emerges from these meetings that I do, rather than how I feel, because it is undeniable anyway, many feelings for what I can tell him, he cannot live, but it helps me to be able to tell him and make he somehow sharer. (ZD, Italian).

That is for me it is physical above all, then it is mental, but the mental issue is also his, but no one ever considers males, and then in this period, that is, I am also trying to ask him, ask him questions. (SS, Italian).

That he's happy. (FE, Italian).

I want him to be happy too, that he feels like a dad ... sometimes I hope he can dedicate the right time to these moments here, because then they are moments that if you lose them you've lost them ... maybe we'll have another one, not I know, but every moment is unrepeatably and a bit exclusive. (MM, Italian).

Let's say that for the moment we do everything not to have problems, to always agree on something [...] I know that for him it is a difficult situation so I do everything to put him well and serene. (DN, foreign).

That he too is calm, even if at first he was a little agitated, he said 'oh my god, another child!' but now he is quieter, it is more peaceful, so even seeing that he is calm, even I am calm. (CH, foreign).

Finally, two Italian women who already had a child, recognized the need for sharing, exchange and gratitude.

Trying to cut out a few moments for us is very difficult, because when you are the first child of time you have, figuratively with XXX [...] tell how the day went 'at work what did you do? Are you Ok? How do you feel? It's just important. It's just a need, because maybe there are days, maybe he gets out of work late and you're already preparing dinner, the time you eat, put to bed XXX and say' eh, but I miss that moment of sharing. (FA, Italian).

Try to meet ourselves, and I must admit that he is often very good, in the sense that he helps me when he can. Now that I've the nausea for example he cooks ... if I have to study he goes out with XXX ... So on that I do not I can absolutely complain. But, however, in fact, even do not take it for granted, because then maybe I take this for granted and he vice versa assumes that I have to do other things, to think of other things, so I would not take for granted and do not ignore. (EF, Italian).

4) The main theme 'Medical care: evaluations and needs' refers to the evaluation process that underlies the choice of medical treatment during pregnancy, and the women's needs in the evaluation process itself. Two sub-themes emerged for Italian women and three for foreign women, as illustrated in Figures X and XI.

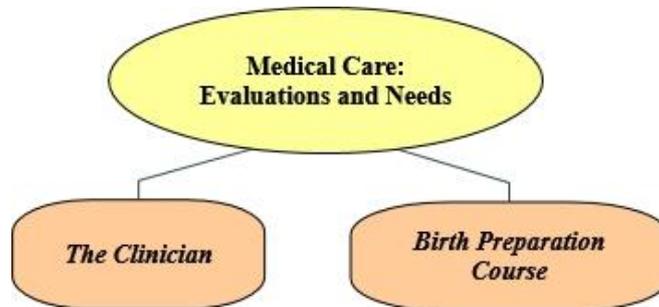


Figure X 'Medical care: evaluations and needs' and related sub-theme. Italian women

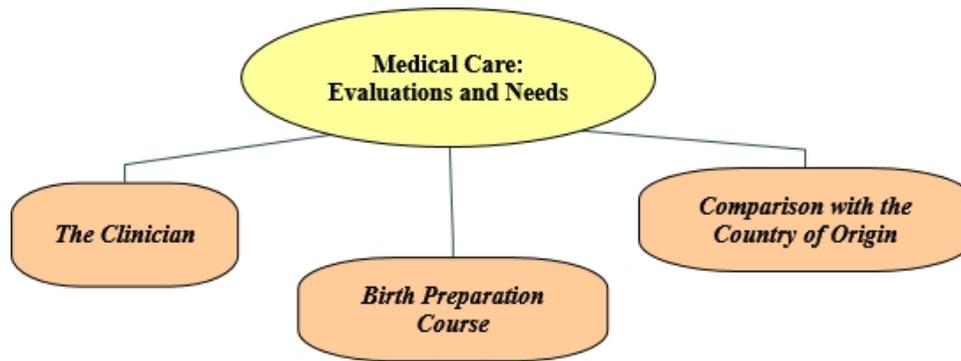


Figure XI 'Medical care: evaluations and needs' and related sub-theme. Foreign women

The sub-theme 'The clinician' consists in the motivation that guided the choice of the professional. First of all, it appeared that all the participating women were performing routine monthly checks, and that all the women were followed by the professional figure of the gynecologist. In this regard, only two Italian women knew of the possibility of being followed by a midwife. Both among Italian women and foreign women, previous knowledge emerged as a motivation in the choice of a particular gynecologist, in addition to suggestions from other women. Among other motivations, first of all economic and relational motivations emerged, while two women reported health reasons.

Because at XXX (hospital) I feel good so I decided, unlike the previous pregnancy that I had the private gynecologist, to go directly to the clinic because now they make you, more or less, that is more or less is scheduled a visit a month. (VC, Italian).

Perhaps even wrongly, I have always looked for doctors with whom to have a little more empathy rather than the doctor. My gynecologist, for example, is very young, in my opinion she is very good but she is very young and someone could say "you could rely on an older professor", instead I find myself very well because I can have more dialogue, I can be quieter with a person I'm more comfortable with. [...] I preferred to give more importance to the relationship than to the fact that she was young and that therefore she could know less about an older doctor and that's ok. (FE, Italian).

I can only go the public, so I do everything public, the less I pay the better it is. However, I started at the XXX Hospital, I don't think they give a bad service, but I personally felt a little neglected, not very careful maybe to my availability, I asked for a change of appointment and absolutely, nothing to see, a change of appointment is impossible! Very rigid [...] I went to YYY and I found myself completely in another

environment, more available, more attentive to the questions I asked them, and they asked me other questions, while at the XXX they only told me 'have you something to say? ' and that's enough, here they did me, not much I tell you, but it is certainly much better than I felt personally at YYY, then I immediately asked for the change, I asked for the appointment for YYY and the visit after I did YYY and until now I'm at YYY. (EP, foreign).

This doctor is specialized for pregnant women with high blood pressure, because after the first birth the pressure has skyrocketed, and she follows me because of the pressure and so she is always there for the visits. (FA, Italian).

In the past they always followed me every year for these checks, because having the polycystic ovary every year I had to come here. (CH, foreign).

The sub-theme 'Birth preparation course' refers to the needs underlying the attendance of a birth preparation course. Although with slightly different variations among the primiparous, both Italian and foreign, the need to acquire knowledge about the birth and the place of birth, and the need to meet other women to share physiological and psychological experience emerged.

I do it a bit to know the environment because the course is not always done by the same obstetrician, so slowly we should know all of them, a bit because I expect it to be useful with respect to the management of labor and childbirth itself. (ZD, Italian).

Because I know nothing, clearer than that! At least to understand what can happen. Yes, because at the beginning I was not so curious, I'm a curious girl, but to go and look for different things related to the births so on the forums that speak, I have them a bit, not knowing how to select well the information I preferred to go to the professionals who know the information, otherwise they become a chat, then I go to do the course just to understand what needs to be done. (VM, Italian).

Since I don't have a direct experience, I hope they give me practical tools, that is, practical knowledge about things that I don't know [...] so I hope I can, on the one hand, to have practical tools, on one side to get to know someone, to have more sharing with other girls. (FE, Italian).

It helps you to not get to the day of delivery without knowing anything, without knowing what to expect, so you go a little more prepared for delivery is useful, then you know other moms you tell the experiences... in my opinion it is really very useful. (PS, foreign).

More than anything else, that is, since I don't have, I never had children, that is, I would also need for, even for the time of childbirth to know, to know what I must do,

because I would not know. I understand past times when you went there blindly and you delivered, but now like now, no, that is, they help you, however, that explain things to you, to you also like it. (MD, foreign).

I'm now enrolled in the hospital and I did the first lesson, and already from the first lesson I feel much calmer [...] because they say that breathing is very important for self-control, in managing the pains that come to you and then, something I didn't know, when you have contractions your body releases a substance [...] I didn't know it. So they say that this oxytocin does a little drugging, so they say that the you feel the pains, but you're not very conscious, so that's what they told me, it changed me a bit all because I didn't know. (EP, foreign).

I think they will teach me a little how to behave during childbirth, before giving birth, I think, to recognize when you are entering in labour and then later, as I don't know, like breathing, the pain. (CH, foreign).

Also the secondiparous spoke about the usefulness of attending it, both for knowledge and for sharing with other women, while one foreign woman reported the usefulness of arriving psychologically prepared also for the unexpected.

I would have redone it but for a question of mine. I'm gladly, I'm glad, since we are not born all learned, I'm glad to hear it even if I've already heard things and also because maybe meet other moms. (VC, Italian).

Let's say that having already done, having already given birth, already having breastfeeding and all the practical information is maybe not that I need so much, that is, maybe even more than anything else for companionship (EF, Italian).

It gives you a guideline, they give you guidelines on how the birth will go, not to be frightened, to better deal with the pain [...] You are better prepared that day there, you know it will not go all smooth, smooth could go like this and then this could happen, however you go there already being psychologically prepared so it was useful to me. (VI, foreign).

About the sub-theme 'Comparison with the country of origin' that emerged from the interviews of foreign women, talking about medical care women reported the advantages in carrying on a pregnancy in Italy compared to their Country of origin, both in economic terms and for the quality of the medical care received.

I come from a country that is not as developed as Italy [...] instead to my country if my child has something, even if I have something and I go to a public hospital ... I can die there ... that is, I can even die there sitting outside waiting for me to die that nobody looks at you ... and instead if I go to a private person when you pay because you have to pay to have a service there.... but we talk about figures that sometimes for a person without work, that is, how you do ... that is, for example I can be one that I do not, in these moments I'm not working [...] anyway I know that I have a support from public health services, in the sense that I know when I will go to give birth even if I were without documents I know that they help me the same, have you understood? (MD, foreign).

Here really in the hospital you are comfortable because they accompany you to the end, but in my country if you do not have much money, even to see if it is male or female you cannot because it takes so much money. (NM, foreign).

Area-3. Expectations and meanings of childbirth

The third area consists of two main themes: 1) 'To feel well; 2) 'Meanings' (Figure XII)

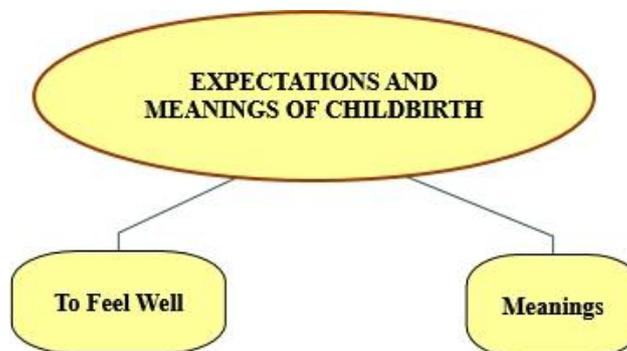


Figure XII Area-3. 'Expectations and meanings of childbirth' and related main themes.

