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The Facilitation Of Effective Coping Strategies Used By Women In Early Motherhood-Implications For Antenatal Education

By: Christine Johnstone RN BN Student Midwife

Supervisor: Dr. Alan Gibbons

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Signed: C.M. Johnston (Student's Name) Dated: 12.11.99

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ABSTRACT

This paper explores the effectiveness of coping strategies used by women in early motherhood. The purpose of the study and Swanson's Theory of Caring were used as a framework to organize the data analyzed. The qualitative research literature reviewed particularly, provided insights into the empowerment of women for transition to motherhood. Three themes evolved from current literature. These were: antenatal education, losses and failing. Women-generated solutions were elicited from the literature. These suggested recommendations were in terms of:

- antenatal education,
- antenatal education being user friendly,
- antenatal education being relevant to counteract feelings of failure.

This treatise recommends philosophical and practical changes to antenatal education.

Chapter One:

1.1 Introduction

The transition to motherhood has been identified in the nursing/midwifery literature as involving losses and immense changes for the woman. Little acknowledgment by way of preparation was seen to be given to this transition either by society or by professionals.

Specifically this treatise explored *the lived experience of women and effective coping strategies they used in early motherhood.* The approach was to conduct a comprehensive literature review of recent material addressing women's views on antenatal education and early parenting. The widespread societal misconception of what early motherhood offers women was examined. The framework used for reviewing the literature in this treatise was examined and arranged around Swanson's Middle Range Theory of Caring.

The study largely focused on qualitative research papers. This was considered most relevant to describe what knowledge women were seeking as a source of effective coping strategies in programs of early motherhood and antenatal education.

1.2 The Purpose Of The Study

The goal of this study was to explore coping strategies found to be effective by women in early motherhood. Recent research has indicated that an early portrayal of how new parents cope should be included in programs of antenatal education (McKay, Gibbons, Kennedy-Clark & Evans, 1999, p. 15; Pound, 1998, p. 97; Rogan, Shmied, Barclay, Everitt & Wyllie, 1997, p. 883). The literature has shown that parents feel there is too much emphasis upon labour, and that this is inappropriate, given birth is a temporary state, while parenting is for the rest of one's life (Rogan et al, 1997, p. 883; Nolan, 1997, p. 21; Smedley, 1999, p. 19).

Becoming a parent for the first time has been regarded as a developmental crisis for both men and women (Stern & Kruckman, 1983, p. 1027). Most current research cited centered upon the woman, and focused on the physiological changes of pregnancy and lactation (Barnett, 1995, p. 129; Barnett & Morgan, 1996, p. 709). The literature confirmed that the woman experienced more life changes than the man, as she was usually more directly involved in child care, especially if she was breastfeeding, and that some of these life changes were regarded as losses (Barclay & Lloyd, 1996, p. 137; Gordon & Gordon, 1960, p. 433; Stern & Kruckman, 1983, p. 1031). One mother was reported as lamenting, "I resent the fact that he (the father) can just get up and go to the shops or go for a walk." (Morgan, Matthey, Barnett & Richardson, 1997, p. 915).

The purpose of this study was to *"describe the lived experience of women who use effective coping strategies in early motherhood."* Such a qualitative type study reviewing phenomenological data was seen to be timely, as recent research had identified the need for "parenting focused issues" to be presented to prospective parents, during antenatal education (Smedley, 1999, p.19). Studies evaluating antenatal education programs indicate that this need is not adequately met (Barclay & Lloyd, 1996, p. 137; Nolan, 1997, p. 6).

However, in order to ease the transition of becoming a mother, it is useful to examine how society perceives new motherhood.

1.3 Societal View Of Becoming A New Mother: the myths of motherhood.

The societal perception of the state of motherhood in Western society has been described as romanticism, glamour and utter fulfillment for women (Barclay & Kent, 1998, p. 4; Bishop, 1999, p. 66). Becoming a new mother was seen to evoke images of romance, with women portrayed as finding their true niche in life once they become loving mothers. Barclay (1995, p. 22) discusses the heritage of Mills & Boon paperback novels that filter into society, perpetuating the romantic character of motherhood. Other roles that women may have apart from motherhood are just facades (Shelton, 1999, p. 11). The women in Mills & Boon novels seemed to be well aware of this. These stories have served the purpose of getting the above message across to society. Older women who read Mills & Boon novels and who have daughters of marriageable, reproductive age were socialized to bring their daughters in line, with remarks like "there's just something about holding a baby in your arms" (MacAllister, 1999, p. 9). Comments like these clearly gave messages of the utter fulfillment that motherhood promised.

For commercial reasons, the media have been extremely active in promoting the new mother image in today's society (Barclay, 1995, p. 22). She is portrayed as a beautiful, impeccably groomed woman (Bishop, 1999, p. 64), holding a healthy chubby white baby (Barclay & Kent, 1998, p. 5). Women in these advertisements or magazines look blissfully happy, in fact, because their stress levels were so low, they seem to have endless time to look dreamily off into the distance. Their babies were either asleep or looking delightfully cute, with no signs of a possit or dribble (Ace Graphics, 1999, p. 1; Avent, 1999, p. 1; Barclay & Lloyd, 1996, p. 137; Gordon, 1998, 11). Society has picked up on this image and imagined that the new mother had endless time to do her hair, which usually seemed to be long and flowing, and to apply makeup.

The reality for some mothers is not what paperback publishers Mills & Boon or the advertising media industry would have the public believe.

This can lead to disillusionment and confusion as some women feel they are unable to live up to their own personal or society's expectation of motherhood. An outcome of the above could be postnatal depression (Barclay & Kent, 1998. p. 4; Bishop, 1999, p. 23). Australian statistics estimate that 15-20% of women experience postnatal depression in the first year of their baby's life (Barnett & Fowler, 1995, p. 5).

Postnatal depression has been discussed in relation to society's distorted image of new motherhood. Strategies by health carers to counteract this discrepancy were to identify the myths of motherhood in postnatal depression groups and give handouts in maternity wards, early childhood health clinics, medical centres, and places that new mothers may frequent (Bishop, 1999, p. 40; Fowler & Gornall, 1996, p. 78).

This study proposed that understanding women's coping strategies, had the potential to influence the content of antenatal education, so as to prepare women in advance for the early days of motherhood. It was anticipated that having a realistic picture of what to expect during these early days of parenting could help decrease anxiety (Barclay et al. 1997, p. 723). Borrill (1998, p. 19) suggests that preparing women for the baby and the reality of changes to their lifestyle, could help to build positive attachments between the mother and infant, and decrease child abuse. The following theoretical framework was used to describe how this study could be applied in midwifery practice.

