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How We Care for Mothers Shapes Who Babies Become: A Support-Based Framework for Maternal Well-Being

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When mothers struggle with their mental health, they often ask, "What is wrong with me?" Less often, they ask, "What do I need?" That question shifts the focus from stigma and shame to solutions that can improve maternal well-being and outcomes for mothers and babies. While maternal well-being is often treated as an individual responsibility, it is heavily shaped by the relationships, institutions, communities, and systems surrounding mothers. According to the World Health Organization (WHO), maternal well-being is defined as:

> A positive state experienced throughout pregnancy and continuing until 1 year after the end of pregnancy, influenced by the world the woman lives in. During this dynamic and adaptive period, the woman, partner, and family receive the support, confidence, and resources needed for her to thrive and realize her full potential and rights. (Le Lez et al., 2025, p. e59)

Prenatal and perinatal psychology recognizes that the world a mother lives in extends to her infant. Her emotional, relational, and physical experiences during pregnancy, birth, and the postpartum period become part of the baby's earliest environment, with lasting implications. How we care for mothers shapes the trajectory of early development.

Research links social support during pregnancy to lower psychological distress and improved maternal well-being, including a reduced risk of postpartum depression (Al-Mutawtah et al., 2023; Dabrassi et al., 2010; Żyrek et al., 2024). However, pregnancy and the postpartum period often intensify feelings of isolation and stress rather than alleviate them. Perinatal mental health conditions range from mood and anxiety disorders, which affect one in five mothers (Howard et al., 2014; O'Hara & McCabe, 2013), to rare, severe psychiatric conditions. Screening and intervention for perinatal mental health remain inconsistent, and support is often offered only after symptoms have worsened. The consequences of these gaps in care are profound. Recent Maternal Mortality Review Committee data show that mental health conditions, including suicide and substance use disorder, account for nearly 28% of pregnancy-related deaths in the United States, far more than any other cause (Hemstad, 2026). A mother's psychological distress provides an

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important lens for assessing whether the relationships, care, and conditions surrounding her are meeting her needs.

Early intervention is essential for preventing and treating perinatal mood and anxiety disorders and nurturing the environment in which babies begin life. Maternal stress and psychosocial conditions can affect biological processes during pregnancy (Dunkel Schetter, 2011); however, a mother provides much more than the fetus's biological environment. The maternal–infant relationship begins before birth and continues to evolve after. Women who feel a strong connection to their babies during pregnancy are more likely to have children with higher socioemotional competence (Hruschak et al., 2022), while maternal depression, anxiety, and stress are consistently associated with challenges in mother–infant bonding (O'Dea et al., 2023).

According to attachment theory, infants develop expectations of safety, responsiveness, and care through repeated interactions with caregivers (Ainsworth et al., 1978; Bowlby, 1969; Cassidy & Shaver, 2016). When caregiving is not consistently responsive to an infant's needs, insecure attachment patterns can develop and are associated with greater risk of emotional and behavioral difficulties in childhood (Fearon et al., 2010; Groh et al., 2012). Early attachment experiences can also contribute to patterns of emotional regulation and relationships that persist into adulthood, with attachment patterns transmitted across generations (Girme et al., 2021; Verhage et al., 2016). Maternal support matters both for mothers' own well-being and for the relational environment in which bonding and attachment develop.

Although publications on maternal and perinatal well-being are steadily increasing, recent reviews and conceptual work continue to identify gaps in how it is defined, understood in context, and translated into responsive maternal care (Baldwin et al., 2025; Jomeen et al., 2025; Massaer et al., 2025; Wadephul et al., 2026). The Support-Based Framework for Maternal Well-Being was developed by synthesizing recent literature from the *Journal of Prenatal and Perinatal Psychology and Health* (*JOPPPAH*). The framework is intended to shift care from reacting to maternal distress to proactively considering what mothers need to thrive. In doing so, it aims to support maternal well-being and the relational and developmental environment in which babies begin life.