1) The main theme 'To feel well' is about what women have reported as useful for feeling well during delivery as well as those aspects able to hinder this feeling. Two sub-themes emerged as illustrated in Figures XIII.

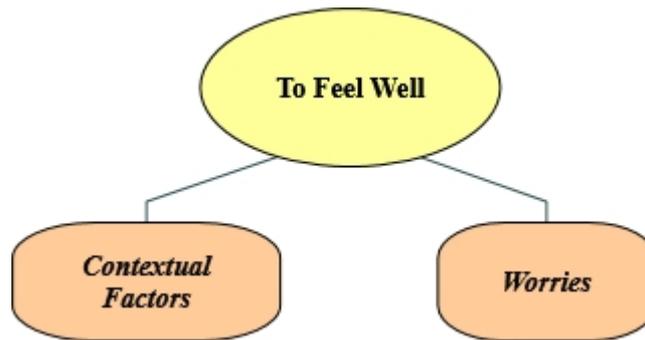


Figure XIII ‘To feel well’ and related sub-themes

Regarding the sub-theme ‘Contextual factors’, in general women reported that to feel well during delivery a supportive environment and welcoming staff is useful from an emotional point of view. About the supportive side, women talked of the presence of their partner, and the foreign women of their mother.

I only hope that the husband arrives in time to have him there. It’s true that I can also call my sister [...] said this, I would the husband to come. (VM, Italian).

During the birth I don’t know, maybe I just need someone there that I know, in this case my partner [...] I think if he’ll be there I’ll be fine. (CH, foreign).

My husband, yes I would it! Then I would, I would like it my mom coming, to have her there at the time of delivery [...] but I’ll need my mother so much. (GA, foreign).

That my mother is there, I’m always thinking [...] my husband, for charity I’m glad, because in the moment, because once I enter the delivery room I’m there to give birth I’m glad that he comes to see that his daughter is being born. But all in all I wish my mom there, because she is a woman and she knows what I’m going through at that moment, I know she can understand me and she knows how to take you and what to tell you. A man no. (MD, foreign).

The secondiparous women referred to their husbands, recalling the support they received during the previous birth

My husband was there, he didn’t leave me for a moment, I think I had crushed his hand breaking something [...] he had a crazy strength, it was just, I could not imagine anyone else, I really want him. (FA, Italian).

With XXX [the firstborn] I had only my husband who was there more than twenty hours with the pains [...] my husband, I would like him. (GA, foreign).

Continuing around the supportive environment, Italian women also referred to an environment that respects their needs in term of time

Time, because surely in the hospital they put you in a hurry, instead the birth also takes three days. In the sense, there is no clock ... so I will need time, serenity, calm, support ... Psychological support, that is to say 'I trust you, I know you know what you are doing I leave it to you and I have it done, I entrust myself ... I expect this and I hope to have it. (NF, Italian).

Being able to do things with my time [...] be in the calmest possible environment, where I know that your times are being respected, rather than a department where there are eight other pregnant women at the same time ... because if I respect my times I'm quieter, if I'm more calm in my opinion he is calmer, things are better, while if the anxiety begins to rise. (MR, Italian).

Regarding the welcoming aspect, characteristics of the medical staff emerged from both a relational and professional point of view. From a relational point of view, women hoped for the presence of kind clinicians, while from a professional point of view they referred to the ability in helping women. In particular, for the professional aspect a foreign woman remarked on the protection of the child's health in the immediate postpartum.

Of a very welcoming midwife that gives me, that makes me feel at ease. (FE, Italian).

A midwife, nurse that however knows what she does and that is prepared, is a wrist person, can give you a path to follow, she helps you at this time when you still however you are not the master of what is happening. (VC, Italian).

A team and an assistance a bit cute, kind. (DN, foreign)

Assistance, a good assistance. (DN, foreign).

A good pediatrician who can immediately watch the baby. (KM, foreign).

The sub-theme 'Worries' emerged from the narratives reported by women when they were asked to imagine themselves during childbirth and to speak of any fears that may hinder feeling well. In general, women showed they could imagine themselves during labor, but above they reported desires, such as being able to lose control and being calm, or the hope of a vaginal birth. Trying to imagine themselves facilitated the expression of worries, such as the fear of caesarean section and concerns for the baby's health.

I've the anxiety that I'm there and then maybe I cannot give birth and I've an emergency caesarean. (PV, Italian).

I would be scared that they would make me a caesarean, it is the only fear. (MD, foreign).

Sometimes the fear comes to me: it goes out and it does not breathe or it goes out and it does not cry; that comes to me...that thought there for natural birth...other complications I know there may be, but I never thought about it; I thought yes more to the child. (MM, Italian).

I often think that maybe then there will be complications at the time of delivery, for example he starts to go out but then on half goes out no more, or the cord that runs around the neck, that maybe strangles the baby and he can die like that. Then, I met many other people who gave birth but after a few minutes the baby died because maybe of asphyxiation, from the cordon or something...I think about it every now and then. (DN, foreign).

Foreign women also spoke of the fears of prolonged labour and of pain.

Having to stay in hospital 12-18 hours with this child who does not go out, does not go out, does not go out ... time, time ... I fear it, yes! (EP, foreign).

The pain is not, the pain is not, often it is true that often think 'no, I do a natural birth' with all the pain, as they say, and all, but I prefer the pain for another time maybe when I will be stronger or already prepared. (DN, foreign).

Referring to the medical staff, the concern of being judged for one's behavior during labour also emerged.

Because I understand that it's their job, and also they have their own things, but precisely not to find them in days no, not to find people who judge. (EF, Italian).

I do not want to make bad figures [...] I imagine that if they see that I am able to self-manage maybe they will have more patience with me, they are more patient, a little more kind. (EP, foreign).

2) The main theme ‘Meanings’ is related both to representations of birth as a risk event and to what the birth means in the women’s life from a personal point of view. As illustrated in Figure XIV, three sub-themes emerged for both Italian and foreign women. Regarding sub-theme ‘Birth and risk’, three conceptualizations were identified: risky because unpredictable; risky according to maternal conditions; risky like everything in life.

It can be risky, in the sense that you do not know what can happen to the last in the sense that ... even when you have the baby in your arms you do not know yet, because in theory he is well, in practice however you do not know yet, so. (EF, Italian).

Risky yes, because however, the child maybe turns at the last moment, he could also have laps of the umbilical cord, in my opinion can happen unfortunately very many things. (PS, foreign).

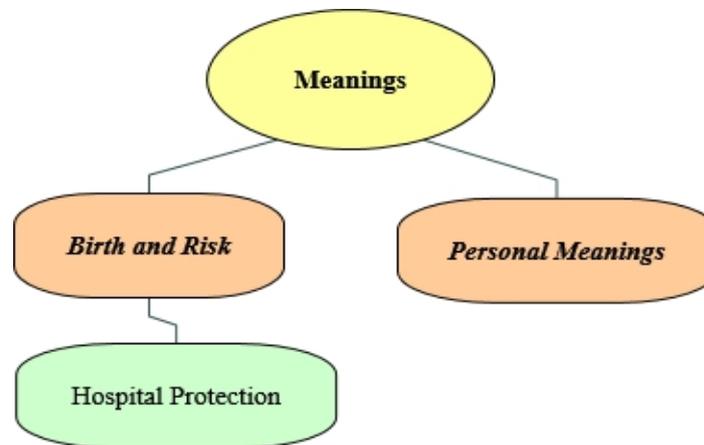


Figure XIV ‘Meanings’ and related subthemes.

In my opinion if you are physically healthy no, then if one has heart problems rather than some illness that now I do not have and therefore I do not know, maybe it can be risky. (PV, Italian).

It also depends on the age because sometimes they say that, when you are younger the risks are a little less, then. (VI, foreign).

How any other thing can be risky, not anything else however, it is logical that however there is a human being that I have to get out of another human being [...] unpredictable factors that can occur there are in everything, in everything there are. Anything can happen even though pregnancy has gone well, despite being the mother in perfect condition, despite being the child in perfect condition, but it is logical that the unexpected can occur in anything. But then if we live, if we live thinking of the unexpected that can happen one does not leave home anymore. (VC, Italian).

Everything on earth has a risk, it is to be accepted. Even walking on the street is dangerous, so everything is risky. (DN, foreign).

The sub-theme 'Hospital protection' reports about the hospital as a place to monitor the progress of the labour, and thus protection against the unexpected and hence reducing fears.

I often read about maternity homes, home births and I think they are wonderful experiences, but I think I would never be able to face them, because then really if all goes well, but if it's not okay I would not be able to live with the remorse of saying 'maybe, if I had not made this romantic choice it would have gone different ' then, it is not necessarily dangerous, but better not joking according to me, that even if you're in the hospital is not said, however, in short, I would not go looking for it. (EF, Italian).

Well yes, there is a risk for both the child and the mother [...] sure, knowing that being in hospital. (VM, Italian).

That I arrive at the hospital, that there is no traffic. I'm more afraid of this thing. Because I know that when you arrive at the hospital and there are professionals nothing happens. (KM, foreign).

Because even in a hospital I also trust a lot, so I know that even if there should be something they can intervene immediately. (PS, foreign).

Only one Italian secondiparous woman spoke about the desire to give birth at home because, she stated, the hospital does not respect the physiology of childbirth.

Then it is also proven that it is no longer risky the home birth with respect the hospital birth, indeed, if you go to see, because I feel more secure at home, I will be much more open and then give birth better and reduce the risks. In fact, the birth of XXX ended up in a caesarean section. So no, I think there are not, there are not risks, if not precisely those like to say statistic, because surely in the hospital will put you in a hurry but the birth requires also three days. (NF, Italian).

Regarding the sub-theme 'Personal meanings', three conceptualizations with a growing reference to vaginal birth were identified: birth as a life change in terms of priority, and as a point of arrival and departure; birth as an extraordinary, magical event; birth as a test of strength / challenge, a moment of personal fulfillment.

A change, because in the end I'm pregnant now, but I don't have a person to take care of; if this afternoon I want to do that, I'll take and go. (PV, Italian).

Giving birth to a woman totally changes your life, because anyway you'll have a child and your life will focus only [...] on this baby. (EP, foreign).

The end of a path and the beginning of another, in the sense that in the end, however, you suffer from this belly, ok that you think but feel it yours. Childbirth in the end is the end of this company that is always with you, so I cannot tell if it's really nice or not if you're fine with this company. On the other hand, then the beauty is the beginning of a creature that finally you see it because so far you can imagine it, but you do not see it, it's not that you can interact, so for me the birth is this. (VM, Italian).

