

5-26-2010

Women's Perceptions of Postpartum Stress: A Narrative Analysis

Nancy Gilbert Crist
University of South Florida

Follow this and additional works at: <https://digitalcommons.usf.edu/etd>



Part of the [American Studies Commons](#)

Scholar Commons Citation

Crist, Nancy Gilbert, "Women's Perceptions of Postpartum Stress: A Narrative Analysis" (2010). *USF Tampa Graduate Theses and Dissertations*.
<https://digitalcommons.usf.edu/etd/3560>

This Dissertation is brought to you for free and open access by the USF Graduate Theses and Dissertations at Digital Commons @ University of South Florida. It has been accepted for inclusion in USF Tampa Graduate Theses and Dissertations by an authorized administrator of Digital Commons @ University of South Florida. For more information, please contact digitalcommons@usf.edu.

Women's Perceptions of Postpartum Stress:

A Narrative Analysis

by

Nancy Gilbert Crist

A dissertation submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy
College of Nursing
University of South Florida

Major Professor: Cecilia M. Jevitt, Ph.D.
Adrienne Berarducci, Ph.D.
Lois O. Gonzalez, Ph.D.
Maureen E. Groer, Ph.D.

Date of Approval:
May 26, 2010

Keywords: Balancing Factors, Content Analysis, Coping, Crisis Theory,
Fatigue, Lack of Support, Role Strain

Copyright © 2010, Nancy Gilbert Crist

DEDICATION

To my patient husband, Milford (Mo) – friend and soul mate.

*To my children, Sean and Bryan — the amazing duo who continue to inspire me and bring
joy to my life.*

*To my father, Franklin Eugene Gilbert and my mother, Betty Louise McClatchey Gilbert,
who lovingly raised me, encouraging the pursuit of education and service to others.*

To my mentor and friend, Dr. Marie Visscher.

ACKNOWLEDGEMENTS

I extend heartfelt appreciation to my Dissertation Committee Chair, Dr. Cecilia Jevitt, CNM, and members, Dr. Adrienne Berarducci, ARNP, BC, FAANP, Dr. Lois Gonzalez, ARNP, CNS-BC, and Dr. Maureen Groer, RN, FAAN, for their expertise, guidance, encouragement, and inspiration during the development of this dissertation. I especially thank Dr. Maureen Groer for encouraging me to do the secondary analysis of her data and Dr. Lois Gonzalez for her invaluable contributions during the preliminary stages of this dissertation. Technical assistance provided by personnel at the Graduate School and USF Health IS is much appreciated. I am forever grateful to Dr. Mary Evans, College of Nursing Associate Dean for Research and Doctoral Programs, for her support and guidance during the extent of my doctoral studies.

TABLE OF CONTENTS

LIST OF TABLES	iv
LIST OF FIGURES	v
ABSTRACT	vi
CHAPTER ONE: INTRODUCTION	1
Background and Significance	1
Problem Statement	2
Purpose of the Study	3
Research Questions	3
Conceptual Framework	3
Methodology	3
Summary	5
CHAPTER TWO: REVIEW OF THE LITERATURE	6
Literature Search Methodology	6
Conceptual Framework	7
Introduction to the Literature Review	10
Postpartum Stressors	10
Postpartum Stressors – First Time Mothers	13
Postpartum Stressors – Women Living Outside of Their Country of Origin	14
Postpartum Stressors – Depression	15
Postpartum Stressors – Other Sample Variations	16
Postpartum Stressors – Summary	20
Perception of Postpartum Stress	20
Perception of Postpartum Stress- First Time Mothers	21
Perception of Postpartum Stress – Women Living Outside of Their Country of Origin	21
Perception of Postpartum Stress – Depression	22
Perception of Postpartum Stress – Other Sample Variations	23
Perception of Postpartum Stress – Summary	24
Postpartum Support	24
Postpartum Support – First Time Mothers	25
Postpartum Support – Women Living Outside of Their Country of Origin	26
Postpartum Support – Depression	27
Postpartum Support – Other Sample Variations	27

Postpartum Support – Summary	29
Postpartum Coping	29
Postpartum Coping – First Time Mothers	29
Postpartum Coping – Women Living Outside of Their Country of Origin	30
Postpartum Coping – Other Sample Variations	32
Postpartum Coping – Summary	33
Discussion and Conclusions	34
Summary	35
 CHAPTER THREE: METHODS	 36
Study Design	36
Study Sample	36
Sampling Procedure and Data Collection	37
Institutional Approval	37
Data Analysis	38
Rigor	39
Summary	41
 CHAPTER FOUR: FINDINGS	 42
Description of the Sample	42
Research Questions	45
Most Stressful Events	45
Multiple Roles/Tasks/Children	47
Health and Safety of Children	48
Lack of Sleep	49
Tired/Fatigue	49
Significant Other Issues	50
Finances	51
Crying Newborn	52
Emergent Themes	53
Environmental Stressors	53
Symptoms of Depression	55
Health and Safety Issues	56
Roles Strain	57
Lack of Support	57
Connections or Associations	58
Summary	58
 CHAPTER FIVE: DISCUSSION	 59
Summary of the Study	59
Discussion of Study Findings	60
Theme – Environment Stressors	60
Theme – Symptoms of Depression	60
Theme – Health and Safety Issues	61
Theme – Role Strain	62

Theme – Lack of Support	62
Strengths and Limitations of the Study	64
Dissemination	64
Implications for Nursing Practice	65
Recommendations for Future Studies	67
Conclusions	68
LIST OF REFERENCES	70
APPENDICES	75
Appendix A: Permission for Use of Original Study Data	76
Appendix B: Informed Consent for Original Study	77
Appendix C: Institutional Approval	78
Appendix D: Narratives and Codings Example	79
Appendix E: Themes, Categories, Events Example	81
Appendix F: Permission For Use of Figure	84
Appendix G: Original Narrative Transcript Example	86
ABOUT THE AUTHOR	END PAGE

LIST OF TABLES

TABLE 1: Reviewed Qualitative Studies on the Postpartum Experience	11
TABLE 2: Components of Crisis Theory Paradigm and Reviewed Qualitative Studies on the Postpartum Experience	12
TABLE 3: Study Sample Demographic Characteristics	43
TABLE 4: Postpartum Stressful Events Categories	46
TABLE 5: Emergent Themes of Postpartum Stress	54

LIST OF FIGURES

FIGURE 1: Crisis Theory Paradigm

9

Women's Perceptions of Postpartum Stress:

A Narrative Analysis

Nancy Gilbert Crist

ABSTRACT

The impact of stress on the health of postpartum mothers is poorly understood. Although the postpartum period increases risk for stress related diseases such as depression and autoimmune disorders, little qualitative research has focused on women's perceptions of postpartum stressors.

A constant comparative content analysis using Atlas.Ti was done on data collected by Groer (NIH R01 NR05000 "Influence of Lactation on Postpartum Stress & Immunity) from 2001 to 2005. Women (n=127) answered the prompt, "Think of any one incident, thought, or feeling that stands out as very stressful to you and describe in as much detail as you choose." Researcher triangulation was provided by independent coding of data by two qualitative researchers.

The women were predominantly white (91%), married (72%), and not yet working following the baby's birth (70%). Only 28% had family incomes greater than \$40,000 per year. Vaginal births were experienced by 66%, 83% without complications. Forty-seven percent were breastfeeding exclusively with 43% bottle feeding. Slightly less than half (48%) were first time mothers. Eighty-nine percent claimed no recent major life event, such as a death in the family. Twenty-seven postpartum stressors were identified that were grouped into five themes: 1) environmental stressors, 2) symptoms of

depression, 3) infant health and safety issues, 4) maternal role strain, and 5) lack of support. Seventeen women identified fatigue or lack of sleep as stressful and each questioned her ability to parent a newborn.

Though these women would seem low risk for stress (having had an uncomplicated birth, being married and not yet back at work postpartum), 27 different postpartum stressors were identified. Stressors such as lack of sleep may be known by maternal-child nurses, but women are unprepared for them. Interventions need to be designed to provide anticipatory guidance for new mothers regarding postpartum stressors. Tools should be developed for use by clinicians to assess maternal stress in the postpartum period. Prenatal preparation anticipating stressors and postpartum vigilance in assessing stressors could ease the transition into motherhood.

CHAPTER ONE

INTRODUCTION

Background and Significance

The birth of a baby is a normal life event. As Groer, Davis, and Hemphill (2002) state, the postpartum period is a time of joy and satisfaction and also a time of vulnerability or even crisis. Mothers may experience numerous stressors after giving birth. Excessive stress may be a threat to maternal well-being. A classic study (N= 95) by Horowitz & Damato (1999) on postpartum stress identified four categories: roles, tasks, resources, and relationships. Stress by itself does not constitute a crisis, however, an actual or perceived stressful event may precipitate a crisis. The literature suggests that new mothers' perception of stressors, degree of social support and other factors related to coping, such as cultural and socioeconomic factors, influence the postpartum experience (Chan, Levy, Chung, & Lee, 2002; Duong, Lee, & Binns, 2005). It is important to examine what specific stressors are identified by postpartum women in order to facilitate prevention or elimination of the stressors and their effects.

Published qualitative studies suggest that postpartum stressors are present in all cultures, although perception of stress and coping may vary (Chan, et.al. 2002; Duong, & Binns, 2005; Edge, Baker, & Rogers, 2004; Hildingsson, & Thomas, 2007; Leung, Arthur, Martinson, 2005; Rodrigues, Patel, Jaswal, & de Souza, 2003; Tammentie, Paavilainen, Astedt-Kurki, & Tarkka, 2004; Templeton, Velleman, Persaud, & Milner,

2003). Relationships are affected after childbirth, and marital problems and in-law conflict can be issues (Chan, et al. 2002; Rodriques, et al. 2003; Templeton, et al. 2003). Expectations of life after childbirth are frequently not consistent with reality (Leung, et al. 2005; Tammentie, et al. 2004). Postpartum women express feelings of entrapment, loss of control, being tied down, being bound to their environment, aloneness, confusion, nervousness, tearfulness, worry, and ambivalent feelings toward the newborn (Chan, et al. 2002; Fooladi, 2006; Leung, et al, 2005; Tammentie, et al. 2004). Lack of practical help and emotional support are frequently cited issues (Rodrigues, et al. 2003). Husbands who are uncaring and disengaged from newborn care and support of the mother have been indicated as causal factors in postpartum depression (Chan, et al. 2002; Rodrigues, et al. 2003). The multitude of problems that many postpartum women endure also include violence, financial difficulties, helplessness, hopelessness, and a feeling of being trapped in a situation in which the only way out seems to be by violent means (Chan, et al. 2002; Templeton, et al. 2003).

Women who breastfeed described a positive impact on the postpartum experience, including improved mental health and sense of empowerment as young mothers (Fooladi, 2006; Duong, et al. 2005). In a study of women who did not breastfeed (N=9), lactation suppression by medication was associated with significant experiences of postpartum blues compared with women who used breast binders to suppress milk production (Fooladi, 2006).

Problem Statement

There is paucity of research addressing the impact of stress on the experience of postpartum women. In order to increase awareness of and sensitivity to the impact of

stress during the postpartum period, specific postpartum stressors need to be identified and described.

Purpose of the Study

The purpose of this study was twofold. First, a narrative analysis of written text was used to identify events which postpartum women consider the most stressful experience since the birth of their babies. Second was to identify and describe common themes regarding stressful events in the experience of postpartum women.

Research Questions

Two research questions were addressed:

- 1) What are the most stressful events experienced postpartum women?
- 2) What are common themes regarding stressful events experienced by postpartum women?

Conceptual Framework

The researcher acknowledges that qualitative research is not undertaken with a preconceived conceptual framework. However, Aguilera's Crisis Theory model was used to guide and organize the literature review. Stress is the central concept of Crisis Theory and the balancing factors are perception of the stress, support, and coping mechanisms, all of which are components found in the qualitative postpartum research.

Methodology

This qualitative study was a secondary data analysis of a larger study funded by the National Institutes of Health (R01 NR05000) focusing on the influence of lactation on postpartum stress and immunity (Groer, Davis, Casey, Smith, Kramer, & Bukovsky 2005). The purpose of the original study was to examine demographic, immune,

endocrine, stress, mood and health characteristics of formula feeding compared to breastfeeding mothers measured between four and six weeks postpartum. The qualitative component was intended to gather more data about postpartum stress in part to help refine the Tennessee Postpartum Stress Scale which the authors developed. Qualitative analysis was used to capture the rich description of postpartum stressors not expressed by aggregate statistical data.

Content analysis, a qualitative research method, was conducted on written narrative responses to the question, “Think of any one incident, thought, or feeling that stands out as very stressful to you and describe in as much detail as you choose.” The subset (n=127) from the larger study (N=200) consisted of women, four to six weeks postpartum, who answered this question in writing on the questionnaire.

The purpose of data analysis in qualitative research is to impose some order on the large volume of data collected. Analysis facilitates clarification of the essential interpretations of the raw data (Miles & Huberman, 1994; Speziale & Carpenter, 2007). The verbatim transcripts were analyzed using content analysis, a method of descriptive analysis of text. It is performed step by step in order to describe prominent themes (Speziale, & Carpenter, 2007). The transcripts of the written text were imported into the software program ATLAS-ti (Muhr, 1997). Initial coding of text fragments based on content was done by the investigator and compared with independent coding by two doctoral committee members proficient in ATLAS-ti. The coding framework was discussed by the investigators and modified until agreement was reached. All text units belonging to a code of the coding framework were sorted according to the themes of the thematic framework. Text units were then re-read to be sure that no “emerging themes”

had been overlooked. Illustrative quotes were selected, translated, and, when necessary, edited to improve clarity without changing meaning.

Summary

Though childbirth and assuming the role of mother are usually thought of as characterizing a time of excitement and joy, there is significant stress experienced by many postpartum women. Postpartum stress is a problem and needs to be looked at in greater depth. This chapter provided an introduction to the study by addressing the background and significance of the study, the problem statement, the purpose of the study, the research questions, the conceptual framework and the methodology. The following chapter summarizes the review of extant literature on qualitative studies addressing the experience of postpartum women.

CHAPTER TWO

REVIEW OF THE LITERATURE

This chapter focuses on conceptualization of the research problem and a review of literature as it pertains to the postpartum experience. First, there is an elaboration of the conceptual framework guiding this review. Second, the literature search methodology is defined. Finally, a synthesis of published qualitative studies structured according to the crisis theory paradigm is presented. Specifically, studies that relate to 1) stressors experienced by postpartum women, 2) perception of stressors experienced by postpartum women, 3) sources of support for postpartum women, and 4) methods of coping utilized by women during the postpartum period.

Literature Search Methodology

The literature search focused on qualitative studies in postpartum health. Qualitative research was specifically targeted in order to ascertain a richness of data often not captured in reports of aggregate statistics. The following key search terms were used in database searches: qualitative studies in postpartum health, qualitative studies in postpartum care, qualitative postpartum experience, and qualitative postpartum stress. Computerized databases, including PubMed, CINAHL and PsycInfo, as well as reference lists from articles, were used to identify qualitative studies in postpartum women's experiences. Inclusion criteria were studies published from 2002 through 2010, in peer-reviewed journals in the English language.

Conceptual Framework

The Crisis Theory conceptual model was used to examine the phenomena of stress and coping in the postpartum period. This conceptual framework was chosen because the dynamics of the postpartum experience as revealed in the literature are consistent with the components of the conceptual model. Crisis Theory provides a way to view the impact of stressors on women's postpartum experience. Stress, a complex psychological and interpersonal phenomenon, is the central concept in crisis theory as explained by Aguilera (1998). The Crisis Theory paradigm is depicted in Figure 1.