The Support-Based Framework for Maternal Well-Being

Recent publications in *JOPPPAH* tell a coherent story. Across topics and methods, the literature shows that relationships, care experiences, community, and structural conditions influence maternal well-being. Postpartum mental health is shaped long before the postpartum period, and the mother–baby relationship begins before birth. Support is most effective when it is accessible, responsive, culturally appropriate, and aligned with the mother's needs and circumstances, particularly during difficult experiences such as loss, neonatal intensive care, and complicated births. This synthesis includes 19 articles published or republished in *JOPPPAH* from 2024 through 2026 that directly address maternal well-being, the framework's support domains, or the developing mother–baby relationship. The publications span all four domains, with many addressing more than one, highlighting their interconnectedness. Together, this work shows the need for support that extends beyond screening, education, or individual coping. Table 1 summarizes how this *JOPPPAH* literature contributes to the framework.

Table 1

Recent JOPPPAH Publications Informing the Framework

Publication	Framework domain(s)	Contribution to the synthesis
Cortizo (2019/2024)	Relational support; care experience	Early intervention model integrates prenatal bonding, maternal trauma treatment, family involvement, and coordinated care beginning in pregnancy
Fowler et al. (2026)	Relational support; care experience; structural conditions	Postpartum depression was associated with declining maternal–infant bonding in the NICU
Goertz-Schroth et al. (2022/2026)	Relational support	Prenatal bonding frames postpartum as a continuation of an emerging relationship
Ikegawa (2026)	Relational support	Responsive Prenatal Engagement positions recognition, inclusion, and engagement as ways of incorporating the fetus into family relational life
McLeod et al. (2024)	Relational support	Attachment security was associated with whether partner support was experienced as matching mothers' needs
Pasari & Prasad (2026)	Relational support	Intentional engagement includes awareness, agency, bonding, identity, and flexibility; connection develops unevenly
Abdi et al. (2025)	Care experience; structural conditions	Participants' experiences highlighted the importance of grief-informed, culturally responsive follow-up after stillbirth
McSorley et al. (2024)	Care experience; community support; structural conditions	Referral and funding barriers restricted access, while insufficient antenatal preparation left needs unmet postpartum
Pierpoint et al. (2025)	Care experience; structural conditions	Prior mental health history identified elevated risk; screening and contact alone did not improve depression scores
Raza & Splevins (2026)	Care experience; structural conditions	Compassion-focused therapy was associated with significant improvements in an inpatient setting where mothers stayed with their babies; flexible attendance supported engagement; access was limited after discharge
Rebelle et al. (2024)	Care experience; structural conditions	Advice was less influential than prior behavior and sociodemographic context, even when providers were the primary source of support
Saragosa (2024)	Care experience	Feeling safe and present during birth was associated with lower postnatal stress and depressive symptoms
Marciniak et al. (2024)	Community support	Physically active and inactive participants reported similar stress levels; participants also relied on emotional and spiritual support
Moran et al. (2025)	Community support; care experience	Specialist community care was associated with reduced distress and improved well-being; the therapeutic relationship was central, but demand exceeded capacity
Thirkettle et al. (2024)	Community support	Community-based compassion-focused therapy was associated with reduced self-criticism and distress; shared experience with other mothers was valued
Zambaldi et al. (2025)	Community support; care experience	Participants described cultivating self-compassion during pregnancy; group format and accessible delivery shaped participation