Definitely a change, because it's just something that changes you, that is when they say 'eh, you don't know what it means the birth' it's true, it's okay the fact of pain, okay, but even when you don't feel it anymore in the belly, that is now this is an impressive thing, he moves from morning to night and every now and then I say 'certain', but then with childbirth, then you do not hear him anymore ... sure you find him there, even worse. But it's a strong thing, strong, beautiful both on one side and on the other, but say 'capers!' [exclamation]. (FA, Italian).

A beautiful thing, not the birth itself, however, then after something that I discovered, if all goes well and the baby is well and even the mother, you immediately put the child on and there is an hour, two hours. That I think is a beautiful moment because finally you see him, he is no longer in here, because as long as he is in here you love him because you still love him though. It's one more step, a very nice. (PS, foreign).

The accomplishment of nine months, of something that I do not even know how to define, that inside your body is formed, born, grows, a child ... something extraordinary I have to say ... but I do not know ... and the fact of giving birth him means on the one hand to separate you from this baby that you kept for nine months in the belly, on the other also make him, not autonomous, also because he is not, but separate from you, that needs you but separate from you. (MM, Italian).

But just the fact that you made a baby, right? it is such a thing, that is incredible that you have created another life [...] there are no words to describe this thing here, and the fact of making a new life and to be able to carry it up to that point is, I do not know, crazy, magical, I do not know, magic is like that, it's something I do not know only you can do it, only a woman can do it, I do not know, it's a thing extraordinary for me, that is, I do not know how to describe it, that is, there are no words. (CH, foreign).

Something beautiful, I said it, being able to give life in my opinion. (VI, foreign).

A moment of personal fulfillment, because however now it is not to be feminist or the champion of women, however, however, give life to a human being, you split, you give life to another human being, it's a beautiful thing that only we women can do and it takes a certain strength. (VC, Italian).

Certainly is a good challenge and certainly, as one may have the support of the midwife, the partner, however, it is something that you have to do individually so I think it's also a challenge on a personal level in the sense of ... that I have to do it just by myself, because ok they can help me but if I do not help myself, I don't go anywhere. (EF, Italian).

At that moment the most difficult thing for a woman because you know that you have to bring a creature to the world and then you feel anxious to know that, that is, to know that maybe there is something that can go wrong or maybe you're not prepared to ... that is, at that moment to bring her to light in the sense that you'll be thinking, you'll be afraid at least I think. (MD, foreign).

A woman who conceived through medically assisted procreation, in particular referred to all three conceptualizations mentioned above, however adding how natural birth can repair the feeling of failure derived from a non-natural conception.

As I am, it's a moment of realization, I mean, I do not know, I do not imagine my life without a birth [...] it is the crowning of a desire that I think it is, eh well it's the climax moment [...] a moment of transition, from the moment you are you, your companion, in the moments when this life that you brought with you before there was not now there is[...] in my opinion the cesarean does not perform the same functions, not complete does not complete you as you complete a natural birth, so I hope to have a natural birth [...] I feel that this way of becoming pregnant is a failure, despite being happy I feel this is a failure. So from now on be able to maintain the maximum naturalness possible. (MR, Italian).

5. Discussion

The present research aimed to explore, through a qualitative methodology, pregnant women's perspectives around psychological health in Italy, in order to extend literature on perinatal well-being from a psychological point of view. The approach was intercultural in order to examine aspects that migration might entail.

With regard to the discovery of pregnancy, women talked of a variety of emotional states, ranging from the joy of a realized desire to the ambivalence and anger of an unwanted pregnancy, in contrast to the culture that romanticizes pregnancy as a glamorous stage for women, denying the presence of fears and conflicting feelings (Bondas & Eriksson, 2001; Marinopoulos, 2008; Peñacoba-Puente, Monge, Abellán, & Morales, 2011). In particular, it emerged that to be pregnant entails, for women, an overall experience of transformation: in their body, emotions, identity, life conditions and projects, similarly to literature reporting about early pregnancy as a life opening both in terms of life affirming and suffering (Carin, Lundgren, & Bergbom, 2011). That is the coexistence of emotions and feelings of opposite polarity that justifies the adoption of a dual approach (i.e. positive and negative aspects of psychological health) to evaluate the psychological health of women during pregnancy (Allan et al., 2013; Hoffenaar, van Balen, & Hermanns, 2010). Focusing on the women's concerns findings emerged that, without circumscribing the analysis to specific aspects, women are exposed to a wide range of worries, ranging from the work/study sphere to those related to childcare after childbirth (Jomeen & Martin, 2005). Concerns emerged regarding the health of the child to be born, which is the most recurring concern reported by quantitative studies (Green, Kafetsios, Statham, & Snowdon, 2003; Öhman, Grunewald, & Waldenström, 2003; Peñacoba-Puente, Monge, & Morales, 2011; Petersen, Paulitsch, Guethlin, Gensichen, & Jahn, 2009). It is noteworthy that the women of the present study also reported the absence from concerns about the fetus' health as being among the important factors to feel good during pregnancy.

As regards women's conceptualization of well-being and ill-being, from the analysis of the interviews it arose that well-being is described as both physical and psychological, and that both physical and psychological are described in terms of the presence of positive aspects and/or the absence of negative aspects. While, regarding ill-being more

descriptions related to the physical aspects emerged, and only in terms of presence of negative aspects. Overall, it is possible to deduce that, for pregnant women, being-well is not merely the absence of disease, and that well-being involves both physical and psychological dimensions (Åsbring, 2012; World Health Organization, 1948). Furthermore, the analysis of relationships between attributes showed that psychological well-being may or may not be influenced by physical well-being, and that it is possible to be well psychologically even in the presence of concerns. The first relational type seems to refer again to well-being in terms of dimensions (i.e. physical and psychological), while the second, in line with the concept of positive and negative experience (Diener et al., 2011), seems to refer to the two psychological continua of health (Bassi et al., 2017) showing the usefulness of measuring both the ups and downs of pregnancy (Dipietro, Ghera, Costigan, & Hawkins, 2004; Dipietro, Christensen, & Costigan, 2008). Finally, comparing well-being and ill-being, the former was described more in depth, making it possible to argue that well-being entails a greater degree of subjectivity than ill-being, similarly to the description of health as a more subjective factor than disease (De Piccoli, 2014).

From what has been reported so far, a close psyche-soma relationship emerged (Åsbring, 2012). An interweaving of physical and psychological, in terms of well-being, ill-being and transformations, which justifies the adoption of an interdisciplinary perspective in the context of prenatal care (Kwee & McBride, 2015). Women spoke about it also referring to the aspects useful in order to be well, since the participants reported the need to be physically active also to feel good psychologically. As regards, the available research evidence suggests that during pregnancy inactivity is associated with worse mood (Costa, Rippen, Dritsa & Ring, 2003; Downs, DiNallo, & Kirner, 2008; Poudevigne & O'Connor, 2006). Speaking of self-satisfaction, women referred to the dissatisfaction resulting from bodily changes. In this regard, the literature reports that women are more satisfied with

changes in the body during pregnancy than in postpartum (Clark, Skouteris, Wertheim, Paxton, & Milgrom, 2009), but the evaluation of body image concerns during pregnancy allows us to identify women at risk of developing disaffection with themselves in the postpartum (Hodgkinson, Smith, & Wittkowski, 2014).

In the representations of well-being and ill-being discussed above the social dimension did not emerge, though it was mentioned as an attribute of well-being in terms of satisfaction (Diener et al., 2009). Women reported that a gratifying relationship with their partner and their parents is important for their life satisfaction. About the relationship with the partner, it also emerged that the partner's support is important to feeling well (Stapleton, et al., 2012). Besides this, woman talked of the need to perceive their partner as a responsible and reliable person and the need to be heard and understood, similarly to previous research reporting the ideal partner during pregnancy as present, accessible, available and understanding (Alio, Lewis, Scarborough, Harris, & Fiscella, 2013). Focusing on couple adjustment, women also talked about the importance of perceiving that their partner is happy and feels well.

Still with regard to the social dimension, when the participants talked about sharing the experience of pregnancy, the need emerged to feel themselves surrounded by people who participate emotionally and are available to listen in order to implement sharing behavior (Bennet et al., 2007; Lu, Chauhan, & Campbell, 2015). The objectives of sharing reported by women refer, in general, to the need for emotional support and specifically to the need for information to support them in terms of exchanging experience on psychological and physiological aspects of pregnancy with other women, both pregnant or mothers, (Hodnett, & Fredericks, 2003; McLeish & Redshaw, 2017). In this regard, in particular it emerged that this type of support is also sought within the contexts of the birth preparation courses, which are also attended to obtain medical information about labour and to familiarize themselves with the environment in which they will give birth.

About the factors that can promote a feeling of well-being during childbirth, other various aspects related to the concept of control in childbirth emerged (Meyer, 2013). Women referred to the need for emotional support from their partner and of kind and competent clinicians, in line with Karlström, Nystedt and Hildingsson (2015) who reported as important for a positive birth experience both the woman's sense of trust and support from their partner and the feeling of safety promoted by a supportive environment. Related to this, women revealed the fear of being judged for their behavior during labour, and the risk of being treated badly as a consequence. A fear of judgement also recurs in a similar way about breastfeeding (Tomori, Palmquist, & Dowling, 2016).

In order to achieve well-being during perinatal period (i.e. pregnancy and postpartum) women also talked about personal characteristics such as determination, feeling strong and effective, positive thinking, characteristics similar to the constructs of self-efficacy, empowerment and optimism (e.g. Fahey & Shenassa 2013; Haslam, Pakenham, & Smith, 2006; Lee-Rife, 2010; Lobel, DeVincent, Kaminer, & Meyer, 2000; Reis & Alligood, 2014). Linked to determination, the achievement of one's goals is widely reported by the research participants as affecting self-satisfaction. Women also reported obtaining satisfaction from objectives in different life contexts, from perceiving their commitment to achieve goals, and the ability to modify their objectives based on possible changes in life project. These aspects, and with them, the gratification that women said they derived from family relationships, seems to refer to the dimensions of the mental health as flourishing construct (Keyes, 2007), recently described by Diener and colleagues (2010) as psychological well-being in terms of aspects of human functioning ranging from positive relationships to feelings of competence and of having meaning and purpose in life.

Even the birth, which was perceived as a turning point and an extraordinary event, was also seen as a moment of personal fulfillment and a challenge, therefore an event that can

be related to eudemonic well-being and with the personal characteristics of strength and determination mentioned above. The literature reports that birth satisfaction enhances a mother's capacity to develop a sense of maternal identity, is a potential factor influencing the development of the mother-child relationship, and is important in preventing postpartum psychological disease (Cipolletta, 2016; Howarth, Swain, & Treharne, 2011; Hollins Martin & Fleming, 2011). The present findings associate delivery with the positive aspects of perinatal psychological health.