Psychological crisis refers to the inability of an individual to solve a problem. Individuals exist in a state of emotional equilibrium, which is a state of balance or homeostasis. The goal is always to return to or to maintain that state of balance or homeostasis. Individuals are regularly faced with a need to solve problems in order to maintain equilibrium. When something occurs that is different, whether positive or negative, or a change, or a loss that creates a state of disequilibrium, people endeavor to regain and maintain the previous level of equilibrium. Depending on past experience related to the immediate problem, some people are more proficient at finding solutions than others. When an individual is in crisis, that individual is at a turning point. After many attempts at solution are made, the coping mechanisms that have worked before are ineffective in readily solving the problem. This results in increased inner tension and signs of anxiety with disorganization of function and the decreased ability to find a solution. The individual feels helpless, caught in a state of immense emotional distress, and feeling unable to act on her own to resolve the problem. Crisis is dangerous in that it

threatens to overwhelm the individual or family, which may ultimately result in suicide or a psychotic break with reality (Aguilera, 1998).

Crisis has four developmental phases (Aguilera, 1998). First, an initial rise in tension exists as the stimulus/stress continues and more discomfort is felt. During the second phase, the stimulus/stress continues and more discomfort is felt due to a lack of success in coping. With the third phase, tension increases further and acts as a powerful internal stimulus; internal and external resources are mobilized. Emergency problem-solving mechanisms are tried. In this stage, a) the problem may be redefined, or b) resignation may occur as selected aspects of the goal may be given up as unattainable. In the fourth phase, a major disorganization occurs if the problem continues without resolution or avoidance. When a stressful event occurs, recognized balancing factors may determine the state of equilibrium. Strengths or weaknesses of any of these factors can be directly related to the onset of crisis or to its resolution. These balancing factors are perception of the event, available situational support, and coping strategies. Aguilera's (1998) paradigm illustrates the effect of balancing factors in a stressful event (Figure 1). The individual's usual initial reaction to a stressful event is demonstrated in the upper portion of the paradigm. The role of the balancing factors is shown in the lower portion of the paradigm. This literature review is structured according to Aguilera's (1998) Crisis Theory paradigm.

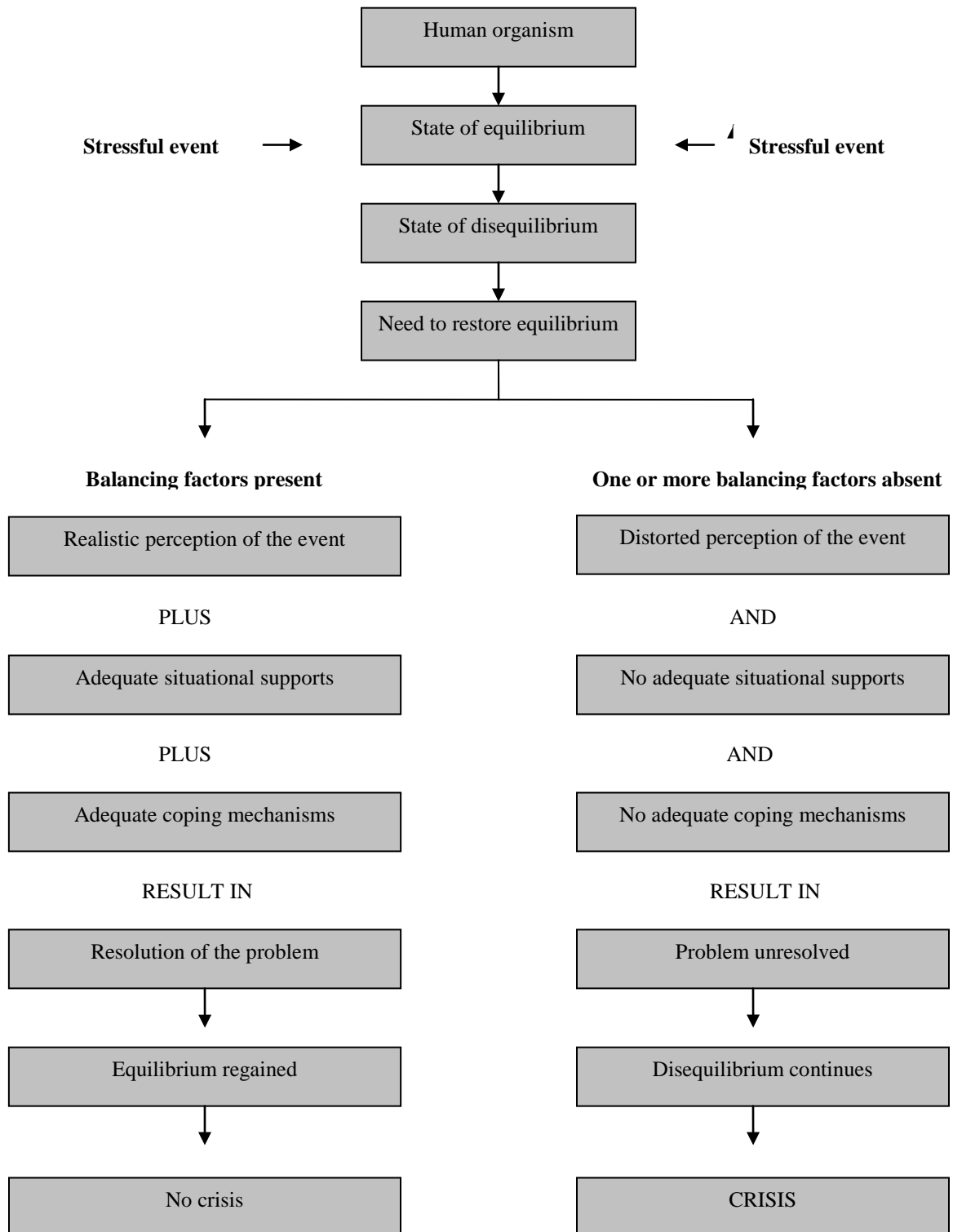


Figure 1 Crisis Theory Paradigm: the effect of balancing factors in a stressful event (Aguilera, 1998)

Introduction to the Literature Review

The time frame for “postpartum” or “postpartum period” described in these studies ranged from several months to 12 plus months. This differs from the conventional American medical definition of the postpartum period being the first six to eight weeks post delivery (Gorrie, McKinney & Murray, 1998; Scott, Gills, Karlan & Haney, 2003). The summary of the retrieved published qualitative literature is depicted in Table 1.

This literature review is structured according to Aguilera’s (1998) Crisis Theory paradigm and is presented in four sections: 1) postpartum stressors, 2) perception of postpartum stress, 3) postpartum support, and 4) methods of postpartum coping. As depicted in Table 2, most of the studies reviewed addressed multiple components of the phenomenon of stress in the experience of postpartum women; therefore, most of the studies are cited in more than one of the following sections.

Postpartum Stressors

Both physiological and psychological stress can be produced by a variety of dissimilar situations. Horowitz and Damato (1999) suggest that maternal stressors may be events, situations, or demands that women identify as sources of mental, emotional, or physical discomfort, anguish, or difficulty during the postpartum period. Groer, et al. (2002) indicate that specific postpartum stressors consist of overlapping categories of physical, intrapersonal, and interpersonal phenomena. According to the crisis theory model stress stimuli, or stressors, are conditions of threat or loss (Aguilera, 1998). The next section explores stressors reported by postpartum women. Qualitative studies are included that identify postpartum stressors. Eighty percent of the retrieved studies address postpartum stressors.

Table 1: Reviewed Qualitative Studies on the Postpartum Experience

Study	N	Location	Sample	Method	Comments
Amankwaa, 2003	12	USA	African American	Interview	PPD diagnosed
Chan, et.al., 2002	35	HK, China		Interview – Phenomenologic	PPD diagnosed
Deave, et.al, 2008	24	UK	1 st time moms	Interview; Content Analysis	
Edge, et.al., 2004	101	UK	Black Caribbean immigrants	Mixed method; Narratives	
Fooladi, 2006	9	USA		Focus groups, Interview; Ethnographic	
Forster, et.al., 2008	42	Australia		Focus groups, Interviews	
George, 2005	10	USA	1 st time moms	Interview – Grounded Theory	
Hanley, & Long , 2006	10	UK		Interview	PPD diagnosed
Hildingsson & Thomas, 2007	827	Sweden		Mailed questionnaire; Content Analysis	
Hoang, et.al., 2009	10	Australia	Asian immigrants	Interview – Grounded Theory	
Kanotra, et.al., 2007	324	USA		PRAMS Survey and Comment data	
Kiernan, 2002	5	USA		Audiotaped	Therapeutic touch
Kurtz Landy, et.al., 2009	24	Canada		Interview; Descriptive Design	SED
Leung, et.al., 2005	20	HK, China		Interview	“Doing the Month”
Nelson, 2004	7	USA	1 st time moms, 36-45 y.o.	Phenomenologic/Hermeneutic	
Parvin, et.al., 2004	25	UK	Bangladeshi immigrants	Focus groups	
Razurel, et.al., 2009	60	Switzerland	1 st time moms	Interview	
Rodrigues, et.al., 2003	39	India		Interview	19 identified with PPD during study
Ross, et al., 2005	17	Canada	LGBQ	Focus Groups	
Shakespeare, et.al., 2004	39	UK		Interview	PPD – EPDS (Edinburgh Postnatal Depression Scale)
Spear, 2006	53	USA	Adolescents	Descriptive telephone survey	
Tammentie, et.al., 2004	9	Finland		Interviews – Grounded Theory	PPD diagnosed
Taniguchi & Baruffi, 2007	45	USA	Japanese immigrants	Mixed Method; Telephone Interview	
Ugariza, et al., 2007	20	USA	Anglo American.	Interview	Prevention activities for PPD
Wilkins, 2006	8	UK	1 st time moms	Interview – Grounded Theory	

Legend:

HK – Hong Kong

LGBQ – Lesbian, Gay, Bisexual & Queer

PPD – Postpartum Depression

SED – Socioeconomically Deprived

UK – United Kingdom

USA – United States of America

Table 2: Components of Crisis Theory Paradigm and Reviewed Qualitative Studies on the Postpartum Experience

Study	Stressors	Perception of Stressors	Support	Coping	Total Components Addressed
Amankwaa, 2003	X	X	X	X	4
Deave, et.al., 2008	X	X	X	X	4
Hanley & Long.,2006	X	X	X	X	4
Kurz Landy, et..al., 2009	X	X	X	X	4
Parvin, et al., 2004	X	X	X	X	4
Razurel, et.al., 2009	X	X	X	X	4
Shakespeare, et al., 2004	X	X	X	X	4
Taniguchi, et al., 2007	X	X	X	X	4
Wilkins, 2006	X	X	X	X	4
Chan, et al., 2002	X	X	X		3
Forster, et.al., 2008	X	X	X		3
George, 2005	X	X	X		3
Leung et al., 2005	X	X	X		3
Rodrigues, et al., 2003	X	X	X		3
Tammentie, et al., 2004	X	X	X		3
Nelson, 2004	X	X		X	3
Spear, 2006	X		X	X	3
Hildingsson, et al., 2007	X		X		2
Kanotra, et.al., 2007	X		X		2
Ross, et al., 2005	X		X		2
Kiernan, 2002	X			X	2
Edge, et al., 2004		X		X	2
Hoang, et.al., 2009			X		1
Fooladi, 2006				X	1
Ugarriza, et al., 2007				X	1
TOTAL	21 (84%)	17 (68%)	20 (80%)	15 (60%)	

Postpartum Stressors - First Time Mothers

In this literature review, five qualitative studies on the postpartum experience of women addressed stressors in samples of first time mothers. George (2005) examined the experiences of first time mothers (N=10) following discharge from the hospital after vaginal delivery. Change in priorities was stressful. There was the need to reorganize everything because the newborn became the priority. Multiple tasks were found to be difficult. There was frustration with the role transition process and confusion about role expectations, a phenomenon that called for definition of the roles. The discomfort and pain from the birthing experience was not anticipated, and interfered with women's ability to care for both themselves and their babies. Lack of sleep and fatigue was of significant concern of the women.

A study conducted in the United States (US) had the purpose of creating a phenomenologic text explicating the experience of older, first-time mothers (N=7) during the first year following childbirth (Nelson, 2004). These women found it a struggle to blend lifestyles. Reconciling their previously formed adult lifestyle and multiple priorities with a very time-consuming new priority, that of motherhood, was often emotionally and physically exhausting.

Deave, Johnson, and Ingram (2008) conducted a study in the United Kingdom (UK) and asked first-time mothers (N=24) and their partners about their transition to parenthood. Breastfeeding was reported as stressful, as well as the pressure from health professionals to continue breastfeeding. The new parent relationships were strained. They were surprised at the demands that had been placed on their relationships, and how having a baby affected them as a couple creating negative interactions, such as snapping

at each other. Wilkins (2006) interviewed first-time mothers (N=8) in another UK study in order to gain an understanding of their postpartum experiences. Primary stressors identified were an unsettled baby, a crying baby, and having little contact outside of the home and the baby.

Postpartum stressful events, social support and coping strategies of primiparous women (N=60) were explored in Geneva, Switzerland, by Razurel, Bruchon-Schweitzer, Dupanloup, Irion, and Epiney (2009). Interaction with caregivers during hospitalization was considered a significant stressful event, primarily because difficulties encountered by mothers were seen as minimized, or there was contradictory information provided. Issues related to breastfeeding, such as pain and difficulties in breastfeeding were stressful events identified in both the hospital and at home for these postpartum women. Other frequently noted postpartum events indicated as stress producing were the logistics of organization, crying and rhythm of the baby, and concern for the health and care of the baby.

Postpartum Stressors – Women Living Outside Their Country of Origin

In this literature review, three qualitative studies on the postpartum experience addressed stressors in samples of women experiencing postpartum living outside their country of origin. Japanese women in Hawaii (N=45) were evaluated by Taniguchi and Baruffi (2007) to assess the stress women experience during childbirth in a foreign country. Findings of postpartum stressors included language barrier, distance from family and friends, different culture, health-care attitude about childbirth, crying babies, lack of breast milk during the first night after hospital discharge, always staying with their baby at home, and weakening of memory and cognitive skills. At the same time, they worried

that their partners did not share an understanding of their physical and psychological postpartum situation, their loneliness, and feelings of isolation.

Hoang, Le, and Kilpatrick (2009) used interviews to investigate Asian migrant women's (N=10) childbirth experiences in rural Tasmania, Australia. Lack of support from extended family in the new country was stress producing for these women. As described by one woman, "I did all the house work and looked after my two children by myself."

Bangladeshi women in the UK (N=25) were studied by Parvin, Jones, and Hull (2004) to explore first-generation Bangladeshi women's understandings of postpartal distress, and to describe postpartum coping strategies. The results revealed the presence of several stressors. Support at home was lacking as the women had no relatives in the UK. These women had little opportunity to rest, as they immediately resumed the roles of mother, wife and housewife after returning from the hospital, having to deal with everything by themselves.

Postpartum Stressors – Depression

Three qualitative studies in this literature review on the postpartum experience addressed stressors in samples of women diagnosed with postpartum depression. In a study (Amankwaa, 2003) designed to describe the nature of postpartum depression among African-American women, the participants (N=12) reported three categories of stressors: physical, mental and external. Pain, surgery, infection, complications, and current health problems were examples of physical stressors. Mental stressors included feelings of loneliness, unmet expectations, birth plan disappointment, and abandonment. External stressors included situations such as colicky newborns, sibling care, lack of

support, partner concerns, employment, and financial concerns. Participants stated that multiple physical, mental, and external stressors contributed to sleeplessness, fatigue, and irritability, subsequently resulting in declining physical health and energy. Moreover, participants expressed opinions, without elaborating, that having “too much” support, being alone without family, and not having their mothers available when they wanted them to be there, were explicated as significant postpartum stressors.