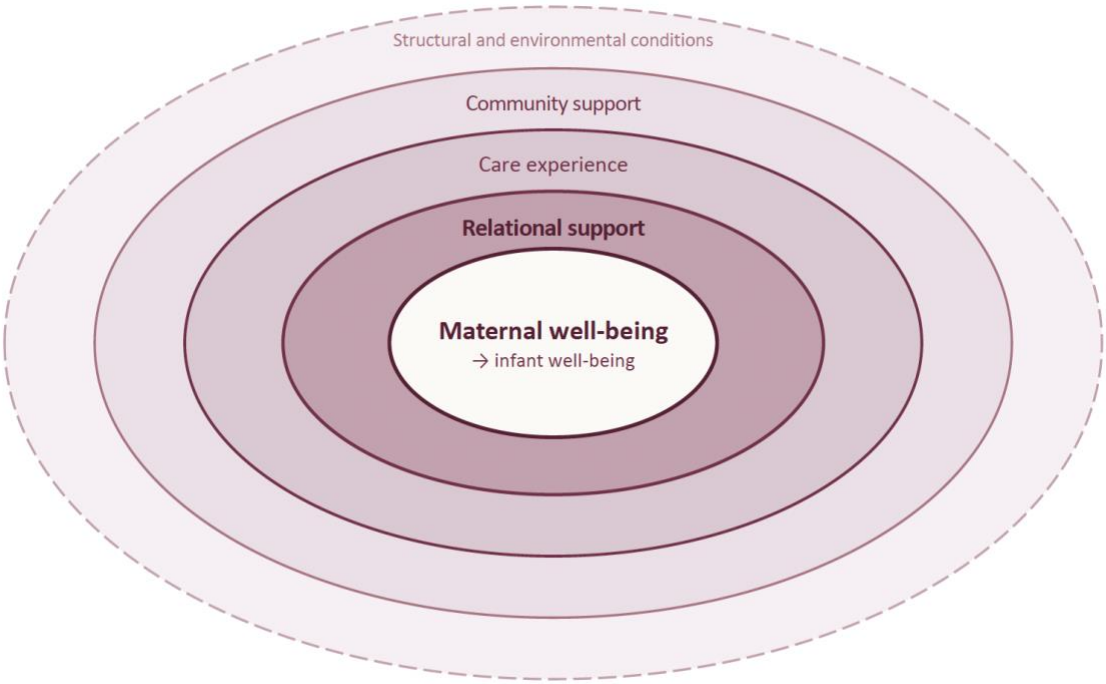
Publication	Framework domain(s)	Contribution to the synthesis
Burkhard et al. (2025)	Structural conditions	Medicaid contracting, reimbursement, and quality measurement determine whether screening guidelines reach practice
Herrick & Burkhard (2024)	Structural conditions; community support; care experience	Racism, chronic stress, and inequitable care compound risk; community-based, culturally congruent care can improve reach
Thayagabalu et al. (2025)	Structural conditions; care experience	Mothers reported low perceived benefit from postpartum care overall, with access and perceived benefit varying by geography

Note. Maternal well-being sits at the center of the framework rather than as a separate domain; each publication included here illustrates a pathway through which one or more domains support maternal well-being. Publications are grouped by the first domain listed and ordered alphabetically by first author within each group.

The Support-Based Framework organizes four domains that shape how support reaches and is experienced by mothers, including relational support, care experience, community support, and structural and environmental conditions (see Figure 1). The domains are dynamic and interconnected, not hierarchical. They are not simply components of maternal well-being but the pathways through which support either arrives in meaningful ways or falls short. The term *mother* is used throughout to reflect the relational focus and language of the cited work. The framework is intended to include all people who become pregnant, give birth, or serve as primary parents or caregivers.

Figure 1

Support-Based Framework for Maternal Well-Being



Note. The domains reflect proximity rather than hierarchy. Maternal well-being influences infant well-being across pregnancy, birth, and the postpartum period. The framework does not imply a single linear or deterministic causal sequence.

Maternal well-being is at the center of the framework, with infant well-being directly linked because maternal well-being shapes the baby's relational and developmental environment through pre- and perinatal bonding, caregiving, and regulation. Relational support is closest to the center because it is often felt most directly. It affects whether a mother feels seen and valued. Care experience determines whether interactions with providers and services create safety, trust, and meaningful pathways to help. Community support can provide a sense of belonging and practical resources beyond sporadic healthcare. Structural and environmental conditions determine whether those forms of support are available and accessible, surrounding and influencing the other domains. These domains are distinct, but together they determine whether a mother feels supported and can access the help she needs.

The framework is grounded in two established theories. Bronfenbrenner's (1979) ecological systems theory underpins its structure, showing that human development is shaped by layered, interacting environments surrounding the individual, from close relationships outward to broader structural and cultural conditions. Bronfenbrenner (1986) later extended the theory to account for time and life transitions, which this framework treats as change over time within each domain rather than as a separate domain. Relational-cultural theory (Jordan et al., 1991; Miller, 1976), based on research into women's psychological development, argues that well-being grows through connection and that disconnection causes harm. Using theory to organize evidence and identify

patterns that can inform practice aligns with established approaches to framework synthesis (Booth & Carroll, 2015).