With respect to those aspects that the migration process can introduce in the experience of pregnancy, it emerged in particular the relevance for foreign women of the distance from their family of origin. Foreign women referred to this both when talking about the concerns related to the absence of practical and emotional support in the postpartum (McLeish & Redshaw, 2017) and when they reported difficulties in sharing the pregnancy experience. In particular, foreign participants reported a feeling of loneliness (Wittkowski, Patel and Fox, 2017) that was also found in the narratives expressing a strong desire to share with their mother, and to have the mother close during labour and delivery. Literature reports this feeling of loneliness as frequently present in women suffering from postpartum depression (Bennett et al., 2007; Renzaho & Oldroyd, 2014) and with the perception of low social support, especially from their partners (Furber, Garrod, Maloney, Lovell, & McGowan, 2009).

Regarding support during pregnancy, analyzing the statements on sharing experience, both for Italian and foreign women a wide range of situations emerged, some women reported a rich network of family members while others reported a lack of support networks. There were no differences between the two groups of participants on this aspect, except for the feeling of loneliness about postpartum. Looking in depth, it is possible to talk of foreign women's feelings of distance from the culture of the country of origin, seen also in foreign women's desire to eat the food of their country. Overall, these

aspects seem to refer to the concept of physical and cultural separation from support systems (Benza & Liamputtong, 2014; Moro et al., 2010; O'Mahony & Donnelly, 2010). From the comparison between Italian and foreign women, differences emerged regarding the involvement of the partner. In this regard, Italian women reported as an emotionally charged event the moment when their partner perceived for the first time the presence of the child. Instead, foreign women did not refer to this aspect, but reported as exciting communicating the pregnancy to their parents. Differences with respect to the partner's involvement also emerged from the remarks related to the sharing of experience. Italian women, compared to foreigners, referred a greater sharing with their partner than with their mother. Furthermore, talking about couple adaptation, Italian women reported how important it is for them that their partner is emotionally involved in the experience of becoming a parent; and women at the second pregnancy talked about a relationship based on sharing, exchange and gratitude. These findings are similar to those reported by Alio and colleagues (2013) which found women emphasizing a sense of togetherness during pregnancy. As regards, research on psychological disease stresses that it is necessary to support greater fathers' involvement during pregnancy and postpartum, including literature of migrant women (Pilkington, Whelan, & Milne, 2015; Renzaho & Oldroyd, 2014).

Further differences with respect to the two groups of participants appears in the references to the economic difficulties that emerged only in the statements of foreign women (Wittkowski et al., 2017). While, only from the interviews of Italian women emerged psychological references to concerns about health and childcare, and fears for the management of possible intrusions in the care of the new born. These last two aspects, like the partner involvement mentioned above, require further investigations because of the socio-cultural aspects linked to Italians or foreigners which could play a role, even if

the linguistic difficulties (Hennegan et al., 2015) can influence the remarks about the transition to motherhood, because it is a subject rich in emotional meanings.

6. Conclusion

Only a few studies have investigated through a qualitative approach the psychological side of the pregnant women's experience. Specifically, to our knowledge, no previous study was designed to explore, through an intercultural perspective, the overall emotional experience of pregnancy or the positive aspects of psychological health during pregnancy. Overall, this research addresses the pregnant women's representations of well-being and ill-being, and the factors that can help women to be and feel well during pregnancy, birth and postpartum. The importance of bio-psycho-social factors in understanding of women's psychological health during pregnancy emerged (Alderdice et al., 2013; Maurya, 2009).

During pregnancy the socio-cultural context is viewed by a woman according to her values, attitude and beliefs, and the context itself affects transition to motherhood in terms of woman's point of view and negotiation (Allan et al., 2013; Darvil, Skirton, & Farrand, 2010). The adoption of an intercultural perspective revealed that migration can influence women's experience of pregnancy with the emergence of a feeling of loneliness. At the same time, the analysis of the interviews showed far more similarities between Italian and foreign women than differences (Wittkowski et al., 2017). Moreover, foreign women reported both on the difficulties and on the positive aspects of migration, such as the opportunity to receive better maternity care in comparison to their country of origin (Higginbottom et al., 2013; Moro et al., 2010, Pérez Ramírez, García-García, & Peralta-Ramírez, 2013). A double perspective seems necessary to analyze the psychological experience of foreign women during the perinatal period: to consider the complexity of

becoming a mother situating this physical and psychological process within the migratory frame, but without overlapping.

The research presents some limitations. Alongside the subjectivity inherent in qualitative analysis, the relatively small number of foreign women involved should be borne in mind, as this may not have favored intercultural comparison. So, for example, major or minor differences introduced by migration might be detected with a larger number of participants. Furthermore, although the present research aimed to investigate the impact of migration in general, the involvement of different, specific and numerically congruous ethnic groups might have helped to clarify some socio-cultural aspects. Future developments of the present work could develop in this direction. Moreover, it might be useful to adopt cultural mediators in order to not exclude women who do not speak Italian and to examine the role of linguistic obstacles as bias. Regarding the objective of the analysis, further research could deepen our understanding of the expectations that women have about postnatal psychological health, what representations they have about it and what they think would help them to feel good, as well as the mother's representations of well-being and ill-being during postpartum.

Overall, the present work provides valuable information to advance research on perinatal well-being, suggesting the usefulness of considering aspects linked to both hedonic and eudemonic well-being. Furthermore, this research suggests new avenues in developing perinatal psycho-social care to promote pregnant women's strengths, for example moments of reflection on the link between the physical and the psychic, the importance of setting and pursuing goals and one's personal skills. It is plausible that also the professional training of the perinatal care clinicians could benefit from the present findings.

CHAPTER SIX

Supporting the *Vaginal Birth After Caesarean* Choice Complexity: Relational and Psychological Factors of Delivery in Italian Women

1. Introduction to Study-VI. Why focus on *Vaginal Birth After Caesarean* (VBAC)?

As argued in previous study, the delivery event is a moment full of expectations and meanings with important psychological implications. In this context, vaginal delivery is considered a facilitating factor. Nevertheless, and despite progress in medical-obstetric knowledge and safety in the field of maternity care, the international rates of caesarean section are steadily increasing in almost all middle- and high-income countries.

To explore this phenomenon, studies have focused on the low diffusion of the practice of *Vaginal Birth After Caesarean* (VBAC). However, a few studies have investigated the psychological factors that lead women to choose and to enhance the likelihood of success with a VBAC. Moreover, there is a need for a more in depth analysis of the socio-cultural factors related to this choice. The aim of the present study was to explore through a qualitative approach the psycho-social factors implicated in this choice in Italy, where this phenomenon has not yet been sufficiently investigated.

2. Study-VI: background

Within the life of a woman, childbirth marks a crucial milestone (Howart, Swain, & Treharne, 2011) that deeply affects her emotional, relationship and social domains

(Kwee & McBride, 2016; Salmela-Aro et al., 2012), particularly when maternity becomes a condition difficult to achieve due to health reasons (Rania & Migliorini, 2015). The process of giving birth emerges as an occasion for the woman to express her psychological background, and lays the foundation of what will be her future experience (Cipolletta, 2016). In particular, the opportunity to give birth to a child naturally can empower the woman in becoming a mother (Salmela-Aro et al., 2012; Leap, Sandall, Buckland, & Huber, 2010). In contrast, a caesarean section seems to hinder this process due to the lack of physical experience of a natural delivery (Bayes, Fenwick, & Hauck, 2012; Bydlowsky, 2000; Di Matteo et al., 1996). Literature actually reports that women who undergo a caesarean section, compared to women who deliver vaginally, can have more negative perceptions of their birth experience. They report feelings of a disconnection from their infants (Herishanu-Gilutz, Shahar, Schattner, Kofman, & Holcberg, 2009), exhibit poorer parenting behaviours, and are at higher risk for postpartum mood disturbance (Lobel & DeLuca, 2007).

2.1. Increasing in caesarean section rates: the poor diffusion of Vaginal Birth After Caesarean (VBAC)

In 2015, the World Health Organization (WHO), replacing the statement suggesting that rates higher than 10–15% were not justifiable (Betran, Torloni, Zhang, & Gulmezoglu, 2016; World Health Organization, 1985), reported that caesarean section rates higher than 10% are not associated with reductions in maternal and newborn mortality rates, and caesarean section should ideally only be undertaken when medically necessary (World Health Organization, 2015). Nevertheless, and despite the considerable improving of medical knowledge in the obstetrical field and the current safety in maternity care (Nilsson & Lungren, 2007) the international rates of caesarean section are steadily increasing in almost all middle- and high-income

countries (Betrán, Moller, Zhang, Gülmezoglu, & Torloni, 2016; Boatman et al., 2018; do Carmo Leal et al., 2012; Gebremedhin, 2014; Torloni et al., 2013). Latest estimates indicate 40.5% in Latin America, 32.3% in Northern America and Australia, and 25% in Europe (Betrán et al., 2016), where wide differences emerged between countries. In particular, the lowest rates of caesarean section were reported in Iceland (14.8%) and Finland (16.8%) and the highest in Italy (38%) and in Cipro (52.2%), with the latest two reporting also the highest rates of caesarean section undertaken or planned before labour (38.8% in Cyprus and 24.9% in Italy) (Macfarlane et al., 2016). This phenomenon and its outcomes have therefore been investigated to better understand and address the issue (Bétran et al., 2015; Bétran, Zhang, Torloni, & Gülmezoglu, 2016; Frost, Shaw, Montgomery, & Murphy, 2009). Several studies focused on the fear of childbirth, particularly the fear of labour pain (Fenwick, Staff, Gamble, Creddy, & Bayes, 2010). The emotions associated with giving birth can be seen as important and even indispensable elements to face the delivery such as the role changes required by the maternity transition (Bewley & Cockburn, 2002; Bydlowsky, 1991; Fisher, Hauck, & Fenwick, 2006; McGrath, 2012; Stern, 1995; Stern, Brushweiler-Stern, & Freeland, 1998). Hence, during pregnancy and delivery psychological factors play important roles (Cole-Lewis et al., 2014; Howarth, Swain, & Treharne, 2010; Tognoli, 2014; Morano et al., 2018) and the fear of labour pain has to be considered a social and personal dimension that is behind the women's wish for a planned caesarean section (Faisal, Matinnia, Hejar, & Khodakarami, 2014; Rahnama, Mohammadi, & Montazeri, 2016; Sahlin, Carlander-Klint, Hildingsson, & Wiklund, 2013). In order to explore this matter, researchers have investigated the factors involved in the choice of delivery method (e.g., Kingdon et al., 2009; Klein, 2012; Watkins & Weeks, 2009; Weaver, Statham, & Richards, 2007) and, within this research field, the poor diffusion of VBAC information and

practice has gradually emerged as another possible explanation of the high rates of caesarean section (McGrath & Ray-Barruel, 2009).