Chapter Two

2.1 Theoretical Framework

Swanson's Middle Range Theory of Caring (1993, p. 352) was selected as the conceptual framework for this study because of its ability to provide an appropriate framework around which the reviewed literature could be arranged. This enables the phenomenon of the *lived experience of women who use coping strategies in early motherhood to be effectively described.*

Swanson's Theory of Caring is of the middle range variety. Within nursing, middle range theories focus on several well-defined concepts. The purpose is to inductively provide care, highlighting a particular event of significance to clients and their needs (Chinn & Kramer, 1995, p. 40; Liehr & Smith, 1999, p. 85; Marriner-Tomey & Alligood, 1998, p. 5).

Further, a middle range theory was chosen over a grand nursing theory in view of other theorists recommendations that they have a broader application. To illustrate this, the writer considered Levine's Conservation Theory, which was seen to have a wide behavioral deductive foundation from other disciplines encompassing the concepts of wholeness, adaptation and conservation (Alligood & Marriner-Tomey, 1997, p. 36; Marriner-Tomey & Alligood, 1998, p. 200). However, recent literature suggested a trend away from grand theories of nursing, to a more defined midrange perspective (Chinn & Kramer, 1995, p. 40).

According to Bryar (1995), midwifery has advocated the use of midrange theories in order to concentrate on the understanding of practice embedded in midwifery (Bryar, 1995, p. 16). Therefore, the writer has chosen Swanson's Theory of Caring for knowledge integration throughout the treatise topic (Chinn, 1994, p. 5).

Grant, Kinney & Davis (1993, p. 52) further suggest that within midwifery the use of an appropriate theoretical framework serves to link knowledge gained from review of literature, to already accepted concrete definitions of concepts. They propose the use of theory as a frame of reference, laying the foundation for sound acceptable knowledge development to emerge, paving the way towards development of a mature discipline of midwifery. Swanson's Middle Range Theory of Caring was therefore used to enhance the treatise topic, by placing significant identified events within the framework of the theory. The subsequent aim was to organize the data generated, in order to contribute to the development of a meaningful, systematic, well-linked body of midwifery knowledge. Swanson's conceptual framework was also selected to extract client understanding of specific phenomena which would ultimately inform midwifery practice facilitating development of new and innovative ways to approach care and increase client satisfaction (Chinn & Kramer, 1995, p. 40; Horsfall, 1995, p. 7; Swanson-Kauffman & Schonwald, p. 97, 1988). It was projected that data collected through this study would lead to more desirable outcomes in midwifery practice, and subsequent greater client satisfaction.

2.2 Emergence of Swanson's Middle Range Theory of Caring

Swanson's theoretical framework of caring emerged inductively through analysis of three phenomenological research studies relating to perinatal nursing. Phenomenological research enabled *"my informants' capacity to teach me about their reality"* (Swanson - Kauffman, 1986a, p. 59). In the first of her studies, the caring needs of women who had recently miscarried, described their *lived experiences* from their perspectives (Swanson- Kauffman, 1986b, p. 38). The second study described caring, related to the experiences seen to be essential to the needs of parents with a sick infant in an intensive care unit (Swanson, 1991, p. 163). The third study involved a descriptive recall by young mothers

(regarded as a high social risk), four years after having been recipients of a long-term intensive nursing intervention program (Swanson, 1991, p. 163).

2.3 Description of Swanson's Middle Range Theory of Caring

In her first phenomenological research project Swanson described *" the human experience of miscarriage as it is lived "* (Swanson - Kauffman, 1986a, p. 61). She identified caring actions and how women responded to understanding and helpful behaviors, as the basis for her five categories of caring. These were ***knowing, being with, doing for, enabling and maintaining belief*** (Swanson-Kauffman, 1986b, p. 40).

These five caring categories were established as separate identities, although they were not seen as mutually exclusive. Swanson (1993, p. 357) described each of the concepts as follows:

Knowing is about attempting to understand the meaning of a particular event, and its significance and effect in the life of the client.

Being with takes the understanding of the event further by being emotionally present for the client. This extends the category of knowing by enabling the client to teach the carer about their reality.

Doing for involves caring for the client in ways that they would do for themselves if it were at all possible, that is treating the client as the carer would wish to be treated, should the roles be reversed.

Enabling is unique to each individual client, and involves empowerment through the use of information, explanations, or giving assistance that may facilitate the person's transition through a particular event.

Maintaining belief is concerned with building hope in the client so as to facilitate their capacity to traverse an event and eventually see meaning in their future (Swanson-Kauffman, 1986b, p. 40).

Her second phenomenological research study took place within a newborn intensive care unit. Research participants included parents and professional caregivers. This resulted in refinement and confirmation of the five categories from a less context-related format, to that of a more understanding, point of view incorporating the perspectives of the one being cared for. This confirmed the five previously identified categories for caring (Swanson, 1991, p. 163).

Swanson's third phenomenological study involved a group of young mothers regarded by health carers as a high social risk. They received long term public (community) health nursing interventions over an eighteen month period. Swanson's purpose for this study was to investigate a past intervention program, planned to enable mothers to take control of their lives and to care effectively for their infants. Four years later, eight of the young women originally interviewed were asked to describe their memories of the relationship between themselves and their nurse. Again the five caring categories were confirmed and refined (Swanson, 1991, p. 162).

As a result of the five caring categories being confirmed by Swanson's three phenomenological research studies, an empirically developed definition of the overall concept of caring was presented as *"a nurturing way of relating to a valued other towards whom one feels a personal sense of commitment and responsibility"* (Swanson, 1991, p. 165).

Swanson (1993, p. 354) used key words to analyze her definition, as follows:

- nurturing (growth and health producing)
- way of relating (occurs in relationships)
- to a valued other (the one cared for matters)

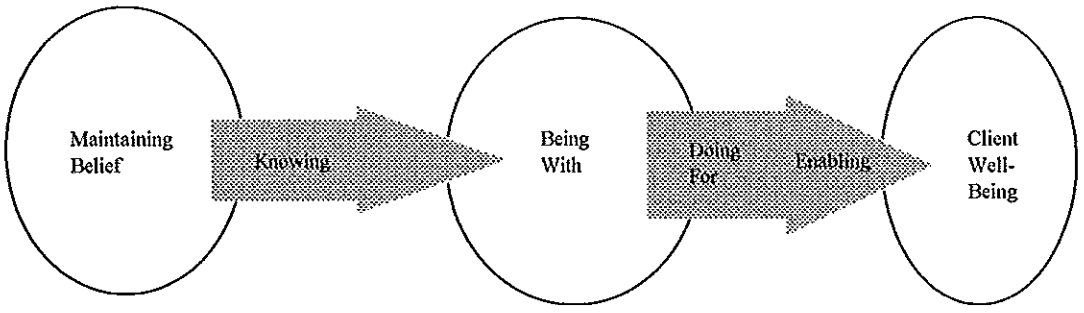
- toward whom one feels a personal (individualized and intimate) sense of commitment (bond, pledge, or passion)
- and responsibility (accountability and duty).