Hanley and Long (2006) examined the experiences of Welsh mothers (N=10) diagnosed with postnatal depression. Economic pressures and financial restrictions necessitated the mothers returning to work, leaving little quality time for their babies and family. The demand of many roles left them feeling exhausted all the time.

In Finland, Tammentie, et al. (2004) conducted a study (N=9) to ascertain experiences of family dynamics when the mother suffers from postnatal depression. Circumstances such as little time for the parents to spend together, infant’s lack of rhythm, infant discordance with family activity patterns, and marital discord were identified as postpartum stressors.

Postpartum Stressors – Other Sample Variations

The following nine qualitative studies on women’s postpartum experience addressed postpartum stressors in various other samples. A US study designed to identify challenges that women face two to nine months postpartum (N=324) found that staying home with the newborn and not going out were difficult to tolerate (Kanotra, E’ Angelo, Phares, Morrow, Barfield, & Lansky, 2007). Mothers were concerned about how to care for their newborn babies at home, particularly regarding activities such as holding, bathing, and clothing. These women also found that returning to work posed a problem

because it was difficult to continue breastfeeding due to limited time, support, and facilities for pumping their milk. In a large city in the northeast US, Kiernan (2002) examined the experience of therapeutic touch in the lives of postpartum women (N=5). Stressors identified were struggling with the demands of newborns, and having little time for themselves.

Spear (2006) used a descriptive telephone survey (N=53) in a US study to examine the breastfeeding experiences and related behaviors of adolescent mothers after discharge from the hospital. Stressful events related to breastfeeding included inadequate milk supply, sore nipples, responsibilities associated with school and employment, and inadequate postnatal breastfeeding support.

In an Australian study (N=42), Forster, McLachlan, Raner, Yelland, & Gold (2008) conducted focus groups and interviews to gain a more in-depth understanding of women's views, expectations and experiences of early postnatal care. These mothers described anxiety and/or fear in two areas: the health and wellbeing of the baby and transition to motherhood and parenting. They were concerned that leaving the hospital too early would interfere with professional support needed while acquiring new skills, establishment of breastfeeding, and the opportunity to rest and be "cared for."

Rodrigues and colleagues (2003) studied postpartum women in India (N=39) to describe attitudes and perceptions toward childbirth. They indicated that economic difficulties, poor marital relationship, gender preference, low involvement of husbands in child care, and insufficient or lack of practical support at home were stressful postpartum experiences. It was noted that strained relationships with husbands and in-laws were centered around the desired gender of the baby.

Hildingsson & Thomas (2007) conducted a study in Sweden (N=827), using a mailed questionnaire and content analysis, in order to solicit and describe women's opinions about what is important to them during pregnancy and birth. Breastfeeding the baby was found to be frustrating and stressful. There was concern about the timing of discharge from the hospital to home. The women didn't want to go home before getting their strength back and having breastfeeding established.

To explore and describe the experiences of socioeconomically disadvantaged (SED) postpartum women (N=24) in the first 4 weeks after hospital discharge, Kurtz Landy, Sword, and Valaitis (2009) interviewed a purposive sample in two large cities in southern Ontario, Canada. One identified stressor was related to financial problems involving material deprivation, poor quality housing, struggling with food security, and difficult access to transportation. Participants described inadequate or lack of social support as being stress producing. The changes and challenges of having a new baby while recovering from childbirth, and at the same time, resuming their day-to-day responsibilities, were described as difficult. Subjects indicated surprise at the hardship of multiple demands placed on them with other children at home. Having their personal information shared among the many community services was stress producing. Absence of help at home with the day to day activities and housework was a strain. A complex relationship with the baby's father was noted to produce stress. These relationships were unstable or nonexistent. Additionally, there were those fathers who refused acknowledgment of paternity. Little or no sleep and fatigue complicated all circumstances. Added to all this was the fear of getting pregnant related to difficulty in accessing birth control.

A Canadian study by Ross, Steele, and Sapiro (2005) looked at a sample (N=17) of lesbian, gay, bisexual, and queer (LGBQ) women to assess predisposing and protective factors for perinatal depression. Lack of social support from their family of origin and from the lesbian and gay community was stressful for these women. Both partners were extensively involved with the baby, which resulted in strain at times. Negotiating the parenting roles to ensure equal opportunity for bonding with the baby proved to be challenging.

Hong Kong Chinese women (N=20) were interviewed to explore their perceptions of stress induced by “doing the month” and the support they received from participating in the traditional postpartum ritual (Leung et al. 2005). “Doing the month” refers to the traditional ritual for Chinese postpartum women which include 1) environmental constraints, 2) prohibitive rituals, and 3) a care provider for the newborn. Environmental constraints include living in a small area, being unfamiliar with the environment, the loss of privacy, and being in someone else’s home. The living area, typically the in-law’s small flat (apartment), is crowded with helpers and relatives and friends paying visits, and the woman is guarded by others from going out. The prohibitive rituals call for specific behavioral restrictions with strict adherence to the ritual without allowing any flexibility. Included in these rituals are refraining from touching water or being exposed to wind, not being allowed to use air conditioning or a fan, and not being allowed to take a bath daily in order to avoid getting the “wind” into the joints. The newborn care provider made all decisions related to child care. Findings revealed sources of stress to be environment constraints, difficulties in following the proscriptions of the rituals, and decreased access to the newborn. Conflict between the parties involved was another

stress producing factor. The conflict may be between the new mother and the care provider, or between mother-in-law and the maternal mother. The conflicts usually centered around the method of child care, how strictly to follow the traditional ritual of “doing the month,” or the actual practice in “doing the month.” The new mother is caught between the mother-in-law and the maternal mother; the husband would agree only with his own mother.

Postpartum Stressors - Summary

In summary, the review of published qualitative literature supports the presence of numerous postpartum stressors. These stressors are related to the needs of a new baby, as well as pre-existing stressors in relationships with the baby’s father, in-law expectations, cultural constraints, and issues related to one’s self as a mother and as a woman.

Perception of Postpartum Stress

Perception, or subjective meaning, is the “mental processes by which intellectual, sensory, or emotional data are organized logically or meaningfully” (Varcarolis, 2006). Emotional and psychological reactions to a life event are influenced by an individual’s perceptions of this event. Perception influences both the meaning assigned as well as personal reaction to stressors (Figure 1) (Aguilera, 1998). What does it mean to the person? How is the event seen to influence the future? Maternal perception of stress is influential in shaping postpartum adaptation (Horowitz & Damato, 1999). This cognitive process, i.e., interpretation, is a primary factor in determining choices of coping behaviors engaged by an individual (Aguilera, 1998). According to the crisis theory model, perception of a stressful event is a recognized balancing factor that may determine the state of equilibrium (Aguilera, 1998). This section will address the affective and

interpretive aspects of the perception of stress in the experience of postpartum women. The affective and interpretive components of perception of stress are interrelated and difficult to separate into concrete entities. Therefore, they are introduced jointly in this section. Included are qualitative studies related to the maternal perception of postpartum stressors. Sixty-four percent of the retrieved studies addressed perception of stressors during women's postpartum experience (Table 2).

Perception of Postpartum Stress - First Time Mothers

In this literature review, three qualitative studies on the postpartum experience addressed perception of postpartum stress in samples of first time mothers. George (2005) found that first-time mothers (N=10) in the US felt overwhelmed by the responsibility and frustration with role transition. First-time mothers in the UK (N=8) expressed feelings of inadequacy related to their inability to recognize their babies' needs without advice from others (Wilkins, 2006). They thought that they would automatically know what to do, that caring for their babies would be instinctual. In addition, primiparous Swiss women (N=60) perceived that their partners lacked understanding of their needs (Razurel, et al. 2009).

Perception of Postpartum Stress – Women Living Outside Their Country of Origin

In this literature review, three qualitative studies on the postpartum experience addressed perception of postpartum stress in samples of women experiencing postpartum living outside their country of origin. Hoang and colleagues (2009), found that postpartum Asian migrant women (N=10) in Australia, were having to do all the work and look after the children with no assistance. This left them feeling lonely, isolated,

tired, and miserable. They looked after their babies in an appropriate manner, but they were not happy and did not find it an enjoyable experience to do so.

Bangladeshi women in the UK (N=25) described emotional responses to postpartum stressors as being 1) restless or without peace in their minds, 2) feeling sad, bad or angry, 3) being tearful, and 4) not getting any comfort from looking after their children (Parvin, et al. 2004). Japanese women in Hawaii (N=45) described having poor body image, feeling loneliness and isolation, and left behind because they always stayed with their baby at home (Taniguchi & Baruffi, 2007).

Perception of Postpartum Stress – Depression

Five qualitative studies in this literature review on the postpartum experience addressed perception of postpartum stress in samples of women diagnosed with postpartum depression. Amankwaa (2003) reported that African-American women (N=12) felt lonely and abandoned. These women held the belief that multiple physical, mental, and external stressors contributed to sleeplessness, fatigue, and irritability, subsequently resulting in declining physical health and energy.

Chan and colleagues (2002) examined the lived experience of Hong Kong Chinese women diagnosed with postpartum depression (N=35). Women expressed feelings of hopelessness, helplessness and loss of control. They felt trapped in a situation with no way of escape except by violent means, such as homicide or suicide. Feelings towards the baby were ambivalent, including both hate and love. The unhappiness expressed by the women was attributed to non-caring husbands, and the controlling and powerful in-laws.

When Welsh women (N=10) (Hanley and Long, 2006) rested or attended to domestic chores, there was a sense that they were abandoning their children and they had feelings of guilt. Their many roles were perceived to be an excessive burden and too demanding thus leaving them feeling exhausted all the time. Among working women, there was resentment at giving up employment. They felt a loss of status, independence and finance.

Shakespeare, Blake, and Garcia (2004) interviewed postpartum women diagnosed with postpartum depression (N=39) in the UK. They reported that breastfeeding difficulties were exhausting and time consuming. In Finland, Tammentie, et al., (2004) (N=9) found that women perceived that the infant tied the mother down. Home was felt to be like a prison, where the highpoint of the day was the postman's visit. There were feelings of inadequacy and that all of the mother's energy was drained by childcare.

Perception of Postpartum Stress – Other Sample Variations

The following five qualitative studies on the women's postpartum experience addressed perception of stress in various other samples. A lack of confidence in themselves as new mothers and their ability to care for their babies was a finding by Forster and colleagues (2008) in a sample of Australian postpartum women (N=42). Postpartum women in India (N=39) described feelings of being overworked and unsupported (Rodrigues, et al. 2003). These feelings were reportedly linked to tiredness and other symptoms, which in turn may have contributed to strained relationships.

Some US adolescent mothers (N=53) perceived breastfeeding to have an empowering effect on them as young mothers (Spear, 2006). Socioeconomically disadvantaged (SED) postpartum women (N=24) in Canada, felt frustration and loss of

dignity at having to rely, for all their needs, on their parents' low incomes (Kurtz Landy, et al. 2009). Their feeling of being out of control was related to the multiple demands of postpartum and the sharing of their private, personal information by many community services agencies. Fatigue contributed to their perception that the first few weeks were overwhelming.

As previously described, "doing the month" refers to the traditional ritual for Chinese postpartum women. Hong Kong Chinese women (N=20) participating in the traditional ritual felt trapped in their environment (Leung, et al. 2005). They felt deprived of the chance to carry or have contact with the baby. The new mothers felt incompetent and worried that they would not be able to handle the baby when the care provider left at the end of the proscribed period.

Perception of Postpartum Stress – Summary

In summary, despite the arrival of the awaited newborn, it is evident that the postpartum experience can be a stressful time as is revealed in descriptive perceptions of the stressors encountered. The effect of the stress on women's postpartum experience is related to perception of the stressors encountered, both the affective reaction and interpretation.

Postpartum Support

Social support, an essential resource utilized in preventing or altering stressful life event responses, is described as evidence, tangible and intangible, that leads the individual to believe she is cared for, loved, and a valued member of her social and familial network (Aguilera, 1998). According to the crisis theory model, available situational support is a recognized balancing factor that may determine the state of

equilibrium (Figure 1) (Aguilera, 1998). This section elaborates on the role of support in the experience of postpartum women. Qualitative studies reviewed addressed maternal support during the postpartum experience. Fifty-two percent of the retrieved studies addressed the concept of support reported by women during the postpartum experience (Table 2).

Postpartum Support – First Time Mothers

In this literature review, three qualitative studies on the postpartum experience addressed sources of support in samples of first time mothers. Deave and colleagues (2008) found that for first-time mothers (N=24) in the UK, the main source of support was female relatives, primarily their mothers. The practical support their mothers provided ranged from baby care to housework. In addition, cooking and babysitting made it possible for some couple “time out” for the parents. Postnatal support groups were useful mainly for reassurance that, as new parents, they were all going through similar difficulties and experiences.

Primiparous Swiss women (N=60) perceived that social support by health professionals was insufficient in the early postpartum (Razurel, et al. 2009). At the same time, these women felt emotional support to be the primary protective factor in the stressful event of breastfeeding. Social support from the maternal grandmother was positively received. On the other hand, women perceived that their partners lacked understanding of their needs during postpartum.

First-time mothers (N=8) in the UK reported that practical help received in the midwife led centers after delivery and peer support were found to be important during postpartum recovery and adjustment (Wilkins, 2006). All participants desired the

availability of “a handy reference guide,” “practical tips,” “a checklist,” or “prompts and cues” at their disposal for reference support.

Postpartum Support – Women Living Outside Their Country of Origin

In this literature review, three qualitative studies on the postpartum experience addressed sources of support in samples of women experiencing the postpartum period living outside their country of origin. Results of an Australian study (Hoang, et.al., 2009) showed that family and community play an important role in supporting Asian migrant women through the postpartum. Four reported that in the month following birth their recovery went well. This was attributed to the great deal of support they experienced from husband, family, friends, and community. Six women reported very little support, as their husbands were the only source of help, while at the same time having work or study commitments. They described their postpartum experiences in contrast to those of women having received a great deal of support. Women receiving little support felt exhausted, tearful, miserable, isolated, and unhappy. Two women reported a lack of extended family support for this postpartum period, after having had previous birth(s) in their country of origin. They attributed their feeling lonely, isolated and tired to the lack of support.

In Bangladesh, women experience a 40 day rest and recuperation period. During this time maternal tasks are delegated to others such as servants or female extended family members. In contrast, the Bangladeshi women in the UK (N=25) did not have this support at home, as relatives were not available (Parvin, et al. 2004). Japanese women in Hawaii (N=45) found that help after childbirth from the participants’ mothers decreased the incidence of postpartum depression (Taniguchi and Baruffi, 2007).

Postpartum Support – Depression

Two qualitative studies in this literature review on the postpartum experience addressed sources of support in samples of women diagnosed with postpartum depression. African-American women (N=12) expressed opinions, without elaborating, being alone without family, and not having their mothers available when they wanted them to be there, were significant postpartum stressors (Amankwaa, 2003). On the other hand, having “too much” support was also perceived as stressful.

Hanley and Long (2006) found that Welsh mothers (N=10) relied on social services and voluntary support groups. The help and guidance of grandmothers, which was the prime support network in previous generations, was not available. A Finnish study (N=9) found that the father’s physical presence was significant to the woman (Tammentie, et.al., 2004). With the concrete support of the father’s physical presence, the infant became the couple’s mutual responsibility. Other important sources of support were the grandparents and peer groups.