The rates of vaginal birth after caesarean are different in Europe and worldwide (Macfarlane et al., 2016). For example, the rate is approximately 29–36% in Italy, Germany and Ireland, 45–55% in the Netherlands, Finland and Sweden, approximately 10% in the USA, and 19% in Australia (Baxter & Davies, 2010; EURO-PERISTAT, 2008; Lundgren, Begley, Gross, & Bondas, 2012). Based on these data, studies foremost highlighted the role of the diffusion of the misrepresentations originates from the common belief that after a caesarean a woman should continue the same method of delivery, and that it is not possible for a following childbirth to be performed vaginally (Godden, Hauck, Hardwick, & Bayes, 2012). As regards, Lundgren and colleagues (2012) found that in general women are in favour of VBAC, because various positive aspects of the vaginal delivery are implicated, such as faster recovery, better infant health and mother-infant bond, and easier breastfeeding. Nevertheless, the VBAC choice appears as a strong personal responsibility for women, because clinicians present VBAC as a dangerous choice and there is limited available information. Godden and colleagues (2012) stated some points that can enhance the likelihood of success with vaginal birth after caesarean: meet others who experienced the same mode of delivery; ensure that all maternity caregivers appreciate and are supportive of women's needs to pursue a VBAC and their involvement in deciding on caesarean section; provide antenatal classes tailored to women who have had a previous caesarean section. Studies have underlined that being part of the decision-making process can increase trust in clinicians and give a feeling of activation and sense of control, and that the values and social context of pregnant women during the prenatal support process should be addressed to help her in the decision making process (Dugas et al., 2012; Emmett, Shaw, Montgomery, &

Murphy, 2006; Moffat et al., 2007; Rees, Shaw, Bennert, Emmett, & Montgomery, 2009; van den Berg et al., 2008).

Previous studies examining factors implicated in VBAC choice, as well as highlighting the importance of the decision-making process, have reported about the women's psychological needs that can influence the women's views on VBAC and its realization. However, there is a need for more studies in countries with both high and low VBAC rates, to explore more deeply also the socio-cultural factors related to the choice of this health practice (Nilsson, van Limbeek, Vehvilainen-Julkunen, & Lundgren, 2017).

2.2. Aims

The overall aim of the present research was to enrich literature, exploring the psychosocial factors (psychological, relational and cultural) that may lead a woman to choose and achieve a VBAC in Italy.

The work was realized within the context of the OptiBIRTH project (2012), an international European research to address the increase in caesarean section rates and focuses on the practice of routine caesarean after a caesarean section. Specifically, the present study consists in a reinterpretation of the Italian data collection.

3. Methods

Because of the lack of information on VBAC in Italy, the researchers decided to conduct a descriptive exploratory research using grounded theory methodology (see Study-V). The study employed the qualitative research method of the focus group, with the aim to access women's experiences and expectations regarding a possible VBAC. This method was adopted because it enables the research participants to share ideas, experiences and feelings (Wilkinson, 2015). The interactions among

participants in focus group discussions provided an opportunity to talk about perceptions induced by the psycho-social beliefs and practices related to VBAC in Italy.

3.1. *Participants and setting*

Eligible participants were Italian pregnant women who had had at least one previous caesarean section for medical indications and who were considered by the research team to have no mental health contraindications, that is absence of psychopathology, and no medical indications for caesarean section. Participants were recruited from a hospital context of low-medium level. Eligible women were selected by operators in pre-natal ambulatory care and trainings or their gynaecologists in a day-hospital for caesarean section, and invited to participate through a telephone call, during which the aims and the methodology of the study were described. This initial contact was followed up by a phone call to verify acceptance and eventually arrange the date of the data collection. The few declines to participate were motivated by lack of time and family problems.

Finally, twenty Italian women aged between 25 and 40 years old ($M = 34$, $SD = 4.46$), all with high-school diploma and equally distributed between workers and non-workers, participated in the project. Fourteen women were pregnant for the second time, and six women had already had a VBAC. Overall, the participants desired to have a vaginal delivery with their second pregnancy but wanted to maximize the likelihood of the desired outcome (Morgan & Krueger, 1998; Stewart & Shamdasani, 1990). Stimulating new ideas and creative concepts was considered important (Brown, 1999; Schutt, 2004).

Data were collected at the hospital within the departments of obstetrics to increase participation, create a positive climate and put the subject at ease; the same moderator and observer ran the focus-groups. Participation in the study was voluntary, and anonymity and confidentiality was assured in compliance with the Italian Law on Privacy n.196/2003 and the Research Ethical Code of the Italian Association of Psychology. The informed consent protocol was provided to the subjects during the presentation of the research aims and before the participants started the focus group. The ethics committee of the hospital approved the study.

3.2. *Data collection and analysis*

A total of three focus groups were conducted by a gynaecologist researcher using a semi-structured question guide developed based on a review of the literature and the previous professional experience of the research group. The guide was focused on exploring the psycho-social aspects of the experiences and expectations of the delivery process, and of the relevant factors to choose and achieve a VBAC. Each focus group involved 6–7 participants and lasted approximately 2 hours.

Each focus group was audiotaped and transcribed. In order to protect participants' anonymity, a new name was assigned to each woman, the initial letter of which was used in reporting the quotations in the section of results.

A thematic analysis of the transcripts was conducted using the *NVivo-9* software, according to the multi-step process illustrated in Study-V. Since that during collection the data were quickly analysed and no new information emerged after completing three focus groups, data saturation was achieved with 20 participants.

4. Findings

Three main analytical and no predetermined themes emerged from the thematic analysis process: 1) 'Relevant aspects during the delivery process'; 2) 'Individual and social obstacles to VBAC choice by woman'; 3) 'Woman's supportive needs for VBAC realization'. As follows, these three main themes will serve as key sub-headings.

- Relevant aspects during the delivery process

The analysis of the focus group discussions revealed the relevant aspects related to the actors in the delivery process: the woman, the clinicians and the woman's partner. Talking about the wish of VBAC, women reported the need to play an active role and to perceive themselves as the authors of the event. In particular, women expressed the need to be the protagonist of the delivery event regarding their first experience of caesarean section:

At least they let you take part in the moment of birth but it isn't the same, you are not the author of childbirth. (M.)

Being awake was important, I felt that not giving birth vaginally was a defeat, I didn't want to miss the moment of the delivery. (P.)

Participants identified one aspect related to clinicians, namely to meet them during pregnancy in order to establish a relationship useful during delivery:

I met the gynaecologist at the moment of delivery, while I had met the obstetrician before. The relationship was important to deal with the situation [the delivery itself]. (L.)

The last aspect that emerged about delivery event is related to the partner. His presence and practical support was reported as very important for women in order to face VBAC, considering the physical and psychological involvement of the woman herself:

For me it was important my husband, who was not having contractions, could talk to people. He was not in a condition with psychological and physical fatigue, in which the pain and the worry destroy you. (A.)

- Individual and social obstacles to VBAC choice by woman

Participants identified possible barriers to VBAC choice in psychological factors of both individual and social origin. The most closely personal aspect refers to the anxiety related to childbirth due to the ignoring of the precise date of delivery that often leads women not to choose VBAC:

You need a lot of patience to get to the end of the pregnancy, often having a caesarean section is tempting, because you have no more patience to wait. (G.)

Another factor hindering the choice of VBAC by woman, halfway between the individual and the social origin, refers to the memory of the previous labour experiences and the fear to find again an inadequate health facility:

I asked for a catheter [epidural anaesthesia] while the person I asked wasn't capable of the procedure in labour; I was told to be quiet because I was disturbing the women who were ready to give birth. There was indifference in the crucial hours when I needed to be guided and a continuous hammering when I was already ready to push. (M.)

Finally, among the factors of closer social origin, women warned that the social belief that after a caesarean, always caesarean, exists and that many people don't even know VBAC is possible, even though these are people with a high level of education. In many cases, this lack of knowledge creates a conflict with family members, who traditionally do not accept the choice of VBAC:

My parents are terrified, they have tried everything to convince me, saying that I'm crazy. This also happens because I come from a family where all women have had caesarean section, even my mother in law; up to now, nobody has succeeded in giving birth naturally, also because of this culture of 'after a caesarean section, always a caesarean section'. (S.)

- Woman's supportive needs for VBAC realization

Participants reported several factors which can affect the VBAC realization, even if the woman at first made the choice of VBAC. These factors are articulated in three domains of needs: receiving information by clinicians; motivational and emotional support to the woman's choice; desirable characteristics in health practices (see Figure I).

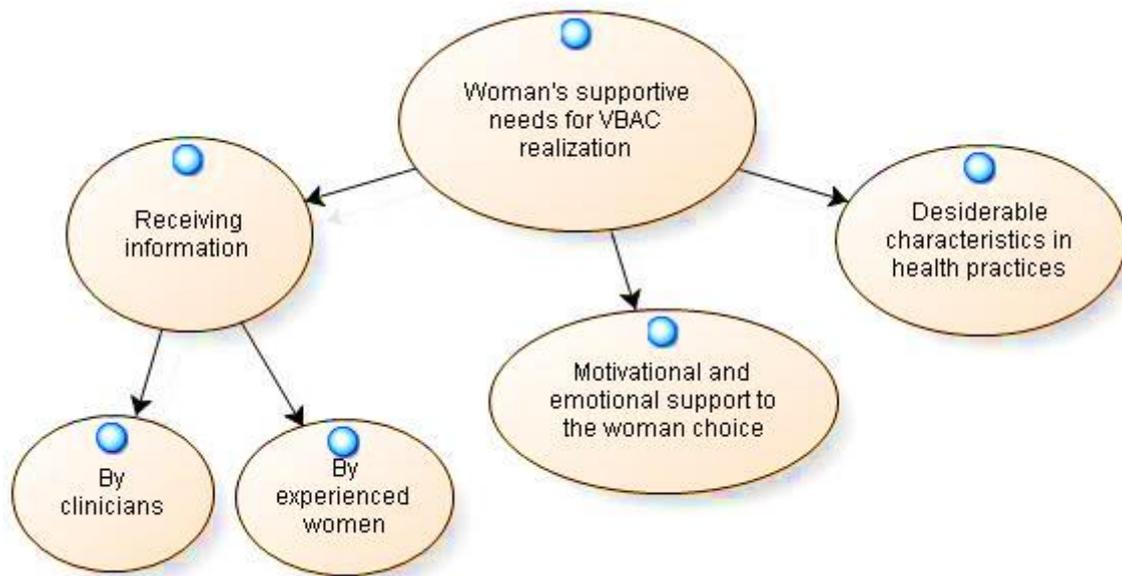


Figure I Woman's supportive needs for VBAC realization: conceptual model configured by software NVivo 9

Women stated that being well informed by clinicians is important for making a more conscious and safer choice. In particular, three interrelated aspects emerged. One is simply related to receiving the information on VBAC as a realistic option to choose, because it must be clear that there is an alternative to caesarean after caesarean. The other two are more specifically pertaining to caesarean section. One refers to obtaining information about general indications for caesarean section, and comparing between the risks associated with caesarean section and those associated to VBAC.