Swanson (1991, p. 164) presented her theory as being compatible to other theories, by submitting evidence of cross-validation of her conceptual caring processes. She aligned her five caring categories with Benner's helping role of the nurse (1984, p. 50), and Watson's carative factors (1988, p. 75). Swanson considered all five of her caring processes were contained within Benner's helping role of the nurse, and Watson's carative factors (Swanson, 1991, p 164).

2.4 Discussion of Swanson's Middle Range Theory of Caring Model

Swanson (1993, p. 355) found her theory lacked structure as to how the intended caring processes related to one another. As a result she proposed a model for her theory which depicted the structure of how the five caring processes could be visualized.

Swanson's Structural Model Of Caring



Philosophical attitudes towards persons (in general) and the designated client (in specific)	Informed understanding of the clinical condition (in general) and the situation and client (in specific)	Message conveyed to client	Therapeutic Actions	Intended Actions

Swanson's theory described five overlapping processes within an enveloping phenomenon of caring, and she proposed a definition of caring which she presented as:

> *Caring as grounded in maintenance of a basic belief in persons, anchored by knowing the other's reality, conveyed through being with, and enacted through doing for and enabling*
>
> (Swanson, 1993, p. 357)

Swanson's five caring processes are further considered in the context of the current study.

Maintaining belief

Swanson (1993, p. 354) delineated a structure in which she viewed *maintaining belief* in the person as the foundation of caring. *Maintaining belief* was seen to have the potential to assist the person to endure events, to cope with transitions and help them to face the future with meaning. Should the midwife perceive *maintaining belief* from this premise, then they would have the capacity to question what is significant for the client, and how to deliver care? Swanson (1993, p.354) considered that *maintaining belief* was the impetus for health professionals to adopt a commitment to helping humanity in general and in assisting each client in particular.

Maintaining belief through midwifery was seen to be comprised of two levels, a societal and an interpersonal component. On the societal level, Swanson believed that it was a fundamental right of all people to proceed through events and to see a future with meaning. For example, a pregnant woman and her significant other may be given an early portrayal of how new parents cope, as part of antenatal education programs. This concept applied to new parents, was seen to have the

potential for facilitating positive attachments between baby and parents. It was also suggested that babies who receive positive responses, form healthier social attachments later in life (Borrill, 1998, p. 19). On the interpersonal level, it was recommended that *maintaining belief* be addressed by the midwife in the antenatal phase, or in early parenting education, by informing women that they may experience losses when they become mothers, and that this could generate feelings of ambivalence towards the baby. This proposal does not mean that the mother has failed; in fact it was considered healthy for the woman to express such feelings (Barclay & Lloyd, 1996, p. 137).

Knowing

Knowing is the anchor that provides the ability to understand events as they have meaning in the life of the other. *" Knowing translates the idealism of belief maintenance into the realism of the human condition"* (Swanson, 1993, p. 355). Swanson believed it is the carer's knowledge of self that lays the foundation for how willing the midwife is to truly know another's reality. True *knowing* means centering on the one being cared for, avoiding assumptions, thoroughly assessing all aspects of the other's circumstances and engaging with the client in a caring transaction to promote well-being. The caring process of *knowing* is seen to be enhanced realistically and competently by empirical, personal, ethical and aesthetic knowledge, thus facilitating understanding of the range of responses that humans experience in relation to actual and potential health conditions (Swanson, 1993, p. 355). Individual ways of *knowing* were recognized to be determined by cultural and historical influences which shape attitudes and beliefs (Davis, 1995, p. 50). Formal education on cultural, physical, spiritual and emotional responses on client reactions to the impact of events on wellness and illness, were also cited to widen the midwife's ability to *know* the other's reality. Swanson (1993, p. 355) suggested that when this education is combined with experience and perception that reflects *knowing,* then the potential for the caring categories of *being with, doing for* and *enabling* were facilitated.

Being with

Being with essentially means being emotionally present to the other. When the caring process of *being with* is present, then the client is subconsciously aware that their person and their life events matters to the caregiver. The pathways of sharing the meanings, feelings and lived experience of the one being cared for, seem to be opened. *Being with* conveys acceptance and encouragement to the client, sends messages from the midwife of availability and a commitment to the one being cared for. In the structure of caring, Swanson (1993, p. 355) used the terms to give time to, *by authentic presence*, *attentive listening* and *contingent reflective responses.* These sentiments were shared by several authors who specifically discussed *being with* as presencing (Benner & Wrubel, 1989, p. 411; Forest, 1989, p. 818; Gaut, 1992, p. 3). Swanson (1993, p. 345) emphasized that carers need to be aware that the caring process of *being with* requires discretion as to who is the receiver of care and who is the provider.

Doing for

This caring process was succinctly described by Swanson as *"doing for the other what they would do for themselves if it were at all possible"* (1993, p. 356). *Doing for* was viewed as related to actions performed for the client with that client's long term well-being as one of two primary motivators, the other being a desire to treat another as one wishes to be treated. In this way the midwife is seen to base their actions ultimately on preserving the client's wholeness. *Doing for* involves anticipating needs and using skill in the performance of psychomotor nursing activities. These were recognized to include *comforting* and *protecting from harm,* to ensure the ultimate preservation of the *dignity* of the one being cared for. The skill set required in the psychosocial range of *doing for* was seen to employ interpersonal therapeutic communication. Used effectively, this skill set was perceived to provide a safe area where people can start to initiate their own healing. *Doing for* requires balance on behalf of the midwife. It is *doing for* the client what they would do for themselves if they had the information and ability, with the ultimate goal of facilitating long term well-being (Swanson, 1993, p. 356).

Enabling

Swanson defined enabling as *"facilitating the other's passage through life transitions and unfamiliar events"* (1991, p. 164). *Enabling* was seen to comprise the giving and explaining of information, providing a supportive atmosphere where the client is able to get to the deeper levels of how an event may have impacted on them. *Coaching* was recognized as a useful way of helping the client to generate alternatives. *Enabling* was also acknowledged in the process of offering constructive feedback, in supporting and validating the other's reality. This caring process of *enabling* was seen to have the capacity to enhance the long term well-being of one being cared for, as well as the caregiver (Swanson, 1993, p. 357).