Postpartum Support – Other Sample Variations

The following five qualitative studies on women’s postpartum experiences addressed sources of support in various other samples. In a US study (N=324), 32% of the comments on postpartum concerns related to perceived need for social support following hospital discharge (Kanotra, et al. 2007). Women expressed interest in postpartum support groups, such as new mother support, breastfeeding support, and couples support. Some stated that lack of support contributed to difficulty in continuing to breastfeed when returning to work. General public attitudes upset some women and discouraged others from breastfeeding. Social stigma attached to breastfeeding in public

and general lack of support for breastfeeding were perceived as prohibitive attitudes. In addition, a desire for additional support in newborn care was expressed by multiparas as well as first time mothers. These mothers wanted more education and advice on holding, bathing, and clothing the baby.

In a Florida study (N=20), Ugarriza, Brown, and Chang-Martinez (2007) assessed postpartum depression prevention activities of Anglo-American mothers. Results revealed that support from family and friends make it possible for the woman to achieve mandated rest, some degree of needed social seclusion, and assistance with tasks. Support is also given by social recognition of the woman's new social status as a mother, such as a baby shower, and behavior that indicates special recognition by the husband.

A majority of socioeconomically disadvantaged (SED) postpartum women (N=24) in Canada (Kurtz Landy, et al. 2009) reported inadequate or a lack of social support. This was related to being raised in SED families. For many, family and friends were not a support as they were too stressed themselves to be able to provide help. Some received material or financial assistance from family members, the baby's father, or friends; however, it had to be "untraceable," to avoid losing government assistance. In general, there was an absence of practical help with the day to day activities and housework, as well as traditional social support.

Among lesbian, gay, bisexual, and queer (LGBQ) women (N=17) in Canada, the lack of social support from the family of origin, as well as the lesbian and gay community, was reported as stress producing. In contrast, participants were very satisfied with their partner's support (Ross, et al. 2005).

Hong Kong Chinese women (N=20), as aforementioned, participating in the traditional postpartum ritual of “doing the month,” reported that this tradition provided abundant material support (Leung, et al. 2005). Rest and early recovery of physical health was enhanced. However, psychological support was lacking to facilitate adjustment to the mother role. The care provider was responsible for child care and the new mother was not included.

Postpartum Support - Summary

In summary, the literature provides examples of appropriate support. However, there is evidence that lack of or inadequate practical and emotional support can contribute to distress in the experience of postpartum women.

Postpartum Coping

Coping is described as reactive adjustments, conscious and unconscious, to environmental stress in order to maintain psychological integrity (Aguilera, 1998). According to the crisis theory model, coping is a recognized balancing factor that may determine the state of equilibrium (Figure 1) (Aguilera, 1998). This section will examine coping in the experience of postpartum stress management. Qualitative studies will be addressed related to maternal coping in the postpartum experience. Sixty percent of the retrieved studies addressed coping methods reported by women during the postpartum experience (Table 2).

Postpartum Coping – First Time Mothers

In this literature review, five qualitative studies on women’s postpartum experience addressed methods of coping with stress in samples of first time mothers. Deave and colleagues (2008) studied first-time mothers (N=24) in the UK. Having been

surprised at the demands placed on their relationship, and how having a baby affected them as a couple, such as snapping at each other, these mothers and their partners found that relationship tension was reduced by spending time together and by making time to talk.

George (2005) found that first-time mothers in the US (N=10) were motivated to information-seeking behavior by their perception of overwhelming responsibility and not knowing what to do. Older first-time mothers in the US (N=7) used intense organization and planning as coping strategies (Nelson, 2004).

Razurel, et al. (2009) identified strategies that Swiss women (N=60) used for coping with postpartum stressors as social support and mobilization of internal resources. Emotional support was seen as the primary protective factor related to the second most stressful event identified, breastfeeding. Avoidance or minimization was used for stressful events related to their own health, such as urinary incontinence.

One sample of women (N=7) in the UK handled postpartum stressors through skill development, organization, and postpartal support groups (Wilkins, 2006). Avoidance was another coping strategy. Because they did not want to reveal mothering inadequacies or they feared the perceived criticism of others, some mothers did not venture into the outside world.

Postpartum Coping – Women Living Outside Their Country of Origin

In this literature review, three qualitative studies on the postpartum experience addressed methods of coping with stress in samples of women experiencing postpartum living outside their country of origin. For Japanese women in Hawaii (N=45), the means of coping with postpartum stresses emphasized social support (Taniguchi and Baruffi,

2007). Some made the journey to Japan to seek support. Others communicated frequently by telephone and email with mothers, sisters, and friends who had experienced childbirth. Still others found social support when their mothers came from Japan to help.

In a mixed method study to compare the prevalence of depressive symptoms during and after pregnancy for black Caribbean women and white British women, Edge, and colleagues (2004) also explored black Caribbean women's help-seeking attitudes (N=101). A powerful counter to depression as described by these women is their self-concept as "strong, black women," suggesting that they shared a common bond with women who not only endured but overcame adversity, disadvantage, and discrimination. As one woman put it, "It all relates to slavery." There was great emphasis placed on autonomy, personal action and means, and mastery over their lives. They felt the need to plan their way out of adversity, and to achieve financial independence, both of which are often linked. Additionally, spirituality was seen as a means to manage adversity. Black-led churches and faith communities were sources from which a majority of these women drew needed spiritual, emotional and practical support. This was true even when the women had no religious affiliation.

The general feeling about coping with the stressors of postpartum for Bangladeshi women (N=25) in the UK was reported as "You do it," not giving thought about "how you would do it" (Parvin, et al. 2004). This could include the woman relying on her own ability to manage problems and emotional distress, "keeping yourself happy," or praying to Allah.

Postpartum Coping – Other Sample Variations

The following seven qualitative studies on women's postpartum experience addressed methods of coping with postpartum stress in various other samples. Using focus groups, a study by Fooladi (2006) of women in Texas (N=9) explored personal experiences with postpartum blues in relation to crying, breastfeeding, lactation suppression, and prior pregnancy loss. Findings revealed that postpartum mental health was improved by the calming effect of breastfeeding. Women who reported breastfeeding for more than six weeks, although they were tired, described feeling "happy, thrilled, content, lucky, and blessed." In addition, "women who used medications and breast binding to suppress prolactin hormone experienced more emotional turmoil compared with women who chose to breastfeed." In the UK, postpartum women (N=39) described three strategies in dealing with the difficulties of breastfeeding (Shakespeare, et al. 2004). The first was total commitment to learning the skill of breastfeeding, at the exclusion of all else. The second strategy used by some was to stop breastfeeding altogether. And the third was to adopt a flexible approach by mixing breastfeeding with bottle feeding. Women in a US study (N=324) expressed interest in support groups to facilitate adjustment during the postpartum, such as, new mother support, breastfeeding support, couples support, and grieving support (Kanotra, et al. 2007).

Kiernan (2002) found Therapeutic Touch (TT) to be helpful to postpartum women. "Therapeutic Touch (TT) is a reciprocal healing modality involving a mutual process of care and concern between two or more individuals. During the process the practitioner quiets, centers, and focuses his or her attention, then moves his or her hands carefully and intentionally in the two- three-inch space around the other person's body

searching for subtle differences in feeling tone. The hands are then used to intervene in a purposeful way to promote well-being and change” (p. 47). This US study (N=5) revealed that mothers found therapeutic touch to be a valuable asset in coping with the demands of a newborn and having little time for themselves. It helped them to stop, refocus, calm, and relax.

In an Australian study, postpartum women (N=42) reported a lack of confidence in themselves as new mothers regarding their ability to care for their baby (Forster, et al. 2008). Coping with this stressor was facilitated by the physical presence and the availability of professional support, which helped alleviate their concerns. Rodrigues, et al. (2003) studied postpartum women (N=39) in India and found two strategies helpful in coping with postpartum stressors. Distraction from their worries was one, such as involving themselves in household work, caring for the children, watching television, or seeking out the company of others. The other strategy was described as “just sit at a table and cry for God’s help.” Socioeconomically disadvantaged (SED) postpartum women in Canada (N=24) described their coping strategies as the use of antidepressants, smoking cigarettes, and receiving limited support from their families (Kurtz Landy, et al. 2009).

Postpartum Coping - Summary

In summary, the literature reveals a variety of maternal postpartum coping methods. Coping methods differ in relation to specific populations. Organization and planning, developing and integrating new routines, maintaining supportive relationships, accessing religion/spirituality beliefs and practices, having an attitude of resilience such as “strong black woman,” breastfeeding, rest, and social rituals are examples of coping factors used by postpartum women.

Discussion and Conclusions

In the 25 retrieved qualitative studies on women's postpartum experience, various population groups were the focus: American, African-American, Anglo-American, Australian, Canadian, Chinese, Finnish, Indian, Swedish, Swiss, Welsh, Bangladeshi in the UK, black Caribbean in the UK, British, Japanese in the US, Asian in Australia, adolescent mothers, first time mothers, lesbian mothers, and women diagnosed with postpartum depression. The overall summary of the retrieved published literature is found in Table 1.

Eighty-four percent of the 25 studies address postpartum stressors, while 68% speak to perception of postpartum stressors. Eighty percent discuss maternal support during postpartum, and 60% address methods of coping with postpartum stress. Each of the four components of the crisis theory paradigm (Figure1) - stressors, perception of stressors, support, and coping - is spoken to by 36 % of the studies, while 32% talk about three of the four components. Two components are addressed by 20%, and 12% discuss one of the four. Table 2 shows the distribution of the components within the retrieved studies.

Numerous postpartum stressors have been identified in the literature review of qualitative studies on the postpartum experience. It is evident that the postpartum experience can be a stressful time as is revealed in descriptive perceptions of the stressors encountered. The literature provides examples of appropriate support. However, there is evidence that lack of practical and emotional support varies in the experience of the postpartum woman. The literature reveals that maternal postpartum coping experiences differ in relation to the specific populations.

This review of literature on qualitative research of women's postpartum experience is consistent with the use of the Crisis Theory model as a framework by which to view the postpartum period (Figure 1) (Aguilera, 1998). Literature reviewed supports the presence of numerous stressors related to coping with the needs of a new baby, as well as pre-existing and co-existing stressors in relationships with the baby's father, in-law expectations, cultural constraints, and issues related to one's self as a mother and as a woman. The review findings support the notion that a negative environment, spanning a continuum of non-supportive to oppressive in nature, disrupts women's connection to community and can produce feelings of isolation, helplessness, and powerlessness.

Summary

This chapter provided a review of the literature in the areas of stressors experienced by postpartum women, perceptions of stressors experienced by postpartum women, support experienced by postpartum women, and coping mechanisms utilized by postpartum women from qualitative studies. The following chapter addresses methods utilized in this qualitative study.

CHAPTER THREE

METHODS

The purpose of this study was to identify events which postpartum women consider the most stressful experience since the birth of their babies and to identify and describe common themes regarding these stressful events. This chapter describes the research methodology and analytical processes that were used in this study. Included sections address study design, study population, sampling procedure, data collection, data analysis, and rigor.

Study Design

Qualitative research is appropriate to discover, describe, interpret and understand human experience (Streubert-Speziale and Carpenter, 2007), and can provide ideas and hypotheses for future study (Robson, 2002). Based on current published research, it is apparent that qualitative research captures some of the postpartum health issues not captured by aggregate statistics. An advantage of qualitative descriptive studies is a comprehensive summary of an event in the everyday terms of those events (Sandelowski, 2000). This qualitative descriptive study utilized the process of content analysis.

Study Sample

Demographic data assessed included several elements. These included age, race, marital status, income, employment status, method of newborn delivery, pregnancy or childbirth complications, major life events, and whether the participant breastfed or formula fed her baby.

Sampling Procedure and Data Collection

This qualitative study was a secondary data analysis of a larger study funded by the National Institutes of Health (R01 NR05000) focusing on the influence of lactation on postpartum stress and immunity (Groer, et al. 2005). The purpose of the original study, conducted from 2001 to 2005, was to examine demographic, immune, endocrine, stress and health characteristics of postpartum mothers, either exclusively lactating or formula feeding, measured between four and six weeks postpartum. The aim of this study was to classify and summarize, via secondary data analysis, the most stressful events in a population of postpartum women in the southeastern United States, utilizing the data from the qualitative component of the larger study (N=200). This subset (n=127) from the larger study answered the stressful event question in writing on the questionnaire.

Institutional Approval

Based on the Code of Federal Regulations, Part 46: Protection of Human Subjects, this study was granted an exempt status by the University of South Florida Institutional Review Board (IRB). This exemption was granted based on the published exempt criteria that 1) the study consist of existing data, 2) the information is recorded so that subjects cannot be identified, and 3) that data exists before the project begins. The data were numerically coded without identifiers in order to provide anonymity. The subjects consented to participation in the original study. A letter from the original investigator granting permission to use the data and a copy of the consent form used are included in Appendix A and B. Approval to conduct the study was obtained from the Institutional Review Board of the University of South Florida (Appendix C).

Data Analysis

The purpose of data analysis in qualitative research is to impose some order on the large volume of data that are collected. Analysis facilitates clarification of the essential interpretations of the raw data (Miles & Huberman, 1994; Speziale & Carpenter, 2007). Analysis was conducted on written responses to the question, “Think of any one incident, thought, or feeling that stands out as very stressful to you and describe in as much detail as you choose” in order to identify events which postpartum women consider the most stressful experience since the birth of their babies and to identify and describe common themes regarding these stressful events.

The qualitative data were transcribed by the original research team. The verbatim transcripts were analyzed using content analysis, the preferred strategy in qualitative studies for descriptive analysis of text. Content analysis is oriented toward summarizing the data by informational content, and is performed step by step in order to describe prominent themes (Sandelowski, 2000; Speziale & Carpenter, 2007).

The data were analyzed utilizing six steps based on Giorgi (1985) for describing psychological meanings:

1. The transcripts were read in entirety to get a sense of the whole.
2. The same descriptions were read again, and meaning units were identified.
3. Meaning units were coded.
4. The meaning units were compared and contrasted in order to eliminate redundancies and to identify essential characteristics.
5. The essential characteristics were reviewed and classified by subject into emerging themes.

6. An attempt was made to integrate and synthesize connected events/themes of the phenomenon.

Transcripts were read and meaning units were marked directly on the transcript. Identified meaning units were then coded. Coding involved summarizing the essence of the meaning unit in the language of the informant. An example of a coded transcript is included as Appendix D. In addition, the transcripts of the written text were imported into the software program ATLAS-ti, which analyzes qualitative data electronically (Muhr, 1997). Initial coding of text fragments based on content was done by the researcher by hand and compared with the independent coding of two qualitative researchers, Lois Gonzalez, Ph.D., and Cecilia Jevitt, Ph.D., proficient in ATLAS-ti. The coding framework was discussed and modified until agreement was reached. The transcripts were re-read and modifications in the coding were established in accordance with the agreed coding framework. In the same way agreement was reached on a thematic framework, consisting of main themes and sub themes. All text units belonging to a code of the coding framework were sorted according to the themes of the thematic framework. Text units were re-read to be sure that no “emerging themes” had been overlooked. Illustrative quotes were selected, translated, and, when necessary, edited to improve clarity without changing meaning. Therefore, dynamics underlying the postpartum experience were examined by identifying, across all informants, stressful postpartum events, categories of stressful events, and emergent themes (Appendix E). Permission was obtained from Elsevier to reproduce Aguilera’s Crisis Theory Paradigm (Figure 1) (Appendix F). This was used as the framework for the final literature review.

Rigor

“The goal of rigor in qualitative research is to accurately represent study participants’ experience” (Speziale & Carpenter, 2007, p. 38). Rigor in this study was facilitated using the method-appropriate strategy of triangulation the qualitative evaluative criteria of auditability.

“Triangulation is an approach to research that uses a combination of more than one research strategy in a single investigation” (Speziale & Carpenter, p.379).

