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Date Feb. 9, 1995
Abstract
The Concerns and Coping Strategies of New Mothers During the Early Postpartum Period

This study explores the concerns and coping strategies of primiparous women during the first one to four weeks following the birth of their baby. A total of 15 English speaking women between the ages of 22 to 34 were interviewed in their homes. Each woman was asked to describe the current changes, challenges, and joys she was experiencing as well as the coping strategies she was using to deal with the changes, challenges, and joys. A descriptive design was used. Data were collected during interviews using open-ended questions. Inductive content analysis was used to analyze the findings. Six concerns (changes, challenges, and joys) emerged from data collected during interviews: becoming a mother, emotional and physical restoration, breastfeeding, balancing roles, developing relationship with baby, and unsupportive attitudes/actions of others. The eight coping strategies used by the women to manage their concerns were: seeking support/advice, accepting support/advice, caring for self, redefining normal, encouraging/accepting partner's involvement, sharing feelings, identifying what was right for self, and utilizing/modifying former coping strategies.

The implications from this research are many. Nurses and childbirth educators need to incorporate specific skills and strategies to deal with the postnatal period in prenatal preparation. Prenatal classes, drop-ins, and information kiosks could serve as a source of information about community resources and how to access them. Alternatively, classes could be offered in the postnatal period. Because breastfeeding issues were such a concern to the women of this study, health care professionals must not stand in judgment of women who wish to bottlefeed from birth, or women who want to switch from breastfeeding to bottlefeeding. Communication between hospital maternity nurses, liaison nurses, and community health nurses needs to be further developed, because community health nurses need to be aware of parental concerns expressed about the postpartum period before they visit parents at home. Nurses, students, and educators must be aware of new mother's concerns during the early postpartum period in order that they can acknowledge, be sensitive to, and respond to these
women and their partners appropriately. Nurses need to be involved in the development and operation of programs that are supportive of new parent's concerns and coping strategies. Students, nurses, educators, and researchers also require education about the concerns and coping strategies of new mothers and their partners in order that they support strategies, they assist with development and utilization of strategies and they address their interventions to strategies used by couples.
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Table 1

Summary of Concepts and Categories

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CHAPTER 1
INTRODUCTION

Background to the Problem

A total of 402,528 live births occurred in Canada in 1991, a slight decrease since 1990 (Statistics Canada, 1993). Over forty-four percent of those births were first births (Statistics Canada, 1993). The average size of the Canadian family has been decreasing since the early 1970's and now stands at 3.1 persons per family (Statistics Canada, 1992). Statistical trends indicate that many families are choosing to limit their numbers of children for many reasons.

One reason is the change in the characteristics of childbearing couples over the past several decades. An increasing number of couples have postponed marriage and conception until later in the childbearing cycle. In addition, the utilization of midwives, the search for active involvement in the decision-making process and the choice of early discharge after birth have placed more emphasis on individual responsibility during the childbearing process.

Becoming a new parent has been labeled as both a transition and a life crisis (Dyer, 1963; LeMasters, 1957; Rossi, 1968). New parents cope with a variety of concerns and issues while navigating this transition or life crisis. A number of studies within the literature have separately explored the variables that affect the transition to parenthood and the parental role, maternal concerns during the transition and the coping strategies utilized by new parents during the transition.

The concerns of primiparous and multiparous women throughout the postpartum period have received a great deal of attention from the research literature (Adams, 1963; Bull, 1981; Chapman, Macey, Keegan, Borum & Bennett, 1985; Fillmore & Taylor, 1976; Graef, McGhee, Rozycki, Fescina-Jones, Clark, Thompson & Brooten, 1988; Gruis, 1977; Harrison & Hicks, 1983; Hiser, 1991, 1987; Moss, 1981; Smith, 1989; Sumner & Fritsch, 1977; Tobert, 1986). These studies have been primarily quantitative in nature. Some studies have presented subjects with a preconstructed set of concerns defined by the investigator, and asked the subjects to prioritize their concerns according to their experiences (Bull, 1981; Fillmore & Taylor, 1976; Gruis, 1977; Harrison & Hicks, 1983; Smith, 1989; Sumner & Fritsch, 1977;
Tobert, 1986). A study by Hiser (1991, 1987) incorporated both quantitative and qualitative methods, however the results documented differing priorities of maternal concerns according to the methods used. None of the previously mentioned studies have gone beyond labeling and prioritizing concerns to investigate how the subjects coped with their concerns. Further, none of the previously mentioned studies have specifically examined primiparas concerns and coping strategies and linked them to each other.

A few studies have explored the coping strategies of new parents in the postpartum period (Alexander, 1984; Bennett, 1981; Miller & Myer-Walls, 1983; Ventura, 1982, 1986). Bennett (1981) and Miller and Myer-Walls (1983) agreed that one method new parents use to cope is seeking and relying on social support systems. Other coping strategies such as balancing multiple roles and seeking assistance from professional and media sources have been identified (Miller and Myer-Walls, 1983). Bennett (1981) described maintaining family integrity, being religious, thankful, and content, and emphasized the usefulness of such information. She recommended further investigations into the subject. In particular, it would be helpful to link specific coping strategies with specific maternal concerns.

Problem Statement

While a variety of literature pertaining to primiparous and multiparous women during the postpartum period was found, the following deficiencies exist:

1) a lack of studies exploring new mothers' greatest concerns during the postpartum period from a qualitative methodological perspective and,

2) a lack of studies linking concerns to specific coping strategies.

Information about the concerns and related coping strategies of primiparous women is of great importance to the health care professionals who serve this population. In particular, because community health nurses (CHNs) prioritize, plan and implement appropriate programs and services for this population within the health care system of the 1990's, they require current empirical findings about concerns and coping strategies germane to primiparas in the early postpartum period. The research problem is a lack of current findings that describe
primiparous women's concerns and coping strategies, link concerns and coping strategies, and capture them from the women's perspective.

**Purpose**

The purpose of the study was:
1) to identify new mothers' greatest current parenting and child-rearing concerns during the first four weeks following the birth of their first infants,
2) to ascertain the coping strategies new mothers' utilized to manage those concerns during the early postpartum period.

**Research Questions**

The research questions were:
1) what were new mothers' greatest identified current parenting and child-rearing concerns during the early postpartum period?
2) what were the coping strategies utilized by new mothers to manage those concerns during the early postpartum period?

**Definition of Terms**

The following terms were utilized throughout the study:

- **new mother**- a primiparous woman who met the inclusion criteria for this study.
- **early postpartum period**- the period of time from the birth of an infant until she/he was four weeks old.
- **a concern**- a current interest or issue of importance that affected a new mother.
- **coping strategies**- ways in which new mothers managed or dealt with their identified current concerns.
- **parenting**- the expression of the maternal/paternal role toward an infant.
- **child-rearing**- the process of physically and emotionally caring for an infant.

**Assumptions**

The following assumptions were made but were not investigated in this study:
1) New mothers are legitimate nursing clients.
2) New mothers provided truthful answers to interview questions and articulated their concerns and coping strategies.

3) The birth of the first child constitutes a transition or life crisis for a new mother.

4) A new mother enters the child-rearing/parenting period with her own history and personal characteristics that uniquely affect her experience.

**Limitations**

Several limitations to the study arose in relation to the sample, the data collection method and the data analysis method.

The study findings may not be applicable nor generalizable to those women who do not meet the inclusion criteria. Because convenience sampling was used to select the study subjects, it was possible that the available subjects were atypical members of the population with respect to their concerns and coping strategies.

The concerns and coping strategies of the new mothers were only those explicated at one to four weeks post discharge and did not account for other time frames either retrospectively or longitudinally.

The presence of an interviewer may have influenced, distorted or limited the responses of the subjects. Interviewing using pre-determined trigger questions also limited the subjects' responses because specific aspects of the experience were being explored.

Content analysis, as a data analysis method, has its own limitations. The main limitation is that the coder is interpreting another person's communication. Judgment is required by the coder in the analysis of the interview and this judgment is at risk of being inaccurate (Waltz, Strickland, & Lenz, 1991).

**Ethical Considerations**

In order to protect the rights of the subjects in this study, several procedures were undertaken before the study could proceed. Prior to contacting subjects, the research proposal received ethical approval from the University of British Columbia's Behavioral Sciences Screening Committee. The proposal required further approval from the Vancouver Health Department. Participation in the study was voluntary and confidential and the subjects had the
option of withdrawing from the study at any point in time. All data was confidential with only the researcher and the study chairperson listening directly to the tapes. The subjects were asked to sign a consent form (Appendix B) that indicated agreement to participate in the study and to be audio tape recorded. Subjects had the option of requesting erasure of the tape or portions of it at any time. In addition, all audio tapes and transcripts were destroyed upon the completion of the study. Finally, all candidates for inclusion in the study were provided with opportunities to question the researcher before inclusion, and participants were encouraged to ask questions related to the study during the research process.

Chapter Summary

In summary, while the transition to motherhood may not be a crisis for most new mothers, it is certainly a stressful life event. In order for health care professionals to facilitate new mothers' transitions to motherhood, they need to be aware of the various concerns and coping strategies that these women experience and use during the postpartum period. The purpose of this study was to identify new mothers' current concerns and ascertain the coping strategies used to manage those concerns. While many studies have explored the concerns of mothers, few have allowed the women to define their own experiences. By using a qualitative methodology, it was felt that the results would reflect the women's experiences. The next chapter will review the pertinent literature.
CHAPTER 2
REVIEW OF THE SELECTED LITERATURE

Overview

This study arose from the author's recognition of the importance of a successful transition during the early postpartum period, as well as the importance of understanding the concerns and coping strategies during this transitional period from a new mother's perspective. This chapter will review selected empirical and theoretical literature that pertains to the variables that affect the transition to motherhood and the attainment of the maternal role, as well as the concerns and coping strategies of new mothers in the postpartum period. The purpose of the literature review is to present the findings of the literature and ascertain the current state of knowledge about new mothers' concerns and coping strategies.

Variables that Affect the Transition to Motherhood and Maternal Role Attainment

The birth of a couple's or an individual's first child and the subsequent development of the parental role has been labeled as both a crisis (Dyer, 1965; LeMaster 1957) and a transition (Rossi, 1968). Dyer's (1965) and LeMaster's (1957) studies which supported the crisis perspective, have been faulted for poor methodological techniques (Miller & Sollie, 1980; Steffensmeier, 1982). More recent work has supported the notion of a transition to parenthood rather than a crisis period (Steffensmeier, 1982). Thus, the term transition, first introduced by Rossi (1968), has become the norm when describing the process of becoming a parent. Because motherhood is viewed as a difficult and demanding role, the transition to motherhood and the attainment of the maternal role has received much attention in the literature. This section of the literature review will describe the variables that affect maternal role attainment. These variables are discussed because it is possible that they may affect the concerns and experiences of new mothers during the early postpartum period.

Women possess personal backgrounds and histories that influence their attainment of the maternal role. Mercer (1981) reviewed the literature and found the following personal factors had an impact on maternal role attainment: age, educational level, perception of birth experience, social stress, support systems, self-concept and personality traits, child-rearing
attitudes, and infant temperament. For example, women who were greater than 20 years had greater psychological readiness for mothering than younger women, but they also had higher morbidity rates and higher expectations for themselves in the role (Ralph, 1977). Women older than 27 years were more depressed postpartally than younger women (Uddenberg, 1974). More highly educated women experienced more stress in the transition to motherhood and enjoyed parenting less than parents with less education (Russell, 1974). Women who had unanticipated cesarean births viewed their birth experience less favourably and made more hostile comments about their infants than women who delivered vaginally (Marut & Mercer, 1979).

According to Mercer (1981) social stress influences pregnancy and parenting. Diffuse long-term social problems and social isolation have been associated with child abuse (Green, 1976: Hunter, et al., 1978). Feiring (1976) observed that adaptive maternal behavior was influenced by the mother's perception of the amount of positive support she received. Support could have an important effect on women's ego strength, self-confidence, and nurturant qualities which have been observed to be determinants of their capacity as mothers (Shereshefsky & Yarrow, 1973). Mothers who rated high in adaptive maternal behavior have been observed to have infants with easy temperaments (Feiring, 1976). All of the personal and environmental factors that have been discussed correlate with maternal role attainment. Therefore, each factor has the potential to affect attainment of the maternal role based on a woman's personal history and characteristics. A combination of factors, each with its own influence, has the potential to significantly affect maternal role attainment and the concerns that new mothers experience (Mercer, 1981).

Rubin (1977) stated that the maternal-child relationship is a process, which she labeled binding-in, that occurs in "progressive stages over a period of 12 to 15 months" (p. 67). Rubin (1977) believed that binding-in was composed of three interrelated steps:

1) polarization- the psychological loosening, without severing, of the experience of the infant from the unity with herself (the mother) to an entity in physical, social and conceptual space, 2) identification of the infant in reality instead of in
the varied hypothetical fantasies of pregnancy and 3) the claiming of the infant by association with significant others in her immediate social environment who, in turn, claim her (the mother) (p. 67).

Three factors that determine the duration of the stage of maternal transition and could potentially determine the success of the transition process are; "1) the mother's own recovery and state of well being; 2) the amount and kind of socially significant support; and 3) the endearing inputs of the baby itself" (Rubin, 1977, p. 67).

There is agreement that motherhood is a dynamic process that is learned, stress producing, lacking guidelines, abrupt, and culturally and socially defined (Chick & Meleis, 1986; Hampson, 1989; LaRossa & LaRossa, 1981; Mercer, 1986; Rossi, 1968; Rubin, 1977). According to Rossi (1968) the development of any social role has four stages. These four stages can be applied to the transition to parenthood: 1) anticipatory stage- pregnancy in the case of the parental role, 2) honeymoon stage- "post-childbirth period during which, through intimacy and prolonged contact, an attachment between parent and child is laid down" (p. 30), 3) plateau stage- the extended middle period during which the role is fully exercised, and 4) disengagement/termination stage- parental role termination is not clearly marked, but ends when the authority and obligations of the parent end. The blending of the following four features makes the parental role relatively unique: 1) the cultural pressure to assume the role, 2) the often involuntary inception of the role, 3) the irrevocable nature of the role, and 4) the lack of preparation for the parenting role (Rossi, 1968). All of these features have the potential to affect the concerns of new mothers.

Lack of preparation for parenting comprises four factors: lack of previous child care experience, lack of realistic training for parenthood, abruptness of transition and, lack of guidelines to successful parenthood (Rossi, 1968). Women in North American society are often inadequately prepared for motherhood (Rossi, 1968). An abundance of prenatal classes focus on pregnancy, and labour and delivery issues. These classes have minimal teaching concerning parenting. While parenting classes are available to new parents after birth, parents have little free time with the arrival of their infant. In spite of the lack of adequate
preparation, attainment of the maternal role is a process that must be completed for a healthy relationship to develop between mother and child.

**Maternal Concerns**

During the transition to motherhood new mothers experience a variety of concerns that have the potential to affect their attainment of the maternal role. This section of the literature review will describe primiparas' general concerns, specific concerns and changes in concerns over time. A critical analysis and summary will follow.

The concerns of primiparous women at various times during the postpartum period have been studied for almost 30 years (Bull, 1981; Chapman, Macey, Keegan, Borum & Bennett, 1985; Graef, McGhee, Rozycki, Fescina-Jones, Clark, Thompson & Brooten, 1988; Gruis, 1977; Harrison & Hicks, 1983; Hiser, 1991, 1987; Smith, 1989; Sumner & Fritsch, 1977; Tobert, 1986). From the outset the emphasis has been placed on health care professionals' perceptions of maternal concerns. In the earliest study, Gruis (1977) developed a questionnaire that listed potential areas of maternal concern that were based on the available literature. Seventeen primiparous mothers and 23 multiparous mothers returned the completed questionnaire one month after delivery. Mothers recalled the areas that were significant to them during the past month and ranked the concerns as either major or minor. Fifteen of the 17 primiparous mothers (88%) ranked return of figure to normal, regulating family demands, infant behavior, infant feeding and emotional tension as their foremost concerns. Gruis (1977) concluded that the primiparas' concerns focused on the newborn itself. The majority of Gruis' (1977) conclusions and recommendations were based on a combination of the results from both the primiparous and multiparous samples. Because the number of primiparas and multiparas within the combined group were unequal, and their foremost concerns differed, any generalized conclusions about the mothers could have been misleading.

Sumner and Fritsch (1977) based their concern study on the type and number of telephone calls received over a one month period during 1974 to a medical center, nursery and consultative nurses' station. A total of 270 telephone calls were received and coded; 62% of all calls were from primiparous mothers. The authors combined the primiparas' and
multiparas' questions. The highest percentage of questions (31%) concerned feeding, with the greatest number of inquiries reflecting breastfeeding concerns. Gastrointestinal concerns (21%) followed feeding concerns, with the greatest number of inquiries being about colic. Questions were most frequent in the first two weeks following hospital discharge but peaked at regular intervals following discharge: 1 to 2 days, then at 7, 10, 14, 21, 28 and 35 days. Primiparous mothers called three and one half times more frequently than multiparous mothers. Once again Sumner and Fritsch (1977), drew conclusions from the primiparas' and multiparas' combined results despite distinct differences between the two groups of new mothers.

Bull (1981) employed a modified version of Gruis' (1977) questionnaire to study the focus of and changes in concerns of primiparous mothers. The 50 item questionnaire contained potential concerns related to the categories of self, baby, husband, family, and community. Thirty women completed the questionnaire at three days and one week postpartum. By the end of one week, the frequency and intensity of new mothers' concerns related to physical discomfort had decreased but the concerns related to emotional self had increased. The concerns related to the infant remained the same as at the 3 day measure. Bull (1981) concluded that the decrease in physical discomfort resulted from normal healing processes, but did not speculate about the increase in concerns related to emotional self.

A study by Harrison and Hicks (1983) also used the questionnaire developed by Gruis (1977) to sample 64 primiparous mothers and 94 multiparous mothers from Canada between 23 to 60 days after delivery. The combined samples identified an average of 5.35 major concerns and an average of 10.65 minor concerns. Primiparas identified significantly more minor concerns than multiparas. Regulating the demands of husbands, housework and children was the greatest concern (81%) of all mothers, followed by the return of figure to normal (80%), fatigue (77%) and emotional tension (77%). Once again the primiparas' and multiparas' concerns were combined during data analysis. Since the study contained fewer primiparas than multiparas, the results could have been biased in favour of the multiparas. The differences in identified concerns from other studies support that conclusion (Chapman et al. 1985, Tobert, 1986).
Chapman, Macey, Keegan, Borum and Bennett (1985) studied the concerns of 50 breastfeeding mothers over the four months after delivery. Thirty-four primiparas and 16 multiparas had their verbal concerns coded by nurses after hospital visits, home visits and telephone calls. Three categories of concerns emerged: breast concerns, infant concerns and postpartum concerns. Breast concerns included amount of milk, sore nipples, frequency of breast feeding, infant having a preferred breast and expressing and saving breast milk. Infant concerns included infant behaviors such as fussiness, sleepiness or day-night mixing, rashes, rapid or slow rate of weight gain and upper respiratory tract infections. Postpartum concerns included fatigue, adjustment of sibling(s), adjustment involved in returning to work or school, lack of weight loss and upper respiratory tract infections. The timing of concerns varied over the four month data collection period, but most of the concerns emerged during the first three postpartum weeks. Chapman et al. (1985) did not speculate about the possible reasons for the decrease in concerns over time and primiparas' and multiparas' concerns were combined for the analysis of the results. Because there were twice as many primiparas as multiparas, the study results appeared biased in favour of the primiparas. However, many of the expressed concerns would also appear to be relevant to a multiparous woman.