2.5 Validation of Swanson's Theory of Caring

Swanson's Theory of Caring was internally validated by her inclusion of quotes of integrated statements by study participants, and externally verified by her comparison of data to current literature (Swanson, 1991, p.162). Burns and Grove (1997, p. 230) discussed internal validity as being the range of aspects discovered in the study to be a true image of reality and not the result of extraneous variables. The concluding test for validity of phenomenological research was concept recognition by research consumers (Swanson, 1991, p. 162). External validation focused upon the extent to which the theoretical study findings could be generalized beyond the sample used in the study (Burns and Grove, 1997, p. 234). Other research using this framework found Swanson's Middle Range Theory of Caring enhanced identification of interaction in maternal satisfaction in childbirth, and caring for Acquired Immune Deficiency Syndrome (AIDS) patients. Devine (1995, p. 74) asserts that applying Swanson's framework had the potential to structure quality midwifery care by increasing the activities of communication, and addressing the emotional needs of the client. Swanson's theory was also utilized in the complex process of negotiating partnership between family caregivers and professionals who cared for people with AIDS. It was observed that using the theory extended the innate dimensions

of negotiating partnership. These actions included conveying information, knowing, being accessible and maintaining belief (Powell-Cope, 1994, p. 326).

2.6 Summary

Swanson's Middle Range Theory of Caring was seen to provide a comprehensive basis for analyzing data relating to women's use of effective coping strategies in early motherhood. This model provides a suitable framework for inquiring into the topic under study through investigating the concepts of: *maintaining belief* in the woman's ability to prepare for early motherhood, *knowing* and understanding her wants and needs, as a new mother by *being with* the woman, *doing for* her, and *enabling* her to increase her knowledge and understanding of the transition to motherhood.

Chapter Three

Literature Review

A review of the current nursing/midwifery literature was conducted in order to *explore the effectiveness of coping strategies used by women in early motherhood.* The reviewed literature was studied and arranged around the concepts established within Swanson's Middle Range Theory of Caring, These included: *maintaining belief, knowing, being with, doing for and enabling* (Swanson, 1993, p. 355).

3.1 Maintaining Belief

Swanson's concept of *maintaining belief* was identified throughout out the literature by three main factors. These being: *the ability to endure events, cope with transitions and face a future with meaning.*

Surveyed literature showed the concept of *maintaining belief* to be fundamental to the needs of women coping with new motherhood. This concept was demonstrated by women and their significant others (attempting to *face the future with meaning*), who gave an explicit evaluation of their experiences of antenatal education. Subsequently women suggested a fresh approach, shifting the focus from the antenatal educator's agenda, or the institution's schedule, to a primary objective of meeting their needs as a prospective mother (Barclay, 1994, p. 15; Fettling, 1998, p. 7; Lamp & Howard, 1999, p. 33; Nolan & Hicks, 1997, p. 187; Nolan, 1997, p. 25; Smedley, 1999, p. 20). Women's demands were seen to help sharpen the focus of the antenatal educator, thereby assisting her to *face the future with meaning* by meeting her requirements for early mothering information, before that of the needs of the instructor or the institution's agenda.

Coping strategies suggested in the reviewed literature highlighted the need for education to access women's thoughts, feelings and perceptions of early motherhood, therefore providing relevant information and insight for antenatal education. Women requested to be asked what aspects of early motherhood particularly concerns them (Barclay, 1994, p. 14; Lamp & Howard, 1999, p. 33; Nolan, 1997, p. 26), and to have this information shared during antenatal education within an adult learning framework (Smedley, 1999, p. 20). Swanson's concept of *maintaining belief* focused the carer's thinking towards those aspects which were seen to be important to the woman and how to best meet those needs (Swanson, 1993, p. 354).

The literature suggested that women's particular concern was to have to *endure events and cope with transitions.* Women requested that antenatal education present a realistic picture of motherhood, including descriptions of low postnatal moods and feelings of ambivalence. In particular, more detail was demanded on how to recognize postnatal mood disorders, and how long to let these feelings continue. In addition, it was proposed that it was important that reassurance be given through provision of statistics emphasizing that other women sometimes have similar feelings, some undergo postnatal mood disorders or depression, and then recover (Bishop, 1999, p. 34; Borrill, 1998, p. 20; Mauthner, 1997, p. 167; Wood, Thomas, Droppleman & Meighan, 1997, p. 316). One women was quoted as saying "if I had known what feelings to be aware of, I would have sought help sooner" (Mauthner, 1997, p. 166). The above statement was viewed to support the notion of *coping through a transition*, a component of *maintaining belief,* and facilitating *hope in the future* (Swanson, 1993, p. 354). Education on feelings associated with low postnatal moods, was also recognized by Fettling (1998, p. 7), who explained it as defusing panic and encouraging personal help-seeking behavior.

The literature review supported the idea of experienced mothers of infants attending antenatal classes, to facilitate pregnant women's *transition to motherhood* (Barclay, 1995, p. 24; Mauthner, 1997, p. 169). It was proposed that observing experienced mothers breastfeeding and caring generally for their infants in an antenatal education setting, would give pregnant women *hope* that motherhood can progress to being enjoyable (Barclay, 1994, p. 14; Rogan et al, 1997, p. 882). These views were validated in the context of giving hope as a component of *maintaining belief,* by one new mother who retrospectively suggested:

> *I think that there should be in your antenatal care a day ...*
> *or a morning where you can actually sit with mothers*
> (Barclay et al, 1997, p. 722)

Literature on the *lived experience* of mothers could encourage midwives to assist women to *endure events, cope with the transition* involved in becoming a new mother, and *see their future with meaning* (Swanson, 1993, p. 354).

Closely related to the concept of *maintaining belief* is the concept of *knowing,* which has been highlighted in the literature as an important component in *facilitating the woman with effective coping strategies in early motherhood.*

3.2 Knowing

The concept of *knowing* as supported in Swanson's Middle Range Theory of Caring, was reported in the current literature to have three characteristics. These were classified as follows: the ability to; *understand events in the life of the other, the capability to engage with the client in caring transactions, and to center on the one being cared for.*

Discussion on issues that could be considered relevant to *knowing* in the literature indicated that women experienced many losses when they become mothers (Barclay & Kent, 1998, p. 5; Fettling, 1998, p. 9; Lawson & Callaghan, 1991, p. 64; McIntosh, 1993, p. 180; Morgan et al, 1997, p. 917) of which they had little expectation. Specifically these losses appeared to involve such factors as income, independence and free time (Bishop, 1999, p 30). In general terms, these losses were seen to include former activities that were now unsuited to the role of a new mother (Barclay & Lloyd, 1996, p. 137; Hendricks, 1998, p. 81). An example of this might be the woman's loss of her artistic pursuits, which were now not viewed to be as important as co-ordinating her household activities (Hatrick, 1996, p. 324). Fundamentally, these losses were encapsulated in the following quote by a new mother:

> *Well none of your time is your own. It's you know, like sort of having a lifestyle where you can actually have a lot of freedom and enjoy your life...(now) you've got this tiny little thing that runs your whole life 24 hours a day. It just doesn't stop*
> (Barclay et al, 1997, p. 724).