The other involves obtaining information tailored to women's needs, such as knowing if the medical reasons for the previous caesarean still subsist or not:

Also know what the mechanisms are, and the situations in which it is really necessary, because there are situations where it is not really necessary. (T.)

Are there any risks in a VBAC? Yes, like everything in life. If we list all the risks of a caesarean section and we compare them to the risk of uterine rupture, probably we have got to put things in the right perspective. (L.)

That the reasons, such as anatomical reasons, absolute grounds, for which you did the previous caesarean aren't there anymore (S.)

Furthermore, women expressed the need to be informed about the experience of VBAC to be better prepared for the event, receiving information about the trial of labour, and suggesting meeting with women who had experienced VBAC:

It is true, it is painful, but if you are accompanied and prepared, trained for the pain, you can make it. It is something natural. There is pain but if it is modulated, accepted, then it gets more bearable, especially if somebody is informed. (P.)

I must say that I have felt a lot of solitude on the path, not finding other people who have had this experience, not knowing the expectations of this pregnancy (C.)

Maybe, after a woman has achieved VBAC, she can convince you (I.)

Among other needs relevant to achieving a VBAC, women mentioned personal motivational aspects, stating that a woman's strong determination and awareness are necessary to be prepared for VBAC. However, participants expressed deeply the importance of being supported in their choice by the partner, and in particular to receiving the agreement of the gynaecologist to pursue a choice that is not common in Italy:

It is the more difficult to find a gynaecologist that agrees. (M.)

When you get to the hospital, which is a very delicate moment, if you find a gynaecologist who will talk about enormous risks and say that a caesarean section would be better, you won't be a heroine and leave your child's life at risk. (L.)

Women also reported about desirable characteristics in health practices in order to choose VBAC and for a successful realization, underlining the need to improve the level of collaboration among clinicians. In particular, regarding the choice, women explained the importance of having a reassuring competent system for VBAC, due to the awareness that the VBAC is a particular case of vaginal delivery:

Knowing that in the hospitals where VBAC is offered, there is an obstetrical staff ready to handle this sort of complication would be reassuring. Even obstetricians must be prepared to handle this kind of delivery in a different way compared to a normal vaginal delivery. (A.)

5. Discussion

The present study, within the context of the OptiBIRTH project (2012), aimed to explore through a qualitative approach the psycho-social factors that may lead a woman to choose and achieve a VBAC in Italy, in order to make a contribution to understanding the reasons that underlie the low rates in VBAC. This research, analysing the socio-cultural factors related to the choice of this health practice, extended literature on the women's psychological needs able to influence the women's views on VBAC and, consequently, its choice and realization (Nilsson et al., 2017). The main findings from this study suggest the following factors in improving VBAC rates: receiving information about VBAC as a possible alternative to caesarean section for all involved; receiving information about general indications for caesarean section, and its risks beside those of VBAC; receiving information during pregnancy tailored to the woman's need of another caesarean section; receiving information about VBAC from experienced women; receiving the support but overall the agreement from the gynaecologist; to improve reassuring competent health facilities for VBAC.

Overall, the analysis of the focus group discussions confirmed findings documented by other studies about women's needs of receiving more information. With regards

to this, and according to Lundgren and colleagues (2012), in the present study women reported the choice of VBAC as a personal responsibility, stressing that there is a strong need for information, starting with VBAC as a possibility, an alternative to caesarean after caesarean for all involved. Similarly to the study of Watkins and Weeks (2009) which researched women's desire to receive more information on the risks and benefits of caesarean section, the women stated that there is the need to receive more information related to general indications for a caesarean section, such as a better explication of its risks beside those of VBAC, useful to guide the choice in favour of VBAC. Furthermore, in focus group discussions it emerged that in Italy women are usually well informed of the negative possible consequences of VBAC, whereas too little information is usually provided about caesarean section risks and negative consequences. As stated by Klein (2012), the women's experiences referred to the existence of a medical discourse that tends to stress the risks of vaginal delivery and, conversely, the benefits of caesarean after caesarean. A social discourse confirmed this, in a convergent manner, when woman talked about the social belief that after a caesarean is always necessary a caesarean (McGrath & Ray-Barruel, 2009; Weaver et al., 2007).

In accord with other studies (Godden et al., 2012; Dahlen & Homer, 2019) besides the need of information from clinicians, the women reported the need to be informed from women with experiences of VBAC. The women also asked for realistic information about the VBAC procedure in order to be better prepared for the event, and for information tailored to the woman's needs such as whether the medical reasons that led to the implementation of the previous caesarean section are absent or not, and therefore if the VBAC is actually a viable option (N2017). As mentioned by other researchers (Kingdom et al., 2009; Moffat et al., 2007), it appears that

women request clinicians to be able to individually evaluate the opportunity of a VBAC, to allow the possibility of VBAC and prevent inappropriate VBACs.

Focusing on the delivery process, women reported their passivity experiences regarding caesarean section, and conversely their willingness to play an active role, so as to experience control. Likewise other studies realized in Italy, it emerged a preference for vaginal delivery (Donati, Gandolfo, Andreozzi, 2003; Torloni et al., 2013; Tranquilli & Giannubilo, 2004), demonstrating the personal value that a vaginal delivery can have for a woman (Lundgren et al., 2012). This aspect is connected to a woman's determination as an influent factor in decision-making process to realize VBAC, as well as the relational aspects with clinicians, and the gynaecologist's agreement and support, underlining the influence of support during delivery for the woman's experiences (Hodnett, Gagtes, Hofmeyr, & Sakala, 2007). Moreover, the previous negative birth experiences which emerged in focus group discussions as an obstacle to VBAC choice, should be taken into consideration. As argued by Nilsson and colleagues (2017), to give the woman the opportunity to recount her childbirth experiences would allow the woman herself to overcome her fears, her anxieties, the main factors able to hinder VBAC. As literature reported, psycho-education group interventions show positive effects in women with fear of childbirth, in terms of increasing childbirth confidence, satisfactory delivery experiences and decreasing caesarean sections (Fenwick et al., 2015; Rouhe et al., 2013; Toohill et al., 2014).

This study has a few limitations. As it utilized a convenience sample and qualitative method, the generalization of study findings is limited. As regards, however, qualitative research applies to a research question that does not consider individuals as part of a sample whose answers can be generalized to a population (Lincoln & Guba, 1985). Furthermore, the main goal of this study was to provide an

understanding of factors implicated in VBAC choice through a contextualized exploration. In terms of possible future developments of this work, a more in depth exploration of a woman's fear of pain, as a psycho-social dimension associated to vaginal delivery could be useful to understand its possible influence in the low rates of VBAC, and more in general in the increase of caesarean section rate in Italy.

6. Conclusion

Only a few studies have investigated the psychological and socio-cultural factors that can lead women to choose and achieve VBAC. This research addresses the psycho-social factors associated with the mode of delivery in women who have had a previous caesarean for medical indications and want to have a vaginal birth. It emerges that VBAC is perceived as a possibility if women: a) have gathered more information about the possibility of having a VBAC, even through the sharing of women's experiences who gave birth with VBAC; b) feel their choice is supported by clinicians, family members and treated in facilities fully equipped for the event.

The results of this work underline that there are two main psycho-social domains to consider. The first concerns the inner aspects of the woman, including her determination and her fears; the second factor involves knowledge and relationships, both with clinicians and women who have experienced VBAC. These findings indicate two possible types of coordinated interventions: psycho-educational groups within the health facility, in which women can meet psychologists, obstetricians and gynaecologists prepared on the issue of VBAC, and women who have undergone VBAC, to whom individual consultations should be provided if requested. This work suggests possible practical implications for clinicians and procedures regarding this type of delivery, to enhance programs that can empower women and inform clinicians.

CONCLUSIONS

The present thesis focused on the analysis of psycho-social and cultural factors that affect women's psychological health during the perinatal period. The drafting of these conclusions is an opportunity to summarize the results obtained, envisioning future developments and reflecting on the overall work done.

Starting from a summary of the 'take-home' points of the studies, Study-I provided a systematic analysis of the research that explored women's psychological health during the perinatal period using at least one standardized measure of well-being developed from the positive psychology perspective. The findings of the scoping review highlighted that in the perinatal area the research on the positive aspects of the woman's psychological well-being it is recently increasing. Overall, the studies identified showed the usefulness of exploring relationships between continua of woman's psychological health (positive and negative aspects) as well as the need to try to identify psychological mediators or moderators other than core components of well-being. One limitation can be identified in not having reviewed the quality of the individual studies identified. The strength of this study was in having adopted a rigorous search strategy by selecting and summarizing systematically. Furthermore, for the purpose of the present thesis, Study-I allowed the identification of the instruments to be used in the subsequent Studies-II and IV.

Study-II adopted several measures of well-being, disease and stress provided correlational evidence of relations among positive and negative aspects of psychological health. Moreover, it suggested the usefulness of studying the relationships between positive aspects, considering also possible moderation effects. Regarding the adoption of an intercultural comparison, a higher psychological vulnerability was found in migrant

pregnant women, who showed higher levels of depression and prenatal specific distress. The study's major limit regards the lack of indications of possible fluctuations of well-being during the perinatal period due to the assessment having been undertaken at a single point. Furthermore, the low number of foreign participants in the postpartum sample did not allow extensive comparison. This study has several notable strengths. First, the adoption of a psycho-social approach to the study of perinatal stress and, related to this, the use of perinatal specific stress measures. Finally, the study explored both subjective and psychological well-being using recently developed measures in order to better assess both hedonic and eudemonic aspects.

Study-III was aimed at exploring the role of: pregnancy and postpartum specific stress on dyadic adjustment, analyzing depression as a mediator; social support as a protective factor of depression through dyadic adjustment and proactive coping as mediators. Results revealed that, both during pregnancy and postpartum: maternal depression mediates the relation between stress and the couple's adjustment; dyadic adjustment mediates the relation between social support and maternal depression. Regarding proactive coping, it emerged as a mediator between social support and depression only during pregnancy. One limit to the study is the relatively small size of the postpartum sample, since this makes the statistical analysis of mediation difficult. Regarding the study's strengths, it extended to pregnancy the exploration of maternal depression as mediator, analyzing topics that have not previously been studied together during pregnancy. Moreover, it investigated a construct that had not previously been studied in the perinatal psychology research area.