Tobert (1986), employing Bull's (1981) 54 item questionnaire, compared the concerns of 31 primiparous and 36 multiparous Canadian mothers at two days and one month postpartum. Primiparous mothers rated recognizing signs of illness as their greatest concern at two days postpartum (58% much concern, 39% little or no concern) followed by being a good mother (59% much concern, 41% little or no concern) and safety (51% much concern, 49% little or no concern). Tobert (1986) did not clarify whether the concept, 'recognizing signs of illness' was related to illness of the mother, infant or both. At one month postpartum, primiparous mothers' greatest concerns were recognizing signs of illness (45% much concern, 55% little or no concern), being a good mother (45% much concern, 55% little or no concern) and return of figure to normal (45% much concern, 55% little or no concern). No statistically significant differences were found in the frequency or intensity of concerns of primiparas when time frames were compared.
In a study by Hiser (1987), a 62 item card sort tool developed by Moss (1981) was adapted in order to study the concerns of multiparous mothers at 10 days to 2 weeks postpartum. After sorting the cards, all mothers were asked to verbally name their one main concern. In this study the verbal answers did not reflect the card sort results. Hiser (1987) speculated that the difference in results could have been due to response set bias, "the participants may have thought it was socially desirable to tell the nurse researcher that they were most concerned about their newborns" (p. 202). Unfortunately, Hiser's (1987) interpretation did not address the possibility of bias with the prewritten card sort tool.

Graef et al. (1988) studied the concerns of 32 breastfeeding mothers: 25 primiparas and 7 multiparas over the first postpartum month. All women were telephoned once per day for the first two weeks and twice per week for the third and fourth weeks. Once again primiparas' and multiparas' responses were combined. Infant concerns were reported by 97% of the new mothers. Feeding was the primary concern, specifically feeding frequency. Baby behavioral concerns such as sleeping, general wellness and growth and development followed feeding concerns. Eighty-one percent of all mothers had concerns for themselves. The major issues here were physiological and mothers relied heavily on physical indicators. Breast discomfort and nipple concerns were of primary concern followed by fatigue. Finally, 19% of women reported concerns about family and friends and lack of paternal and family support. Women in this study were asked to verbally state their concerns rather than choose possible concerns from a pre-written list. When women had the opportunity to express their own concerns, their major concerns related to their infants.

Smith (1989) employed Gruis' (1977) questionnaire to sample the concerns of 19 primiparous and 22 multiparous Canadian women at three and a half weeks after delivery. Primiparous mothers were concerned about feeding (63%), fatigue (53%), breast soreness (53%), and baby behavior (47%). Primiparous mothers also had major concerns related to learning to care for and meet the needs of a dependent infant much like the results of Tobert's (1986) study. This study focused separately on primiparous and multiparous women and revealed that primiparous women were most concerned about learning to care for their infants.
In a further study by Hiser (1991), Moss' (1981) 64 item card sort tool was again used to sample the concerns of 110 mothers, 49 primiparas and 71 multiparas at 10 to 14 days postpartum. The prewritten cards were separated into 10 items related to the family, 22 items related to the mother and 32 items related to the infant. The new mothers were asked to sort the cards into three piles: no concern, interest or worry. Primiparas' and multiparas' data were combined for analysis. The women's greatest worries were about family finances (50%), meeting the needs of everyone at home (46.4%), being a good mother (41.2%) and mother's weight (38.8%). Their main interests included knowing how babies grow and develop (72.4%), knowing how babies act (60.8%), babies' blood tests (50.5%) and babies' health (48%). In spite of having three times as many cards related to infant concerns, the women's foremost concerns related to their families. This may have been due to the fact that the combined group of mothers contained 45% more multiparas than primiparas.

In this study, Hiser (1991) viewed concerns, interests and worries as mutually exclusive, in that the mother could put each card into only one pile. The possibility that some of the cards could have been both an interest and worry to some primiparas was not discussed. After the card sorting, all mothers were asked to verbally state their greatest concerns. Twenty-one percent replied that infant feeding was their greatest concern followed by health items (15%) and managing needs of the family (9%). Once again the verbal concerns did not reflect the card sort results. Hiser (1991) speculated that this variation in participants' responses may have been related to the use of different methodologies, "spontaneous sorting of card items may be less biased than the answer a new mother gives a nurse when asked directly about her main concern" (p. 172). Open questions were not considered as the less biased venue for accessing mothers' perceptions.

**Summary of Maternal Concerns**

The maternal concern studies addressed a variety of sampling times, samples, methodologies and instruments. The studies ranged from 1977 to 1991. Few changes in concerns were noted over these 14 years. For example, one of the earliest studies (Sumner & Fritsch, 1977) reported feeding to be the major concern of new mothers, and that major
concern was also identified in the most recent studies (Graef et al, 1988: Hiser, 1991: Smith, 1989). Sampling ranged from as early as one day postpartum to 4 months postpartum. Only one of the previously mentioned studies sampled and contrasted primiparas on two separate occasions (Tobert, 1986). At 2 days and 1 month after birth, primiparous mothers had the same major concern, which related to their infants: recognizing signs of illness (Tobert, 1986).

In one study that sampled new mothers over a specified period of time, Chapman et al. (1985) reported that the majority of concerns were expressed during the first three weeks postpartum. Bull (1981), Hiser (1991) and Smith (1989) sampled new mothers in a similar time frame. Their results included concerns about self, concerns about family, and the concerns about infant. The remaining studies (Graef et al., 1988: Gruis, 1977: Sumner & Fritsch, 1977) sampled women at or during the first month postpartum. Gruis (1977) reported that the women's foremost concern was return of figure to normal, while Sumner and Fritsch (1977) and Smith (1989) reported infant feeding as women's foremost concern. It appears that new mother's concerns change over time.

Of the studies that reported the concerns of primiparas and multiparas independently, feeding concerns (Smith, 1989) and recognizing signs of illness (Tobert, 1986) were the major concerns of primiparous mothers. Primiparous mothers seemed to focus their concerns on the newborns. The focus of concerns for mothers appears to change with the birth of subsequent children due to previous experience with infants, increasing family size and responsibility of more than one child. Many studies combined primiparas and multiparas into one group of mothers for analysis of data and treated them as equal groups (Chapman et al, 1985: Graef et al, 1988: Gruis, 1977: Harrison & Hicks, 1983: Hiser, 1991: Sumner & Fritsch, 1977). None of these studies sought to include equal numbers of primiparas and multiparas within the sample and none of these studies commented about how combining the two groups of mothers could have affected their results.

Only two studies (Hiser, 1991, 1987) employed a qualitative methodology (verbal questioning) as well as a quantitative methodology (card sort tool). As stated previously, new mothers' verbalized major concerns differed from concerns selected from prewritten cards.
Card sort tools produced major concerns including: meeting the needs of everyone at home (Hiser, 1987) and family finances (Hiser, 1991). Verbal questioning produced major concerns including: the newborn (Hiser, 1987) and infant feeding (Hiser, 1991). Employing different methodologies resulted in different findings. Which method of inquiry addressed mothers' perceived concerns? Prewritten questionnaires, that offered preconceived concerns to new mothers, might limit access to mothers' perceptions more than open questions that provided an opportunity for mothers to respond in any way they wished. In addition, because the cards were divided into three unequal categories (infant, mother and family), the new mothers had a much greater opportunity to pick baby concerns as opposed to family concerns. Surprisingly, in both studies, the women chose family concerns as their foremost concerns from the cards but verbally reported concerns related to their infants.

Three of the previously mentioned studies concluded that feeding was the number one concern of primiparas and/or a combined group of primiparas and multiparas (Graef et al, 1988: Smith, 1989: Sumner & Fritsch, 1977). Other primary concerns ranged from return of maternal figure to normal (Gruis, 1977), to regulating the demands of husband, housework and children (Harrison & Hicks, 1983), recognizing signs of illness (Tobert, 1986), and family finances (Hiser, 1991). Much relevant information was lost when primiparous and multiparous women were grouped together in order to analyze results.

Thus in summary, although the literature which addresses maternal concerns is extensive and spans three decades, it does not comprehensively address maternal postpartum concerns from primiparous women's own perspectives. Research is required which addresses maternal perceptions of concerns in the early postpartum period.

**Parental and Maternal Coping Strategies**

Only a few studies have explored the coping strategies of new mothers and parents (Alexander, 1984; Bennett, 1981; Miller & Myer-Walls, 1983; Ventura, 1982, 1986). Bennett (1981) performed a two stage study to elicit information from new mothers about a variety of topic areas; one topic explored the help new mothers needed in coping with their babies. Seventy-eight women were sampled between 20 to 32 years. Sixty one were primiparas.
During stage one, 30 subjects completed a series of eight open-ended questions (question example: How can the father of the new baby be of help to the mother, both practically and emotionally, in early child care?). Subjects' written answers were coded using content analysis. All answers verbalized by at least two subjects were included in the second stage questionnaire. A 90 item questionnaire based on the answers from stage one, was then presented to another 48 new mothers. During this stage, subjects were asked to rate the importance of the 90 items using a visual analogue scale. The highest rated items deemed to be helpful to the mother in the early puerperium were: someone to go to for advice, someone to look after baby occasionally so (mother) can go out with partner, and someone to look after baby occasionally so (mother) can go out by herself. Unfortunately many of Bennett's (1981) open ended questions assumed that husbands were helpful during pregnancy, childbirth and in early child care. Bennett (1981) concluded that her findings "support(ed) the notion of a common reality of experience" amongst newly parous women (p. 20).

In a study about women who delayed motherhood until after age 30, Alexander (1984) explored the experiences, problems and coping strategies of 15 (8 primiparous and 7 multiparous) well educated, financially secure women. After interviewing the women and coding the data, Alexander (1984) uncovered a variety of problems and their accompanying coping strategies. For example, the women in the study found that finding time alone with their husbands was a problem. They coped with this problem by taking steps to correct it through hiring outside help. The women found that their role expectations were quite different from their husbands. Coping strategies for this problem included resignation, issuing ultimatums and seeking professional counseling. A feeling of decreased physical attractiveness troubled the women; they coped primarily through exercise. Women who needed access to support on a regular basis emphasized the importance of support groups. A lack of energy was a further problem for the women. They coped with this problem through exercise and 'getting away for a while'. Finally, the women felt a lack of control over time and activities. They coped with these feelings through exercise, getting away and laughter. Alexander (1984) felt that this particular concern may have arisen because "they (the mothers) may have been
accustomed to controlling events and being responsible for only themselves for many years. They (the mothers) may be inflexible to adjusting to anothers' demands" (p. 107). Because this particular group of women were financially secure, they had options (hiring outside help), that might not be accessible to other less financially secure women.

A study by Ventura (1982) addressed how parents coped with the everyday stresses during the transition to parenthood. Ventura (1982) started from the assumption that much of the stress a family experiences during this transition may be due to the addition of a new member and the resulting major reorganization of the roles and tasks in the family system. Two to 3 months postpartum, 200 hundred parents aged 19 to 48 years (mean 28.8 years) were asked to complete a 154 item self-administered questionnaire. The questionnaire consisted of a family coping inventory, an individual functioning subscale and an infant temperament questionnaire. Three coping patterns emerged:

1) seeking social support and self-development (including such behaviors as engaging in relationships and friendships, keeping in shape and becoming independent), 2) maintaining family integrity (including behaviors such as trying to be a parent to the baby and to other child(ren) and doing things with the child(ren)) and 3) being religious, thankful, and content (including the behaviors of believing in God, telling myself that I have things to be thankful for and belief that life would not be any better without the baby) (p. 271).

No significant differences were found between first-time parents and parents of several children for the three coping patterns. Unfortunately Ventura (1982) did not define the terms 'becoming independent', 'self development' or the behavior of 'trying to be a parent to the baby'. Without these critical definitions, Ventura's (1982) results are open to interpretation.

In their discussion of the stresses and coping strategies of parenthood, Miller and Myer-Walls (1983) suggested that three primary functional coping techniques were used by parents, based on their review and interpretation of the available literature. These were: "1) reliance on support systems and natural helping networks (family, friends and neighbours), 2)
application of methods for balancing multiple role responsibilities and 3) the seeking of assistance from professionals and from media sources" (p. 68). Miller's and Myer-Walls' (1983) coping techniques were employed by parents throughout their parenting and not only during the postpartum period.

In 1986, Ventura replicated her 1982 study using 47 couples of 2 to 3 month old infants. Thirty-one parents of first-born and 16 parents (ages unspecified) of second or third children completed the questionnaire. During this replication the parents answered 139 questions: 34 questions related to coping, 53 questions related to individual functioning and 52 questions related to infant temperament. The findings of the previous study (1982) were confirmed. Once again the three coping patterns of seeking social support and self-development, maintaining family integrity and being religious, thankful and content emerged from the data analysis. A fourth coping pattern, being responsible was also added but not defined. The findings suggested that "optimal family coping involved couples' actions directed at anticipating and managing family tasks. In other words, mothers' and fathers' combined behaviors resulted in family coping" (p. 80). Unfortunately, Ventura (1986) did not explain this statement which leaves the reader unsure about how parents contributed to and/or combined behaviors.

Summary of Parental and Maternal Coping Strategies

Although the number of parental and maternal coping studies were limited, agreement on several coping strategies for new parents emerged. Miller and Myer-Walls (1983) and Ventura (1982, 1986), who all studied parental coping, concluded that utilizing social support systems and maintaining or balancing family integrity were two common parental coping strategies. Bennett (1981) and Alexander (1984), who studied maternal coping, concluded that going to someone (a professional) for advice and 'getting away' were possible maternal coping techniques. However, "someone to go to for advice" and "getting away" may be techniques that are open to interpretation. In addition, except in Alexander's 1986 study particularly important to older, more educated women, these were general coping strategies that were not related to specific concerns or challenges during the postpartum period. These deficits create
difficulties for health care professionals trying to offer anticipative guidance or to evaluate the effectiveness of coping during the postpartum period.

**Chapter Summary**

In summary, numerous studies have described the variables that affect the transition to parenthood and the concerns of primiparous mothers. Few studies have clearly described the coping strategies utilized by new parents and mothers during the postpartum period.

Mother’s concerns included: return of the prepregnancy figure, regulating family demands, infant behavior, infant feeding, breast concerns, emotional tension, fatigue, being a good mother, family finances, lack of time for self, and safety issues.

Mother’s coping strategies included: someone to go to for advice, someone to look after baby, hiring outside help, resignation, issuing ultimatums, seeking professionals, exercise, taking time for self, seeking/relying on support systems, maintaining family integrity, being religious, thankful, and content, seeking assistance from professionals and media sources, and anticipating and managing family tasks.
CHAPTER 3
METHODOLOGY

A Descriptive Research Design

In 1968, Dickoff and James related nursing research to theory development. Four levels of theory were identified: factor-isolating, factor-relating, situation-relating and situation-producing. Each level was based on the existing information about a specific topic. The four levels continue to be used today by researchers to address the appropriate level of research question in the context of existing theory (Woods & Catanzaro, 1988). Factor-isolating theory, as the first level, attempts to answer the question, "What is this?" (Woods & Catanzaro, 1988). The purpose of a study at the factor-isolating level is the identification and classification of concepts (Woods & Catanzaro, 1988). Factor-isolating theory is appropriate when little or no information is known about a particular subject (Woods & Catanzaro, 1988).

The studies that were reviewed in the previous chapter were researched at the factor-isolating level in order to describe and label new mothers concerns. As stated in chapter 2, the concerns of new mothers have been studied extensively from a quantitative perspective, while the coping strategies of new mothers to deal with those concerns have been largely ignored in the literature. Nurses and other health care professionals must understand the client's perspective of health related events if they are to provide holistic and appropriate care. It is this researcher's belief that quantitative methodologies fail to allow the subject's perspective to be heard. By presenting new mothers with prewritten questionnaires, previous researchers have used their own perspectives to direct their subjects and not allowed the subjects' experiences to be explored. Descriptive research from a qualitative perspective does allow for the subjects' identification of phenomena of interest. Therefore, this study was undertaken using a qualitative descriptive design to address the mothers' perspectives. This study addressed the insufficient depth of understanding of maternal concerns in extant literature and the lack of identified coping strategies by new mothers to specifically deal with these concerns.
Subject Recruitment

Subject recruitment took place through the Burrard Health Unit of the Vancouver Health Department. Letters of information were distributed to the community health nurses at that unit (See Appendix A). To be included in the sample, each subject had to meet the following criteria:

1) primiparous women who had had either a cesarean or vaginal delivery,
2) women who were between the ages of 20 to 45,
3) women who were currently residing with the baby's father,
4) women who had undergone a medically uncomplicated pregnancy, labour and delivery, (any medical condition that occurred during pregnancy, labour or delivery such as PIH, gestational diabetes or fetal distress had been successfully resolved without sequelae following the delivery of the baby),
5) women who had experienced a full term delivery in hospital (37 weeks gestation or longer),
6) women who had delivered a healthy singleton infant (baby's APGAR score was 6 or above at five minutes),
7) women who had received at least one visit from a community health nurse (CHN),
8) women who were able to read and speak English,
9) women who had telephones.

Seventeen subjects (2 pilot plus 15 actual subjects) were recruited in total. Recruitment stopped after the fifteenth interview due to data saturation.

Community health nurses (CHNs) at the Burrard Health Unit contact new mothers after receiving a hospital referral and attempt to make home visits as soon as is feasible following the new mother's discharge from hospital. The CHNs agreed to provide mothers with information about the study. If, during an initial home visit, a new mother met the recruitment criteria for the study, then the CHN presented the mother with an "Information and Consent to Contact Form" (See Appendix B). If the new mother read and signed this form, the CHN returned the signed form to a drop-off file at the health unit. The researcher called the health unit weekly to retrieve information from the file and then contacted mothers as soon as
possible to assess their willingness to participate and to arrange for an interview within one to four weeks following hospital discharge. At that time verbal consent was obtained for participation. Following contact, the women were visited in their homes. Prior to being interviewed, mothers were encouraged to ask questions about the study. Then, informed consent was obtained (See Appendix C).