Women were also reported as saying that their life as a new mother felt unreal. Some women perceived that this could not be their life now, it was someone else's life, it was like a dream, or a movie (Barclay, et al, 1997, p. 721; Barclay & Lloyd, 1996, p. 137; Bishop, 1999, p. 15; Gonda, 1998, p. 37). This sense of unreality was seen to result in feelings of confusion, resentment, and a plunging loss of self esteem (Barclay et al, 1997, p. 724; Bishop, 1999, p. 23). One woman was quoted as saying, " it's a big change....it really is" (Rogan et al, 1997, p. 882). Swanson's concept of *knowing* (1993, p. 355) has been perceived as providing a basis for midwives to reflect and comprehend, that becoming a mother required adjustment by the woman in a *personal, physical, and emotional sense*. This adjustment was revealed in the literature to be

consuming and involved. For some women, becoming a mother can come as a shock (Bishop, 1999, p. 65; Rogan et al, 1997, p. 882). If midwives convey the message it is acceptable that some of theses losses can be felt as a void, women may come to true *understanding of the events in the transition of motherhood.*

First-time mothers often find that the constant learning, coupled with no apparent rewards can be despairing and engender feelings of confusion and exhaustion (Barclay et al, 1997, p. 721; Bishop, 1999, p. 66; Hendricks, 1998, p. 83). The review of the literature uncovered the idea that conflicting emotions may arise in some women, whose perceptions were that pregnancy culminates in a beautiful settled baby, and blissful fulfillment for the woman. This widespread misconception was also perceived by society as the reality of life with a new infant (Barclay, 1995, p. 22; Barclay & Kent, 1998, p. 5; Barclay & Lloyd, 1996, p. 137; Bishop, 1999, p. 66; Fettling, 1998, p. 9). The literature review indicated that it was not surprising that women feel incompetent when they are unable to live up to this image (Barclay, 1995, p. 25; Barclay & Kent, 1998, p. 6; Barclay & Lloyd, 1996, p. 137; Bishop, 1999, p. 17; Meager & Milgrom, 1996, p. 852). In addition, women who were not coping were found to develop fear of being considered a failure at mothering (Bishop, 1999, p 23; Gonda, 1998, p. 37; Mauthner, 1997, p. 169; Meager & Milgrom, 1996, p. 852). The literature proposed that when the mother is feeling unsupported, isolated, and exhausted, fear often prevents her from seeking help (Hendricks, 1998, p. 83; Small, Astbury, Brown & Lumley, 1994, p. 94). Swanson (1993, p. 355) specifically advocated that true *knowing* on behalf of the carer for the client, *" translates the idealism of belief maintenance into the realism of the human condition."* This idea recognized the carer *centering* on the client's needs, and deliberately taking actions to avoid assumptions, thereby facilitating openness of interactions and *caring transactions.*

Prior knowing has been a recurrent theme noted in the literature as a form of a coping strategy (Nolan, 1997, p. 25; Small et al, 1994, p. 474). An example of how this theme relates to the new mother is that of 'the settling of a crying baby' (Moran, Holt & Martin, 1997, p. 30). The questions which need to be answered for these women included: *Does the pregnant woman and her significant other know that new babies cry, and that this is common? Has the woman seen or been shown settling strategies? How often and when is the baby unsettled? Does the woman feel supported in coping with settling the crying baby?* (Rogan et al, 1997, p. 882). These were viewed in the literature as significant questions and all being related to *knowing* in advance. Learning to settle a crying baby has been described as involving anxiety for the parent because of the societal perception that all new babies only sleep and eat (Barclay & Lloyd, 1996, p. 137). This sentiment was shared by Beck (1998, p. 44) who discussed risk factors for postnatal depression in a prediction inventory. Two predictors related to babies who were perceived to cry a lot and were difficult to settle. Beck (1998, p. 40) proposed that some risk factors in these predictors were modifiable, particularly through *prior knowing,* by antenatal presentation of a realistic picture and useful coping strategies as determined by women in early motherhood. *Knowing,* with the perception of what needs are experienced by the new mother, is the connection that the carer uses to attempt to *understand the woman's transition to motherhood. Knowing* facilitates the carer's *capacity to center on the client,* and to allow the interaction of *caring transactions* to take place. When experience and perception compliment *knowing,* then the following caring categories of *being with, doing for* and *enabling* are facilitated.

3.3 Being with

Swanson described the concept of *being with* as having the *emotional capacity to be present for the other.* This was regarded as the first of three dimensions of *being with* which were illustrated as allowing the carer to step into *the meanings,*

feelings and lived experiences of the other (Swanson, 1993, p. 355). The second dimension of *being with,* was enabling the person, to be *aware of events encountered in their experiences,* and that they were important to the carer. Through the third dimension, the person was able to receive messages of *acceptance* and *encouragement,* helping them to endure the transition of new experiences.

Articles associated with the concept of *being with* focused on women who were using effective coping strategies in early motherhood. Women were empowered to feel that they were not *"bad mothers who have failed,"* (Mauthner, 1997, p. 169). They were encouraged to feel comfortable, have a safe place to express feelings of ambivalence and perceive a sense of *acceptance* by others (Barclay & Lloyd, 1996, p. 137; Bishop, 1999, p. 40; Mauthner, 1997, p. 169; Wood et al, 1997, p. 316). The three dimensions of *being with* were encapsulated by women being free to openly express their thoughts, feelings and ambivalence associated with *the lived experience* of motherhood, that was perceived as contrary to societal perception. For the woman to get to this point, the literature supported the notion that a carer would have *focused emotional presence* upon the woman. Genuine *emotional presence* was acknowledged by Swanson, (1993, p. 355), to have the potential to be perceived by the woman as *acceptance* and *encouragement.* This process of *being with* was seen to involve the woman in the deeper levels of reflection on the meaning of ambivalence and how it impacted on the woman. Using reflection when *being with* another was noted to encourage ways that could reduce the woman's trauma of transition to motherhood (Mauthner, 1997, p. 168).

The *acceptance* and *encouragement* aspects of the *being with* concept, were observed by women to be virtually non-existent in discussions during antenatal education. This was obvious when the subjects of *emotional and difficult*

aspects of having a baby were broached, other than the topic of the baby blues (Mauthner, 1997, p. 166 ; Wood et al, 1997, p. 316). Antenatal education was also seen by women and their significant others to be deficient by not providing a realistic picture of becoming a mother, and how to lower her expectations of the transition to motherhood (Hendricks, 1998, p. 82; Nolan & Hicks, 1997, p. 189; Mauthner, 1997, p. 169). This factor was cited to be necessary as women placed high expectations upon themselves, they believed they should be able to manage baby care, the household, and the family's emotional stability by themselves (Morgan et al, 1997, p. 915). One mother was reported as saying,

> *I think society plays a big part in saying that a mother will cope with her child, and they will be able to*
> (Hendricks, 1998, p. 82).