Study-IV was aimed at examining the role of social support as a promotion factor of subjective and psychological well-being through dyadic adjustment and proactive coping as mediators. Overall, results revealed that during pregnancy social support positively affects subjective and psychological well-being through both dyadic adjustment and

proactive coping. Instead, during postpartum it emerged that only dyadic adjustment mediates the relation between social support and subjective and psychological well-being. The major limitation of this study is the fact that the theoretical framework, in large part, does not belong to the perinatal psychology area, so the evidence for the interpretation of the results is limited. On the other hand, similar to the previous study, the strength of the study consists in the attempt to investigate constructs that have not previously been studied in perinatal psychology.

Study-V was aimed at examining pregnant women's points of view about various aspects of perinatal psychological health. Findings revealed the women's representations of well- and ill- being, and the factors that can help women to be and feel well during pregnancy, birth and postpartum, highlighting the usefulness of adopting an interdisciplinary perspective in the study of perinatal psychological well-being. It emerged that, while migration can add some critical points to the transition to parenthood, overall the points of view of Italian and foreign women related to perinatal psychological health are very similar. Regarding limits to the study, it is possible that some themes did not emerge because of the relatively small number of foreign participants, and furthermore due to linguistic barriers. The strengths of this study are having analyzed for the first time pregnant women's experience of the positive aspects of psychological health and their representations of well- and ill- being, involving both native and foreign women.

Study-VI was aimed at exploring the psychological and socio-cultural factors that can lead women to choose and undergo VBAC in Italy. Suggesting the factors affecting VBAC rates, the findings underlined women's fears about VBAC as well as their relational and knowledge needs. A limit to the study can be identified in the little weight given to the exploration of the fear of labour pain, which is highlighted by the literature as a factor that can influence the choice of both VBAC and caesarean section. A strength of the study is related to its adoption of the method of using focus groups because this

allows the interaction among research participants, and can be considered an ideal method to explore people's views on health and disease concepts.

On the whole, the present thesis has highlighted how in the study of perinatal psychological health it is important to also focus on subjective and psychological well-being and on the psycho-social and individual aspects which promote a good adaptation by the woman to the transition to maternity, and consequently of the whole family nucleus.

Regarding method, despite the limits highlighted, the present thesis has shown how to analyze, from a psychological point of view, a complex topic such as the transition to parenthood, it is useful to adopt quantitative and qualitative research methodologies. Connected to this last aspect, a limit is that of having to distinguish partially the results of quantitative studies from those of qualitative ones, because different groups of participants were used and the data were not triangulated. Furthermore, a preliminary exploration of the experiences, representations and expectations of women during the perinatal period could have further directed the choice of tools for quantitative studies. Nevertheless, because the study of perinatal well-being is at its beginning, knowledge of women's points of view can be a good way to design future quantitative studies. Finally, about the methodological criticalities of conducting a research in a mother tongue different from that of the participants, several actions were used for limiting the interference of any distortions in the results. Beside the choice to include only women able to speak and understand the Italian language, it was decided to remain at the disposal of each participant to verify the effective understanding of the instructions and items of the questionnaire, also providing a brief test administration for the compilation of the same. Concerning the qualitative study, the interviewer implemented reformulations of the questions and explicated the meaning of the words when necessary.

This thesis is a first step and reflecting on what has been presented as a limit, future research should be addressed towards a greater focus on the fathers' point or view. Other possible extensions include the investigation of the expectations that pregnant women have about being well and being ill during motherhood, as well as the mother's representations of well-being and ill-being during postpartum.

A further important aspect of this work lies in the implications for psycho-social intervention programs to promote well-being for pregnant women. In particular, this thesis suggests to include paths of reflection on: 1) well-being, ill-being and their relations; 2) how dyadic adjustment prevents disease and promotes well-being; 3) on the emotional complexity of pregnancy, and the role of bodily changes, pursuing goals and personal skills for being well and self and life satisfaction; 4) the dimensions of control in childbirth.

The studies presented are part of a research doctorate which, as already mentioned, was developed in the well-being perspective: specifically, the study of how to generate well-being by focusing on the individual's strengths, and hence the achievement of well-being in order to develop the individual's potential. The personal consideration that emerges from this research is that the study of well-being cannot be separated from that of meanings.

Focusing on the thesis, becoming a mother is the fulcrum of all the studies presented. Becoming a mother entails transformation of one's identity, a process that takes place in a social context through meanings and values that influence the way women see and negotiate this transition. Few experiences are characterized by such intense personal and social pressure as pregnancy, childbirth and motherhood. What can help in this process, starting from pregnancy? Even feeling well is a concept steeped in subjectivity and culture. I think the intrinsic value of this work consists in allowing reflection on the need

to focus on personal meanings, in order to support mothers and pregnant women in ways that contribute to their well-being.

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Presentation brochure
(Study-II, Study-III, Study-IV, Study-V)

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STAR BENE IN GRAVIDANZA: UNA RICERCA QUALI-QUANTITATIVA SUL BENESSERE PSICOLOGICO NELLA PERINATALITÀ*

<p>Divenire genitore è un percorso che comporta per la donna importanti cambiamenti a livello personale e familiare.</p>  <p>Cambiamenti fisici Cambiamenti psicologici Cambiamenti sociali</p> <p>Il progetto di ricerca condotto dal Dipartimento di Scienze della Formazione dell'Università di Genova, si propone di far emergere possibili e differenti percorsi di adattamento in cui ogni donna si possa riconoscere.</p>	<p style="text-align: center;">PARTECIPANTI</p> <p>La ricerca verrà realizzata con la partecipazione volontaria di donne in stato di gravidanza, che afferiscono ai Servizi per i controlli medici di routine e/o ai percorsi nascita.</p>  <p>Con le partecipanti e i Servizi interessati verranno organizzati momenti di incontro collettivo per la presentazione dei risultati complessivi della ricerca.</p>	<p>L'obiettivo generale dello studio è quello di esplorare e approfondire il concetto di benessere psicologico perinatale attraverso l'esperienza e i racconti delle donne.</p> <p>Particolare attenzione verrà dedicata allo studio delle percezioni, delle valutazioni e delle credenze soggettive delle donne in merito ai vissuti emotivi, al sostegno sociale, alle relazioni familiari e all'evento nascita.</p> <p>Tutti i dati raccolti verranno trattati in forma anonima, ai sensi del D.lgt.sulla Privacy n. 196 del 2003.</p> 
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INFORMED CONSENT FORMS

Study-II, Study-III, Study-IV, Study-V



Modulo di consenso informato

Per la partecipazione alla ricerca:

Star bene in gravidanza: una ricerca quali-quantitativa sul benessere psicologico nella perinatalità.

Responsabili del progetto: Prof.ssa Laura Migliorini e Dott.ssa Tatiana Tassara

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Prima di decidere liberamente se vuole partecipare a questa ricerca, per cortesia **LEGGA ATTENTAMENTE** questo consenso informato e ponga ai responsabili del progetto tutte le domande che riterrà opportune al fine di essere pienamente informato degli scopi, delle modalità di esecuzione della ricerca e dei possibili inconvenienti connessi.

La preghiamo di ricordare che questo è un progetto di ricerca e che **la Sua partecipazione è completamente volontaria. Lei si potrà ritirare in qualunque momento senza fornire alcuna motivazione.**

SCOPO DELLO RICERCA

La ricerca, per la quale si richiede la Sua collaborazione e disponibilità, si propone di esplorare il benessere psicologico della donna prima e dopo il parto. Sono previsti due studi, di seguito illustrati. L'adesione allo studio1 non vincola a partecipare allo studio 2 e viceversa.

STUDIO 1

STRUMENTI UTILIZZATI. Questionari auto-compilati (self-report) circa i vissuti emotivi, la percezione di supporto sociale e di proprie caratteristiche di personalità. La compilazione dei questionari è molto semplice, in quanto non ci sono risposte giuste o sbagliate: Le viene chiesto di rispondere liberamente, facendo riferimento alla Sua esperienza personale.

PROCEDURA SPERIMENTALE. Sono previste due somministrazioni: prima del parto, tra il terzo e l'ottavo mese di gravidanza; dopo il parto, dal secondo mese del bambino fino all'anno. A riguardo, Le ricordiamo che potrà ritirarsi in qualunque momento dalla ricerca, decidendo dopo il parto se partecipare o meno alla seconda somministrazione, per la quale verrà contattata via telefono.

DURATA DELL'IMPEGNO RICHIESTO. Il tempo necessario per ogni somministrazione è di circa un'ora.

RISCHI, DISAGI ED EFFETTI COLLATERALI. La compilazione dei questionari potrebbe indurre un lieve stato di affaticamento. Pertanto, Le garantiamo le pause che riterrà necessarie.

TIPO DI RESTITUZIONE PREVISTA. I risultati complessivi della ricerca verranno restituiti in un incontro collettivo. Le verrà data opportuna comunicazione circa la data dell'evento, attraverso contatto telefonico e/o via e-mail.

STUDIO 2

STRUMENTI UTILIZZATI. Intervista sulle rappresentazioni del benessere, del parto e della maternità. L'intervista consisterà in un colloquio in cui non ci sono risposte giuste o sbagliate alle domande che le verranno poste, e Lei potrà liberamente raccontare la Sua esperienza.

PROCEDURA SPERIMENTALE. La realizzazione dell'intervista è prevista prima del parto, tra il terzo e l'ottavo mese di gravidanza. L'intervista verrà audio-registrata per consentirne trascrizione e analisi. Tale audio-registrazione verrà custodita dai responsabili della ricerca in un luogo sicuro e sarà condivisa esclusivamente tra i membri del gruppo di ricerca.

DURATA DELL'IMPEGNO RICHIESTO. Il tempo necessario per ogni intervista è di circa un'ora/un'ora e mezza.

RISCHI, DISAGI ED EFFETTI COLLATERALI. L'audio-registrazione potrebbe indurre un'iniziale sensazione di intrusività/imbarazzo. Il ricercatore sarà a disposizione per rispondere a suoi eventuali dubbi e curiosità in merito.

TIPO DI RESTITUZIONE PREVISTA. I risultati complessivi della ricerca verranno restituiti in un incontro collettivo. Le verrà data opportuna comunicazione circa la data dell'evento, attraverso contatto telefonico e/o via e-mail.

ALTRE INFORMAZIONI UTILI

Riservatezza. I dati raccolti saranno trattati in accordo con le leggi sulla privacy e in conformità al Decreto Legislativo 30 giugno 2003 n. 196 "Codice in materia di protezione dei dati personali", garantendo l'anonimato dei partecipanti. La privacy dei partecipanti sarà garantita assegnando un codice numerico al soggetto, ed il materiale sensibile sarà custodito dai Responsabili della ricerca, presso il DISFOR, stanze 4A4 e 4A6, C.so A. Podestà 2, 16128 Genova.