Triangulation is further explained by Speziale and Carpenter (2007). The purpose in qualitative research is to increase the credibility and validity of the results. Applying the principles of triangulation in a study design facilitates confirmation of findings and conclusions by cross checking data from multiple sources and decreasing potential for bias. There are four basic types of triangulation: data, investigator, theory, and methodological. Investigator triangulation was used in this study. This is when two or more researchers work together on the same study, each having divergent backgrounds yet possessing areas of expertise that are complementary. The process in this study was previously addressed in analysis of the data. The areas of expertise are distinct yet complementary: maternal child nursing and mental health nursing.

“Auditability refers to whether another researcher can follow the thought process of the research as the data were being analyzed” (Nelson, 2004, p. 286). This was previously addressed by outlining the steps taken in analysis of the data. Speziale and Carpenter (2007) refer to the establishment of rigor through an audit trail by the term dependability. “The researcher is responsible for providing enough information so that another researcher reading the study would come up with similar conclusions” (Speziale

& Carpenter, 2007, p. 38). A method of determining dependability outlined by Lincoln and Guba is the dependability audit. This entails an outside person examining both the process and the product to determine if the former is dependable and that the latter is internally coherent. In this study, an outside researcher, Lois Gonzalez, Ph.D., reviewed the whole data set to confirm that the process was dependable. The outside researcher was provided with the data set in the form of an audit trail. This audit trail included: raw data in the form of transcriptions (Appendix G), coded transcriptions (Appendix D), and an outline of the emergent themes and essential characteristics (Table 5).

Summary

This chapter described the research methodology and analytical processes that were used in this study. There was discussion of the study design, study population, sampling procedure, data collection, data analysis, and rigor. The following chapter will discuss the findings of the study.

CHAPTER FOUR

FINDINGS

This chapter reports the study findings. Sections address the description of the study sample, frequently occurring postpartum stressors, and salient themes of postpartum stressors that emerged during the analysis.

Description of the Sample

The sample for this investigation (N=127), which is the subset from the larger study (N=200) (Groer, et.al., 2005), consisted of women four to six weeks postpartum who answered the qualitative question in writing on the questionnaire: “Think of any one incident, thought, or feeling that stands out as very stressful to you and describe in as much detail as you choose.” Ninety-one percent of participants were Caucasian, 72% were married, 70% were not employed, and 40% had an income of less than \$20,000 annually. The annual income for 28% of participants was greater than \$40,000. Vaginal delivery was experienced by 66%, complications of delivery were rare at 14%, and method of infant feeding was almost equally divided at 47% breast feeding exclusively and 43% formula feeding. Fifty-two percent of the participants were 20 to 29 years of age, 89% reported experiencing no major life event prior to the study, and 45% did not routinely exercise. Regarding parity, 43% had one child, 39% had two children, and 14% reported having three or more children. Demographic characteristics are summarized in Table 3.

Table 3: Study Sample Demographic Characteristics

<u>Characteristic</u>	<u>n</u>	<u>% of N</u>
Race/Ethnicity		
White	116	91%
Asian	1	1%
African American	4	3%
Hispanic	3	2%
Native American	0	
Other	1	1%
No Response	2	2%
Marital Status		
Single	31	24%
Married	91	72%
Divorced	1	<1%
Widowed	1	<1%
No Response	2	<2%
Response Undeterminable	1	<1%
Employment Status		
None	89	70%
Part Time	11	9%
Full Time	25	20%
No Response	2	1%
Annual Income		
Less than \$10,000	27	21%
\$10,000 - \$20,000	24	19%
\$20,000 - \$30,000	21	17%
\$30,000 - \$40,000	11	9%
Greater than \$40,000	36	28%
No Response	8	6%
Type of Delivery		
Vaginal	84	66%
Cesarean	42	33%
No Response	1	<1%
Delivery Complications		
No	106	83%
Yes	18	14%
No Response	2	<2%
Response Undeterminable	1	<1%

Table 3: Study Sample Demographic Characteristics (continued)

<u>Characteristic</u>	<u>n</u>	<u>% of N</u>
Method of Infant Feeding		
Breast	60	47%
Formula	55	43%
No Response	12	10%
Age		
Less than 20	19	15%
20 - 29	65	51%
30 - 39	39	31%
No Response	4	3%
Experience Major Life Event		
No	113	89%
Yes	9	7%
No Response	3	2%
Response Undeterminable	2	2%
Exercise Routinely (minutes per week)		
None	57	45%
0 – 30	25	20%
30 – 60	19	15%
60 – 90	9	7%
90 – 120	13	10%
No Response	4	3%
Number of Children		
Zero	4	3%
One	54	42%
Two	49	39%
Three	13	10%
Four	4	3%
Five	0	
Six	1	<1%
No Response	2	<2%

Research Questions

Narrative responses to the question “Think of any one incident, thought, or feeling that stands out as very stressful to you and describe in as much detail as you choose” were obtained to better understand women’s postpartum experience. Two research questions guided the study. First, what are the most stressful events experienced by postpartum women? Second, what are common themes regarding stressful events experienced by postpartum women?

Most Stressful Events

The first research question was, “What are the most stressful events in the experience of postpartum women?” From the 127 informants, 171 stressful events were indicated. Multiple events were reported by some participants. In some instances, an individual event could have more than one coding. The coded text fragments were categorized. Categories of stressors reported by the population sample are shown in Table 4. Seven categories were salient, containing 114 (67%) of the 171 coded events. These most frequently occurring stress experience categories include multiple roles/tasks/children, health and safety of children, lack of sleep, significant other issues, finances, fatigue, and crying newborn.

Table 4: Postpartum Stressful Events Categories

<u>Category</u>	<u>Coded Events</u>	<u>% of Total Events</u>
Multiple Roles/Tasks/Children	32	(19%)
Health & Safety of Children	24	(14%)
Significant Other Issues	14	(8%)
Lack of Sleep	14	(8%)
Finances	10	(6%)
Tired	10	(6%)
Crying Newborn	<u>10</u>	<u>(6%)</u>
	114	67%

School or Work	7	(4%)
Breastfeeding	7	(4%)
Miscellaneous Incidents	7	(4%)
Alone	5	(3%)
Housing	5	(3%)
Car Problems	5	(3%)
Child Care	4	(2%)
Parent/In-Law Intrusion	4	(2%)
Own Illness	3	(2%)
Away from Family	3	(2%)
Newborn Contact with Dad	2	(1%)
Extra People Around	2	(1%)
Self Image	2	(1%)
Depressed	<u>1</u>	<u>(1%)</u>
	57	33%
Total	171	100%

Multiple Roles/Tasks/Children

The stress experience category of multiple roles/tasks/children includes 32 (19%) of the 171 coded events. To illustrate, several examples of narrative follow.

“My 3 year old and new baby crying and husband wanting lunch all at one time (three people wanting one person – me) that’s hard on me but I seem to do it. Mothers have to be strong for their family no matter what.”

“Going to store with all three of my kids. Worrying if there is enough buggy room. If I got enough food. Getting kids and food in van. Getting kids and food in house. Putting stuff up.”

“Trying to clean house, take a shower, and watch the baby all at the same time.”

“Supermom. I have a two year old and five year old twins. Everyone thinks that I can do everything all by myself. I can’t and I can’t get anything done with two needing bottles and two others needing things, too. It seems never ending.”

“Currently, the most stressful part of my life is trying to care for a newborn, clean the house, cook, getting my two older children to mind me and cook meals.”

Health and Safety of Children

The stress experience category of health and safety of children includes 24 (14%) of the 171 coded events. For illustration, several examples of narrative follow.

“The baby had awful diarrhea for about five days right after birth. It caused a terrible diaper rash that made her miserable.”

“Evenings are stressful due to baby’s colic. Wish I could make her better. Parents are stressed and tired.”

“One thing that causes a great deal of stress is my older son who has been diagnosed as ADHA. He ignores me when told/asked to do/not do something. He teases his younger cousin when I sit down to feed the baby. He wants to pick up the baby and carry him and bounce around with him.”

“The baby wasn’t gaining weight like her doctor wanted her to and I had to keep taking her for infant weight checks and paying for them. The stressful thing is that she is eating but just not gaining weight.”

“I spilled the baby out of the car seat (the handle wasn’t locked right) as I head outside to go gardening. He only fell onto the bench he was sitting on, but onto his face and was screaming for a short while. Not even a mark on him, but I had to call my husband to tell him and calm down (the baby stopped crying right away but I took a bit longer). Felt so guilty but thankful he hadn’t fallen all the way to the floor.”

Lack of Sleep

The stress experience category of lack of sleep includes 14 (8%) of the 171 coded events. Several examples of narrative are as follows:

“How can I get sleep when baby is up all night and day?”

“Some days I am so tired that I stress out not knowing when I will be able to sleep more than two hours at a time.”

“At times I am very sleepy which becomes very stressful for me to get some sleep since I have to focus on the baby and her needs. I try to sleep a little while she sleeps but I just cannot fall asleep thinking she might wake up any moment.”

“I don’t hardly get any sleep because of my baby. But it’s okay.”

“Just very, very tired due to lack of sleep.”

Tired/Fatigue

The stress experience category of tired/fatigue includes 10 (6%) of the 171 coded events. Following are several examples of narrative illustrating this category.

“Being tired makes me more irritable and I get upset or frustrated easily.”

“On my second and third nights home I was exhausted and my baby cried all night and wanted to eat constantly. I didn’t know if he was getting enough milk and my husband thought he was starving. We almost gave him formula but I wouldn’t. My nipples were raw and I was so tired. If I had any energy I could have been more patient. Instead I cried and doubted my abilities as a mother.”

“My three year old son has been having a hard time adjusting to the new schedule lifestyle of having a new baby and summer schedule changes. He also got a cold. All of this has caused him to have more temper tantrums and night terrors than usual. This has caused stress for me as a parent and my husband as arents/spouses. Are we handling it right? How long will this last? We are so tired and are we reacting correctly or not because we are so tired?”

“Always being tired.”

“Many times I feel I can’t take care of the baby. I have to wake up several times in the night and she does not sleep unless I hold her. I am so tired and frustrated. I feel like I am not a good mother.”

Significant Other Issues

The stress experience category issues with significant other includes 14 (8%) of the 171 coded events. Several examples of narrative illustrate this category.

“Getting into arguments with spouse then having the fear of losing him.”

“My baby’s dad is not with me any more. Seeing him when he comes to visit the baby is stressful.”

“My husband decided to stay home with the baby and our thirteen year old. He considers weekends as his days off. When asked to come with me and the kids to a little event, he answers

‘no’ with a hurtful comment: ‘Why would I waste my days off with you guys!?’ This comment bothered me and still hurts a lot.”

“Just having a baby and my husband never really helps me. And on top of that having to cook and eat, clean and waking up every hour or two to feed. I am happy he is here, but he wears me out and I have been so tired since the first day that I always fall asleep feeding him.”

“I’m feeling sad in a way because things have changed between me and my spouse for the better but we don’t have any time to ourselves anymore.

“My husband and me fighting ‘cause I was not spending a lot of time with him, so he was going to leave. But we talked and it’s fine now. I’m finding more time for him.”

Finances

The stress experience category of finances includes 10 (6%) of the 171 coded events. For illustration, several examples of narrative follow.

“I have been extremely worried about finance. My husband only makes \$16,000 a year and that scares me. I have been worried about him getting a new job.”

“Lack of finances. Finances cause a lot of stress as far as frequency but a lot of stress regarding to the amount. This stress leads to feelings of not being able to provide for our child, losing

what things we currently have, keeping a roof over our head, food on the table, clothes on our backs, etc.”

“BILLS.”

“Going back to work. I desperately want to stay home with my baby but we can’t afford it.”

“My husband came in at three o’clock a.m. and when I complained about it he packed his stuff and left me and my kids with all the bills.”

Crying Newborn

The stress experience category crying newborn includes 10 (6%) of the 171 coded events. Several examples of narrative illustrating this category follow.

“The baby seems to cry often and for no reason that I can tell. I find that I count down the time until my husband comes home from work so that I can get things done at home.”

“When the baby cries, I feel like I need to just run away. Because my husband sleeps during the day and works at night, the baby does not want his father, just me.”

“My baby crying non-stop when nothing I do helps.”

“When my son wakes up and screams, it is like he is in excruciating pain and it is difficult for me to console him. I worry that he will get no relief. I just have to try anything to get him as comfortable as possible.”

“Baby’s crying at night for hours, after being fed, changed, etc.

Sometimes it seems like it will never stop.”

Emergent Themes

The second research question was “What are common themes regarding stressful events in the experience of postpartum women?” Categories of coded stressful events emerged from the content analysis of text fragments using the agreed upon coding framework. Emergent themes were identified based on content and logical reasoning. From the responses of the 127 informants, five salient themes emerged from the data across informants: 1) Environmental Stressors, 2) Symptoms of Depression, 3) Health and Safety Issues, 4) Role Strain and 5) Lack of Support (Table 5).

Environmental Stressors

Environmental stressors is the predominant theme of this study. Of the 171 coded stressful events in this study, 52 (30%) fit in the Environmental Stressors theme. Three categories accounted for 53% of the events in this theme: 1) “crying newborn,” 2) “finances,” and 3) “school or work.” Other categories include “newborn contact with dad,” “extra people around,” “child care,” “housing,” “car problems,” and ‘miscellaneous incidents’ (Table 5).

Mothers spoke of the newborn crying as occurring “all night,” “for hours,” “often,” “long term,” “three days,” and “seems like it will never stop.” The crying newborn was “difficult to console.” Mothers reported that “nothing I do seems to help,” or they had “no idea what was going on,” or that they didn’t know what was wrong; the baby was crying “for no reason that I can tell.” One mother expressed that when her baby cries, she feels the “need to run away.” Of concern was the comment that the baby was

Table 5: Emergent Themes of Postpartum Stressful Events

<u>Theme</u>	<u>Coded Events</u>	<u>Stressful Events Categories</u>
Environmental Stressors	51	Crying Newborn Finances School or Work Newborn Contact with Dad Extra People Around Child Care Housing Car Problems Miscellaneous Incidents
Symptoms of Depression	35	Lack of Sleep Tired Alone Poor Self Image Own Illness Depressed
Health and Safety Issues	31	Children's Health/Safety Breastfeeding
Role Strain	32	Multiple Roles/Tasks/Children
Lack of Support	21	Significant Other Issues Parent/In-Law Intrusion Away from Family

“crying purposefully.” Another category in the Environmental Stressors theme was “finances.” Concerns ranged from needing a better paying job, to the husband walking out and leaving his wife and the children with all the bills. Other elaborations on financial concerns were that the husband was out of work, or the husband’s income was \$16,000, or that the state of the economy was such that the mother couldn’t afford not to work. One woman spoke of the lack of finances to continue providing the basic necessities for her children – food, clothing, and a home – and the fear of losing what they had.

Other notable environmental stressful events reported in this study were returning to work and returning to school. Some women expressed the stress as 1) having to leave the newborn and other children, 2) not being around them, or 3) leaving them in the care of others.

Symptoms of Depression

Of the 171 coded stressful events in this study, 35 (20%) fit in the Symptoms of Depression theme. Three categories account for 83% of the events in this theme: 1) “lack of sleep,” 2) “tired,” and 3) “alone.” Other categories are “poor self image,” “own illness,” and “depressed” (Table 5).