The review of the literature uncovered that women perceived health professionals to be hesitant when addressing complex issues such as postnatal depression, and the unrealistic expectations of motherhood (Buist, 1995, p. 73; Hendricks, 1998, p. 82; Nolan & Hicks, 1997, p. 189; Mauthner, 1997, p. 169). The message as interpreted by women was *" we don't want to give you too much knowledge, "* as this could be frightening (Mauthner, 1997, p. 166). The reviewed literature elaborated on this theme by reporting that women who obtained knowledge about feelings associated with postnatal depression, were not predisposed to develop the condition (Mauthner, 1997, p. 169). This view was also shared by Buist (1995, p. 73) who proposed that several factors were seen to be highly preventative against developing postnatal depression, including education on identification of feelings associated with postnatal depression, and the unrealistic expectations of motherhood. Therefore it would be ideal to share this information during the antenatal phase.

Swanson's Theory of Caring (1993, p. 355), specifically described the caring category of *being with as appreciating meanings, feelings and lived experiences* of others, such as women who need to be trusted by carers, and to be given a realistic picture of the emotional ups and downs associated with having a baby. *Being with* in this context has the capacity to demonstrate to the woman, you are not alone, I am aware of what you are going through, you are doing well, and I am here for you.

The above category of *being with* demonstrated how the open sharing of thoughts and feelings had the capacity to strengthen and facilitate the caring process of *doing for*.

3.4 Doing for

The literature seen to be associated with the caring process of *doing for* supported two main motivators. The primary motivator to be demonstrated by the carer was *treating the person as the carer would wish to be treated if the roles were reversed.* The carer's secondary motivator focused towards *preserving the individual's wholeness, and well-being.*

Swanson identified three facets of *doing for*. The first facet directs the carer towards *"doing for the other what they would do for themselves if it were at all possible"* (Swanson, 1993, p. 356). The second facet of *doing for* the other included *comforting, anticipating* their needs, providing *competent and skillful care* to protect the person from harm, thereby *preserving their dignity.* The third facet of *doing for* operated in the physical and psychological realms (Swanson, 1993, p. 356) . Physically, *doing for* was interpreted as activities such as setting up, or facilitating groups. Psychologically, *doing for* involved the carer using interpersonal therapeutic skills to enhance communication. In these ways *doing for* was seen to *"provide safe areas within which people can bring about their own healing"* (Swanson, 1993, p. 356).

The literature argued that from a *doing for* perspective, women and their significant others have identified that antenatal classes focus too much upon what the woman should do at birth and did not offer sufficient preparation for early motherhood (Barclay et al, 1997, p. 722; McKay et al, 1999, p. 15; Pound, 1998, p. 97; Rogan et al, 1997, p. 883; Smedley, 1999, p. 21). Several reasons were given for the discrepancies in the content and presentation of antenatal classes. The institution usually determined course content, and this may not be offered to prospective parents within a framework of adult education. Further, antenatal instructors were not always seen to be skilled in utilizing adult education principles or were not allowed to use the principle. Institutions were cited to often keep antenatal education under obstetric control, rather than (its intended capacity) as a parenting educational tool.

A solution endorsed by women was to move antenatal education out of institutions, to community settings (Nolan & Hicks, 1997, p. 187). Offering antenatal education within the community setting was viewed firstly as providing a *safe area* where women could feel comfortable. Secondly, giving women the time and opportunity to discuss their issues of concern, and at the same time providing an environment for the educator to teach from a community rather than an institutional perspective. Obtaining information in relation to these issues was recognized as being *comforting* for the woman, thus decreasing her level of anxiety (Mauthner, 1997, p. 166). This change was considered to ensure the educator had appropriate *competence and skill* in the real world areas of early motherhood, and in this way to be able to anticipate the women's needs, *"treating her as the carer would wish to be treated if the roles were reversed"* (Swanson, 1993, p. 356).

Preserving the woman's ultimate well-being from a holistic viewpoint was first proposed in early research studies by Janis & Hovland (1959, p. 258). They suggested it was beneficial to provide the prospective mother and her significant

other with opportunity in antenatal education, to do the anticipatory work of thinking about what happens physically, socially and emotionally after the birth of the baby. This sentiment was also supported by Nolan (1997, p. 26) who added that antenatal educators could then "devise appropriate learning opportunities."

Swanson (1993, p. 356) suggested *"doing for the other what they would do for themselves if it were at all possible,"* can also be viewed as facilitating actions that have the person's long term well-being as a priority. In this context, *doing for* was related to *knowing* in advance, or in the practical sense, prior experience. Antenatal education discussion was seen to be necessary to get the household organized, dividing the housework, arranging social support, and self-care strategies which could include time out from the baby. These learning opportunities would offer the woman and her significant others time to think about the organizational changes they could make before the baby arrives (Nolan, 1997, p. 25; Small et al, 1994, p. 474).

The caring process of *doing for* was seen to be closely aligned with *enabling,* which contained many aspects of coaching, as used to enhance *the effectiveness of coping strategies used by woman in early motherhood.*

3.5 Enabling

The caring concept of *enabling* was understood as helping the person towards practicing self-care and well-being (Swanson, 1993, p. 356). This idea suggested that the caring process of *enabling* had three broad sections, which were observed to be: *"facilitating the other's passage through life transitions and unfamiliar events,"* giving *information* and *explanations* to the person and their significant other that enable them to *make sense of their experiences,* and *coaching* to *generate alternative ways* of managing the impact of events (Swanson, 1993, p. 356).

The literature identified that new mothers attempted to come to terms with their role while meeting the needs of their baby (Barclay & Lloyd, 1996, p. 137). For some women, this often resulted in feelings of confusion and resentment, and a plunging loss of self esteem (Barclay et al, 1997, p. 724).

One reason suggested for this confusion was that Western society valued the individual who was seen as existing by oneself, autonomous and self responsible. On the other hand, Western society viewed a good mother as self-sacrificing, and being prepared to renounce her needs for the needs of the baby. This perspective "contradicted the traditional notion of self existing within a single being" (Hatrick, 1996, p. 317). As a result, some new mothers need to conceptualize a profound reorganization of their sense of self (Barclay & Lloyd, 1996, p. 137), as their previously held self concept conflicted with their new role as mothers (Rogan et al, 1997, p. 884). First-time mothers often found that these adjustments engendered feelings of confusion and exhaustion. The conflict between self concept and new motherhood was not recognized or acknowledged by women or society (Barclay et al, 1997, p. 721; Hendricks, 1998, p. 83). Examining society's perception from the above viewpoint was seen to be enlightening for some women and their significant others. This idea was considered unfamiliar to some woman, and they learned that they were not to blame for feeling confused and resentful. The actual process of *enabling* used to analyze the above statement related to *"facilitating the other's passage through life transitions and unfamiliar events"* (Swanson, 1993, p. 356). The aspect of *generating alternatives* within the caring process of *enabling* was seen to be used in antenatal education in discussing key points that the literature had uncovered. These included such issues as how life and relationships will be changed once the baby is born (Nolan, 1997, p. 24). Nolan (1997, p. 26), and Smedley (1999, p. 19), in discussing this issue, proposed that more *explanation* and instruction was needed in baby care skills, plus *information* on what to

expect with a small baby on a day-to-day basis. Presentations involving *information* and *explanation* on comparative coping strategies were also highlighted as a method of *generating alternatives* in the context of *enabling* (Hendricks, 1998, p. 83).