**Data Collection**

Data were collected during structured interviews. The forty-five minute interview was scheduled at a time and place that was convenient for the new mother. All interviews occurred in the subject's homes. The researcher asked for the interview to be scheduled at a time when the new mother and baby would be alone, without friends or adult family members present who might act as distractions.

Predetermined questions were developed to sensitize the researcher to important areas (See Appendix D). Each question was very general in nature. These open-ended questions were used to elicit data so that the women were not forced to respond in particular ways. This allowed each woman to freely express her ideas about her experiences. All trigger questions were assessed by two members of the thesis committee for suitability and clarity before the interviews were initiated. In addition, the interview questions were pilot tested with two women. The researcher also used these two interviews as an opportunity to develop her interviewing skills.

During the interview, the researcher used prompts if the participant had difficulty responding to the trigger questions. For example, when one mother was asked about the changes, challenges and joys that were affecting her she answered, "We had a bit of difficulty getting pregnant so it's just a joy to have her (the baby), the biggest challenge has been day to day just making sure that we are always doing things properly", to which the researcher replied, "So it's doing things properly that is a challenge?", "Yeah" was her reply, which was followed by the prompt, "Can you give me some examples of those things?".

Although the predetermined trigger questions provided focus for the interview, spontaneous questions were asked throughout the course of the interview in order to clarify the
subjects' answers. For example, one new mother, when speaking about her career said, "I've always had senior positions in jobs and firms and its funny that all of a sudden you are not in control at all, like if she (the baby) decides you're up then you're up and if she decides that you are not going anywhere then you're not", to which the researcher replied, "That idea of you being in control at your job and now having to relinquish control to this little person, can you tell me what that experience has been like for you?". After each interview, the new mother was asked to answer demographic questions (See Appendix E).

Over the course of the interviews, the researcher found that her ability to listen and respond to subtle responses from the new mothers improved dramatically. During the initial interviews the researcher was very focused on getting all of the trigger questions answered rather than listening to the subject's responses. With experience and the assistance of the first two committee members, the researcher was able to focus her listening on the subject's ideas and let those ideas guide the spontaneous questions and the direction of the remaining interview. Over time this resulted in richer data from the interviews.

A second interview was arranged with 5 previously interviewed subjects in order to validate the data. The last 5 women to be interviewed were asked to participate in the further untaped interview (See Appendix F). Each of the 5 woman was sent a copy of the findings by mail. She was asked to comment on the findings: specifically, did she agree with the findings, could she see herself in the findings, and did she agree with the wording of the findings? The results of this second interview will be described in the analysis section of this chapter.

Characteristics of the 15 Participants

Subject recruitment took place from August 1993 to April 1994. The new mothers ranged in age from 22 to 34 years, with the average age being 30 years. Thirteen women (87%) delivered vaginally while 2 women (13%) experienced cesarean deliveries. The 11 female babies (73%) and 4 male babies (27%) ranged in age from 9 to 30 days old. They were an average of 21 days old by the interview date. Eight babies (53%) were 18 days old or less at the time of the interview, while the remaining 7 babies (47%) were 22 days or older. The level of education attained by the women ranged from high school to graduate work. The
women were all fluent in English. All but 5 of the women (33%) were working up until 2 weeks before their EDC. The average length of hospitalization was 3 days, while the average length of time at home was 18 days by the time of the first interview. Thirteen women (87%) attended prenatal classes. While all of the women resided with only their partner and baby, 4 women (27%) had a family member living with them temporarily after the birth of the baby and 1 had a daytime housekeeper. All of the women were breastfeeding to some extent at the time of the interview.

Data Analysis

Content analysis, a content focused method of data analysis "involves the systematic and objective reduction or simplification of recorded language to a set of categories... that represent the... nature of selected characteristics" (Waltz, Strickland, & Lenz, 1991. p. 299). Content analysis is defined by Krippendorff (1980) as "a research technique for the objective, systematic and quantitative description of the manifest content of communication" (p. 21). In other words, content analysis is the analysis of the overtly communicated content of speech. This type of design allows the subjects' feelings, emotions and personal experiences within their environment to be explored in depth (Waltz, Strickland, & Lenz, 1991). The term content analysis "is used to describe both inductive, theory-building techniques wherein categories for describing data evolve during the analysis and deductive, theory-testing techniques wherein theory-based categorical schemes developed before conducting the analysis are used to analyze data from subjects" (Waltz, Strickland, & Lenz, 1991, p. 299).

For the purposes of this study, inductive content analysis was utilized. By performing inductive rather than deductive content analysis, the categories were induced directly from the words and expressed opinions of the new mothers. The steps of Waltz, Strickland and Lenz's (1991) inductive content analysis were employed for this study:
1) The universe of content to be examined was defined. This was defined as all audio tape recorded responses of new mothers during home interviews.
2) The characteristics or concepts to be measured were identified. The concepts to be measured were concerns and coping strategies.
3) The unit of analysis to be employed was selected. The units of analysis were the sentences and phrases expressed during the interviews.

4) The sampling plan was developed. Once the unit of analyses were identified as the sentences and phrases, it was necessary to determine how the universe of content was to be sampled. In this study the entire universe was examined.

5) A way of categorizing the content was developed. Each interview was analyzed for emergent categories and concepts that described concerns and coping strategies. The researcher analyzed all the interviews using Maxwell and Maxwell's (1980) steps of continuous comparative analysis. The steps employed were:

   a) Analytic units were created. Analytic units are equivalent to Waltz, Strickland and Lenz's (1991) universe of content to be examined, therefore this step involved audio tape recording and transcribing the interviews.

   b) Concepts were formulated. Each interview was analyzed immediately following the interview. Each interview was read twice in order to get a sense of the whole. During the third and fourth readings, the interview was broken down into words and/or phrases. Concurrent data analysis occurred wherein interviews were being compared and contrasted over the course of data collection. Each interview was compared with the interviews preceding it in an attempt to "uncover similarities and differences or patterns in the data" (Maxwell and Maxwell, 1980, p. 234). Accordingly, "each comparison- each similarity and difference- provided tentative conceptual categories (and concepts) of limited generality" (Maxwell and Maxwell, 1980, p. 235).

After completing these steps with the first three interviews, the researcher went back to the interviews and further refined the categories, concepts, changes, challenges, joys, and coping strategies. Refining changes, challenges, joys and coping strategies continued throughout the analysis as earlier interviews were compared with later interviews. Descriptions also got more specific over the course of the interviews. For example, while "breastfeeding" was an early concept label for all breastfeeding concerns, specific issues within breastfeeding such as "physical experiences associated with breastfeeding" and "positive emotional reactions
to breastfeeding" emerged with further interviewing and rereading of the earlier interviews. This process continued and categories such as "physical experiences associated with breastfeeding" were explicated by specific sub-categories such as "lack of milk supply", "pain associated with breastfeeding" and "leaking breast milk". After inductively developing sets of concepts from the data collected in five interviews, the early concept labels were evaluated for relevance, clarity, completeness, mutual exclusiveness and exhaustiveness with the assistance of the study chairperson and the second thesis committee member.

c) Concepts were developed. A comparison was made among and between the concepts generated from the interviews and the theoretical concepts generated from the existing literature. Studies were found that supported or refuted the initial findings. Accordingly, "These comparisons aided in the development of each concepts' characteristics and enabled (the researcher) to specify the conditions under which each concept was applicable. This comparison was a constant on-going process, that continually generated new properties" (Maxwell & Maxwell, 1980, p. 235). This step was limited due to the lack of qualitative studies about the concerns and coping strategies of new mothers.

d) The preliminary analysis was completed. Analysis employed the previously mentioned steps. For example, after the interview was finished, it was typed verbatim into a computer. Once printed, the interview was read once to get a sense of the woman's issues. During the second reading all words and phrases that pertained to changes, challenges or joys were underlined in red. All phrases or words that pertained to coping strategies were underlined in green. The interview was then read again to verify the previous findings. The words and phrases were then grouped into similar concepts that related to either concerns or coping strategies. With the completion of more interviews, the words and phrases could be further refined into specific categories within each concept. The concepts and categories grew, developed and were refined following further interviews. Concept and category labels were constantly changing to reflect the meaning of the women's issues and encompass all that they were expressing.
6) The analysis was validated. The researcher selected five previously interviewed mothers and asked them to participate in a further untaped interview. This second interview took place after all other interviews were completed. The researcher asked each new mother to verify and validate the preliminary findings that had been analyzed by the researcher from the previous interviews.

Once the preliminary data analysis was complete, the last 5 subjects were mailed a copy of the analysis along with a covering letter describing their role in validating the findings (See Appendix F). Since the initial interviews began in August, 1993 and the final interviews were completed in April, 1994, the final analyses were sent to the five women in May, 1994. A week later the 5 mothers were telephoned in order to discuss their feelings about the results. The first 2 mothers who were contacted both said that they could see themselves in the results and did not have any recommendations for changing any of the wording. The third mother who was contacted had many recommendations. For example, she felt that "sitz baths" were a coping strategy that should be included under the concept "recovering physically from birth". This mother also felt that the word "sensations" in the category "physical sensations associated with breastfeeding" was inappropriate and should be replaced with another word that better incorporated the categories. The word "sensations" has since been replaced with the word "experiences". Several of this mother's recommendations were directly incorporated into the final analysis while several were not. For example, this mother also felt that another category, "lack of support from partner" should be added under the concept "unsupportive attitudes/actions of others". The researcher and first two committee members felt that, because this category was an issue when the baby was four months rather than during the primary interview, these were not valid for the stated time period of the study. The final two mothers that were involved in validating the analysis also felt that the analysis was accurate as it stood, and when questioned about the third mother's ideas, agreed with most of her suggestions. Both agreed that "lack of support from partner" was not a category that should be added to the analysis.
Summary

In summary, a descriptive research design was employed. A total of 15 women between the ages of 22 to 34 were interviewed for approximately 1 hour in their homes, 1 to 4 weeks following the birth of their first infant. The women answered open-ended questions about the changes, challenges and joys they were presently experiencing, as well as the coping strategies they used to deal with those changes, challenges and joys. Inductive content analysis was used to analyze the findings. Maxwell's and Maxwell's (1980) steps of continuous comparative analysis were used to formulate and develop the concepts. The next chapter represents a summary of those findings.
CHAPTER 4
PRESENTATION OF FINDINGS

Introduction

The following chapter presents the findings of the study which described new mothers' concerns and coping strategies during the early postpartum period. Fifteen primiparas between the ages of 22 to 34 were interviewed in their homes for approximately one hour. During the interview the women were asked to describe the changes, challenges, and joys they were presently experiencing as new mothers. The women were then asked to describe the coping strategies they were using to deal with the changes, challenges, and joys.

Inductive content analysis was used to analyze the data. This type of design allows the subject's feelings, emotions, and personal experiences to be explored in depth. Maxwell's and Maxwell's (1980) steps of continuous comparative analysis were used to formulate and develop the concepts. This chapter is organized according to the six concern-related concepts which emerged from the data analysis (See Table 1). The concepts that represented the women's concerns were: becoming a mother, emotional and physical restoration, breastfeeding, balancing roles, developing relationship with the baby, and unsupportive attitudes/actions of others. The eight concepts that represented the coping strategies the women used to manage their concerns were: seeking support/advice, accepting support/advice, caring for self, redefining normal, encouraging/accepting partners involvement, sharing feelings, identifying what is right for self, and utilizing/modifying former coping strategies. The order in which the concepts are presented is not hierarchical.

Throughout this chapter the new mothers' thoughts about the changes, challenges, and joys they experienced in the early postpartum period have been labeled with the word "concern". The words "changes, challenges, and joys" were used during the interviews with the new mothers instead of the word "concern" because of the negative connotation that the word "concern" implies. As stated in Chapter One, the definition of the word "concern" is "a current interest or issue of importance that affects a new mother". Therefore, when the word "concern" is used in this chapter it can imply a negative and/or positive experience.
The 6 concern-related concepts and the 8 coping strategy concepts are illustrated in Table 1 and are described in the sections that follow.

Table 1

**Summary of the Concepts and Categories**

<table>
<thead>
<tr>
<th>CHANGES, CHALLENGES, JOYS</th>
<th>COPING STRATEGIES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>becoming a mother</strong></td>
<td></td>
</tr>
<tr>
<td>-personal tension</td>
<td>-sharing feelings</td>
</tr>
<tr>
<td>-embracing motherhood</td>
<td>-redefining normal</td>
</tr>
<tr>
<td>-total responsibility</td>
<td>-caring for self</td>
</tr>
<tr>
<td></td>
<td>-seeking support/advice</td>
</tr>
<tr>
<td><strong>emotional and physical restoration</strong></td>
<td></td>
</tr>
<tr>
<td>-body discomforts and mood changes</td>
<td>-redefining normal</td>
</tr>
<tr>
<td>-fatigue</td>
<td>-caring for self</td>
</tr>
<tr>
<td><strong>breastfeeding</strong></td>
<td>-seeking support/advice</td>
</tr>
<tr>
<td>-physical experiences</td>
<td>-accepting support/advice</td>
</tr>
<tr>
<td>-positive emotions</td>
<td>-sharing feelings</td>
</tr>
<tr>
<td>-negative emotions</td>
<td></td>
</tr>
<tr>
<td><strong>balancing roles</strong></td>
<td></td>
</tr>
<tr>
<td>-reincorporating paid work role</td>
<td>-seeking support/advice</td>
</tr>
<tr>
<td>-changing spousal relationships</td>
<td>-identifying what is right for self</td>
</tr>
<tr>
<td>-changing family relationships</td>
<td>-sharing feelings</td>
</tr>
<tr>
<td>-accepting losses from individual role</td>
<td>-caring for self</td>
</tr>
<tr>
<td></td>
<td>-utilizing/modify former coping strategies</td>
</tr>
<tr>
<td></td>
<td>-encouraging/accepting partners’ involvement</td>
</tr>
<tr>
<td><strong>developing relationship with baby</strong></td>
<td></td>
</tr>
<tr>
<td>-being fascinated with baby’s personhood</td>
<td>-sharing feelings</td>
</tr>
<tr>
<td>-providing adequate care for baby</td>
<td>-accepting support/advice</td>
</tr>
<tr>
<td>-making sense of baby’s needs and behaviors</td>
<td>-seeking support/advice</td>
</tr>
<tr>
<td><strong>unsupportive attitudes/actions of others</strong></td>
<td></td>
</tr>
<tr>
<td>-information issues</td>
<td>-identifying what is right for self</td>
</tr>
<tr>
<td>-lack of consideration of mother’s needs</td>
<td>-seeking support/advice</td>
</tr>
<tr>
<td>-disagreement with parenting style</td>
<td>-accepting support/advice</td>
</tr>
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</table>

**Becoming a Mother**

For many of the primiparous women who were interviewed, becoming a mother was overwhelming because it was fraught with numerous hurdles. The new mothers responded to these hurdles with feelings of powerlessness and anxiety. At the same time, they delighted in this new role and the arrival of their babies. Thus there was a tension created between these positive and negative aspects. Becoming a mother included feelings of personal tension, embracing the maternal role, and total responsibility. These were viewed as concerns by the
mothers and were intrinsically linked to the changes the arrival of this new person introduced to the women's lives.

Personal Tension

Several women spoke about an increased level of anxiety since the birth of their first child. They felt much closer to the edge. Things seemed to spiral out of control more quickly. One new mother expressed her personal tension when she stated, "I just get at the end of my rope very quickly... I'm a disaster". Another mother said, "You find your nerves not quite what they used to be... I tense up instantly". The anxiety threshold level for these women had decreased since the birth of the babies largely because their routines were disrupted and they felt as if they had entered a completely new world. Although this new world was full of uncertainty, it also involved embracing the maternal role. In contrast to the negative feelings that the increased personal tension created, the introduction of the maternal role elicited strong, almost overwhelming positive feelings.

Embracing the Maternal Role

Embracing the maternal role was integral to becoming a mother. The women were anxious to be all they could be as mothers and felt that the birth of their first child had a positive effect on their self concept. Initially they believed coming through the birthing process had intensified their feelings of mastery and self esteem. As one new mother put it:

The whole childbirth experience for me, the labour and delivery, it was a very intense experience for me, but I found that afterwards it made me feel more confident in myself and I felt if I could do that then I could do anything.

Successful completion of the pregnancy and birth gave this woman the feeling she could accomplish other insurmountable tasks. The first part of the childbearing experience gave this woman confidence to take on her mothering role.

For all of the women, the maternal role was a new dimension to be added to their existing roles. But the women did more than just add it to their repertoire of roles, they truly enveloped it:

I'm a mother now. A mom. What could be more important than that? I mean, I look at
him (the baby) and I can't believe that I am his mother. It's all so unbelievable, so very unbelievable, it's hard to put into words... it's really been a joy. It's unreal to just see him. I spent all that time during pregnancy being terrified of labour and delivery and I never thought about the end result which was so astounding.

For this mother, like the rest, part of the process of internalizing the maternal role was all encompassing and filled with joy. It seemed that many of the women had thought about the idea of being a mother, but had not truly understood how powerful the maternal feelings would be until they experienced them first hand. Only after becoming a mother did they really understand how important motherhood was for them, but also what it meant to be totally responsible for another human being.

**Total Responsibility**

Total responsibility reflected thinking about and being with their infants 24 hours a day. The women described this as the feeling that whatever happened was under their control and the "buck stopped" with them:

I can't even get a break when I sleep 'cause I dream about him (the baby) too. I'm with him all day by myself and I'm the only one who can do it. I'm his mom, no one else can do it, but it's annoying when you can't stop thinking about him, even for a little while. It would be nice to be able to think of something other than him for just a little while.

This quote reflects the sense that "I", the mother, am the only one who can meet my baby's needs. It reflects the all encompassing responsibility that invaded all aspects of the mothers' lives including their sleep. When the women felt there was no one else who could do what they did, they felt as if they couldn't let go. There was no room for anything else. These dynamics, including overwhelming feelings of joy at becoming a mother, anxiety due to increasing tensions and feelings of total responsibility, created tensions in the women's lives they had never experienced before. To respond to these tensions they had to develop coping strategies.
Coping Strategies for Becoming a Mother

The women used a variety of coping strategies to deal with becoming a mother. These strategies enabled them to manage the positive and negative aspects of motherhood. They all relied heavily on support from others to do so. The coping strategies the women used included sharing feelings, redefining normal, caring for self, and seeking support/advice (Table 1).