Le ricordiamo che in caso lei abbia bisogno di delucidazioni su qualunque aspetto della procedura sperimentale, I responsabili della ricerca, Migliorini Laura, Tassara Tatiana, e i loro collaboratori, sono a Sua completa disposizione.

STUDIO 1
QUESTIONARI

CONSENSO INFORMATO SCRITTO

Sigla Partecipante _____

Per cortesia compili la parte seguente

Io sottoscritta (cognome e nome)

nata a (Città)_____ Stato (Nazione)_____

il (giorno/mese/anno) _____

recapito telefonico _____

indirizzo e-mail _____

Dichiara:

- di aver letto attentamente le spiegazioni relative a questo studio e l'intera procedura sperimentale;
- di essere stata informata riguardo alle finalità e agli obiettivi della ricerca in questione;
- di aver avuto la possibilità di porre domande a proposito di qualsiasi aspetto della procedura sperimentale e di aver ottenuto risposte soddisfacenti;
- di essere a conoscenza dei disagi della ricerca;
- di aver ricevuto soddisfacenti assicurazioni sulla riservatezza delle informazioni ottenute dall'esame della propria persona;
- di essere consapevole di potersi ritirare in qualsiasi fase dello studio;
- di aver liberamente dato il consenso alla partecipazione a questo studio;

Data _____

Firma della partecipante: _____

Firma del ricercatore _____

STUDIO 2
INTERVISTA

CONSENSO INFORMATO SCRITTO

Sigla Partecipante _____

Per cortesia compili la parte seguente

Io sottoscritta (cognome e nome)

nata a (Città)_____ Stato (Nazione)_____

il (giorno/mese/anno) _____

recapito telefonico _____

indirizzo e-mail _____

Dichiara:

- di aver letto attentamente le spiegazioni relative a questo studio e l'intera procedura sperimentale;
- di essere stata informata riguardo alle finalità e agli obiettivi della ricerca in questione;
- di aver avuto la possibilità di porre domande a proposito di qualsiasi aspetto della procedura sperimentale e di aver ottenuto risposte soddisfacenti;
- di essere a conoscenza dei disagi della ricerca;
- di aver ricevuto soddisfacenti assicurazioni sulla riservatezza delle informazioni ottenute dall'esame della propria persona;
- di essere consapevole di potersi ritirare in qualsiasi fase dello studio;
- di aver liberamente dato il consenso alla partecipazione a questo studio;

Data _____

Firma della partecipante: _____

Firma del ricercatore _____



Modulo di consenso informato

Per la partecipazione alla ricerca:

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Prima di decidere liberamente se vuole partecipare a questa ricerca, per cortesia **LEGGA ATTENTAMENTE** questo consenso informato e ponga ai responsabili del progetto tutte le domande che riterrà opportune al fine di essere pienamente informato degli scopi, delle modalità di esecuzione della ricerca e dei possibili inconvenienti connessi.

La preghiamo di ricordare che questo è un progetto di ricerca e che **la Sua partecipazione è completamente volontaria. Lei si potrà ritirare in qualunque momento senza fornire alcuna motivazione.**

SCOPO DELLO RICERCA

La ricerca, per la quale si richiede la Sua collaborazione e disponibilità, si propone di esplorare il benessere psicologico della donna dopo il parto.

STRUMENTI UTILIZZATI. Questionari auto-compilati (self-report) circa i vissuti emotivi, la percezione di supporto sociale e di proprie caratteristiche di personalità. La compilazione dei questionari è molto semplice, in quanto non ci sono risposte giuste o sbagliate: Le viene chiesto di rispondere liberamente, facendo riferimento alla Sua esperienza personale.

PROCEDURA SPERIMENTALE. È prevista una somministrazione dopo il parto, dal secondo mese del bambino fino all'anno.

DURATA DELL'IMPEGNO RICHIESTO. Il tempo necessario per ogni somministrazione è di circa un'ora.

RISCHI, DISAGI ED EFFETTI COLLATERALI. La compilazione dei questionari potrebbe indurre un lieve stato di affaticamento. Pertanto, Le garantiamo le pause che riterrà necessarie.

TIPO DI RESTITUZIONE PREVISTA. I risultati complessivi della ricerca verranno restituiti in un incontro collettivo. Le verrà data opportuna comunicazione circa la data dell'evento, attraverso

contatto telefonico e/o via e-mail.

ALTRE INFORMAZIONI UTILI

Riservatezza. I dati raccolti saranno trattati in accordo con le leggi sulla privacy e in conformità al Decreto Legislativo 30 giugno 2003 n. 196 “Codice in materia di protezione dei dati personali”, garantendo l’anonimato dei partecipanti. La privacy dei partecipanti sarà garantita assegnando un codice numerico al soggetto, ed il materiale sensibile sarà custodito dai Responsabili della ricerca, presso il DISFOR, stanze 4A4 e 4A6, C.so A. Podestà 2, 16128 Genova.

Le ricordiamo che in caso lei abbia bisogno di delucidazioni su qualunque aspetto della procedura sperimentale, I responsabili della ricerca, Migliorini Laura, Tassara Tatiana, e i loro collaboratori, sono a Sua completa disposizione.

CONSENSO INFORMATO SCRITTO

Sigla Partecipante _____

Per cortesia compili la parte seguente

Io sottoscritta (cognome e nome)

nata a (Città)_____ Stato (Nazione)_____

il (giorno/mese/anno) _____

recapito telefonico_____

indirizzo e-mail_____

Dichiara:

- di aver letto attentamente le spiegazioni relative a questo studio e l'intera procedura sperimentale;
- di essere stata informata riguardo alle finalità e agli obiettivi della ricerca in questione;
- di aver avuto la possibilità di porre domande a proposito di qualsiasi aspetto della procedura sperimentale e di aver ottenuto risposte soddisfacenti;
- di essere a conoscenza dei disagi della ricerca;
- di aver ricevuto soddisfacenti assicurazioni sulla riservatezza delle informazioni ottenute dall'esame della propria persona;
- di essere consapevole di potersi ritirare in qualsiasi fase dello studio;
- di aver liberamente dato il consenso alla partecipazione a questo studio;

Data _____

Firma della partecipante: _____

Firma del ricercatore _____

Interview: semi-structured question guide

(Study-V)

Consegna

La ringrazio molto per essere venuta. Le spiego brevemente in cosa consiste l'intervista che, come le avevo anticipato, verrà audio registrata per consentirmi di analizzare meglio quanto lei mi dirà, ovviamente solo per fini di ricerca.

Si tratta di un'intervista riguardante la gravidanza, il parto e la maternità. La sto realizzando a scopo di tesi di dottorato. In particolare sono interessata a comprendere che idea hanno le donne di benessere perinatale e cosa può favorire il benessere prima, durante e dopo il parto.

Con questa intervista le chiedo di raccontarmi le sue esperienze, i suoi pensieri, le sue fantasie, aspettative. Proprio perché le chiedo di raccontarmi di lei, non ci sono risposte giuste o sbagliate, soltanto racconti: per questo non le fornirò un elenco di risposte tra le quali scegliere, come in interviste più strutturate o nei questionari.

Io sono qui per ascoltare quello che lei vorrà raccontarmi in seguito a diverse mie domande, e cercherò soltanto di suggerirle, se necessario, qualche aspetto sul quale concentrare la propria attenzione. Ho qui davanti a me una traccia dell'intervista che ogni tanto consulterò per evitare di essere ripetitiva o di perdermi qualche domanda importante. Potrei prendere qualche appunto per lo stesso motivo, oppure per segnarmi di un particolare aspetto che potrebbe essere interessante approfondire insieme a lei.

Anche i dettagli, anche i più piccoli che le verranno in mente, sono molto importanti per descrivere la sua specifica esperienza, quindi si senta libera di comunicarli. Quanto più farà riferimento alla sua specifica esperienza, senza pensare a quello che potrebbero dire altre persone, tanto più lei mi sarà di aiuto.

Tutto quello che diremo rimarrà tra me e lei e verrà utilizzato in modo da preservare la sua privacy.

È d'accordo?

Grazie, allora possiamo cominciare.

Domande introduttive generali

È la sua prima gravidanza?

Si ricorda del giorno in cui ha scoperto di essere incinta? *(Mi può raccontare cos'è accaduto?)*

Area_1: Il benessere prima e dopo il parto

- Domande introduttive di area

La sua è una gravidanza ricercata/voluta?

Quali professionisti la stanno seguendo per l'evolversi della gravidanza? *(Da cosa è motivata la scelta?)*

- Focalizzazione di area

C'è qualche particolare attività che svolge per stare bene in gravidanza? *(Perché?)*

Può dire di sentirsi bene in questo periodo? *(Perché? Cosa significa per lei stare bene?)*

Mi può raccontare di un episodio per lei particolarmente emozionante legato alla gravidanza? *(non il giorno in cui ha scoperto di essere incinta)*

Quali sono le emozioni, i sentimenti di questo periodo?

Ha delle preoccupazioni? *(Dei pensieri ricorrenti che la infastidiscono?)*

Sta per diventare madre in un paese diverso da quello delle sue origini. Mi racconta la sua esperienza a riguardo? *(Cosa prova?)*

Abbiamo parlato di stare bene e male, soddisfazione, emozioni. Secondo lei come si intrecciano tutti questi aspetti? *(Si può stare bene quando si sta male? Si può stare male quando si sta bene?)*

Sta condividendo con qualcuno questa esperienza? *(Si sente sostenuta da queste persone?)*

Pensando al suo partner e alla vostra relazione, per lei cosa è importante in questo periodo?

Ci sono particolari aspetti di lei, caratteristiche che si riconosce, che la stanno aiutando a stare bene? ...E dopo il parto?

Area_2: Il parto

- Domande introduttive di area

Quali sono le prime immagini/parole che le vengono in mente pensando alle seguenti parole: parto vaginale; parto medicalizzato; parto cesareo; parto naturale; parto ideale

Dove partorirà? *(Perché? È il luogo dove desidera partorire?)*

- Focalizzazione di area

Lei pensa di frequentare/sta frequentando un corso di preparazione al parto? *(Perché? Che aspettative ha a riguardo? Esperienza?)*

Immagina mai il suo parto? *(Sé stessa? Ha dei timori?)*

Di cosa pensa avrà bisogno durante il parto? *(Cosa potrebbe esserle di aiuto per sentirsi bene?)*

Secondo lei il parto è rischioso? *(In che senso?)*

Nella vita di una donna, il parto cosa rappresenta?

Domande di chiusura

C'è qualcos'altro di cui le farebbe piacere parlare?

Se ha voglia, mi farebbe piacere avere alcune sue opinioni sull'intervista.

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