Discussion on the nature of support agencies and how to access them was viewed as an important *enabling* aspect of antenatal education (Borrill, 1998, p. 20; Mauthner, 1997, p. 167). The literature review indicated that many new mothers were often unaware of the nature of support services (Hendricks, 1998, p. 83; Rodd, 1992, p. 25). It was perceived by women that to ask for help required assertiveness and confidence, as using support services was regarded as demeaning (Hendricks, 1998, p. 83; Rodd, 1992, p. 25). Giving permission for women to get help apart from that offered by their partners was proposed as a way of increasing the acceptability of using support services (Barclay & Kent, 1998, p. 84), and helping to prevent a cumulative build-up of stress (Hendricks, 1998, p. 84). *Information* and *explanations* giving permission for everybody's eligibility to use support services assisted with ultimately practicing *self care* and enhanced *well-being.* This was subsequently seen as an *enabling* theme identified by *women to effectively aid their coping strategies used in early motherhood.*

Facilitating the concept of networking was perceived to be an effective *enabling* process for the woman. An important networking strategy also cited was keeping antenatal education classes to a manageable size, so as to encourage networking amongst participants (O'Meara, 1993, p. 218). Women further emphasized the advantages of developing friendships with other women who have babies the same age. This was perceived to reduce their personal isolation, build their confidence, and encourage sharing emotional and social support (Hendricks, 1998, p. 84). Networking using *coaching* was also seen to provide

alternative ways of lessening the impact of emotional and social isolation in women (Nolan, 1997, p. 26). In this way the woman was seen to develop the practice of *self care, by facilitating her passage through life transitions and unfamiliar events* (Swanson, 1993, p. 356).

The following is a description of qualitative and quantitative methodologies used in this literature review describing women's requests for a realistic picture of early motherhood in programs of antenatal education.

3.6 Research Methodologies used in the Literature Reviewed

The majority of methodologies used in the research reviewed were qualitative in character. These studies explored women's needs and experiences as mothers (Barclay et al, 1997, p. 719; Hendricks, 1998, p. 81; Mauthner, 1997, p. 164; McIntosh, 1993, p. 178; McKay et al, 1999, p. 24; Nolan & Hicks, 1997, p. 179; Rogan et al, 1997, p. 877). The participant samples ranged from seven to fifty seven. In these studies, data were collected using open-ended and semi-structured questions. This style of questioning allowed women to set their own agenda (Mauthner, 1997, p. 165). Developing theory was observed in the grounded methodology, as data emerged from the research questions. *Phenomenological* research studies facilitated the development of emerging themes and patterns of concern to mothers through studies of their own *lived experiences* (Burns & Grove, 1997, p. 32; Hatrick, 1996, p. 323). Analysis and comparisons between each piece of the literature reviewed allowed for the emergence of patterns, themes and preferred differences to be established (Burns & Grove, 1997, p. 75; Mauthner, 1997 p. 165).

The inclusion of quantitative research papers used in this literature review was purposely kept to a limited number. The approach was chosen because it was perceived that the input of the *lived experience* from women would be minimal.

Quantitative research in its objective nature, was not seen to be based upon *"lived experiences"* (Burns & Grove, 1997, 791). Recent research conducted by Condon & Corkindale (1997, p. 358) who were cited to use the quantitative technique, found it proved inadequate because of failure to "capture those features more specific to depression in the early postnatal period." An earlier quantitative research study by Cramer (1993, p. 286) found non-specifics such as the woman's perceptions, may be a reflection of her depressed viewpoint rather than her ability to make an accurate appraisal.

The majority of the literature reviewed for this treatise, consisted mainly of the qualitative methodology, researching the *lived experiences of the effectiveness of coping strategies used by women in early motherhood.*

A summary of the findings and recommendations are outlined in chapter four.

Chapter Four

Summary of the Literature Review

The data for this literature review was analyzed using Swanson's Theory of Caring. The major themes were collected and collated, then summarized in order to describe *the effectiveness of coping strategies used by women in early motherhood.*

Upon analyzing the literature review, the writer found the concepts of Swanson's Theory of Caring were not mutually exclusive. Blurring occurred across the concept borders of the emerging themes, from one concept to the other, as expected (Swanson, 1993, p. 357). However, this allowed for the re-classification and emergence of three important new themes on coping strategies, to surface from the review of the literature.

The focus of the three emerging themes, were seen to be:

- women's opinions on antenatal education
- women's perceptions on their losses experienced with the birth of the first baby
- women's thoughts and feelings about failing at mothering.

Central to these emerging themes were the concrete suggestions put forward by women to counteract negative aspects arising from the above issues. These were observed to be:

- women's suggestions on user-friendly antenatal education
- women's suggestions on antenatal education addressing losses associated with birth of the first child
- women's suggestions on counteracting thoughts of failure at mothering.

Each expanded theme was followed by an analysis of women's suggestions on how to make antenatal education user-friendly.

4.1 Theme One: Women's opinions on antenatal education.

The literature review revealed that women were not having their particular needs met through antenatal education, nor was the information adequate on how to cope with their new infant. Women identified the limited use of adult learning principles by the educators to be a major factor in her needs for *coping strategies* not having been met. The literature revealed that antenatal educators were often restricted in their use of the above principles, due to their lack of knowledge of the benefits of adult learning, and their ability as teachers. Other identified factors included constraints imposed by the institution or by the obstetricians, who were seen to want to retain control over the content of antenatal education. Additionally, the application of the principles of adult learning to antenatal education were perceived to have the potential to eventually change midwifery practice.

The literature has shown that women insist on relevant information relating to the emotional, difficult and demanding aspects of having a baby. In particular, recognition of possible feelings regarding postnatal mood disorders and depression, and when and where to get help. The literature supported the reality that women have identified benefits from knowing about these conditions, arguing that it was preventative and that knowledge does not translate to being predisposed to developing postnatal depression.