Participants reported a lack of sleep, being tired and alone. These categories accounted for 83% of the events in this theme. Some women said they were tired all the time. With others, dealing with newborn colic left them stressed and tired. For some, frequent newborn feedings, every one to two hours, left little opportunity for sleep. One woman stated that she has “been so tired since the first day that I always fall asleep feeding him.” Another woman asked, “How can I get sleep when the baby is up all night and day?” As another put it, “Some days I am so tired that I stress out not knowing when I will be able to sleep more than two hours at a time.” One woman explained her sleepiness as “I do not like being so tired that I feel like I am going to pass out.” Some described the effects of lack of sleep and being tired as irritability, getting upset or frustrated easily, not having “the nerves to stay calm,” crying, and headaches. One woman had to explain to her friend that sleep deprivation was the reason for her behavior; she was not avoiding her or being aloof. Still others were so tired and frustrated

that they doubted their abilities as a mother. Women spoke of being alone, feeling lonely and forgotten, and having “no one to turn to.”

Health and Safety Issues

Of the 171 coded stressful events in this study, 31 (18%) fit in the Health and Safety Issues theme. “Children’s health and safety” accounted for 78% of the events in this theme. “Breastfeeding” is the other category (Table 5).

Stressful events regarding newborn safety were 1) aggressive four year old sibling who hits the baby, 2) older sibling with ADHD who wants to pick up the baby and carry and bounce him around, 3) newborn fell out of the car seat, 4) newborn in a life jacket, sleeping soundly, feared strangled, 5) newborn safety in dad’s care – he used drugs and his live-in girlfriend could be violent, and 6) day care – will newborn be well cared for? One woman felt lack of control over the total safety of her children, worrying about her children getting hurt in an accident of some kind. Stressful events regarding newborn health were 1) a possible problem with the spine, 2) diarrhea and diaper rash, 3) lack of weight gain, 4) colic, 5) not taking newborn out in public to avoid illness, 6) avoiding illness when newborn has five older siblings, and 7) needed blood work drawn at four days of age. For one woman, an older child had surgery soon after her baby’s birth. Another woman didn’t want her brother, who had obsessive compulsive disorder (OCD), around her children. He was aggressive, emotionally abusive, and had frequent and unpredictable outbursts. Several women questioned their mothering abilities, usually related to times when they were tired, frustrated, or didn’t understand what was going on with the newborn’s behavior. Issues related to breastfeeding were reported by the women

as stressful events. These issues were primarily clustered around the establishment of breastfeeding in the early postpartum.

Role Strain

“Multiple roles/tasks/children” is the one category of stressful events in the Role Strain theme. Of the 171 coded stressful events in this study, 32 (19%) are accounted for in this theme (Table 5).

One-half of the events in this theme mentioned being the mother of multiple children. In addition, there are the attention demands of older children, conventional schooling or home schooling, sibling adjustment and jealousy, and dealing with older children difficulties such as truancy or ADHD. There are multiple roles and multiple tasks – mother, wife, domestic tasks, MD appointments, and chauffeur – which complicate these postpartum women’s lives.

Lack of Support

Of the 171 coded stressful events in this study, 21 (12%) fit in the Lack of Support theme. “Significant other” is the category that accounts for 67% of the events in the theme. Other categories include “away from family,” and “parent/in-law intrusion” (Table 5).

Almost one-half of the events reported were arguing or “fighting” with the husband or boyfriend. One woman reported “fighting” with her husband because he wanted more of her time or he was going to leave. Again, almost one-half of the reported events revealed that the husband would not help with the children or the home. In addition, one woman shared that her husband made her choose between his help and her mother’s help with the newborn. Another woman stated she had sustained a significant

emotional hurt by her husband that resulted in her feeling depressed and having trouble focusing. She describes being so stressed that she wrecked her car and then was even more stressed. Also, little or no parent 'together time' was a stress factor.

Connections and Associations

Another analysis was undertaken to look at the events and themes to determine whether there were any connections among them. No findings seemed to be connected except that all those who expressed that they were tired or lacked sleep, also questioned their ability to parent. Seventeen of the 127 participants (13.3%) expressed a connection between tiredness or not enough sleep with either direct statements (overt) or implied (covert) questioning of their ability to parent.

Summary

In addition to a demographic description of the sample, this chapter presented the results obtained in this qualitative secondary data analysis. Findings identified 1) the most stressful events in the postpartum experience of these women since the birth of their babies and, 2) common themes regarding stressful events in the experience of these postpartum women. Among the findings, one association was found. The following chapter will summarize the study including discussion of the findings, implications, strengths and limitations of the study, recommendations, and conclusions.

CHAPTER FIVE

DISCUSSION

The purpose of this final chapter is to provide a summary of the study and a discussion of the research findings presented in Chapter Four. In addition, strengths and limitations of the study, plans for dissemination, implications for nursing practice, and recommendations for future studies are included.

Summary of the Study

This was a qualitative descriptive study of postpartum women (N=127) undertaken to identify their stress producing events. A secondary analysis was conducted on qualitative data collected (2001 to 2005) in a larger study (Groer, et al. 2005). The study sample consisted of women, four to six weeks postpartum, from the southeast United States. Content analysis included identification and coding of text fragments based on content, elimination of redundancy to identify stressful events, and examination of these stressful events to identify emergent themes across informants. Five salient themes emerged. These themes are a) External Stressors, b) Symptoms of Depression, c) Health and Safety Issues d) Role Strain, and e) Lack of Support. Lack of sleep / fatigue and questioning ability to parent was the one connection between themes that emerged from the findings.

Discussion of Study Findings

Theme - Environmental Stressors

This prominent theme primarily dealt with the stressors of crying newborns, financial concerns, and returning to school or work. The comment that the baby was “crying purposefully” is a concern. This could suggest that there is a lack of maternal knowledge about newborn development, possibly putting babies at risk for abuse.

Literature reviewed reported that a crying baby (Razurel, et al. 2009; Taniguchi & Baruffi, 2007; Wilkins, 2006), an “unsettled” baby or a baby’s “lack of rhythm” (Razurel, et.al., 2009; Tammentie, et al. 2004; Wilkins, 2006) were found to be postpartum stressors. Similarly, Amankwaa (2003) indicated newborn colic, which is accompanied by crying, to be a stress factor. These findings of financial concerns and restrictions as postpartum stressors are also documented (Amankwaa, 2003; Hanley & Long, 2006; Kurtz Landy, et al. 2009; Rodrigues et al. 2003). As with the study sample, returning to work due to financial constraints (Hanley & Long, 2006), was a significant stress factor. In contrast to the findings of this study, Hanley and Long (2006) found that some postpartum women resented giving up employment, due to loss of status, independence, and income.

Theme - Symptoms of Depression

Lack of sleep, being tired / fatigued and feeling alone were stressors identified by the study sample. Lack of sleep and being tired were coded separately, however, in this discussion they will be considered together, as one is closely associated with the other. A great deal of energy is required for the postpartum restorative period. Fatigue impacts the health and parenting ability of the mother, interfering with self care as well as newborn

care. Women questioned their mothering abilities, usually related to times when they were tired, frustrated, or didn't understand what was going on with the newborn's behavior. The one connection between themes that emerged from the findings, being tired / fatigued and questioning parental abilities, was also found by Killien (1998), who reported that fatigue and depression were associated with greater parenting stress and anxiety and a decreased sense of gratification from parenting.

Similar findings of lack of sleep, being tired, fatigued, and exhausted during postpartum are well documented in the literature (George, 2005; Kurtz Landy, et al. 2009; Hanley & Long, 2006; Hoang, et al. 2009; Nelson, 2004; Parvin, et al. 2004; Rodrigues, et al. 2003; Tammentie, et al. 2004). As with the findings, feelings of loneliness and/or isolation during postpartum were reported by Taniguchi and Baruffi (2007), Hoang, et al. (2009), and Amankwaa (2003).

Theme -Health and Safety Issues

In this study, "children's safety" and "children's health" were the predominant categories in this theme. Of these, safety and health of the newborn was the primary factor. One study reviewed found that breastfeeding was the second most stressful event immediately after delivery, and the primary stressful event after going home (Razurel, et al. 2009). Yet, in this study, stress related to breastfeeding was not a prominent issue. In contrast to study findings, Spear (2006) found that breastfeeding empowered adolescent mothers as women and as mothers. While concerned for the health and wellbeing of their babies, postpartum women lacked confidence in their parenting skills and their ability to care for their newborns, thus the stress factor (Forster, et al. 2008; Kanotra, et al. 2007).

Theme - Role Strain

The role strain theme includes the stress of occupying multiple roles, having the responsibility for multiple tasks and multiple children. An expectation of being all things to all people at all times is unreasonable and may well lead to exhaustion. There were similar findings in reviewed literature, women spoke of the multiple roles of postpartum as 1) dealing with everything by themselves (Parvin, et al.2004), and 2) being burdensome and too demanding (Hanley & Long, 2006; Kurtz Landy, et al. 2009). The process of role transition, with the new priorities, is challenging, frustrating, and emotionally and physically exhausting (Forster, et al. 2008; George 2005; Nelson, 2004). Amankwaa (2003) and Kurtz Landy, et al. (2009) found multiple children to be stress producing for the postpartum woman.

Theme - Lack of Support

This theme primarily included husbands that would not take mutual responsibility for the home or children, as well as overt discord in the parental relationship. There were similar findings in the reviewed literature. Several studies reported partner relationship strain (Deave, et al. 2008; Razurel, et al. 2009; Ross et al. 2005). This ranged from tension on the relationship due to the demands of changes in the family composition, to perception that the partner lacked an understanding of the postpartum woman's experience. In Chinese traditions, the husband always sides with his mother whenever a conflict occurs between his wife and his mother (Leung et al. 2005). Lack of social and practical support during the postpartum is well documented, also. Women felt that lack of support contributed to difficulty in continuing breastfeeding when returning to work (Kanotra, et al. 2007). Psychological support was lacking for the adjustment of the

woman to the mother role in the traditional Chinese postpartum rituals (Leung et al. 2005). Yet, at the same time, there was plenty of practical support in the traditional postpartum rituals for rest and physical recovery, unlike the study sample of same sex couples who found the lack of support from their families of origin and the gay and lesbian community to be stressful (Ross et al. 2005). Women living outside their country of origin reported lack of support at home from the extended family (Hoang, et al. 2009; Parvin et al. 2004). And socioeconomically deprived women experienced a lack of support from family and friends primarily because they were too stressed to help (Kurtz Landy, et al. 2009). Important sources of support were found to be grandparents, support groups, and peer groups (Deave, et al., 2008; Hanley & Long, 2006; Razurel, et al. 2009). The physical presence of the father is significant to the woman (Tammentie et al. 2004). With the father's physical presence, the newborn is the couple's mutual responsibility. Support of family and friends enhance the possibility of getting needed rest and assistance with tasks, as well as important social recognition of the new status of mother (Ugarriza, 2002). Women in the UK shared that practical help after delivery at the midwife led centers and peer groups were important to their recovery and adjustment during postpartum (Wilkins, 2006). Hoang, et al. (2009) found that family and community have a significant support role in postpartum. With a great deal of support, recovery went well. When there was little support, the women were exhausted, fearful, miserable, and felt isolated and unhappy. With lack of extended family support, the women were lonely, isolated, and tired. A significant finding by Taniguchi and Baruffi (2007) was that help from the woman's mother decreased the incidence of postpartum

depression. The review of literature and the findings of this study highlight the basic principle of a woman's need for a supportive environment during postpartum.

Strengths and Limitations of the Study

A major strength of this study was the use of a method appropriate to the nature of the phenomenon under investigation. The aim of this study was to identify the most stressful postpartum events and to identify themes regarding stressful events in the experience of postpartum women. The qualitative description method of content analysis was used to fulfill the purpose of this study. A second strength of this study was the rigor of the method chosen, using investigator triangulation and providing an audit trail, establishing dependability.

Limitations of the study include data that was already collected, thus making it impossible to clarify analytic findings with participants through the process of member checking to help improve accuracy, credibility, validity, and transferability. Also, it was not a diverse sample, and given the small sample size, it is unclear to what extent that findings generalize to a broader population. Another limitation of the study was that the sample did not include a significant number of non-Caucasian participants.

Dissemination

An abbreviated report of these findings is being prepared for submission to either the *American Journal of Maternal Child Nursing* or the *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, peer-reviewed nursing specialty journals. Dr. Maureen Groer, having conducted the original study yielding the qualitative data for this study, will use these data in future presentations and research.

Implications for Nursing Practice

Findings may contribute to increased awareness of and sensitivity to the impact of stress on the experience of postpartum women. It is important to examine what specific stressors are identified by postpartum women in order to facilitate prevention of stressors or to decrease the negative impact of stressors. Support groups may offer a sense of validation for postpartum women and a feeling of universality, that their experiences are shared by others. Community resource referrals should be made when appropriate and community health follow-up for mothers identified to be at risk for failure to assume the maternal role, i.e., inadequate social support should be arranged. Practical support by health professionals should be standard, particularly in the early postpartum period, for breastfeeding, self care, newborn care skills, while making available quick reference materials, i.e. pocket guides, checklists, DVDs.

The nurse is in a unique position to facilitate this process. Nursing education focuses on health promotion, patient education, and communication. Education related to caretaking skills and use of communication skills to assist the family in expressing their feelings and concerns so that the changes in redefining roles can be accomplished with a minimum of stress. Education could include a component for mothers about the need to access, recruit, and delegate to helpers for household activities. At the same time, the women could be helped to have more realistic expectations about life after childbirth emphasizing the need for support and the use of coping mechanisms and offering anticipatory guidance about postpartum fatigue. Troy (2003) advises, “Since we know that postpartum fatigue is progressive, and since nurses have so little physical time with the women in hospitals and birthing centers, it is important for women to be empowered

with knowledge in order to manage postpartum fatigue.” Assessment of postpartum fatigue should be a part of postpartum care.

Findings increase the body of knowledge for nursing so that appropriate evidence-based curricula can be developed to address the phenomenon of the postpartum experience. The nurse views a person from a holistic perspective, and uses developmental theory in providing appropriate care. The classic work of Rubin in the 1960's expanded developmental theory for postpartum by introducing the concepts of postpartal restorative phases and maternal role attainment (Gorrie, et al. 1998; Rubin, 1967; Rubin, 1984) She described the maternal role as a complex cognitive and social process which is learned, reciprocal, and interactive. In the postpartal restorative process, mothers progress through fairly discrete phases of recovery following childbirth. The mother must go through these restorative phases to replenish the energy lost during labor and to attain comfort in the role of mother. These postpartal phases are called taking-in, taking-hold, and letting-go. During the taking-in phase, the mother is focused primarily on her own need for fluid, food, and deep restorative sleep, the major task being to integrate her birth experience into reality. With the taking-hold phase, the mother becomes more independent and teachable, exhibiting concern about managing her own body functions and assuming responsibility for her own self-care. The letting-go phase is a time of relinquishment for the mother. This may be acknowledging the loss of a carefree lifestyle, giving up idealized expectations of the birth experience, or relinquishing the newborn of her fantasies and accepting the real newborn. These losses may provoke feelings of grief, though subtle. The 3 phases may provide a useful method to plan and implement nursing

care by observing progressive change in maternal behavior, anticipating maternal needs and intervening to meet the needs.

“Qualitative research is an accepted, meaningful, and important methodologic approach to the development of a substantive body of nursing knowledge” (Speziale & Carpenter, 2007, p. 1). Stress is the central theme in Crisis Theory and the balancing factors are perception of the stress, support, and coping mechanisms. These components were found in the qualitative research reviewed. This is consistent with the use of the Crisis Theory model (Aquilera, 1998) as a framework by which to view the postpartum period. Therefore, it may be useful as an assessment tool in postpartum care. Horowitz and Damato (1999) recommended that postpartum assessment of mental health status and adjustment should be a standard part of clinical care. The exploration and implementation of personal resources have the potential for expanding coping skills. Accessing prior and new methods of coping have the potential to facilitate a healing process (physically, emotionally, and cognitively) in the postpartum period. The crisis theory model may also be useful as a decision-making framework in women’s health.