The Support-Based Framework presents four propositions to guide practice and future research:

1. Maternal well-being is influenced by interconnected support domains: relational, care, community, and structural.
2. The effectiveness of support depends on its quality, fit, accessibility, and timing, not just availability.
3. Maternal well-being influences the relational and developmental environment that shapes infant well-being.
4. These relationships evolve throughout pregnancy, birth, postpartum recovery, and early development.

What Recent JOPPPAH Literature Shows

Before determining how to support maternal well-being, it is important to recognize that mothers enter pregnancy with different histories, experiences, strengths, relationships, resources, and needs. These differences can provide a useful starting point for tailoring support during the pre- and perinatal period, ideally before symptoms escalate. Cortizo's Calming Womb Family Therapy Model illustrates how a mother's trauma history and family relationships can inform support beginning in pregnancy through trauma treatment, prenatal bonding, family involvement, and coordinated care (Cortizo, 2019/2024). Related work emphasizes prenatal assessment of trauma and dissociation so support can begin earlier in pregnancy (Cortizo, 2020). Pierpoint et al. (2025) found that prior mental health diagnoses and a history of postpartum depression were associated with higher postpartum depression screening scores. Sauer et al. (2023) similarly found that greater psychological inflexibility was associated with higher perinatal anxiety, while higher anxiety was associated with lower life satisfaction among pregnant participants.

Many recent *JOPPPAH* publications show that mothers are already working to protect their well-being, understand their emotions, prepare for parenthood, connect with their babies, and adapt to uncertainty. Pasari and Prasad (2026) described parents as active participants in pregnancy, using reflection, agency, bonding, identity development, and acceptance to navigate an experience they could not fully control. In Rebelle et al. (2024), anxiety and depression were mothers' primary health concerns, and physical activity was widely viewed as a way to relieve stress and improve mental health. While providers were considered their primary source of support, counseling was not associated with increased physical activity. Marciniak et al. (2024) similarly found that participants used both problem-focused and emotion-focused coping strategies, including prayer and religion, but physically active participants did not report significantly lower stress. Taken together, these findings suggest that mothers are actively trying to support their own well-being, but individual effort alone does not ensure better outcomes. Whether those efforts translate into improved well-being depends on time, safety, practical resources, responsive relationships, and accessible support.

The mere presence of support does not ensure it is helpful. McLeod et al. (2024) found that support may be offered yet not perceived by the mother as matching her needs. In clinical and

community settings, women described benefits when care was compassionate and respectful and when they felt understood and safe (Abdi et al., 2025; Moran et al., 2025). Compassion-focused therapy (CFT) was particularly notable across levels of care, reducing distress and self-criticism while increasing self-reassurance and connection in both community and inpatient settings (Raza & Splevins, 2026; Thirkettle et al., 2024). Zambaldi et al. (2025) similarly highlighted the value of self-compassion, shared experience, and connection with other mothers. Conversely, Abdi et al. (2025) documented dismissive communication and retraumatizing follow-up after stillbirth, while Herrick and Burkhard (2024) described discrimination, cultural mismatch, and barriers to care operating at multiple levels. Saragosa (2024) found that mothers who felt unsafe or not fully present during birth reported higher post-traumatic stress and depressive symptoms. Across domains, whether support helps depends on its quality, fit, and responsiveness, not simply on whether it is offered.

While screening, clinical contact, and advice can help identify or address needs, they are insufficient without meaningful follow-up or support. Pierpoint et al. (2025) found that adding a three-week telehealth visit did not reduce postpartum depression scores. Thayagabalu et al. (2025) found that many mothers perceived limited benefit from postpartum care. McSorley et al. (2024) described referral requirements, funding constraints, and mothers arriving postpartum without preparation that should have begun during pregnancy. At the policy level, Burkhard et al. (2025) show that even evidence-based screening recommendations depend on reimbursement, quality measures, and managed-care requirements for providers to deliver care. These studies show that recognizing concerns is only the first step. Mothers also need clear and accessible pathways to effective support.