One coping strategy identified by the new mothers was sharing feelings. New mothers shared their feelings of tension with others. By sharing their feelings with trusted friends, their partners and prenatal class members, the new mothers were able to vent, to feel they were not alone, and to release their built up tensions. As one mother said, "I talked to two girls from my prenatal class, and I mean we talked and talked and talked. And they're going through the same stuff as me. So I'm not crazy... or we're all crazy". By talking and sharing with others who understood exactly what she was going through, this mother was able to feel that she was not alone and that she was feeling and experiencing very normal feelings.

A second coping strategy identified by the mothers was redefining normal. By redefining normal, the women also created viable options to concerns they never had to face before. By changing their expectations, the women could make a new schedule that revolved around the baby's schedule, do tasks when the baby slept, nap when the baby slept, be content to stay at home, rebudget their income, plan in advance, and be more patient. One mother who originally thought that the baby would fit into her schedule said, "We tried to make him (the baby) fit into our lifestyle but there was no way. We soon learned that he rules and you just have to fit around him".

This coping strategy helped the women accept the responsibility to meet the babies' needs 24 hours a day. They redefined normal by accepting that their lives and lifestyles would never be quite the same. As one new mother stated, "It helps just to realize that this (lifestyle with baby) is the now the new normal". The women could accept the overwhelming sense of responsibility because their lives now held exciting possibilities for themselves and their babies. Redefining normal helped to relieve their understandable feelings of anxiety. They did so by finding out about other women's experiences either through talking or reading. The
women chose particular support persons. Partners and friends were trusted not to judge. They were unlikely to be critical of the women's experience of "normal". Prenatal class members were all entering or coping with parenting and were experiencing similar feelings and dimensions. This coping strategy was used by the women over and over again.

A third coping strategy identified by the new mothers was caring for self. New mothers cared for themselves through meeting their own needs. They did this by napping while the baby slept and going out while having their partner give the baby expressed breast milk. This required a reliance on their partners' willingness to be supportive. However partners could not be there all the time and the women had to recognize their own limits. One mother described how she did that, "I just walk away. I thought I'm starting to lose it here and I'm not speaking to you (the baby) so I just walked away--and frayed nerves--you just have to nap, you have to get some sleep". Removing themselves from the situation and sleeping enabled the women to deal with total responsibility without doing anything harmful to the baby. Part of feeling that they were "losing it" related to the women's ongoing experience with sleeplessness because of the babies' needs for attention around the clock. This coping strategy was one way to deal with to the total responsibility for childbearing experienced by the women.

A fourth coping strategy identified by new mothers was seeking support/advice. Most new mothers sought support/advice to cope with their overwhelming feelings. The primary support person was their partner. Support took the form, in this instance, of the partner providing childcare, helping with household tasks and attending to the baby at night. By allowing their partners to shoulder some of the responsibility, although usually for short periods of time, new mothers were able to take time for themselves. This short time frame was often used to regain a sense of self as a person versus self as a mother. Basically, a supportive partner eased the woman's transition to becoming a mother by taking some of the responsibility.

**Emotional and Physical Restoration**

A second concern-related concept arising from the data was emotional and physical restoration. At the point of the interview, emotional and physical restoration consisted of body
discomforts and mood changes, and fatigue. Many of the new mothers spoke about their emotional and physical sequelae during the interviews. While many of the women realized that they would be tired during the early postpartum period and that their bodies would need time to recover, they were not prepared for the intensity of the emotional or physical feelings. Tiredness which developed into mental and physical fatigue, body discomforts and mood changes made the women feel that they were caught somewhere between their pregnant bodies and the body they used to have before the pregnancy.

**Body Discomforts and Mood Changes**

The women were clear that physical changes did not end at the time of their deliveries. They indicated that their bodies felt very different from the nonpregnant state. They still felt their hormones were adjusting and that there were other physical signs that indicated they had not returned to their prepregnancy state. One mother summed it up by saying:

> For me physically I feel like I'm honest to God I'm changing every single day and the hormones and everything is going crazy and still having lots of bleeding and I know with the breast milk I am hungry all the time, tired all the time but not grumpy because I have her (the baby). But I just feel like I am a completely different person, like I am out in space sometimes.

The feelings about being out in space indicated that this mother felt somewhat disconnected from her physical self and the rest of the world. Another mother reflected on getting over some of the early discomforts but still experiencing some of the hormone swings:

> I have more energy now 'cause with the delivery and stuff like it just knocked me out for a couple of weeks. I was just so tired and sore I couldn't do much... Then you are so sore that you can hardly get up and down off the couch, you feel really old and you can't move quickly, you just waddle... and then there's the hormones from hell.

Given all the physical discomforts and hormonal changes these women were experiencing, their feelings of being disconnected were not surprising. This may have been due, in part to fatigue.
Fatigue

Fatigue was a concern experienced by all of the new mothers. Naturally they were concerned about the implications of their fatigue not only because of the feelings the fatigue induced but also because fatigue made it harder to manage. One mother reflected on these feelings when she said:

Sleep deprivation is a big challenge, it's a big shock to your system, it makes it hard to cope... It's more than just being tired, it's exhausting and then your brain turns to mush and you can't remember anything.

Their descriptions of fatigue went beyond brief episodes of being tired. The fatigue was ongoing and seemed to reach a level of sleep deprivation. Emotional and physical restoration were linked to becoming a mother. Without emotional and physical restoration and especially without sleep, personal tensions might be greater, and embracing motherhood might be more challenging. This was especially true when dealing with feelings of total responsibility. Many women spoke about how their fatigue and interrupted sleep affected their daily lives. Several new mothers believed that if they could only get the sleep they felt they needed, then many of their other concerns might not have seemed so overwhelming.

Coping Strategies for Emotional and Physical Restoration

Body discomforts and mood changes required a variety of coping strategies. The women had to rely on a number of internal resources. The women utilized the coping strategies of redefining normal and caring for self to deal with their concerns (Table 1).

Redefining this physical situation as normal permitted the women to realize that the discomforts and mood changes were part of the normal postpartum healing process that required time to resolve. The women used information from their physicians, community health nurses (CHNs), or midwives about the physical discomforts they were experiencing to redefine the situation as normal. They used health care professionals to assist them to feel comfortable with what they were experiencing. One woman who consulted her physician about her physical discomforts said, "I just needed to hear I was O.K. and then I could deal with it". Defining physical discomforts as normal and expected helped them. The women used physical
resources to care for themselves. They ate nutritious foods and used sitz baths to enhance the healing process.

A second coping strategy used by the women to cope with emotional and physical restoration was caring for self. They coped with fatigue by napping when the baby slept. When they tried to decrease their napping time during the day, they found the results disagreeable. They realized they needed that sleep time to care for themselves. One new mother stated:

I started to feel better, it was about the second week, things were going great and I stopped taking my nap in the afternoon. Well that just threw me for a loop and I just didn't know what to do. I had to start napping again and that did the trick. You can't believe how a little bit of sleep can make such a difference.

Although the women were able to alleviate some of their feelings of fatigue, even napping during the day and when the baby slept did not alleviate all the fatigue. It seemed that emotional and physical fatigue were a part of mothering that went with the new role.

**Breastfeeding**

A third concern-related concept arising from the interview data was breastfeeding. Breastfeeding was a major concern for most of the new mothers. When the women spoke about their breastfeeding experiences, they spoke at length and with great intensity. Every mother from the study had initially used breastfeeding as the method of choice for feeding her baby. At the time of the interview all of the women were still breastfeeding but several had started to introduce a bottle as well. The women described physical experiences, positive emotions, and negative emotions associated with breastfeeding.

**Physical Experiences**

Physical experiences included such problems as lack of milk supply, pain associated with breastfeeding, and leaking breast milk. These physical sensations varied in their importance. Although leaking milk was a nuisance, this sensation was not tied up with their sense of motherhood in the way that an adequate milk supply was. The women defined successfully breastfeeding the baby as not only the ability to feed the baby adequately but also
to do so without intense discomfort. One new mother who had great difficulty, initially, with a lack of milk supply stated:

My milk didn't come in for the first week at all, so I went to Grace (Women's Hospital) and they helped a lot, but I nearly died when they took her (the baby) clothes off. 'Cause you know I always just take off little bits just the diaper or the T-shirt or whatever and they took it all off and her skin was just hanging off her and I said I can't do this. I can't feed my baby. I am a total failure and I was very depressed about that.

This quote illustrates the intensity of this woman's feelings about the effects of her inadequate milk supply. Weight loss or inadequate weight gain of the baby were viewed as indications of total failure in nurturing. Many women also spoke about the physical discomfort and pain they experienced during breastfeeding. They made comments about sore or cracked nipples:

At the beginning she (the baby) didn't latch on properly so I had very sore nipples and then my breasts got quite painful I don't know if they were engorged... It was so painful I couldn't go to sleep for 3 nights in a row.

For this mother the pain was so intense, it interrupted her sleep.

Several women went on to describe their over-production of milk and its subsequent effects. For the following mother, leaking breast milk meant having to change her clothes and worry about her appearance in front of others, "My breasts were so engorged and I was just leaking everywhere all the time so I was worried about being soaked in front of company. I must have changed my shirts 3 or 4 times a day".

Although the physical experiences such as discomfort, inadequate milk supply and leaking breast milk were perceived as negative, they varied in their centrality to the women's experience. Many of the women had expected breastfeeding to involve commitment; they did not anticipate the degree of the negative physical effects. Part of the difficulty may have been the lack of preparation for any difficulties, the women's perception that breastfeeding was instinctual, or perhaps it was because nothing they read or were told could prepare them for the intensity of the experience. One mother reflected on this intensity when she said, "It's funny how the perception is that it all comes easily and naturally, it does, but it is a learning
experience for everybody and it takes awhile". Still another mother said, "You read about sore nipples and engorged breasts but having it is nothing like reading about it". Both of these comments show that the women had preconceived ideas about breastfeeding, but the reality of breastfeeding did not necessarily correspond to those ideas. Not all of the reality of breastfeeding was, however, negative.

**Positive Emotions**

While many of the women described negative physical aspects of breastfeeding, they countered with positive emotional reactions. Most also had some positive emotional reaction to breastfeeding. For them, breastfeeding was equivalent to successfully nurturing. The women felt gratified about being the sole/successful supply of food for their babies, and felt close to their babies because of it. Many women described their feelings of joy and importance at being the only person who could feed the baby in this way. As one mother said:

I know his (the baby's) dad plays a huge role too but I'm his mom, there is only one mom, there is only one person who can do this (breastfeeding). I am the only person who can nourish him and that is such a huge thing, its a great thing, it makes me feel very important.

Breastfeeding also allowed the mothers to feel physically and emotionally closer to their infants. The time spent breastfeeding meant the women could focus their attention specifically on their babies. This allowed the mother-infant attachment process to develop further. As one mother said, "I think it's a good thing being able to breastfeed. It certainly brings you closer".

**Negative Emotions**

Breastfeeding represented a mixed emotional experience. Some mothers also experienced negative reactions. These reactions were tied up with feeling pressured to breastfeed and with breastfeeding not meeting their expectations. The pressure to demonstrate effective mothering through "breast is best" seemed to produce very negative feelings if the women were unsuccessful. One mother described her reaction:

When I had to formula feed him out of necessity (due to severely cracked nipples) I felt very very guilty and what kills me I guess is the media pressure and the societal
pressure to breastfeed and you think I'm not a good mom if I don't breastfeed. Now I battle with that everyday when I think about quitting.

This mother was expressing guilty feelings about even thinking about quitting breastfeeding. This seemed a very common feeling shared by many women. It was as if successful breastfeeding was a crucible for the ability to mother, "Whenever I think about it (switching to bottled formula) I feel bad like I should be able to do this but it's so hard". Even some women who were successful felt breastfeeding was not meeting their expectations. They weren't prepared for the amount of time taken up by feeding. This quote illustrates the sense of total involvement with feeding:

I guess I didn't expect the breastfeeding to take so long. Like he (the baby) feeds every hour and a half to two hours and he will feed half an hour to an hour and then he still needs to be burped. Some days it seems like I never get off that couch.

Mothers also expected the feeding to be straightforward. They did not expect starting and stopping, the infant swallowing lots of air, or the general messiness of the feeding. This quote illustrates those issues:

Now the biggest problem with breastfeeding is that it comes out so quickly he (the baby) just seems to gulp it down and then he gets so much wind that he is burping and so he mucks around some days, comes on and off and burps and it is very messy I didn't think it would be so messy.

To deal with physical sensations, external pressure, and positive feelings, externally imposed guilt and disappointment arising from their breastfeeding experiences, these mothers used a variety of coping strategies.

Coping Strategies for Breastfeeding

New mothers coped with their concerns about breastfeeding in a variety of ways. They sought support/advice, accepted support/advice, and shared their feelings (Table 1). When the women sought support/advice, for the most part, they relied heavily on health care professionals. Partners were expected to "understand" but not necessarily to offer concrete suggestions. The women sought support/advice about the physical sensations from
CHNs, hospital maternity nurses, the Breastfeeding Clinic at Women's Hospital, books, other breastfeeding mothers, the Vancouver Breastfeeding Centre at Vancouver Hospital, La Leche League, their physicians, friends and family. This support/advice took different forms for different women. One woman spoke to a friend who was also breastfeeding and said, "She's a month ahead of me so she knows about the trouble this (breastfeeding) can be. I needed to hear from someone who had done this that my nipples will one day feel normal again". Once armed with this support/advice the women were able to accept their early difficulties with breastfeeding, but they also sought help to solve them by using breastfeeding techniques.

A second coping strategy used by the women to manage breastfeeding was accepting support/advice. The new mothers accepted the support and advice offered by CHNs, hospital maternity nurses, the Breastfeeding Clinic at Women's Hospital, books and other breastfeeding mothers. Accepting support and advice provided them with ways to address their breastfeeding difficulties or to maintain their confidence about their efforts. One woman who was successfully breastfeeding her baby required ongoing reassurance from a professional to feel she was breastfeeding competently: "I've been back to Grace (Women's) Hospital to the lactation consultant to make sure that I am producing milk and that he (the baby) is latching on properly and just that I am doing all the right things to help my nipples heal". The women also looked for signs to validate the usefulness of the techniques. Specifically they looked for positive indicators such as the baby gaining weight and baby satisfaction. These positive indicators increased the women's self-confidence. They also reassured the women about continuing to use support/advice The women also explored alternate strategies such as using a breast pump, changing positions, having the baby sleep in the mother's bed (as opposed to in a separate room), and relying on the partner to give expressed breast milk. The women considered new options such as weaning, and supplementing with a bottle. They followed advice by purchasing breast pads, nursing bras, topical nipple cream, and button down shirts which aided the women in easing the physical sensations and making breastfeeding that much easier.
A third coping strategy used by the new mothers was sharing feelings. By sharing their feelings about breastfeeding with their partner, friends and family many new mothers confirmed their commitment to breastfeeding and also convinced themselves that, even though they were experiencing negative physical side effects, breastfeeding was worth it. As one mother who spoke about quitting said, "I need him (partner) to understand how difficult this (breastfeeding) is. I mean, I know he will never really understand what an engorged breast feels like at three a.m., but at least he listens. He's the one who tells me that I can do it". Although this woman often thought about weaning her baby, her partner's understanding and active listening made it possible for her to continue.

These new mothers avoided discussing negative feelings about breastfeeding with health care professionals such as CHNs, their physician, lactation consultants and hospital maternity nurses. Because some of the mothers felt pressured by society, the hospital staff and CHNs to breastfeed, they rejected most health care professionals as a source of emotional support. They believed sharing feelings would result in negative reactions from caregivers. Therefore, when they did seek out the professionals for advice, they avoided discussing any of their negative emotional reactions with them. The new mothers specifically sought out individuals whom they thought would be non-judgmental regarding their negative feelings about breastfeeding. The women relied on partners, family and friends for this kind of emotional support.

Balancing Roles

A fourth concern-related concept arising from the interview data was balancing roles. Becoming a new mother posed a number of changes, challenges and joys for the women who were engaged in balancing all the other roles in their lives. Developing and internalizing the motherhood role meant changing and sometimes losing various aspects of long established roles and changing accepted roles. It was the issue of loss that most affected these women. They had to deal with losses around their work role, their spousal roles and their individual roles. Now balancing roles involved reincorporating the paid work role, changing spousal relationships, changing family relationships, and accepting losses from the individual role.
Reincorporation of the Paid Work Role

Reincorporating the paid work role included a number of aspects. The women had already given up paid work for the short term, now they questioned whether and/or when to return to work. One mother who had a professional career before the birth of her daughter expressed her thoughts about the decisions facing her: "I'm sure, eventually, I will want the intellectual stimulation (of work) but it must be tough. I can't imagine wanting to go back to work". The decision was not just influenced by a woman's own needs but also by what she felt was best for her child: "I don't even know if I want to go back to work. I don't know if I want a daycare kid. So this is a big change for me. How am I going to deal with a career?" As stated previously, 10 of the women were working up until 2 weeks before their expected date of delivery. Most women said they would be returning to work some time in the future. Thinking about returning to work so soon after the infant's arrival indicated the seriousness of these considerations. Thus, these decisions were very real to them.

Financial issues were also important. Although several of the women said they would prefer to stay home and raise their children, financial constraints ruled out that option. For women with less pressing financial situations the best solution was part-time work. Only a few women described missing their jobs at the time of the interview. When considering financial options, one mother expressed her concerns about her lack of choice for returning to work, "I like my job and everything but I really wish I could stay home with her (the baby) but there is really no choice, financially we (partner and new mother) can't make it without my income". For the women, this whole issue of the lack of perceived choice was upsetting. They were not choosing the best option, they were pursuing what they viewed as the only option.

Changing Spousal Relationships

All of the women had concerns about loss in some areas of the couple relationship. These concerns were significant because they were often one of the first changes or challenges mentioned during the interviews. A changing spousal relationship was a complex issue. There were losses, but the women also described gains resulting from changing family relationships. Few women had predicted the major losses to their relationships with their partners. These
included loss of couple intimacy, lack of spontaneity, and loss of time with partner. One new mother who experienced loss of couple intimacy described the loss of a sense of togetherness:

The change between my husband and I, just being a couple to the dynamics of having a third person in our world that is a huge change. We had such a close relationship, the two of us lived in Japan and we did almost everything together, but all of a sudden you have a third person.

None of the women who spoke about the loss of couple intimacy described it specifically as a loss of physical intimacy. Intimacy seemed to refer to psychological closeness; losses were involved in the sense of togetherness and engaging in activities specific to being a couple. For example, one new mother stated, "We used to go to Europe every year and now we won't be able to do that, not until she (the baby) is a lot older".

While loss of intimacy was an issue, there was also a sense of a loss of spontaneity that was tied to intimacy. The perception of freedom to spontaneously do something together had been permanently changed. As one woman said:

It really changes your lifestyle, definitely, completely, and 'cause we (partner and new mother) were so used to going out all the time and we were really spontaneous, and we do lots of things together almost every weekend but now it's different with him (the baby).