Another implication would be to bring these findings to the attention of those making decisions regarding health policy. Given the current climate for health reform in the country, now would be an important time to seriously address the needs of postpartum women.

Recommendations for Future Studies

Future research is warranted including replication of this study with different populations, i.e. different cultural backgrounds in other geographic locations. These data could be used with the quantitative data (i.e., stress and immunity measures) from the

original study. Further study is needed to evaluate postpartum women's response / adaptation to stress / crisis so that timely intervention can be initiated and evaluated. The Crisis Theory model (Aguilera, 1998) is suggested as a method of structuring evidenced-based clinical research. Intervention research is needed to identify and validate needs of postpartum women as well as to measure progression through a developmental growth process that, hopefully, will lead to an increased sense of competence and empowerment as a mother and as a woman.

The connection between fatigue and feelings of inadequacy regarding parenting could be further examined by follow up with a new population, and a correlational study. More in depth phenomenological study could be undertaken to examine concepts of bonding, self-identity, fatigue and lack of confidence in parenting, as well as support from fathers.

Conclusions

This study identified stressful events in the experience of postpartum women from a qualitative perspective. In this study, for the most part, the factors associated with postpartum stress are not major life events, but rather daily hassles. It is evident that the postpartum experience can be a stressful time and is revealed in descriptive perceptions of the stressors encountered. Content analysis revealed five themes: Environmental Stressors, Symptoms of Depression, Lack of Self Confidence, Role Strain, and Lack of Support. Findings revealed a connection between lack of sleep / fatigue and questioning parenting ability. The findings establish a base for further investigation to learn about the role of stress, perception of stress, support, and coping during postpartum. Ideas for future research were suggested. It is hoped that the identified dimensions of the

phenomenon of stress in the postpartum experience will provide a stimulus for further empirical research.

LIST OF REFERENCES

- Aguilera, D. (1998). *Crisis intervention: Theory and methodology* (8th ed.). St. Louis, MO: Mosby.
- Amankwaa, L. (2003). Postpartum depression among African-American women. *Issues in Mental Health Nursing*, 24(3), 297-316.
- Chan, S., Levy, V., Chung, T., & Lee, D. (2002). A qualitative study of the experiences of a group of Hong Kong Chinese women diagnosed with postnatal depression. *Journal of Advanced Nursing*, 39(6), 571-579.
- Deave, T., Johnson, D., & Ingram, J. (2008). Transition to parenthood: the needs of parents in pregnancy and early parenthood. *BMC Pregnancy and Childbirth*, 2008(8), 30.
- Duong, D., Lee, A., & Binns, C. (2005). Determinants of breast-feeding within the first 6 months post-partum in rural Vietnam. *Journal of Paediatric Child Health*, 42(7), 338-343.
- Edge, D., Baker, D., & Rogers, A. (2004). Perinatal depression among black Caribbean women. *Health and Social Care in the Community*, 12(5), 430-438.
- Fooladi, M. (2006). Therapeutic tears and postpartum blues. *Holistic Nursing Practice*, 20(4), 204-211.
- Forster, D., McLachlan, H., Rayner, J., Yelland, J., Gold, L., & Rayner, S. (2008). The early postnatal period: exploring women's views, expectations and experiences of care using focus groups in Victoria, Australia. *BMC Pregnancy and Childbirth*, 2008(8), 27.

- George, L. (2005). Lack of preparedness: Experiences of first-time mothers. *MCN. The American Journal of Maternal Child Nursing*, 30(4), 251-255.
- Giorgi, A. (1985). *Phenomenology and psychological research*. Pittsburgh, PA: Duquesne University Press.
- Gorrie, T., McKinney, E., & Murray, S. (1998). *Foundations of maternal-newborn nursing* (2nd ed.). Philadelphia, PA: W. B. Saunders.
- Groer, M. Davis, M., Casey, K., Smith, K. Kramer, V., Bukovsky, E., (2005). Immunity And infection: differences between breastfeeders, formula feeders and controls. *American Journal of Reproductive Immunology*, 54, 222-231.
- Groer, M, Davis, M., & Hemphill. J. (2002). Postpartum stress: Current concepts and the possible protective role of breastfeeding. *Journal of Obstetrics Gynecology and Neonatal Nursing*, 31(4), 411-417.
- Hanley, J., & Long, B. (2006). A study of Welsh mothers' experiences of postnatal depression. *Midwifery*, 22(2), 147-157.
- Hildingsson, I., & Thomas, J. (2007). Women's perspectives on maternity services in Sweden: Processes, problems, and solutions. *Journal of Midwifery and Women's Health*, 52(2), 126-133.
- Hoang, H.T., Le, Q., & Kilpatrick, S. (2009). Having a baby in the new land: a qualitative exploration of the experiences of Asian migrants in rural Tasmania, Australia. *Rural and Remote Health* 9 (online), 1084.
- Horowitz, J. & Damato, E. (1999). Mother's perceptions of postpartum stress and satisfaction. *Journal of Obstetrics Gynecology and Neonatal Nursing*, 28(6), 595-605.

- Kanotra, S., D'Angelo, D., Phares, T., Morrow, B., Barfield, W., Lansky, A. (2007).
Maternal Child Health Journal, 2007(11), 549-558.
- Kiernan, J. (2002). The experience of therapeutic touch in the lives of five postpartum women. *MCN. The American Journal of Maternal Child Nursing*, 27(1), 47-53.
- Kurtz Landy, C., Sword, W., & Valaitis, R. (2009). *Qualitative Health Research*, 19(2), 194-206.
- Leung, S., Arthur, D., & Martinson, I. (2005). Perceived stress and support of the Chinese postpartum ritual "doing the month." *Health Care for Women International*, 26(3), 212-224.
- Miles, M. & Huberman, A. (1994) *Qualitative data analysis* (2nd ed.). Thousand Oaks, CA: Sage Publications.
- Muhr, T. (1997). *User's Manual for ATLAS.ti 5.2*, ATLAS.ti: GmbH, Berlin: Scientific Software Development.
- Nelson, A. (2004). A qualitative study of older first-time mothering in the first year. *Journal of Pediatric Health Care*, 18(6), 284-291.
- Parvin, A., Jones, C., & Hull S. (2004). Experiences and understandings of social and emotional distress in the postnatal period among Bangladeshi women living in Tower Hamlets. *Family Practice*, 21(3), 254-260.
- Razurel, C., Bruchon-Schweitzer, M., Dupanloup, A., Irion, O., & Epiney, M. (2009). Stressful events, social support and coping strategies of primiparous women during the postpartum period: a qualitative study [Epub ahead of print]. *Midwifery*, 2009, Sept.22. <http://www.sciencedirect.com/ezproxy.shc.usf.edu>.

- Robson, C. (2002). *Real world research: A resource for social scientists and practitioner researchers* (2nd ed.). Malden, MA: Blackwell Publishers.
- Rodrigues, M., Patel, V., Jaswal, S., & de Souza, N. (2003). Listening to mothers: Qualitative studies on motherhood and depression from Goa, India. *Social Science and Medicine*, 57(10), 1797-1806.
- Ross, L., Steele, L., & Sapiro, B. (2005). Perceptions of predisposing and protective factors for perinatal depression in same-sex parents. *Journal of Midwifery and Women's Health*, 50(6), e65-e70.
- Rubin, R. (1967). Attainment of the maternal role. Part 1: Processess. *Nursing Research*, 16(3), 237-245.
- Rubin, R. (1984). *Maternal identity and the maternal experience*. New York, NY: Springer.
- Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing and Health*, 23, 334-340.
- Scott, J., Gills, R., Karlan, B., Haney, A. (Eds.). (2003). *Danforth's obstetrics and gynecology* (9th ed.). Philadelphia, PA: Lippincott, William & Wilkins.
- Shakespeare, J., Blake, F., & Garcia, J. (2004). Breast-feeding difficulties experienced by women taking part in a qualitative interview study of postnatal depression. *Midwifery*, 20(3), 251-260.
- Spear, H. (2006). Breastfeeding behaviors and experiences of adolescent mothers. *MCN. The American Journal of Maternal Child Nursing*, 31(2), 106-113.

- Speziale, H. & Carpenter, D. (2007). *Qualitative research in nursing: advancing the humanistic imperative* (3rd ed.). Philadelphia, PA: Lippincott, William & Wilkins.
- Tammentie, T., Paavilainen, E., Astedt-Kurki, P., & Tarkka, M. (2004). Family dynamics of postnatally depressed mothers – discrepancy between expectations and reality. *Journal of Clinical Nursing*, 13(1), 65-74.
- Taniguchi, H., & Baruffi, G. (2007). Childbirth overseas: The experience of Japanese women in Hawaii. *Nursing and Health Sciences*, 9(2), 90-95.
- Templeton, L., Velleman, R., Persaud, A., & Milner, P. (2003). The experiences of postnatal depression in women from black and minority ethnic communities in Wiltshire, UK. *Ethnicity and Health*, 8(3), 207-221.
- Troy, N. (2003). Is the significance of postpartum fatigue being overlooked in the lives of women? *MCN. The American Journal of Maternal Child Nursing*, 28(4), 252-259.
- Ugarriza, D. (2002). Postpartum depressed women's explanation of depression. *Journal of Nursing Scholarship*, 34(3), 227-233.
- Ugarriza, D., Brown, S., & Chang-Martinez, C. (2007). Anglo-American mothers and the prevention of postpartum depression. *Issues in Mental Health Nursing*, 28(7), 781-798.
- Varcarolis, E. (2006). *Foundations of psychiatric mental health nursing* (3rd ed.). Philadelphia, PA: W.B. Saunders
- Wilkins, C. (2006). A qualitative study exploring the support needs of first-time mothers on their journey towards intuitive parenting. *Midwifery*, 22(2), 169-180.

APPENDICES

APPENDIX A

PERMISSION FOR USE OF ORIGINAL STUDY DATA

USF College of Nursing
November 2, 2007

Dear Nancy,

I am pleased to give you access to data collected as part of the "Pips" study, done during 2001-2005 while I was a faculty member at the University of Tennessee, Knoxville. The data includes demographic, stress, and mood data which is available on an SPSS file, and unanalyzed data, which is the response in the questionnaire booklet to the question, "Think of any one incident, thought, or feelings that stands out as very stressful to you and describe in as much detail as you choose". This pertains to 4-6 weeks postpartum and refers to the period since the baby was born. The data had been previously transcribed by me while I was at Tennessee and is identified with the participant id number.

I am attaching the Consent Form which every mother signed.

Sincerely yours,

A handwritten signature in cursive script, appearing to read "Maureen Groer", written over a horizontal line.

Maureen Groer, R.N., Ph.D., F.A.A.N.

Gordon Keller Professor

APPENDIX B

INFORMED CONSENT FOR ORIGINAL STUDY



INFORMED CONSENT STATEMENT The "PIPS" Study

You are invited to participate in a research study. The purpose of this study is to look at how mothers' stress and mood are related to their physiology.

INFORMATION

Mothers who volunteer to participate in this study will be sent a questionnaire booklet about their health and stress around the 4th to 6th postpartum week. You will fill these out at your own convenience in your home the evening before, or day of your first postpartum visit. Blood will be drawn by a registered nurse researcher who will see you at your doctor's office to take the samples and collect the booklet at week 4-6. You may prefer to have the researcher visit you at home. If so, we will arrange a home visit. The amount of blood drawn will be 10 ml (about 2 teaspoons). You will also be asked to collect a saliva sample at home and bring it to the visit. Instructions on collection will be given instructions on how to do this. The average amount of time devoted to filling out the booklet will be about 20-30 minutes. The nurse will also take your blood pressure at the time of the interview.

RISKS

There are no foreseeable significant risks for you to participate in this study, except for the risks involved in a routine blood withdrawal of 10 ml from a vein in your arm. We will use the usual careful precautions in blood withdrawal, thoroughly cleaning the area and providing a pressure dressing after the blood withdrawal. Nevertheless, you may experience some bruising around the needle site. You will be given instructions about care of the puncture site in your arm.

The research nurses doing this study are not able to provide therapeutic health care, and will refer you to appropriate health care professionals for any physical or mental health problems which require further diagnosis or intervention.

EMERGENCY MEDICAL TREATMENT

In the unlikely event of physical injury resulting from your participation in this research, emergency medical treatment will be provided at no cost to you. Be certain that you immediately notify the researcher if you are injured. If you require additional medical treatment you will be responsible for the cost. No other compensation will be provided if you are injured in this research.

BENEFITS

The benefits of this study are to expand the knowledge of the way mothers who have recently given birth experience stress, and how stress may affect hormones and immune factors and general health in both mothers and infants. We will provide you with a report of the results of the study, when it is completed, if you should so wish. All participants will also be given \$25.00 in appreciation for their contribution to the research.

CONFIDENTIALITY

The information in the study records will be kept confidential. All data will be stored securely in a locked file cabinet in Room 345, College of Nursing and will be made available only to persons conducting the study unless you specifically give permission in writing to do otherwise. No reference will be made in oral or written reports that could link you to the study.

CONTACT

If you have questions at any time about the study or the procedures you may contact the researcher, Dr. Maureen Groër, R.N., at Room 345, UTK College of Nursing, 1200 Volunteer Blvd., Knoxville, TN 37996-4180, and (865) 974-7615. If you have questions about your rights as a participant, contact the Compliance Section of the Office of Research at (865) 974-3466.

PARTICIPATION

Your participation in this study is voluntary; you may decline to participate without penalty. If you decide to participate, you may withdraw from the study at any time without penalty and without loss of benefits to which you are otherwise entitled. If you withdraw from the study before data collection is completed your data will be returned to you or destroyed.

CONSENT

I have read and understand the above information. I have received a copy of this form. I agree to participate in this study.

Participant's signature _____

12/18/02

Telephone number (so we may contact you). () _____

groer/lactating/infconstatement011602

APPENDIX C
INSTITUTIONAL APPROVAL



January 9, 2008

Nancy Crist
1938 Bear View Dr
Apopka FL 32703

RE: **Exempt Certification** for IRB#: 106393G

Title: *Women's Perception of the Most Stressful Event Experienced in the Postpartum Period: A Narrative Analysis*

Dear Nancy Crist:

On November 27, 2007, the Institutional Review Board (IRB) determined that your research **meets USF requirements and Federal Exemption criteria four (4): Existing data, documents, records, pathological specimens, or diagnostic specimens publicly available or recorded without identifiers, secondary data analysis with anonymous data.** It is your responsibility to ensure that this research is conducted in a manner reported in your application and consistent with the ethical principles outlined in the Belmont Report and with USF IRB policies and procedures.

Please note that changes to this protocol may disqualify it from exempt status. It is your responsibility to notify the IRB prior to implementing any changes.

The Division of Research Integrity and Compliance will hold your exemption application for a period of five years from the date of this letter or for three years after a Final Progress Report is received. If you wish to continue this protocol beyond those periods, you will need to submit an Exemption Certification Request form at least 30 days before this exempt certification ends. If a Final Progress Report has not been received, the IRB will send you a reminder notice prior to end of the five year period; therefore, it is important that you keep your contact information current with the IRB Office. Should you complete this study prior to the end of the five-year period, you must submit a Final IRB Progress Report for review.

Please reference the above IRB protocol number in all correspondence to the IRB c/o the Division of Research Integrity and Compliance. In addition, we have enclosed an Institutional Review Board (IRB) Quick Reference Guide providing guidelines and resources to assist you in meeting your responsibilities when conducting human subjects research. **Please read this guide carefully.**

OFFICE OF RESEARCH • DIVISION OF RESEARCH INTEGRITY & COMPLIANCE
INSTITUTIONAL REVIEW BOARDS, FWA NO. 00001669
University of South Florida • 12901 Bruce B. Downs Blvd., MDC035 • Tampa, FL 33612-4799
(813) 974-5638 • FAX (813) 974-5618

APPENDIX D

NARRATIVES AND CODINGS EXAMPLE

NARRATIVES

Participant #

4

Just trying to meet the demands of 2 children so far apart in age (4 years and 6 weeks

12

When my husband would leave to go to work I would cry all day long.