Structural and environmental conditions shape the resources, opportunities, and support available to a mother. Recent publications in *JOPPPAH* highlight the roles of racism and chronic stress (Herrick & Burkhard, 2024), geography (Thayagabalu et al., 2025), transportation, childcare, leave, and financial constraints (Fowler et al., 2026), and funding, service availability, and reimbursement structures (Burkhard et al., 2025; McSorley et al., 2024). Fowler et al. (2026) specifically identified transportation, childcare, leave, and financial constraints as reasons a mother may be unable to be present with her infant in the NICU. What may appear to clinicians or systems as an individual behavior or constraint can reflect larger conditions that limit what a mother is realistically able to do.

Health-system design can support maternal well-being and the mother–infant relationship by enabling intensive psychiatric care without separating mothers from their babies. Raza and Splevins (2026) studied CFT in a UK Mother and Baby Unit (MBU), where mothers with severe mental health difficulties are admitted with their babies. Participants showed large, statistically significant improvements despite attending an average of only three of five sessions. They valued the supportive environment and the flexibility to bring their babies and come and go as needed. This model shows that comprehensive perinatal psychiatric care can support maternal well-being while allowing mothers to maintain a connection with their baby. Although specialized perinatal inpatient programs exist in the United States, there are currently no MBUs that admit mothers with their infants (Toor et al., 2024). This contrast shows how health-system design can determine whether treatment supports the mother–infant relationship or comes at its expense.

The literature positions maternal well-being within the evolving relationship between mother and baby. Goertz-Schroth et al. (2022/2026) describe prenatal bonding as a method of support during pregnancy that fosters an emotional connection before birth. Ikegawa (2026) emphasizes recognition, inclusion, and engagement with the unborn baby, while Pasari and Prasad (2026) describe prenatal bonding and parental identity as developing throughout pregnancy. After birth, maternal psychological well-being continues to interact with the developing relationship, including under difficult circumstances such as neonatal intensive care (Fowler et al., 2026). This body of recent *JOPPPAH* literature shows that supporting mothers also supports the relational and developmental environment in which babies begin life.

A Convergence in the Literature

The Support-Based Framework emerges within a broader convergence in how maternal well-being is understood. The WHO's recent framework identifies maternal well-being across interconnected domains, including health, experience of care, safety and environment, relationships, agency, and culture (Le Lez et al., 2025). That maternal well-being framework builds on earlier WHO work in child and adolescent health, including the 2018 Nurturing Care Framework for Early Childhood Development (Le Lez et al., 2025; World Health Organization et al., 2018), and provides the working definition of maternal well-being used in this article. Recent work published in *JOPPPAH* reinforces many of the same principles, viewing maternal well-being as dynamic, multidimensional, and shaped by relationships, care, community, and broader social conditions. The Support-Based Framework organizes these influences around the practical question of support, including where it comes from, how it reaches the mother, and whether it is what she needs.

The broader literature reflects growing recognition of the importance of maternal well-being and the conditions that shape it. Recent reviews describe maternal and perinatal well-being as complex and dynamic, shaped by maternal identity and transition as well as relationships, social circumstances, and structural factors (Baldwin et al., 2025; Jomeen et al., 2025). Jomeen et al. (2025) further emphasize that maternal well-being is distinct from broader concepts of general well-being. Wadephul et al. (2026) found that mothers actively worked to sustain or restore well-being through agency, self-care, and managing uncertainty, while relationships, healthcare, work, environment, and personal history could support or constrain those efforts. Likewise, Massaer et al. (2025) identified social support, economic stability, access to healthcare, psychosocial resilience, and cultural and environmental factors as antecedents of perinatal mental well-being. Across different research methods and settings, maternal well-being emerges as unique, deeply shaped by the conditions surrounding mothers, and deserving of greater attention in research, care, and policy.