Several of the women did not specifically use the words lack of spontaneity, rather they spoke about the loss of flexibility. Flexibility was linked to spontaneity because the arrival of the infant had introduced constraints. "We (partner and new mother) use to go for a latte at 8 every Saturday morning. Now we go at 11 if at all. So it's the flexibility I find we don't have anymore". In essence, this mother describes giving up routines and being more flexible, and less spontaneous.

A different issue was loss of time with partner. This was an issue that also required families to be more flexible. Either they redefined their time as family time or women forfeited time with their partner because they and their infant were excluded:

Normally I would be up at 5 o'clock going fishing with him (partner) as well but
somebody has to stay to look after the baby. So that is different 'cause (partner) and I use to do everything together and now that has changed forever.

If families could not redefine time as family time, mothers found they spent many hours alone with their infants. It seemed that the responsibility of childcare fell to the women while their partners were still able to pursue former activities.

**Changing Family Relationships**

While many women felt losses around their relationships with their spouses, many felt also that there were gains in the positive feelings of creating a new family. Changes in the family relationships included developing a new lifestyle which encompassed the baby and the new mother's perceptions of her partner as a father. Often these changes created positive effects for family relationships. After the birth of their first child, many women realized that returning to the prepregnancy lifestyle was impossible. Even though, during the pregnancy many of the women had anticipated a lifestyle change, few seemed to be prepared for the intensity of the change. As one mother said:

> I want to get back to the ways things were before the baby but I realize it can never be exactly the same so we (partner and new mother) will just have to make the best of it and include the baby. But I don't think even with all the reading I did that you can ever be prepared for this, you think it can't be so different.

While this mother had initially thought she was prepared for the change from a couple to a family, in reality she was not, but she recognized that only after the baby's arrival. Her reaction to the changing family relationships was one of resignation due to the irreversible nature of the change. Another mother put her reaction in more positive terms:

> I know our (new mother and partner) lives will never be the same, but we are a family now, a mom and dad and kid. We may not be able to go dancing for awhile but who cares? Now we can go to the park instead.

This mother seemed more accepting of the changes to her lifestyle. Instead of focusing on her losses she chose to see the changes as gains for her lifestyle.
Several new mothers found that the birth of their first child had a positive effect on the family relationships. Mothers spoke about changes from a twosome to a threesome, and focused on how the changes had brought them closer to their partners:

We (partner and new mother) are now a family. We were always two independent individuals that were together but now we seem to have this partnership. We are much more of a family. It's been quite an amazing change in our relationship.

Another mother stated, "It (the birth of baby) brought our relationship to such a lovely special height... I can't explain the joy part 'cause it really is just so wonderful, there really aren't words for it". For both of these women, the change from a partnership with two individuals to a partnership with a baby meant truly becoming a family which brought them great joy.

Only a few women spoke about how they perceived their partners as fathers. Because their partners were not present at the interviews, the issues that the new mothers expressed were from their perspective and therefore do not represent the fathers' perceptions of their feelings. Nevertheless, the new mothers' perceptions of what their partners felt is still very relevant. The mothers focused on jealousy, and competent care giving. Jealousy was about the men being unable to achieve the same closeness with the baby that the women were able to achieve.

Only a few new mothers commented that their partners were jealous of the mother/baby relationship:

He (partner) is a little jealous right now. He is at work 8 hours a day and he misses being with her (the baby). He thinks she will be closer to me because of all the time we spend together.

This mother's comments reflect the reality in many families. While the women are on maternity leave and at home full time, most partners are working 5 days a week. As a result the partners might have felt they had limited time with their infants and that their wives had more opportunity to develop a relationship with the baby.

Finally, several new mothers made comments about the quality of the care their partners were providing to their babies. On the one hand the women wanted their partners to
be more involved with the infant, but at the same time they were critical of the father's efforts. This is interesting given that the mothers made comments about their visitors being insensitive to the mothers' needs. Perhaps due to their proximity to their infants, they gained confidence so quickly they had forgotten about the initial feelings of ineptness around the infant:

He (partner) is so afraid of hurting her (the baby), so you know he takes 20 minutes to take her shirt off let alone change her diaper. He really thinks that she is a little China doll and that he will break her fingers or something.

Several mothers concurred that the fathers were afraid of hurting their babies when they handled them. They felt their partners were "all thumbs" and that the partners would rather leave the childcare to them. None of the women said they had brought up their concerns directly with their partners; instead they used coping strategies to subtly direct their partners to how they wanted them to behave.

Accepting Losses from Individual Role

All the women expressed concerns related to the losses from their roles as individuals. Once again this concept was placed high on new mothers' concern lists. Many of the women spent much of the interview discussing varying aspects of this issue. Losses from the individual role included lack of time for self, lack of self expression, and putting goals on hold.

The requirements of the maternal role de-emphasized the women's individuality. Subsuming themselves in the maternal role presented many challenges for the women. Many women made comments similar to this mother: "You can't really do anything. Like yesterday it was a big deal for me to find time to have a shower and is there time to make something to eat". The women often expressed great difficulty in finding time to start to address their basic needs.

Many new mothers spoke of a lack of time for themselves to complete tasks they deemed necessary. The tasks could be either simple or complex and involved doing things that were central to them as individuals: "Last night was the first time in the month since she (the baby) has been born that I have been out by myself and it felt kinda good... It's nice to see
other people and be yourself". For this mother going out by herself and being with her coworkers allowed her to define aspects of herself as an individual. Another mother who found there was not enough time for individual tasks said, "If you want to do something for yourself right now you just can't". The tasks the women did not have time for were more than just incidental ones. These tasks were vital to the women's sense of self concept. The loss of such aspects as going out with coworkers were significant for the women.

As well as lack of time for self and tasks vital to self, the women lacked the time and energy for self expression. To the women self expression was being able to reveal themselves through thoughts and actions. Lack of self expression was expressed in the following way by one new mother: "My life now revolves around hers (the baby's), there is no time to be me, to be who I need to be". In committing so much psychological and physical time to their new infants, the women were left feeling that the meaning of who they were as individuals was sacrificed for the short term. While this sacrifice was temporary, the women still found it difficult to accept and were at a loss about how to resolve it. Fatigue and feeling overwhelmed further complicated this issue.

Putting goals on hold was another area that reflected a loss at the level of the individual role. This is one example of a goal a mother had to abandon for the short term:

I just finished school ten days before I had her (the baby). I finished night school and I wanted to start looking for a new job and everything and I just can't go and start looking for a new job right now. And the school that I went to that's what I wanted to base my career out of and I can't. I have to wait to get myself established.

Only a few mothers felt as this mother did and commented on putting goals on hold for the short term. Several mothers felt they had accomplished many of their goals before their pregnancies due to their choices to postpone motherhood until later in adulthood. Half of the women who were interviewed were over 30 years of age and many of them planned to start their families at this later age. This postponement of motherhood may have been due to the needs of these women to accomplish career or financial goals before having a baby. It was, in general, the younger mothers in the group who commented on putting goals on hold.
Several women described losing aspects of themselves and their personalities. In part they identified a lack of time and energy to recognize their own needs as well as a de-emphasis of their own needs. They subsumed who they were in the ongoing demands of motherhood, and this was particularly apparent with breastfeeding. Most of the women were not prepared to face the totally absorbing nature of the breastfeeding experience. The women had not realized how much of their own existence would be taken up by feeding their babies. One new mother described her feelings this way: "Every time she cries I think she's hungry you know. It's like you feel like a big boob that's what you feel like a large breast and that's all. Like I'm not a mom I'm just a feed bag right now". The nature of this quote illustrates the intensity of the loss of self for women having their first child. The women gave the impression that they had not anticipated this level of intensity.

Coping Strategies for Balancing Roles

New mothers coped with balancing their roles in a variety of ways. The women used seeking support/advice, identifying what is right for self, sharing feelings, caring for self, utilizing/modifying former coping strategies, and encouraging/accepting partners' involvement to deal with their concerns (Table 1).

One coping strategy identified by the new mothers to balance roles was seeking support/advice. The new mothers looked for advice about how to cope with returning to work and young children from others who had been through the same dilemma. As one women said when she contemplated having another child and going back to work, "How do they (women with children and jobs) do it? I mean I've just got one and I can't even imagine going back to work but how do they do it? I talked to a friend who has two (children) and a job but I don't think I could do it after listening to her stories". The women also sought information and strategies from couples with babies who were friends or family members. This coping strategy not only allowed the new mother and partner to feel that their experiences were similar to other new parents but also provided pragmatic ways of dealing with working and parenting. Other couples suggested such strategies as taking the baby out with them and fitting their
schedule around the babies. None of the women mentioned talking to their partners about the issue of returning to work.

Women who thought about returning to work in the future utilized personal soul searching as a coping strategy and a way of identifying what was right for themselves. They thought about the meaning of their jobs, its financial rewards and their current lifestyle versus their desire to spend quality time with their new infants. One mother who questioned returning to work said:

She (the baby) is just more important than the money. I know everybody needs money to live, but I think my values have changed too. I mean I've spent a lot of time thinking about what is the best thing for her and what is the best thing for me and what is the best thing for us (new mother and partner) and it plays on your mind. I have some really big decisions to make very soon and they will affect everything.

This woman, like many others, spent a great deal of time and mental energy thinking about returning to work and the resulting sequelae. The women realized that the return to work would have an impact on their lives, their babies, and their relationships with others. At the time of the interview very few women had resolved their issues around returning to work.

A second coping strategy used by the new mothers was sharing feelings. The women spent much of their time sharing their feelings with others. Partners were the primary resource for sharing feelings about the changing spousal relationships. Together they explored their feelings as a couple by comparing themselves to other couples. By doing this, the new mother and partner were able to determine that they were not alone in their experiences. Many women realized after talking with their partners that their partners had some of the same concerns and questions: "Talking is so important. He (partner) was feeling the same way I was and I didn't know it. Now we are on the same wave length". Sharing feelings meant that the women got feedback from their partners about their partners' feelings.

A third coping strategy used by the new mothers was caring for self. Many accomplished their goals before or during pregnancy in an attempt to feel comfortable about achieving their personal goals before embarking on this new stage in their lives. Traveling,
education and obtaining financial security were accomplished before starting a family. Most of the women who did this were the older women from the sample. As one older mother said, "I couldn't have done this (had a baby) any sooner 'cause I just had too many other things to do. Thank God for the pill". Postponing pregnancy allowed many of the women to fulfill other desires and then feel less loss about putting their lives "on hold". In a sense, they had allowed time to care for themselves and to meet their needs before embarking on motherhood.

Women also cared for themselves by taking time for themselves. This time offered an opportunity to shift their thoughts from the baby and motherhood to other aspects of the women's lives. For example, one new mother stated:

If I can get out for 5 minutes I'm O.K. That 5 minutes on the way to Safeway is enough to let me be me again. I'm not somebody's mother when I'm on the street, I'm just another person and I think non-baby things, things that are important to me.

Being able to acknowledge that there were other aspects of life that were important in addition to motherhood and take time for these was important.

A fourth coping strategy identified by the new mothers was utilizing/modifying former coping strategies. The women utilized former coping strategies such as going out with partner and using humour. They modified other coping strategies such as adjusting household noise levels to fit with their current situations. This allowed the women to maintain some contact with their former personal lives. This was the only time that this coping strategy was used. By listening to loud music and going out to dinner and the movies with their partners, new mothers were able to retain certain aspects of their prepregnancy lifestyle that they deemed important. For several women the use of humour was very important, "You just have to laugh. I mean the alternative is crying so why get all worked up about it. I've always laughed. My sense of humour has got me through lots of tight situations before so why not keep laughing". By maintaining a previously successful coping strategy in their repertoire of coping strategies, the women retained some of their previous identity.

A fifth coping strategy identified by the new mothers was encouraging/accepting their partners' involvement. New mothers coped with both partner jealousy and the question of
partners' competencies in care giving by encouraging/accepting their partner's involvement in childcare. The women encouraged their partners to perform childcare tasks by demonstrating childcare tasks. As one mother said, "You have to be subtle. She (the baby) cries and I say 'H (partner), could you check her diaper for me, I've got my hands full with this'. That way he does the little things but doesn't really have too much time to think about it". Several women acknowledged that breastfeeding represented an activity their partners could not copy. Between breastfeeding the mothers encouraged their partners to do basic childcare tasks such as bathing, changing and cuddling. In this way the mothers felt the partners would perceive their time with the baby as fulfilling and vital and perhaps to get to know their infants better. The women also encouraged their partners to consult books. As one mother stated, "I have to show him (partner) the book so that he doesn't think that I'm saying that I'm the better parent here. Then he's got something to look at". This mother made the book the "authority" so that she and her partner did not feel as if she was the "expert". By doing this, the woman was able to teach her partner childcare skills, while avoiding the feeling that she was telling him what to do.

Developing Relationship with Baby

A fifth concern-related concept arising from the interview data was developing a relationship with the baby. For many women, talking about their infants was a great source of joy, pride and confusion. At some point during the interview each woman spoke about her feelings toward her baby. Many women who were holding their infants during the interview would pause occasionally and look longingly at their infants, or smile, or speak directly to them. When speaking about their babies, the women's voices would change and often take on an air of pride. In many instances, the women showed their love nonverbally. Developing relationships with the baby consisted of fascination with the baby's personhood, providing adequate care for the baby, and making sense of the baby's needs and behaviors. The women had to come to terms with who this baby was, how to care for him/her, and how to understand what he/she wanted.
Being Fascinated with Baby's Personhood

Most women in the study contrasted their love for their new babies with the more negative issues associated with new motherhood. Fascination with the baby's personhood involved feelings of pride about creating a separate person, being awed by the baby's appearance, facial gestures and sounds, and being personally satisfied with having a baby after a difficult conception.

Several new mothers experienced intense feelings about creating a separate person through themselves and their partners. One new mother stated:

I use to look at him (the baby) in the beginning and I was awe struck. I'd look at him and think wow he was inside me... I look at him and he looks like my husband and I just see my husband in him and I feel so happy that we've been able to do this. To think he is actually a part of me and a part of my husband is unreal.

This statement reflects the overwhelming feelings of love and pride experienced by this mother. Knowing that the baby is a part of her and her partner brings her great joy. The idea of creating a life and being responsible for it was inspiring to most of the women. The birth of the child that was part of them seemed to confirm themselves.

Other mothers, spoke about their awe with the baby's appearance, facial gestures and sounds:

He (the baby) truly amazes me. I lie on the bed sometimes and just stare at him, like 40 minutes has gone by and I've just stared at him and memorized all the little head veins and looked at his ears... Everytime time I look at him I just fall in love with him again.

Many mothers spoke about how they could spend large parts of the day just becoming intimate with the details of their babies. Again, time spent with the baby, or thinking about the baby solidified mother-infant attachment. Even though the women wanted more time to deal with other issues, the time spent with their infants was not seen as wasted time.

Four of the 15 new mothers spoke about their personal satisfaction with having a baby after a difficult conception. One of these mothers said:
Well it's amazing that they (babies) are even here you know. You go through all this and sit here and go 'We (partner and new mother) did this'. And that small thing created such a perfect person. It's just so amazing. It's a miracle that they are even here. We had lots of talks before we got pregnant and we had such a hard time getting pregnant that we even thought about adopting and we may end up doing that if we want another one.

For some women having their babies achieved greater significance because of these difficult conceptions. These women had a very special appreciation of their infants. The first thing that two of these women described after the initial interview question about their changes, challenges and joys, was the joy of just having their babies. For one mother who had 4 miscarriages before the birth of her son, the fact that she was holding him was in her words "a miracle".

Providing Adequate Care for Baby

Concern about providing adequate care for the baby focused on taking the baby out, and issues in the baby's future. Even though many women had read about childcare for an infant after birth, the women seemed unprepared for the reality of the situation.

For several new mothers taking the baby out was a big concern. One new mother stated:

I'm so afraid to take her (the baby) out by myself. I have this ridiculous fear of baby nappers. I've always got my hands on her and she is wrapped in my coat... But I guess you can never be too cautious.

For this mother of the 90's, child abduction was a serious issue that she thought about every time she left her house with the baby. She also admitted that taking her baby out was not something she thought would be an issue after the birth. This only became an issue when she first took the baby out in public.

Concerns about the child's future encompassed several issues for new mothers. Several were concerned about their babies' immunizations, for example one mother said:

The doctor gave me a list of the immunization shots that she (the baby) is going to be
having and I'm going to discuss this with her because I do have a lot of concerns about some of the shots... I wonder if they (the shots) need to be done?

Several women wondered about the necessity of immunizations and their side effects. Other women focused on issues in their children's future, such as education:

We already think about her (the baby's) education... We are starting to think about what if the school system doesn't change. We need to make sure she gets the best so she can develop you know, as she should and hopefully under optimum conditions.

Other new mothers were also concerned about finding competent childcare in the future. One mother stated:

It worries me to think about someone else looking after her. I mean I am her (the baby's) mother and who can look after her the way I do? No one knows her better than I do. I should be that person, but I realize that if I want to go back to work or even go out with my husband again on our own, someone else will have to baby-sit her.

This new mother questioned whether anyone else could be as competent a caregiver as she could with her baby. At the same time she realized that at some point in the future she would have to find another caregiver.

**Making Sense of Baby's Needs and Behaviors**

Many new mothers appeared to have trouble understanding and interpreting their babies' needs and how to deal with them. Infant crying presented a great challenge to most of the women. While crying made it obvious that the baby needed or wanted something, women were at a loss to interpret crying that was not related to wet diapers, hunger or excess gas. Appropriate childcare tasks, and perception about feedback from the baby were the women's greatest challenges.

Childcare tasks were a concern that was mentioned by most of the new mothers, and that concern is reflected in this mother's statement:

The biggest challenge is learning to be a mother and knowing how to do all these things... Some things you can't learn until you do it on your own child. Things like breastfeeding and burping and changing and comforting and knowing how to put them
to sleep on their sides and just all the little techniques.

This woman believed that the reality of direct care with an infant cannot be realized until one has done it for oneself. Another mother also elaborated on this issue:

The first week and a half after she (the baby) was born, you just don't know what it is that she wants, and when she cries you check the three things. Is she wet? Does she need to be burped or is she hungry? After I ruled those out, I didn't know what to do.

This mother tried to resolve the infant crying by attending to the 3 infant behaviors; but these did not address the baby’s needs, and she was at a loss about what to do next.

Several new mothers were concerned about the perceived lack of feedback from their babies. Some recognized that crying was the baby's way of communicating while other mothers did not. One mother who did not understand the baby's messages or did not believe that the baby communicated said:

Just taking care of him (the baby) and knowing what he wants is a challenge... I wish he could just tell me what he wants because I don’t know sometimes. He just cries and we can't have two way communication like adults do. I wish he could talk to me it would be so much easier if he could tell me what he wants.