14

The long afternoon-I have another child that is almost three yrs old. He wanted to play outside .Due to the new baby I could not go out so I called a neighbor boy to come play. I needed to nurse the baby but had to leave the blinds open to keep watch on children. The neighbor is a 15 yr old boy so I was trying to watch without being seen nursing .He knocks on door-I had to put myself back together, the baby is crying ,the phone rings with people wanting to come and visit. I finally get the 3 yr old

Inside and baby fed .Company shows up and 3 yr old runs out back door and jumps in baby pool with all his clothes. I get him back in and I start to walk visitors out front as 3 yr old runs out naked. Whew!

17

Getting children off on mornings. Everyone's moving at a slow pace.

18

The death of a 2 yr old daughter of a church member was most stressful. She drowned in a pool. Her mom thought she was with the dad and the dad thought she was with her mom. She died the day my baby was born. I felt guilty at first and very sad. My husband and I discussed how easily this could have happened to us and how bad we felt for her parents.

21

:I feel a little guilty for some of the feelings I have had .I am extremely happy and love my baby but sometimes I feel a little lonely. It's like everybody has forgotten us some days.

23

Wondering if I will lose my weight.

CODING

Demands of 2 children

Being alone

Needs of multiple children
Visitors

Multiple children

Death of friend's child on day of NB's birth

Lonely, forgotten

Losing pregnancy weight

APPENDIX D (continued)

28

I have to start back to school about two months after the baby was born. I worry about leaving him for even a couple of hours at a time. I worry about him being hungry. I have chosen not to give a bottle yet if possible. I am trying to cope better with my stress and worries. three pounds in his first month. He sleeps well and is content.

Leaving NB to return to school

29

Going back to work. I desperately want to stay home with my baby but we can't afford it.

Finances
Not wanting to leave NB

30

When Andrea was four days old and she would not breastfeed any more. I switched her to formula and she ate just fine.

Breastfeeding

31

Getting into arguments with spouse then having the fear of losing him.

Spouse – arguing
Fear of losing

32

In-laws come over and just take my baby away from me without even asking and I get very frustrated and angry. I have to leave my own house just to keep from going off on them. This happens quite often too.

In-Law take NB from me

36

My baby's dad is not with me any more, seeing him when he comes to visit the baby is stressful. I never know when he is going to ask to keep the baby overnight which I don't like and I don't want him doing drugs around the baby. Plus he'd take the baby to his girlfriend's house (where he lives) and his girlfriend can be violent towards him when jealous.

NB dad's visits
NB safety in dad's care

37

My mother-in-law wrecked our car. I feel that I dealt well with the whole situation. I was very thankful that she was okay.

In-law wrecked car

38

We went to the fair today and we had free tickets but there weren't any rides open while the tickets were good. It stressed me out because it was my husband's first fair and he didn't get to enjoy it.

Spouse didn't get to enjoy first fair

40

The baby seems to cry often and for no reason that I can tell. I find that I count down the time until my husband comes home from work so that I can get things done at home.

Crying NB
Not getting things done at home

APPENDIX E

THEMES, CATEGORIES, EVENTS EXAMPLE

Health and Safety Issues – 31 coded events

Children's Health/Safety – (24)

- 25 – NB safety
- 36 – NB safety in dad's care
- 46 – getting NB to sleep after eating
- 53 – limited ability in helping child when NB upset/hurting
- 65 – NB physical health
- 69 – older child had surgery soon after birth of NB
- 71 – maternal brot with OCD, don't want around her children, (words, aggressive behavior, emotionally abusive)
- 74 – NB not sleep, colicky
- 85 – questioning mothering, good mother?
- 94 – wondering if good mother
- 103 – lack of understanding of what was going on with NB
- 109 – NB diarrhea with diaper rash
- 114 – doubted abilities as a mother
- 116 – NB safety, fell out of car seat onto bench
- 121 – NB not gaining wt.
- 124 – worry of children's total safety, feeling lack of control over..)
- 128 – NB in day care, take care of well?
- 146 – NB colic
- 149 – NB safety, older child with ADHD
- 164 – NB safety, aggressive 4 y.o.
- 170 – tho't of taking NB out in public, sick again?
- 179 – NB hospitalized
- 194 – NB possible problem with spine
- 195 – NB needed blood work redone at 4 days of age

Breastfeeding – (7)

- 30 – not breastfeeding
- 78 – breastfeeding in hospital, interruptions
- 80 – not as easy as tho't, difficulty establishing, nipple shield, UT staff not helpful
- 96 – breastfeeding, not latch on, painful at beginning
- 114 – breastfeeding, enough?, nipples raw, constantly
- 128 – breastmilk production enough?
- 158 – breastfeeding, rough start

APPENDIX E (continued)

Role Strain – 32 coded events

Multiple Roles/Tasks/Children - (32)

- 4 – demands of 2 children
- 14 – needs of multiple children
- 17 – multiple children
- 24 – meeting needs of children & spouse at a 1 time
- 40 – not getting things done at home, when by self with NB
- 41 – 2 very young children
- 50 – arrangements for MD visit, d/t car problem
- 59 – not spending time with older child (19 mos.)
- 65 – multiple children
- 65(2) – home schooling, organization
- 65(3) – 5 y.o. “bugging” her
- 68 – constantly on the run with MD appts, kids’/mom’s
- 75 – attention demands of older daughter
- 99 – mother multiple children
- 102 – never ending mothering of multiple children, super mom
- 101 – truancy of an older child; Social Worker visit
- 117 – multiple roles, multiple children, care of NB, clean, cook, older child not mind
- 126 – multiple children, HS – 2 y.o. to bed, NB crying, husband not there or asleep
- 129 – both children crying at same time
- 138 – sibling jealousy, 2 children different dads
- 138 (2) – giving necessary attention to both children
- 143 – 3 y.o.’s adjustment, not sure how to handle
- 144 – meeting needs of 2 children at once; have enough to fulfill demands of motherhood?
- 149 – child with ADHD
- 153 – not able to take care of everything multiple children need
- 170 – store trip with multiple children
- 171 – multi-tasking with multiple children
- 181 – watch NB while doing self-care/household tasks
- 185 – getting kindergartener to school
- 191 – 3 kids under 5 y.o.
- 196 – regain children
- 198 – 2 y.o., “big kid” now

APPENDIX E (continued)

Lack of Support – 21 coded events

Significant Other – (14)

- 31 – spouse, arguing, fear of losing
- 36 – NB dad's visit
- 45 – NB dad's arguing
- 48 – spouse left
- 52 – me breaking it off with NB's dad
- 55 – spouse, lack of sharing total care of children
- 58 – spouse, lack of helping with NB & home
- 90 – spouse, constantly fighting
- 97 – boyfriend, fight a lot
- 135 – spouse, hurt her emotionally
- 147 – not time for spouses to themselves
- 157 – spouse, made her choose between his help & her mom's help with NB
- 168 – spouse, not help with NB
- 175 – spouse, fighting with, wanted more of her time, going to leave

Parent/In-Law Intrusion – (4)

- 32 – in-laws take NB from mom
- 130 – mother-in-law questioning her childcare
- 155 – mother-in-law asking negative questions
- 182 – her mom going on about having BTL (bilateral tubal ligation)

Away from Family – (3)

- 76 – not able to see family at holiday
- 132 – mom 10 hrs. away
- 176 – missing family

APPENDIX F

PERMISSION FOR USE OF FIGURE



Windows Live™

RE: Obtain Permission

From: Jones, Jennifer (ELS-OXF) (J.Jones@elsevier.co.uk)

Sent: Tue 12/04/07 6:29 AM

To: nfcrist@hotmail.com

Dear Nancy F Crist

We hereby grant you permission to reproduce the material detailed below in print and electronic format at no charge subject to the following conditions:

1. If any part of the material to be used (for example, figures) has appeared in our publication with credit or acknowledgement to another source, permission must also be sought from that source. If such permission is not obtained then that material may not be included in your publication/copies.

2. Suitable acknowledgement to the source must be made, either as a footnote or in a reference list at the end of your publication, as follows:

"This article was published in Publication title, Vol number, Author(s), Title of article, Page Nos, Copyright Elsevier (or appropriate Society name) (Year)."

3. This permission is granted for non-exclusive world rights in all languages.

4. Reproduction of this material is granted for the purpose for which permission is hereby given, and includes use in any future editions.

Yours sincerely

Jennifer Jones
Rights Assistant

Elsevier is pleased to announce our partnership with Copyright Clearance Center's Rightslink service. Rightslink will handle Elsevier's journal permission requests. For your future requests, you have to go through Rightslink to obtain permissions. With Rightslink (r) it's faster and easier than ever before to obtain permission to use and republish material from Elsevier. Using Rightslink is as simple as:

Simply visit: <http://www.sciencedirect.com/> and locate your desired content.

Open the abstract or summary and then click on the 'Request Permission' button to open the Rightslink web page which will launch you into the Rightslink application and then follow the steps below.

1. Select the way you would like to reuse the content
2. Create an account if you haven't already
3. Accept the terms and conditions and you're done

<http://by117w.bay117.mail.live.com/mail/PrintShell.aspx?type=message&cpids=a0af2a61-...> 12/6/2007

APPENDIX F (continued)

Please contact Rightslink Customer Care with any questions or comments concerning this service:

Copyright Clearance Center Rightslink Customer Care

Tel (toll free): 877/622-5543 Tel: 978/777-9929

E-mail: customercare@copyright.com

Web: <http://www.rightslink.com>

Elsevier Limited, a company registered in England and Wales with company number 1982084, whose registered office is The Boulevard, Langford Lane, Kidlington, Oxford, OX5 1GB, United Kingdom.

APPENDIX G

ORIGINAL NARRATIVE TRANSCRIPT EXAMPLE

SUBJECT NUMBER: 66

STRESSFUL EVENT: Going back to work and leaving my newborn and two year old at a day care. I hate the thought of other people taking care of my kids more than me but financially I have no other choice. I worry that something would happen without me around or that they will not need me as much as they do

SUBJECT NUMBER: 67

STRESSFUL EVENT: My best friend accused me of being aloof and said I didn't want to spend time with her. I explained that I was only sleep deprived and she understood and apologized.

SUBJECT NUMBER: 68

FRIENDS POS: Friends commented on how good I looked.

FRIENDS NEG:

SPOUSE/PARTNER POS:

SPOUSE/PARTNER NEG:

FAMILY POS:

FAMILY NEG:

STRESSFUL EVENT: There are so many appointments; between me going to the doctor and my kids going to the doctor, I get very stressed out because I am nervous, tired, aggravated, irritable because I have to constantly stay on the run.

HEALTH CHANGES: C-section infection, red, pus filled sore.

BABY'S HEALTH: Perfect, eats very well.

SUBJECT NUMBER: 69

:

STRESSFUL EVENT: The most stressful event had been when my first daughter had surgery. We had Cal and then her surgery and I never thought we were going to get to come home.

SUBJECT NUMBER: 70

SUBJECT NUMBER: 71

:

STRESSFUL EVENT: My younger brother has OCD-he lives with my parents because he is unable to care for himself. He is a very difficult person to be around because of his aggressive behaviour. He can be emotionally abusive too. This is an extraordinarily stressful situation for everyone involved particularly when he uses these words in front of my children (especially the two year old). Even though he loves his nieces I have decided they cannot be around him since his outbursts are so frequent and unpredictable.

APPENDIX G

ORIGINAL NARRATIVE TRANSCRIPT EXAMPLE (continued)

SUBJECT NUMBER: 73

FRIENDS POS:

STRESSFUL EVENT: At times I am very sleepy which becomes very stressful for me to get some sleep since I have to focus on the baby and her needs. I try to sleep a little while she sleeps but I just cannot fall asleep thinking she might wake up any moment.

SUBJECT NUMBER: 74

:

STRESSFUL EVENT: The baby will not sleep. She is very colicky.

SUBJECT NUMBER: 75

STRESSFUL EVENT: My oldest daughter is very jealous of the new baby and she's all the time. I can't put her down at all without her crying.

HEALTH CHANGES: Breast infection. Saw a health care practitioner. Treatment was to keep them in a very,

SUBJECT NUMBER: 76

STRESSFUL EVENT: I was really upset and sad because I was not able to see my family for thanksgiving.

SUBJECT NUMBER: 77

SUBJECT NUMBER: 78

STRESSFUL EVENT: The most stressful event was trying to breastfeed in the hospital. The baby was not staying latched on well to begin with. There were too many interruptions from nurses, water changers, meal delivery-pickup etc. I was exhausted and had pain and was worried about the baby eating. She caught on and everything worked out but it was a very stressful few days.

SUBJECT NUMBER: 79

STRESSFUL EVENTS: The baby had a very restless night and we were awake for a very long time. I was so tired and I couldn't make the baby happy. She was fighting her sleep. I had to remember she is just a baby and she will finally fall asleep as she did and we both slept until 2pm that day.

SUBJECT NUMBER: 80

STRESSFUL EVENT: I am very stressed with breastfeeding. It isn't as easy as I expected. My baby has been using a nipple shield to nurse and I'm having extreme difficulty in weaning her from this. I feel like somewhat of a failure when it comes to breastfeeding. Several times I felt like giving up. Also the UT hospital staff weren't so helpful with feeding as I expected.

APPENDIX G (continued)

SUBJECT NUMBER: 81

STRESSFUL EVENT: My husband is self employed and we are worried about finances due to it being the holidays and him being out of work with me during the birth of our baby.

SUBJECT NUMBER: 82

SUBJECT NUMBER: 83

STRESSFUL EVENT: My biggest issue is with my self image. I gained 80lb with pregnancy and obviously it's going to take a while to get it off. I have become obsessed with my weight, looks, hair, nontanned skin etc and I can hardly stand to look at myself in the mirror. It has made me down in the dumps when rationally I realise it is going to take a while but I can't seem to shake tho depressed feelings. It is not affecting my interactions with my baby- I adore and love every minute spent with him. It has not gotten in my way of everyday activity, I have just been down on myself.

SUBJECT NUMBER: 84 (SPANISH)

SUBJECT NUMBER: 85

FRIENDS POS: My friends are helping by bringing dinner for us or helping with my oldest daughter.

FRIENDS NEG:

STRESSFUL EVENT: Many times I feel I can't take care of the baby. I have to wake up several times in the night and she does not sleep unless I hold her. I am so tired and frustrated. I feel like I am not a good mother

SUBJECT NUMBER: 86

SUBJECT NUMBER: 87 (SPANISH)

SUBJECT NUMBER: 88

STRESSFUL EVENT: When my son wakes up and screams it is like he is in excruciating pain and it is difficult for me to console him. I worry that he will get no relief. I just have to try any thing to get him as comfortable as possible.

SUBJECT NUMBER: 89

STRESSFUL EVENT: I got a stomach virus and had to ask for someone to come and watch the baby for me.

ABOUT THE AUTHOR

Nancy Gilbert Crist received a B.S. degree in Nursing from Walla Walla College and a M.S.N. degree from the University of Florida. She holds a certification as Registered Nurse Certified in In-Patient Obstetrics with the National Certification Corporation. In addition to the years of varied clinical experience with a focus on areas of maternal-newborn nursing, Nancy has 19 years of experience in academia at the collegiate level primarily with maternal-newborn nursing and mental health nursing concentrations. She has overseen major nursing program curriculum changes as well as the process for National League for Nursing program accreditation.