Implications for Practice and Research

Clinical application of the framework begins by understanding a mother's history and assessing the support around her, rather than focusing on symptoms alone. Prior diagnoses, experiences, beliefs, and behaviors can provide early indicators of where support may be needed, enabling providers to intervene before symptoms escalate (Pierpoint et al., 2025; Rebelle et al., 2024). Providers can then ask what a mother needs, who is available to help, whether the available

support aligns with her needs, and what barriers make it difficult to follow the recommendations. Screening should lead to meaningful follow-up, collaborative care, referrals, resources, and repeated assessment at key transitions. The emotional experience of care should be considered alongside physical outcomes in settings such as birth care (Saragosa, 2024), neonatal intensive care (Fowler et al., 2026), and care after stillbirth (Abdi et al., 2025). Programs should be designed around accessibility, belonging, continuity, and lived experience, rather than expecting mothers to navigate fragmented services independently.

Recent studies in *JOPPPAH* demonstrate the value of compassionate group care and peer connection (Thirkettle et al., 2024; Zambaldi et al., 2025), flexible care delivery (McSorley et al., 2024; Zambaldi et al., 2025), and specialist community services (Moran et al., 2025). The same literature documents barriers related to geography and staffing (Moran et al., 2025) and referral requirements and funding (McSorley et al., 2024). Policy also shapes whether support is available and usable. Insurance structures and reimbursement influence whether care can be delivered (Burkhard et al., 2025), while inequities in care and access to culturally responsive services affect whether support reaches mothers in ways that meet their needs (Herrick & Burkhard, 2024). Paid leave, transportation, childcare, and financial constraints can further limit mothers' ability to participate in care or be present with their infants (Fowler et al., 2026). Across these settings, support must be offered in ways that mothers can access, trust, and experience as helpful.

Future research can examine whether the framework's four domains can be measured reliably, how they interact over time, and whether the quality, fit, accessibility, and timing of support predict maternal well-being beyond the mere availability of services. Longitudinal research could examine how structural conditions influence access to and continuity of care, how care experiences affect trust and help-seeking, and how relational and community support relate to maternal and early parent–infant outcomes. Research should also assess maternal experience rather than relying only on service utilization or symptom scores. Mixed-methods research may be particularly useful for identifying measurable pathways through which support affects well-being while preserving maternal experience, and testing across diverse family structures, cultural contexts, health systems, and communities will help determine where the framework generalizes and where adaptation is needed. Finally, for this work to shape care, research must be freely accessible to the clinicians, community organizations, advocates, and families who can use it.

Strengths and Limitations

A strength of the Support-Based Framework is its synthesis of *JOPPPAH* literature on multiple aspects of maternal well-being, spanning several countries and cultural contexts and addressing maternal experience throughout pregnancy, birth, and the postpartum period. Although these publications address different questions, their convergence highlights recurring patterns in how relationships, care, community, and structural conditions support or undermine maternal well-being. The framework situates these findings within established theory and a growing international literature on maternal well-being, organizing them into a structure that can inform practice and future research.

This synthesis focused on recent *JOPPPAH* literature because of the journal's interdisciplinary focus on prenatal and perinatal psychology and health, and it was not intended

as a systematic review of the broader maternal health literature. The publications also vary in design, population, and purpose and should not be treated as equivalent forms of evidence. Finally, although a breadth of literature informs the framework, its four domains and proposed relationships have not yet been directly tested.

Conclusion

The literature synthesized in this article tells a consistent story about how support shapes maternal well-being. Mothers enter pregnancy and parenthood with different histories, strengths, relationships, resources, and needs, and they actively try to care for themselves and their babies. However, maternal well-being does not depend on individual awareness, agency, or effort alone. It is also shaped by whether the relationships, care, communities, and structural conditions surrounding mothers provide support that is timely, responsive, accessible, and aligned with their needs. Screening, advice, and individual coping strategies matter, but they cannot substitute for the conditions that make help available and usable.

The Support-Based Framework for Maternal Well-Being organizes these influences into four interconnected domains. It offers a practical way to ask what a mother needs and what must happen around her for those needs to be met. Maternal well-being matters because mothers' health, safety, dignity, and quality of life matter. At the same time, it shapes the relational and developmental environment in which her baby begins life. Supporting mothers across the pre- and perinatal period is our shared responsibility. The framework offers guidance for organizing that responsibility and for examining whether support is accessible, responsive, and effective. A mother should not have to ask, "What is wrong with me?" Instead, we should be asking, "What does she need?"

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