Several women made comments about what they perceived as a lack of two-way communication with their infants. Specifically they did not perceive infant crying as a method of communication. Perhaps at this point they still hadn't gotten to know the meaning of the individual cries. All of these women talked about a more positive future where their children could speak to them and tell them what they wanted.

Coping Strategies for Developing Relationship with the Baby

New mothers coped with the developing relationship with their baby in a number of ways. They shared feelings, sought support/advice, and accepted support/advice (Table 1).

One coping strategy identified by the new mothers was sharing feelings. By sharing positive feelings, new mothers could convey their personal joys to people who were important to them. The women's partners were their primary targets for sharing feelings. Other people included family and friends. Many of the women described the pleasure sharing feelings of joy
about the baby brought them. As one mother said, "My husband loves it when I talk about the baby. He says I glow with pride". This new mother received positive reinforcement for sharing her feelings, which in turn made her feel good about herself. Another woman felt like a family when she shared her feelings with her partner, "Just having him (partner) here to talk to and to listen and to tell me what he thinks is helpful. Then I know I'm not alone, we are in this together". Sharing feelings increased this mother's sense of security.

A second coping strategy identified by new mothers was seeking support/advice. New mothers sought support/advice from CHNs, family members, friends, their physicians, the newborn hot line and books. Specifically they were looking for new information about how other women coped with similar concerns. New mothers were hoping to find additional coping strategies that they could combine with their own. One mother who called the newborn hotline specifically for advice about relieving colic said:

When I called the newborn hotline I was asking what sort of things I could do to relieve her gas and she (the nurse) gave some suggestions like rubbing the baby's back or tummy and maybe putting a warm hot water bottle under her (the baby's) tummy to sort of calm her down. I asked about giving the baby gripe water and she said you could try but that it doesn't work for everybody.

The women mostly accepted the support/advice that confirmed or refuted other information the mother had received. Mothers made decisions based on what was best for them in the context of their resources.

A third coping strategy identified by the new mothers was accepting support/advice from their babies in the form of positive reinforcements. The women learned to deal with baby behaviors and needs through practicing, and spending time getting to know their babies. They received positive reinforcement from the babies, learned to anticipate their babies' needs, and received reinforcement from their positive accomplishments. In a sense they were reinforced by their babies' reactions. The women looked forward to a positive future, and felt they could anticipate and meet the needs of their babies. Many mothers compared how they felt when
they first got the baby home and how they now felt several weeks later during the interview. For example, this mother's comments reflected what many other women said:

You learn as you go along. Each day you learn more. It's much easier now than when I brought her (the baby) home. I know so much more now than I did at the beginning.

You just have to do it. She tells me if I'm doing it right or wrong anyway.

The women dealt with concerns on an ongoing basis. Because the women were often the only adults present when the baby needed something, they had no choice but to act immediately. If one coping strategy did not relieve the infant's crying, they quickly reacted with another.

The women also purchased baby equipment and services such as baby swings, baby slings, toys from friends, second hand products, diaper services, disposable diapers, strollers and car seats to help them care for their babies. The equipment and services augmented the other coping strategies many of the women were already using.

**Unsupportive Attitudes/Actions of Others**

A sixth concern-related concept arising from the interview data was unsupportive attitudes/actions of others. Many of the women were surprised and disappointed with the attitudes and actions of various individuals they encountered in their early postpartum periods. They found many persons they encountered focused on horror stories, ignored their needs or openly confronted them about their parenting style. The women included information issues, lack of consideration of a mother's needs, and disagreement with parenting style in their descriptions of unsupportive others.

**Information Issues**

Information issues addressed both the paucity of information, the conflictual information, and the negative confrontative information the mothers received. Most of the time the women found that they were surrounded by others: professionals, friends and family who were always willing to give information. However, several women commented on a lack of teaching particularly from nurses in the hospital maternity settings. Even though the births had occurred several weeks before the interview, some women still commented about the lack of teaching while they were in hospital:
I guess my main concern is looking back on my experience in the hospital... My postpartum experience was something that I felt was really lacking in the teaching. Unfortunately, after the first night I really didn't see any nurses... I would have looked forward to having at least a little more teaching going on.

This woman in particular was concerned because she herself is a nurse. She felt she may have been neglected by the maternity nurses due to her profession but also felt concerned that the other women on the maternity ward without her education may have also been neglected. While several women felt neglected by health care professionals, other women commented on the high quality of care they received from various health care professionals.

Many new mothers felt that they received conflicting and/or negative/confrontative information from health care professionals, friends, family and books. Conflicting information referred to information that was contradictory to previously received information, while negative/confrontative information referred to information that lacked positive qualities such as enthusiasm or optimism or challenged the women's parenting practices. As this mother stated:

You get a little tired of all the advice but you've got to understand where it comes from... I got stopped by an old British lady in the mall who said 'where's her (the baby's) hat?'. I said I don't have a hat on and it is really hot in here I didn't think she needed a hat on but I didn't feel like explaining myself. But when I first got pregnant I thought it was really interesting, because the first 3, 4, or 5 months they tell you miscarriage stories and it's always prefixed with 'I shouldn't tell you this but', and then you get baby problem stories, and then you get dead baby stories. And just before you are due people tell you about their friend who was in labour for 800 hours and the baby was dead and it keeps you awake at night. And when you are having the baby people start telling you about their friends whose babies died at 3 months.

This mother conveys the multitude of negative/confrontative information received from friends, family, and even strangers. She makes it clear that at no time during the pregnancy, birth, or the postpartum period was she immune from unsolicited negative information. Another mother stated, "We had a lot of people tell us about the negative things and they
would never talk about the love and joy". Many women commented on the lack of positive information from any source. The way they remembered it, everyone with whom the women came in contact with had something negative to say.

The women also found conflicting information in resource materials. Books were places they turned for answers. One mother describes it this way:

I'd look up something in one book and then just double check it by looking it up in another book, but the second book would say something different. So then what are you supposed to do? These books should say the same things but they don't and that leaves you in a total panic about what to do.

This statement is an example of conflicting information that the new mothers received during the early postpartum period. Instead of getting useful information, conflicting information served to raise anxiety levels to mothers who were already looking for answers.

**Lack of Consideration of Mother's Needs**

Many mothers had concerns about the lack of consideration of their needs from family members and friends during the early postpartum period. The women had expected their friends and family to be supportive and understanding of the changes, challenges and joys they were experiencing. In reality, they found that they were not. As one mother stated:

On about the fourth day I had had enough. It was really hard for me especially 'cause this place is so small and so many people in here and everybody is excited and happy but we (partner and new mother) were having a hard time... Having all the noise in here and people crowding in every corner, I was really really upset and they didn't understand as much as you think they would after someone had just had a baby.

This new mother's statement is typical of many of the women. They found it difficult to understand why others were not sensitive to their situations as new mothers. One mother believed that people with no children were the worst offenders because of their lack of knowledge about the situation.
Disagreement with Parenting Style

Several new mothers found that some of their family members and friends disagreed with their parenting style. Some friends and family members had differing opinions about how to parent and readily shared those opinions with the new parents. Differing opinions ranged from breastfeeding approaches to discipline issues. One mother explained it this way:

My parents don't understand, like I am demand feeding and my mother bottle fed me so they keep saying 'why don't you just feed her (the baby) every 3 or 4 hours and let her sleep in between?'. But they think I am spoiling her, they don't understand how demand feeding works. After a while you just listen with one ear to what they have to say.

Several women found that their mothers and other women of differing generations had differing ideas of how to parent. Many new mothers stated that their families thought they were spoiling their babies with their style of parenting. Parenting in the 90's seemed to have changed considerably since the women's parents were new parents.

Coping Strategies for Unsupportive Attitudes/Actions of Others

In order to deal with unsupportive attitudes/actions of others, new mothers used a number of strategies. They decided what was right for them, sought support/advice, and accepted support/advice (Table 1).

One coping strategy identified by new mothers to deal with unsupportive attitudes/actions of others was identifying what was right for themselves. The women made their own decisions about what was right for them. They came to their own decisions by mentally sorting through all the different information they had received, amalgamating it into a workable form and then selectively choosing those options that they felt would work positively for them as individuals.

One way the women identified what was right for themselves was by ignoring conflicting information. The women ignored the conflicting information they received from a variety of sources. Community health nurses, maternity nurses, family members and friends all gave conflicting information to the new mothers at some time. When they did, the women
chose what they wanted and ignored the rest. The women gave feedback to maternity nurses via a hospital evaluation form and verbally to their friends and family members. As one mother said about the conflicting information she received from her mother and books about breastfeeding, "In the end I said 'Mom, its been a long time since you had a baby and times have changed. I'm going to do things differently and you are just going to have to get used to it'". By confronting her mother and telling her she would do the breastfeeding her own way, this mother rejected advice that she felt would not be helpful to her.

New mothers further coped by seeking emotional support/advice from their partners about the unsupportive attitudes/actions of others. The women felt that their partners were the people who would be on their side and support them in their decision making. Based on previous experience, using only acceptable advice and trusting their instincts, the women were able to make their own decisions. In the end, the women decided how to parent based on selected information. Even with all the unsolicited advice they received, the women used only what they deemed worked. When asked how she coped with all the advice, the mother who was questioned in the mall by a stranger said:

I just laughed. You get at a point where you just can't say anything. Everybody has got advice and opinions about labour and delivery and all the way through and you just agree with them. You say 'That's exactly what I am going to do, that's a great idea' and then I just do what I want anyway. I learned don't argue, don't discuss it, tell them they're brilliant and go on and do what you want to do, that is the best way, 'cause in the end, I am the one who has to live with the results.

The women made decisions about whom they would use for support/advice. If they believed people were unhelpful they found ways of avoiding/accepting advice from them. They used their answering machines, avoided getting back to others right away and refused to invite others over. This way, the women felt more in control. As one mother said when dealing with visiting friends, "They (friends) were here and I just said, 'Sorry but I need to sleep' and I just went to bed". Initially this mother said she would have never said that right
after the birth, but she found that her ability to assert about what she needed changed with experience.

A fourth coping strategy identified by the women was accepting support/advice. Women did not want to reject the support from their family and friends along with their advice. Thus they accepted the deficiencies but made their own preferences clear. The women attempted to rationalize the behavior of family and friends. As one new mother said, "You have to understand where it (unsolicited advice) is coming from. Everybody (friends and family) has their own way of doing things and they will just have to get used to yours".

Coping in the Future

After answering the researcher's questions about their current changes, challenges, joys and coping strategies (Appendix D), each new mother was asked how she would cope with changes, challenges and joys in the future. By far the majority of the replies were something like this new mothers' response:

Well so far so good, I think we (partner and mother) will keep doing what we have been doing 'cause it's hard to know what will happen and it depends on what happens. We will do what we have been doing so far and if it doesn't work we will try something else until it does, it all depends on the problem really.

The answers of three new mothers were significantly different than the rest. These three women appeared to the author to be having some difficulty in adjusting to their new role. These three women had many more concerns than the other twelve mothers did. When asked about their coping strategies, they had few strategies or indicated the strategies they did use were not working.

These three also appeared ill at ease when handling their new infants. At times their high pitched voices suggested anxiety. A number of common traits were noted. All three women preferred to stay at home with their babies and rarely ventured outside of their houses or apartments. Although all the women were living with the baby's father, according to them, the fathers were not very involved in caring for the infant. None of the women had family members close by and they had spent very little time with friends since the birth of the baby.
Two of these women described how they felt they got little or no feedback from their babies. They felt that communication with the baby was one way and all three mothers looked forward to a more positive future. Finally they all discussed their previous lack of experience with young children and babies. When these women tried to use the coping strategies the other women had found successful, they were often disappointed in the results. For example, when these women sought advice from friends or health care professionals they would often reject the solutions.

When asked how they would cope with their concerns in the future, they answered that they did not know how they would cope. After all the interview questions had been answered and the interviews were complete, the researcher stayed and discussed some possible solutions to these women's concerns and/or referred them to community support groups, agencies or back to the CHNs.

**Review of the Concern-Related Concepts**

The changes, challenges and joys that the women experienced during the early postpartum period are represented by 6 concerns. Each concern is unique and reflects issues of importance to the women. Becoming a mother encompassed the overwhelming positive and negative feelings the women experienced. The feelings ranged from anxiety to new found joy. All were part of internalizing the maternal role. Emotional and physical restoration refers to the women's ongoing recovery from the early postpartum period. Physical aches, hormone swings and all encompassing fatigue dominated the first few weeks at home with the new baby. Breastfeeding refers to the physical and emotional adjustment to this new skill. It encompasses the positive and negative feelings that breastfeeding caused as well as the physical sequelae. Balancing roles was a concern for all of the women. A new role was added to existing roles and this caused turmoil, loss and role redefinition. Some women were more accepting of this turmoil than others. Developing a relationship with their babies meant the women had to figure out who this little person was, how to relate to him/her and what the baby wanted. The development of this relationship also elicited both positive and negative
feelings in the women. Finally, unsupportive attitudes/actions of others refers to other's actions that were perceived as negative or not helpful or useful.

Review of the Coping Strategy-Related Concepts

The women used a variety of coping strategies to deal with the changes, challenges and joys they were experiencing during the early postpartum period. A variety of coping strategies were identified. Seeking support/advice refers to actions the women took to find specific support/advice or answers to specific questions. Accepting support/advice was different from seeking support/advice in that often the women had not asked for the support/advice but ultimately they decided to use it for their benefit. Alternatively, the women may have sought support/advice but decided not to use it. The women cared for themselves emotionally and physically by meeting their own needs. Meeting their needs ranged from taking sitz baths to taking walks alone. Many women redefined normal by comparing themselves to others in order to determine if their experiences were normal and then by accepting their new lives with all its changes, challenges and joys. Normal was defined by the women to include the baby. Encouraging/accepting their partners involvement in the parenting experience was one coping strategy used to deal with the women's perception of their partner's as fathers. Sharing feelings with those people around them allowed the women to vent and feel listened to. The women shared positive as well as negative feelings with selected others. Identifying what was right for them encompassed making personal decisions based on knowledge, experience and intuition. Ultimately, the women were the primary caregivers and had the final say about what options they considered viable. Finally, utilizing/modifying former coping strategies allowed the women to use previous coping strategies and to keep some contact with their former lives.

The strategies of seeking support/advice, sharing feelings, accepting support/advice, and caring for self were commonly identified by the mothers as being useful for managing concerns. Seeking support/advice was the most frequently mentioned coping strategy utilized by the women. The women were particular about who they shared their feelings with and what concerns they shared with them. Caring for self was used for both physical and emotional concerns.
Chapter Summary

In summary, the analysis of the 15 interviews elicited 6 concerns: becoming a mother, emotional and physical restoration, breastfeeding, balancing roles, developing relationship with baby, and unsupportive attitudes/actions of others. Each concern includes specific categories that described the new mothers' thoughts, issues and feelings about that concern. The concerns reflect the changes, the challenges and the joys the new mothers experienced in the early postpartum period. For each concern the mothers used a number of specific coping strategies. A variety of coping strategies emerged from the data: seeking support/advice, accepting support/advice, caring for self, redefining normal, encouraging/accepting partners involvement, sharing feelings, identifying what was right for self, utilizing/modifying former coping strategies. The next chapter focuses on a discussion of these findings as well as their implications for nursing practice, education, and research.
CHAPTER 5
SUMMARY, DISCUSSION OF THE FINDINGS, CONCLUSIONS AND IMPlications FOR NURsING

Summary

This study was undertaken to explore the concerns and coping strategies of 15 primiparous women, one to four weeks following the birth of their infants. The women were asked about the current changes, challenges, and joys they were experiencing as well as the coping strategies they were using to deal with those changes, challenges and joys.

The study was descriptive. Interviews using open-ended questions, and conducted in the new mothers' homes, were used to obtain the data. The women discussed and described their experiences in their own words and from their own perspectives. Each interview was audio-tape recorded and then transcribed verbatim with the use of a computer.

Inductive content analysis was used to analyze the findings. Waltz, Strickland and Lenz's (1991) steps of content analysis were utilized, as well as Maxwell's and Maxwell's (1980) steps of continuous comparative analysis. Inductive content analysis permitted concepts to be derived from the feelings, emotions and personal experiences described by the participants (Waltz, Strickland, & Lenz, 1991).

Six concern-related concepts emerged from the analysis: becoming a mother, emotional and physical restoration, breastfeeding, balancing roles, developing relationship with the baby, and unsupportive attitudes/actions of others. Each concern-related concept was made up of categories that reflected the new mothers' experiences. Becoming a mother included personal tension, embracing motherhood, and total responsibility. Body discomforts and mood swings, and fatigue are subsumed under emotional and physical restoration. Breastfeeding was a concern that comprised physical experiences, positive emotions, and negative emotions. Balancing roles included reincorporation of the paid work role, changing spousal relationships, changing family relationships, and accepting losses from the individual role. In the context of the joy associated with developing a relationship with the baby, the mothers described being fascinated with baby's personhood, providing adequate care for baby, and making sense of
baby's needs and behaviors. Unsupportive attitudes/actions of others concerned the mothers because of the negative/conflictory nature of the information, lack of consideration of mother's needs, and disagreement with parenting style.

The mothers used a variety of coping strategies to deal with their concerns. Eight coping strategies emerged from the analysis. They were: seeking support/advice, accepting support/advice, caring for self, redefining normal, identifying what was right for self, utilizing/modifying former coping strategies, encouraging/accepting partner's involvement, and sharing feelings. The women sought partners, family and friends most often for support and advice. Health care professionals such as CHNs, physicians and lactation consultants were also utilized for specific types of support.

Chapter 4 presented the concerns and coping strategies identified by primiparous women. In this chapter, the findings are discussed in relation to the current literature. Conclusions and implications for nursing practice, education and research are also presented.

Significance of the Study

Research has not explored the concerns or the corresponding coping strategies of new mothers from their perspective during the early postpartum period. How can CHNs, as well as hospital maternity nurses provide quality care to new mothers and their infants without understanding maternal perceptions of concerns and coping strategies? Interventions that do not address women's concerns and coping strategies are neither safe nor cost effective and may result in unsatisfactory outcomes for this population of women. CHNs in the City of Vancouver telephone and visit new mothers in the first weeks following discharge from hospital. Empirical data have not been generated for the specific time frame associated with this study and that data is needed to provide direction for nurse-mother interactions as well as the interactions of other health care professionals who work with new mothers. The information provided by such data could serve to facilitate the design of new and ongoing programs and support services for new mothers. In addition, anticipatory guidance and support services could be made available before new mothers find themselves challenged or unable to cope with the transition to mothering.
Discussion of Findings

The findings of this study must be placed in the context of currently available literature. Otherwise, the congruence between the findings and the literature and the contributions made by the findings to empirical knowledge will not be apparent. Concerns will be discussed first, followed by coping strategies.

Becoming a Mother

The arrival of a new baby caused many overwhelming feelings for the women who were studied. The women described feeling personal tension, embracing the maternal role and taking on total responsibility. There are several authors who have explored the conflicting feelings associated with motherhood and have placed these in a social context. The studies which addressed maternal role attainment and management provide support in part for the concerns that were categorized as becoming a mother (Hall, 1987; Mercer, 1986). Becoming a mother evoked intense feelings for the women of this study. The women felt overwhelmed by the all consuming responsibility of caring for another human being. Their feelings resulted in further feelings of powerlessness and tension. Their nerves were frayed. Many of the women felt that they were the only people who care for their infants adequately. But becoming a mother was not all bad. Many women experienced overwhelming positive feelings. Their self-esteem increased and they internalized the mothering role.

Mercer (1986) in her intensive study of 242 primiparous women, tried to determine if there were age differences in mothering behaviors and responses to the maternal role. She concluded that only 17% of the women described "the first few days after returning home from the hospital overwhelming. They stated that they had been afraid of the baby and had compulsively checked on the baby every hour" (p. 130). Although Mercer's (1986) sample of women were overwhelmed with the responsibility of caring for the baby 24 hours a day, their feelings differed from those of the women from this study. None of the women in this study described being afraid of the baby. Also, the feelings of the women from this study went beyond just being overwhelmed to encompass tension, anxiety, and intense positive feelings about internalizing the maternal role.
While the women of this study had not yet returned to employed work, a study of women who had supported this studies' findings. Hall (1987) studied primiparous women who had returned to work and concluded that the women experienced role strain. According to Hall (1987), the women felt overwhelmed due to a lack of energy, time, or resources and "because most of them believed that they alone were responsible for the baby" (p. 191). Again the idea of being the sole adult responsible for the infant created strong feelings that affected the women returning to work in Hall's (1987) study and the women who were internalizing the maternal role in this study. While the women of this study had not yet returned to work, they were already feeling fatigued and overwhelmed by their new roles.

**Emotional and Physical Restoration**

The women who were studied by the author expressed great concern about their emotional and physical restoration. Once again the body discomforts and mood changes the women of this study experienced evoked intense feelings. The women felt their bodies were not their own; they were neither pregnant nor prepregnant, but caught somewhere else. They felt disconnected. Fatigue went beyond tiredness to reach a level of sleep deprivation that affected many other areas of their lives. All of the women from this study discussed fatigue as a concern.

Very few studies in the literature have specifically considered this issue. Tulman and Fawcett (1988) studied the return of functional ability to women who had either vaginal or cesarean deliveries. Functional ability was defined as resumption of household, social and community, occupational activities and assumption of infant care responsibilities. Tulman and Fawcett (1988) noted that most textbooks consider physical recovery to take place during the first 6 weeks following childbirth. By 6 weeks only 51% of the 70 women in their study reported that they had regained their usual level of physical energy. Tulman and Fawcett (1988) concluded that "recovery from childbirth encompasses more than the healing of the reproductive organs... Recovery to full functional ability requires more than 6 weeks and cesarean section women require considerably more time than their vaginally delivered counterparts" (p. 80). The definition of physical recovery needs to encompass more than the
time it takes for a uterus to involute. It must also take into account the emotional restoration that new mothers must achieve. More than half of the women from the study reported here had not regained their physical or mental energy by the time of the interview which occurred at 1 to 4 weeks postpartum. While the women of the study reported here had resumed some household responsibilities, few had resumed social and community activities. None of the women had resumed their occupations, while all had assumed most of the responsibilities associated with infant care. The women of this study had not achieved Tulman and Fawcett’s (1988) definition of functional ability by the first 1 to 4 postpartum weeks, nor had the women in Tulman and Fawcett’s (1988) study.

Gardner (1991) studied the types of fatigue of 35 postpartum women. Four types of fatigue were assessed: normal, pathophysiological, situational and psychological. The women were found to be mildly fatigued over the study period and fatigue was categorized as situational and/or psychological fatigue (Gardner). Gardner also found that older women were less fatigued, fatigue increased with childcare problems, mothers with more education were less fatigued and less fatigue was noted with increased household help. The women of the study reported here experienced situational and psychological fatigue that appeared to be deep and lasting. These study findings would indicate that the impact of sleeplessness and fatigue in the women’s lives constituted more than just being "mildly fatigued". They described being "out in space" and "having their brains turn to mush". They linked support from their family, partner, and friends to less fatigue. They identified a willingness by these people to give them time to rest or get away. This finding is not surprising. When women have instrumental support, they are able to find time to nap or sleep for longer periods thus decreasing some of their fatigue, relieving some of their responsibility, and assisting them to feel more connected.

**Breastfeeding**

Breastfeeding was a major concern for the women of this study. Their concerns focused on the physical experiences, negative and positive emotional reactions to breastfeeding. All of the women in this study reported they had chosen to breastfeed their infants at the time of birth. By the time of the interviews all of the women were continuing to breastfeed but many
had started supplementing with a bottle. Any woman who did not have an adequate milk supply took this to be a reflection of her inability to nurture her baby. Many women also felt pressured to breastfeed by society and health care professionals. While women could go to health care professionals for advice about physical sequelae associated with breastfeeding, they could not share their negative feelings about breastfeeding with these same professionals. But breastfeeding was not all negative. It evoked strong positive feelings for the women. They felt important and nurturing because only they could feed their infants.

Several other authors have explored breastfeeding in the postpartum period. Morgan (1986), interviewed 78 primiparas about feeding problems and concerns. In the immediate postpartum period the women expressed concerns about not having enough milk, milk quality, breast and nipple discomfort, feeding frequency and duration, comfortable positions, and the best type of nursing bra for unobtrusive public nursing. At one month, women were concerned about insufficient milk, lack of sufficient sleep due to night feedings, and feeding techniques. The women who were studied by the author were very concerned about adequate milk volume and discomfort. Many women from the author’s study had concerns about breast and nipple discomfort, while a few mentioned insufficient and thin looking milk. Breastfeeding positions were also mentioned. Again fatigue was a concern that was exacerbated by night feedings and that made dealing with the negative feelings about breastfeeding more difficult. As stated previously, inadequate milk or an inability to breastfeed due to sore nipples not only produced concerns about physical sequelae, but also negatively affected feelings about the quality of their nurturing for the women in this study.

In a literature review by Kearney (1987), personalities, personal and cultural attitudes, and emotional states were found to have effects on the success of breastfeeding. Research suggested that "the ideal breastfeeding personality is calm, mature, independent, accepting of the giving of oneself, involved in the mothering role and accepting of the unpredictable nature of childbearing" (Kearney, 1987, p. 99). This description is hardly realistic considering the fatigue and overwhelming emotions new mothers experience. It does not describe the women reported in this study.
Infant temperament also was found to have an effect on breastfeeding outcomes. Kearney (1987) considered newborns who were irritable, resistant to soothing and hard to feed to contribute to breastfeeding difficulty. Family members', friends', spouses', the media's and health care professionals' attitudes towards breastfeeding were also found to have an impact on the success of breastfeeding. In general, positive reinforcement and positive attitudes were more conducive to breastfeeding success. Several of the women in the study reported here found breastfeeding extremely difficult and time consuming. The people around the new mothers had both positive and negative impacts on the women, depending on their attitudes toward breastfeeding. The women felt pressured to breastfeed by society and health care professionals and guilty every time they thought about weaning. People who were positive with new mothers about breastfeeding were seen as a supportive, while people with negative attitudes were seen as problematic. The women, when they experienced negative emotions related to breastfeeding, did not look to health care professionals for support. Like Kearney's (1987) findings, the women of this study with positive attitudes toward breastfeeding and positive support, had more positive comments about breastfeeding and appeared to enjoy it more than women with negative attitudes.

**Balancing Roles**

Balancing the roles in their lives concerned all of the women in this study and was usually the first mentioned concern during the interviews. The women were particularly concerned about accepting the losses they perceived as a result of the new baby. Every woman interviewed discussed positive and negative changes to her roles. The women experienced a lack of time for themselves and for meeting their own needs. Changing spousal relationships meant a loss of spontaneity in their lives. Many women felt the responsibility of the child had been left to them as opposed to their partners. The women were already thinking about the lack of choice about whether to return to work. In general, the women were unprepared for the intensity of the changes to their lives brought about by the birth of their first child.

Cowan et al. (1985) studied new parents' roles and concluded that "both men's and women's parent aspects of self seem to expand, the partner/lover aspect gets squeezed and
marital conflict increases" (p. 477), after the birth of a child. They also found that husbands and wives traveled different pathways to parenthood. Mothers, for example, experienced a more radical shift from the work world to home, "with a significantly larger portion of herself devoted to the care and nurturing of the baby" (p. 477). While none of the women from this study discussed an increase in marital conflict directly, they did speak about how the introduction of the maternal role "squeezed" aspects of their roles as a spouse, worker and individual. Only one woman spoke about increased arguing between herself and her spouse since the birth of the baby, but the women were not specifically asked if marital conflict had increased. Like the Cowan et al. (1985) study, the data from this study also indicated that women felt they devoted a lot of time to the care of their infants. But beyond the findings of Cowan et al. (1985), this study went on to conclude that this time spent nurturing was at the expense of time for themselves and their partners.

Mercer (1986) asked primiparous women to describe the most difficult aspect of the mothering role:

The lack of time and extreme pressure posed by this lack of time was a central issue the first month following birth. The lack of time to go on outings with the baby caused the women to feel tied down and isolated. Erratic infant schedules made it difficult to plan time and interfered with time that might otherwise be available for taking a bath or reading a book. Women commented that there was no time for caring for themselves (p. 133).

Most of the women studied by this author also spoke of the lack of time for themselves, their self-interests, and time as a couple at some point during the interview. These concerns were also some of the first mentioned concerns for most of the women in this study. But again, the women of this study went beyond Mercer's (1986) findings when they discussed their loss of personhood and a lack of time to express themselves in contexts beyond the maternal role.

Only a few women spoke about their perceptions of their partners as fathers. The women were concerned about their partners' jealousy and their abilities to provide care to the baby. LaRossa (1988) argued that "the culture of fatherhood (society's norms, values, and
beliefs about parenting) have changed more rapidly than the conduct of fatherhood (what fathers do, their paternal behaviors)” (p. 451). A study by Rustia and Abbott (1993) supports LaRossa’s findings. They found that the "actual behaviors of fathers lagged behind the normative expectations of both themselves and their wives" (p. 474). In this study, mothers reported that partners had little time to spend with their infants because of employment and because maternal breastfeeding precluded their involvement in many aspects of feeding. Also, the women were somewhat amused by their partners’ clumsy efforts at caregiving. These findings may shed some light on reasons for fathers' behaviors lagging behind their expectations.

While the women of this study suspected that their partners were jealous of the mother-baby relationship and wanted their partners to take a more active role in household tasks and infant care, the women were critical of the care their partners were providing. Jordan (1990) studied the experiences of new fathers before and after the birth of their first child. According to Jordan (1990), "man labours to perceive the paternal role as relevant to his sense of self and his repertoire of roles. He labours to incorporate the paternal role into his self-identity as a salient and integrated component of his personhood, and to be seen as relevant to childbearing and childrearing by others" (p. 12). Further, Jordan (1990) states, "men in this investigation wanted to be involved parents, but they did not believe they had the knowledge, skills or support to do so" (p. 15). The women of this study, while critical of their partners involvement in parenting, perceived themselves as supportive to their partners because they made efforts to include their partner in childcare tasks.

**Developing Relationship with Baby**

Nearly all the women of this study talked about the joy the new baby brought into their lives. Most of the women spoke about their fascination with the baby’s personhood. They were amazed that, with their partners, they had been able to create another human being who was part of themselves. However, the women also went on to discuss the trouble they had understanding and interpreting their babies' needs and how to deal with them. They then went on the speak about the confusion these infants caused as well. Crying was one issue that they
were at a loss to interpret successfully. Several women did not see crying as a form of communication by the baby. Drummond et al. (1993) studied the development of mother's understanding of infant crying. They reported that "at 6 weeks, crying was perceived as a signal or noise of little or unknown meaning... trial-and-error soothing led to the use of extensive intervention lists to diminish infant crying" (p. 400). The results of Drummond et al. (1993) support the findings of this study with regard to crying.

Pridham (1989) studied the meaning of a new infant to mothers, in a combined group of primiparas and multiparas. At one month postpartum the women identified perceptions of life, self and others (baby's growth and development, personality expression), infant care tasks (feeding baby), and relationships (having a baby to relate to and interact with) as their most satisfying factors. The most difficult factors were infant care tasks (getting up at night to feed the baby), lifestyle (pattern of daily activities including amount of sleep), and resources (not having enough time for oneself). This study's findings were not congruent with Pridham's (1989) findings regarding the women's most satisfying issues at one month. Infant care tasks and perceptions of life (loss of roles), self and others were all of great concern to the women but were not viewed as joys.

Unsupportive Attitudes/Actions of Others

Unsupportive attitudes/actions of others surprised and disappointed many of the women in this study. The women were concerned about information issues, lack of consideration of their needs and disagreement with their parenting style. Many of the women from this study reported that the information they received from their partners, family, friends and health care professionals was often negative, conflictual or unsubstantive. Friends and family members always seemed ready to share their opposing opinions about how to parent. Overall, new mothers found that others wanted to focus on the negative aspects of parenthood rather than the positive ones.

While most of the women studied by the author made comments during the interview about how useful and helpful the CHN's visits had been, only a few women mentioned that they had contacted the CHN through their own initiative. This may have been due to a
hesitancy to express personal needs to a professional, but could also have been due to their feelings that they could cope without the CHN. Reading was an important source of information for the women of this study, but it was not the single most important means of gaining information for the women. Partners, family, and friends were the most important source of information for the women of this study. A study by Rovers and Isenor (1988) investigated mother’s perceptions of community health services during the postpartum period. The findings suggested that "half of the mothers… indicated at least some hesitancy, if not total reluctance (to) actively seek out CHN services" (p. 198). Mothers also reported that reading was the single most important means of gaining information.

Several women in this study discussed the lack of teaching during their hospitalization from health care professionals. They felt ignored and described information they did receive as conflicting. Field and Renfrew (1991) conducted two surveys to identify the strengths and weaknesses of postpartum teaching. Their findings which concurred with this study’s results concluded that hospital stays are relatively short and concentrated on infant feeding and physical care of the mother. Problems with breastfeeding were likely to occur after hospital discharge and before the CHN visits. Follow-up visits in the community were frequently motivated by problems with newborn feeding (Field & Renfrew, 1991). Several women from this study commented that the CHN's visit had been too late to deal with some of their breastfeeding concerns. However, these women sought out other sources of care such as the breastfeeding clinics at Vancouver or B. C.’s Women’s Hospital and the La Leche League. Like Field and Renfrew’s (1991) findings, newborn feeding was one of the main concerns of the new mothers studied by the author.

A study by Ventura (1987) examined the stresses of parenthood between the third and fifth postpartum months. Four categories of stress were described: interactions with other family members; demands of parent, spouse and worker; infant care; and interactions with spouse. Eighteen percent of mothers reported stresses in the interactions with other family members category. Stresses ranged from loss of a family member, and disagreement with in-laws and friends to mediating or organizing other family members. Sixty five percent of
mothers had stresses associated with multiple role demands such as parenting versus job activities. Thirty five percent of mothers described stress in relation to the infant's fussy behavior around feeding or soothing. Fourteen percent of mothers felt stressed with their spouse. While the time period covered by Ventura's (1987) study and this study do not overlap, some of the same concerns were also identified in this study. The women in this study had concerns about interactions with family members but unlike Ventura's (1987) findings, their concerns were about disagreements with parenting styles. But like Ventura's (1987) findings, the women of this study also had concerns about the difficulties associated with multiple role demands such as parenting and returning to work.

Coping Strategies

The women in this study used a variety of coping strategies to deal with their concerns throughout the early postpartum period. As stated previously, the 8 coping strategies were: seeking support/advice, caring for self, accepting support/advice, redefining normal, identifying what was right for self, utilizing former coping strategies, encouraging partner's involvement, and sharing feelings. Seeking support/advice, sharing feelings, caring for self, and accepting support/advice were the coping strategies which emerged most often. Some strategies were used across most of the concern-related concepts while others were only used for specific concerns. For example, seeking support/advice was the most widely utilized coping strategy. It was used to deal with becoming a mother, breastfeeding, balancing roles, developing relationship with baby, and unsupportive attitudes/advice of others.

A number of strategies were used across maternal concerns but were not the primary coping strategy. Sharing feelings was a widely utilized coping strategy and permitted the women to address becoming a mother, breastfeeding, balancing roles, and developing a relationship with baby. Caring for self was used often to deal with becoming a mother, emotional and physical restoration, and balancing roles. Accepting support/advice was used to deal with breastfeeding, developing a relationship with baby, and unsupportive attitudes/actions of others. Redefining normal and identifying what was right for self were used to deal with fewer concerns. Redefining normal addressed becoming a mother, and
emotional and physical restoration. Identifying what was right for self helped women to manage balancing roles, and unsupportive attitudes/actions of others. Finally new mothers utilized/modified former coping strategies and encouraged/accepted their partner's involvement only to deal with balancing roles.

The concern-related concept, balancing roles, required the greatest number of coping strategies. This is not surprising considering that balancing roles was the most talked about concern by the new mothers and most often the first mentioned concern during the interviews. This suggests that balancing roles was a very difficult concern to resolve and that for many of the women it was an ongoing issue. Becoming a mother also required the use of a number of coping strategies. Again it was a concern that was discussed at great length and with much intensity by the women.

The women of this study found that positive attitudes and support from significant others were beneficial. This study went beyond other studies to determine exactly who the women choose for support and under what conditions. For example, the women would seek support from health care professionals for solutions to breastfeeding sequelae but would not go to them for support for negative emotional reactions to breastfeeding. Studies by Cronenwett and Wandersman (1980), and Wandersman and Kahn (1980) indicated that social support may lesson the impact of the crisis component in adjusting to a new baby. In a literature review by Koniak-Griffin (1993) a variety of other researchers have also concluded that "the availability of positively perceived informal and formal support systems are essential for successful maternal role transition and the development of confidence in parenting during the prenatal and postnatal periods" (p. 260).

The women studied here also reported that partners were their first and most utilized source of support. Spouses in this study were used for physical support such as sharing household tasks, psychological support such as dealing with others who disagreed with parenting styles, and emotional support such as sharing negative feelings toward breastfeeding. Majewski (1987) studied social support and the transition to the maternal role by examining the most supportive individuals for first time mothers from a physical, psychological and
emotional perspective. The study concluded that "while extended family members were identified as supportive, spouses were overwhelmingly the major source of support for first time mothers" (p. 405). However, spouses provided more physical support than emotional support.

Curry (1983) linked previous experience with small children to an easier adjustment to motherhood. Difficulty adapting to motherhood was associated with little help at home from extended family or friends. Several women studied by the author said that they believed previous experience with small infants and children had helped them to cope with the needs and behaviors of their own infants, but most felt they learnt childcare tasks through practice with their own babies. The women felt that learning with their own babies was more beneficial because each baby was an individual with his/her own characteristics, and time and practice with their own baby meant they could interpret the needs of their own baby. Women who had little or no help from extended family or friends also had greater difficulty with concerns such as becoming a mother, emotional and physical restoration and balancing roles. This is because, without help, fatigue increased and increasing fatigue made coping with other concerns much more difficult, especially the concerns that affected the women directly. As stated previously, the women believed that fatigue made dealing with their concerns worse. They felt that if they could get more uninterrupted sleep then their fatigue would decrease and they could either deal with their concerns more effectively or the concerns would not seem so overwhelming.

In a study by Pridham and Zavoral (1988), a group of 49 primiparous and multiparous women were asked about their perceptions of support and stress. The women reported that help with infant care was more frequent than help with household tasks. Fathers provided more help than grandparents. Fathers were also seen as more helpful and supportive than grandparents in the author's study, but this may have been due to the fact that all the fathers lived with the mothers and were more easily accessible than grandparents. As with Pridham and Zavoral's work (1988), this study also found partners to be the most widely used source of support and the person the women most often went to first for support.
Mercer (1986) asked new mothers to identify their resources and coping strategies for mothering at one month. The women's partners were the first and most frequently identified source of support. They were followed by the women's parents, then friends and finally other mothers or friends with children. Once again these findings support this study's findings. Partners were the most frequently cited source of support. In no particular order, the women's parents, friends, and others with children were also mentioned as sources of support. The women also sought community agencies, health care professionals, and prenatal class members for support. These supports were not sought by women in Mercer's (1986) study, possibly due to the fact that the women of Mercer's (1986) study were American and could not afford or access these types of support or possibly because of the differences between the American and Canadian health care system. The findings from this study extend the possible sources of support used by primiparous women during this time frame.

Conclusions

The following was concluded:

1) While the transition to motherhood was a stressful life event, it was not a crisis for most of the women in this study. However, becoming a mother evoked intense positive and negative emotions and being responsible for another human being 24 hours a day was overwhelming for the women.

2) Physically and emotionally the women were caught somewhere between a pregnant and prepregnant state. Fatigue bordered on sleep deprivation and was mentioned by all of the women in this study.

3) When breastfeeding was successful it brought the women closer to their babies because they felt they were providing something no one else could. When it was unsuccessful the women felt they were unsuccessful nurturers and described themselves as failures at mothering.

4) All of the women from this study discussed the changes and losses to their roles. They discussed the lack of choices about returning to work. They felt the relationship with their spouses had changed in a positive manner but had also experienced some lapses. They
described losing parts of themselves as individuals and were unprepared for the intensity of the changes to their lives.

5) Although all of the women spoke about or displayed affection for their infants, they had a difficult time interpreting and dealing with their babies' needs. The negative or conflictual information received from their families, friends and health care professionals contributed to their difficulties.

6) Each woman is an individual with personal experiences and a unique history. Her personality affects the concerns and coping strategies she experiences and uses during the early postpartum period. While many of the concerns and coping strategies experienced by the new mothers in this study were common to all of them or most of them, the women did experience concerns or use coping strategies that were unique to them.

7) While a variety of parenting programs and literature are available to new mothers in the community, the needs of the women of this study were not met completely by those current programs or literature. Health care professionals must question why that is and look for appropriate solutions.

8) The new mothers' greatest source of support during the early postpartum period were their partners. Partners were used for sharing feelings, instrumental support and, at times, emotional support. New mothers also saw themselves as a source of support for their partners, who they believed were jealous of the maternal-child relationship and lacking confidence with childcare tasks. However, they described relying on their partners far more often than they referred to acting as a support for them.

9) Seeking support/advice, sharing feelings, caring for self, and accepting support/advice were the coping strategies which emerged most often. Balancing roles and becoming a mother were the two concern-related concepts that required the most coping strategies. These two concerns were also the most often talked about concerns during the interviews.

10) While health care professionals were a source of support for the women of this study for such issues as concerns related to the physical sequelae associated with breastfeeding,
the women avoid discussing negative emotions with them. The women felt that health care professionals would not be empathetic or supportive of concerns that did not reflect current health care practices. For example, the women would not speak to health care professionals about wanting to wean their infants from the breast.

11) Seeking support/advice was the most widely utilized coping strategy across all concerns, but also it was the first coping strategy that was used by mothers. Very often the person the new mothers sought out first for support or advice was their partner.

12) For the majority of coping strategies, the women had to depend only on themselves. Redefining normal, caring for self, utilizing/modifying former coping strategies, identifying what was right for self, and encouraging/accepting partner's involvement were coping strategies that the women developed on their own. Sharing feelings, seeking support/advice, and accepting support/advice required the women to involve others into their coping. Many of the coping strategies that the women used by themselves were used in conjunction with coping strategies that involved others. The coping strategies that involved utilizing others were the most often used and first used coping strategies.

The findings and conclusions from this study have implications for nursing practice, education and research.

Nursing Implications

The findings of this study suggest a variety of implications for nurses who practice with both new mothers and pregnant women. Implications for nursing education and nursing research are also evident.

Implications for Nursing Practice

Nurses who work with both pregnant women and new mothers in a variety of settings must be prepared to acknowledge the difficulties and joys associated with the transition to the maternal role and to respond to their concerns and coping strategies appropriately.

The Prenatal Phase

During pregnancy, nurses and childbirth educators (CBEs) who teach prenatal classes have the opportunity to discuss the early postpartum period. While prenatal classes focus
mainly on coping with labour and delivery, they could incorporate possible concerns and
develop coping strategies that are effective to deal with these concerns as part of the
curriculum. For example, CBEs could encourage communication strategies between partners,
and sharing of expectations, as these areas emerged as concerns from the study. Further, CBEs
could facilitate networking between prenatal class members before and after the births of their
children, so partners could have access to a source of support. The CBE must be aware that
the women in the class and their partners are very focused on their labour and delivery and the
timing of the discussion of concerns and coping strategies must be appropriate. Childbirth
educators could begin with couples' concerns in the prenatal period, develop coping strategies
and then assist couples to apply these strategies in the postpartum period. If prenatal classes
currently attempt to address these postnatal issues, then it is obvious from the findings of this
study that the classes are not able to entirely meet the intensity and number of concerns
described by the women studied. Perhaps CBEs should survey their new parents during the
reunion classes, and ascertain their concerns and coping strategies, as well as their ideas about
the timing and format of the classes, so that future prenatal classes could incorporate and better
address their issues.

Since breastfeeding was such a concern to the women of this study, nurses and CBEs
could encourage pregnant women to attend breastfeeding classes before the birth of their
infants. In this way, new mothers could obtain some information and insight into potential
concerns before they begin breastfeeding. The breastfeeding classes need to focus on the
normal and potential physical sequelae associated with breastfeeding, as well as the negative
and positive emotions that breastfeeding can produce. Women need assistance to put
breastfeeding into perspective so that they do not feel they are failures if breastfeeding is
unsuccessful or they are bad mothers because they have negative feelings or find bottle-feeding
their infants acceptable. Health care professionals who teach these classes must also be aware
of their impact on new mothers, new fathers, and pregnant women. They exist to provide
information and support women, not to instill "breast is best" under any conditions. Health
care professionals must support women and men in their choice of infant feeding method.
Prenatal classes could also serve as a source of information about community resources and how to access them. If new parents were aware of services provided and available in the community before birth, they may be more willing and able to access them in times of need. The resources the parents access would depend on their individual concerns. For example, women with breastfeeding concerns could access the newborn hot-line, La Leche League, lactation consultants in the community or in out-patient departments, or CHNs. It is time for North American society to go beyond prenatal classes that tend to focus on coping with pain during delivery and acknowledge that the postpartum period is the beginning of a life long relationship between mother, father and babe that requires attention before birth. It may be time to explore a new care delivery model for new mothers and parents, as the old model is not meeting the needs of new parents. The new model could focus on issues in a preventative way and take some of the focus away from coping with labour and delivery.

The question must also be asked, can teaching about postnatal issue in the prenatal period really be effective? Pregnant couples have many issues to deal with surrounding pregnancy and labour and delivery. Are they really able to absorb more information about issues that do not currently affect them? These questions do not mean that teaching about postnatal issues in the prenatal period should not occur, only that the teaching that does occur needs to be creative and carefully planned to be relevant to the couples.

The Early Postpartum Period

Maternity nurses who work with new mothers in hospital following birth have very little time to provide teaching due to short postpartum stays in hospital. The short time available could be used to provide both physical and anticipatory care. Anticipatory care would address new parents' greatest or most urgent concern(s) and would also entail referring them to the appropriate community agency. Hospital nurses could also provide the new parents with lists of community resources, their addresses, telephone numbers, and hours of operation for times of need. The list of community resources would be specific to the geographical location of the city or town and be comprised of all the profit and non-profit, governmental and non-governmental agencies that serve new parents and infants. Upon leaving hospital, new parents
receive a lot of brochures about various topics. Perhaps it is time to evaluate the effectiveness of this form of communication in order to decrease its bulk, increase its effectiveness and create a situation that is less overwhelming.

Some type of system needs to be put in place so that maternity nurses share information with CHNs about areas they identified as concerns of the new mothers and fathers in hospital and the teaching that was provided. This flow of information could provide greater continuity of care for women going from the hospital to home. According to several CHNs in the Vancouver area, this system does exist in some larger hospitals, but the flow of information from hospital to community does not occur or is limited. If a system exists that addresses continuity of care, there must have been a perceived need for such a system. Unfortunately if CHNs, the professionals who are supposed to receive and interpret this information, say it is not effective, then perhaps the system needs to be evaluated and possibly redesigned. Input is required from the hospital nurses to find out why, in their opinion, the system in not accessed and therefore unsuccessful.

The Late Postpartum Period

Nurses who work in the community have opportunities to spend time with new mothers. All primiparas in the Vancouver area are to receive at least one telephone call from a CHN after discharge from hospital. Therefore every new mother has the opportunity to discuss her concerns at least once with a nurse. CHNs also make home visits, answer questions on a newborn hot line, and operate a variety of drop-in clinics that all focus on the early postpartum period. Ample opportunities are available for discussions around new mothers concerns and their subsequent coping strategies. Community health nurses could use the findings of this study as a basis for questioning new mothers about specific concerns they are experiencing and coping strategies they are using. The findings could also be used to assist CHNs to assess specific issues and suggest or augment possible coping strategies. The findings of this study illustrated that often the new mothers with the greatest concerns were the women who did not access community agencies. Community agencies need to recognize that a needy population of mothers exists who, for many reasons, do not use their services. These agencies must find
ways to reach these women. If these mothers could be identified, they could be offered home visits. If new mothers knew that community agencies could provide care at home in times of great need, the women might be more willing to access the agencies.

Similar to prenatal classes focusing on the issues of importance to women during pregnancy, postnatal classes could be established that deal with the issues of the postpartum period. These classes could include both new parents and their babies. Each class could focus on a different concern identified by women in this study and potential coping strategies that could be used to manage the concern. While some parent-child drop-ins do already exist, health care professionals must be aware of the parents needs and concerns rather than what they think the parents' concerns are. Just as prenatal classes have videos, posters and props, postnatal classes could also utilize these techniques. Classes would necessarily be informal to allow for breastfeeding as necessary. Guest speakers such as lactation consultants or parents with older babies could share their skills, knowledge, experiences, concerns and coping strategies. Classes need to be offered in a variety of locations and languages.

Creative approaches to providing care for new parents need to be sought and encouraged. For example, while prenatal classes are fairly well attended, classes in the postpartum period would be scheduled at a time when new parents are very busy and overwhelmed with the new baby. Attending a class may also be problematic. Providing classes during the day and on weekends rather than just weekday evenings could be explored. Free childcare should be offered so that parents could focus on the class itself while their children were receiving care. Classes or information kiosks could be located in places that new parents frequent such as malls or community centers. Intimate classes with only a few couples could be taught in one of the couple's homes so that new parents who are not able to get out to classes can still benefit from them. Father and baby groups could be expanded to acknowledge and deal with new father's concerns. Evening or weekend classes and meetings for fathers would provide new mothers with a much needed break.
Implications for Nursing Education

The acceptance and utilization of early discharge programs as the norm for maternity care in the 1990's and continuing establishment of prenatal classes that focus primarily on the labour and delivery experience require nursing students to be aware of the potential concerns of new mothers during the early postpartum period. They must also learn about the large number of coping strategies that are available for new mothers to deal specifically with their concerns. This study presents some concerns and coping strategies of new mothers in the early postpartum period. The various concepts provide nursing students with a basis to develop their care within the context of an individual mother's concerns. Nursing students, at all levels, could use the information provided in this study as a beginning point for assessing women's psychosocial and learning needs during maternity practicums. Once aware of the new mother's personal concerns, the student could facilitate potential coping strategies.

Educators who teach nursing students must also incorporate the information on new mothers' concerns and coping strategies into nursing curricula. Students need to be provided with information about the variety of community programs, hospital programs and literature available to new mothers if they are to be effective at facilitating support networks. Educators and nursing students must study and contribute to cost effective strategies to deal with new mothers' issues.

Implications for Nursing Research

It cannot be assumed that the concerns and coping strategies described by the women in this study reflect the concerns and coping strategies of the population of all new mothers in the 1990's. The women in this sample were middle class and did not represent varying ethnic groups. A variety of other questions arose from the findings of this study:

1) What are the concerns and coping strategies of new fathers? Because new fathers are the main source of support for many new mothers, it is important to know how the birth of their first child and the mother's reaction to it affects them. Are the concerns and coping strategies of fathers different from mothers and if so how do couples sort out the differences in order to care for infants together?
2) Are the concerns and coping strategies of multiparous women different from those of primiparous women? Because multiparous women have previous experience with young infants, and now have an older child to care for as well as a new baby, they may experience different concerns and coping strategies. Primiparous women and multiparous women, by their nature, are different. Thus, their concerns and coping strategies could be studied to discern similarities and differences.

3) Are the concerns and coping strategies different for women from other ethnic and socioeconomic groups? Once again this study focused on the concerns and coping strategies of middle class, Caucasian women. Women who are economically disadvantaged or do not speak the prevailing language are at a disadvantage when it comes to prenatal classes, teaching during hospital stay, postpartum drop-in groups, home visiting and the literature. As the world continues to become a global village, health care professionals need to know about the concerns and coping strategies of all the citizens they serve.

4) Are the concerns and coping strategies of teenage mothers and older mothers different from the women in this study? Because the women of this study ranged in age from 22 to 34 years, the concerns of women younger and older than this are unknown. Women outside of this study sample's age group could face a variety of other issues due to their education, experience and susceptibility to physical complications during pregnancy, and labour and delivery.

5) Are the present programs available to new parents meeting their needs? The concerns and coping strategies that emerged from this study could be used as a basis to evaluate the effectiveness of current programs aimed at middle class Caucasian parents. It is important for programs to be both current and effective. Ongoing evaluation is a necessary part of any program.

In conclusion, women bring their own unique history and personal characteristics to developing their maternal roles. To provide new mothers with the care they require, nurses must be aware of the possible concerns experienced and coping strategies used during the early postpartum period. The information provided by this study gives nurses insight into some of
the concerns and coping strategies of new mothers in the 1990's. Specifically, the transition to motherhood is fraught with both positive and negative experiences and emotional reactions. When breastfeeding is successful, it brought powerful feelings of accomplishment, but when it was not, it brought feelings of failure as a mother. While balancing all the new and old roles was positive because it involved the creation of a family, the women of this study were very concerned about the losses it produced in their lives. Becoming a mother produced two extremes of emotion: tension and overwhelming joy. As health care professionals, nurses need to know about all the aspects of the transition to motherhood in order to provide competent care for maternity clients.
References


Appendix A
Letter of Explanation to Community Health Nurses

Dear Community Health Nurse,

My name is Laurie Cadman, I am a student in the Masters of Science in Nursing program at the University of British Columbia. I will be recruiting subjects for my thesis titled "Concerns and Coping Strategies of New Mothers in the Early Postpartum Period" at the Burrard Health Unit.

In order to recruit subjects for this study, I will require your assistance. You are the first contact the new mother has with the health care system after delivery. During your first visit, I would like you to introduce the new mother to this study.

To be a subject in this study, the new mother must be:
1) a primiparous woman who has had either a cesarean or vaginal delivery
2) between the ages of 20 to 45
3) currently residing with the baby's father
4) medically uncomplicated, e.g. (any medical condition that occurred during pregnancy, labour or delivery such as PIH, gestational diabetes or fetal distress should be resolved without sequelae following the delivery of the baby)
5) delivered at full term in hospital (37 weeks gestation or greater)
6) caring for a healthy singleton infant (baby's APGAR score was 7 or above at five minutes)
7) able to read and speak English
8) able to access a telephone

I would like you to give any new mother who meets the inclusion criteria an "Information and Consent to Contact Form". This form is an information form only. By signing it, the new mother has agreed to let me call her by phone, and has not agreed to participate in the study. The signed forms will be returned to the Burrard Health Unit to a drop-off file. I will collect the signed forms and call the new mothers to answer all their questions and to arrange for home interviews if the new mother agrees to participate in the study.
I agree to allow the community health nurse to give my name, address and phone number to Laurie Cadman, University of British Columbia, School of Nursing masters student.

Name: __________________________
Address: _________________________
Phone number: ___________________
Signature: _______________________
Date: ___________________________
Appendix D

Sample Questions for Interview

For many people, having a new baby brings many changes, challenges, and joys into their lives.

1) What are the greatest changes, challenges, and joys for you at this time? Can you describe them in more detail? How do they make you feel? (examples of prompts: getting to know your baby, becoming a mother)

2) What kind of things are you doing to manage ________________ (insert answer to number 1 here)? Did that way of managing work for you? If yes, then what about this way of managing do you think made it successful? If no, then why do you think that that way of managing didn't work? If this same issue were to arise again, what would you do? (examples of managing prompts: crying, calling partner, reading a baby book, watching a baby video)
Appendix E

Demographic Information

Mother's age: ______________
Child's date of birth: ______________
Sex of child: ______________
Ethnic group: _______________________
Highest level of education attained: ______________
Occupation before birth of child: _______________________
Occupation of partner _______________________
Attendance at prenatal classes?: _______
Type of delivery: _______________________
Interview date: ______________
Number of days at home: ______________
Dates of hospitalization: _______________________ 
Identity of other adults living in residence: ______________