In women's experience, the present model of antenatal education was seen to focus upon the birthing process, and they pointed out a balance was needed between giving birth and early parenting information. In particular, it was apparent that women want a realistic picture of the early days of parenting. Discussion was cited to be lacking on practical organizational changes which could be applied during the antenatal phase, to ease the adjustment required in parenthood This was reported to be beneficial, so that plans for their particular situation may be organized prior to the birth.

4.2 Women's Suggestions in Response to Theme One: User-friendly antenatal education.

The review of the literature indicated women were explicit regarding their suggestions to improve shortfalls in antenatal education. Women felt they were able to make a valuable contribution to antenatal education by suggesting ways to ease the transition to motherhood. Women proposed that antenatal education become user-friendly by regular employment of the information collected in their retrospective evaluations, and that their suggestions be utilized to meet the identified shortfalls.

Women were reported to particularly request that their needs for realistic information on early motherhood be met. This was viewed to be achievable by additionally using the principles of adult education. This sentiment was extended by Nolan & Hicks (1997, p. 187) who proposed that adult learning in antenatal education would, "empower class attenders to make their own choices which may be out of line with hospital protocols." The women supported the moving of antenatal education to community settings to give educators the opportunity to respond in a relevant manner to women's needs for information, by devising appropriate learning sessions.

Women suggested that open discussion in the antenatal period on postnatal mood disorders and depression, would be beneficial. They proposed that this would facilitate the understanding that if depression did occur, then help was available. Additionally, women implied that open-ended discussion would help decrease isolation, and feelings of despair. Women said it was reassuring to know others have been there and recovered. The literature reported that women requested that they need to be trusted by carers, and that they need to be given prior knowledge on postnatal mood disorders and depression, so they can then act accordingly if necessary.

Having prior knowledge on settling a crying baby was seen by women to make the early days of motherhood easier. Requests by women on how to get the best out of day-to-day life with a new baby, were evident throughout the literature. Such practical applications were suggested by women to include such issues as dividing housework and shopping, and be offered in the antenatal phase.

4.3 Theme Two: Women's perceptions on their losses experienced with the birth of the first baby.

A perception shared by women throughout the literature review was that sometimes fundamental losses can be felt with the birth of the first baby. This loss concept was cited to infer that individual needs were not seen as important by others, which left women feeling they were required to give way to family needs, thus, their mother role being viewed as absolute. Conflicts were seen to arise in women between Western society valuing the autonomous individual, over the mother role. Compounding issues of losses, conflict, confusion, negativity, loss of self esteem, were viewed to lead to women regarding themselves failing as a mother. The question that arose from this literature review, was: '*how can these losses be rationalized if they were not acknowledged by women or society?*'

4.4 Women's Suggestions in Response to Theme Two: Relevant antenatal education to address these losses.

Women have proposed that receiving rationales for the inclusion of the baby into their lifestyles and family relationships prior to the birth would encourage the development of coping strategies.

Women indicated that society's and the media's portrayal of motherhood had very little to do with the reality of caring for a new infant. Some women stated that this realization was a shock. Their adjustment was not automatic, and could take time. Some women reported that they seemed to be operating from a

confused self concept, and thought how could this be my life now? Having discussion on this unexamined concept during antenatal education would promote a level of consciousness.

Women requested a safe place where they can feel comfortable expressing feelings of ambivalence about one's adjustment to motherhood. This was viewed by women to give them a sense of being secure. Open expression of ambivalence was seen to be a strength, counteracting women's feelings of being inferior mothers who had failed

To strengthen gains during the early days of motherhood, women requested opportunity to interact with an experienced mother, and observe her caring for her infant. Women emphasized this would be a "real life" opportunity, giving them a sense of hope. The notion of expert status reflected the traditional role shared by experienced women in the community, who managed childbirth and cared physically and emotionally for new mothers (Barclay et al, 1997, p. 722).

4.5 Theme Three: Women's thoughts and feelings about failing at mothering.

The literature revealed some women felt they were failing as a mother if they felt unhappy, unsupported, or exhausted. When combined with isolation, these factors were seen to result in some women being afraid to seek help. Further, it was argued that asking for help required personal resources such as assertiveness and knowledge of the support services. This was viewed to be difficult when feeling physically and emotionally exhausted. The availability and use of support services were also regarded by some to be demeaning as society was perceived to assume that new mothers should not require help from anyone. To complicate the issue, the use of supportive services was not presented as fitting in with society's view of an autonomous individual.

Women indicated the societal expectations of motherhood seemed unobtainable. In some cases the anticipated blissful feelings of motherhood were not seen to eventuate. Instead feelings of failing at the mother role surfaced, especially when their expectations could not compare with the reality of life with a new baby.

4.6 Women's Suggestions in Response to Theme Three: Counteracting failure at mothering during antenatal classes.

Women stressed the benefits of developing social contacts with other women during antenatal classes. This proposal was seen to be helpful in preventing social isolation once the baby was born. To encourage this concept it was suggested to keep the size of antenatal classes small.

To prevent feelings of being unsupported, exhausted and overwhelmed, women suggested that antenatal education include more discussion on these topics, and on support services and what they can offer new mothers. Stressing the value of support services and that everybody is eligible was seen as an important strategy for helping women to cope. The demeaning societal misconception regarding support agencies should be examined at this time to dispel this image. Women wanted help in facilitating the exchange of information and parenting know-how, such as contact with experienced mothers and joining new mothers groups to network

Throughout the literature review women recommended that a realistic picture of motherhood be presented in antenatal education as a coping strategy. This was cited by women to counteract confusion and the constant learning required by the new mother, once the baby has been born. This opportunity was seen to offer women and their partners the chance to think of how to implement coping strategies during the antenatal phase, to offset the constant learning required with a new infant.

It was noted by women that the recurrent theme of deficient antenatal education surfaced by failing to diffuse the myth of the supermum. The common myths of motherhood were regarded in the literature, as a widespread misconception that could be examined effectively in the antenatal phase so as to lower the expectations of women, and to effectively make the early days of life with their new infant easier

The following model, "user-friendly antenatal education for women, by women" evolved through an analysis of the literature on women's perceptions of effective coping strategies used in early motherhood. Their suggestions on corrective modifications to facilitate change were viewed as an essential component of the model.

4.7 User-Friendly Antenatal Education For Women By Women

Theme one: *Women's opinions on antenatal education:* • acknowledged the urgency for antenatal education to be redeveloped to meet women's wants and needs for realistic information • advocated that antenatal educators apply adult learning principles • desired a realistic picture of early motherhood to be presented antenatally • requested more information on what happens after birth to balance the content of antenatal education	**Women's suggestions:** *User friendly antenatal education:* • evaluate antenatal education programs so as to cater for women's needs for information • educator's to develop skill and confidence, to respond appropriately to women's questions • provide more information and open discussion on postnatal depression • discuss how to become more organized while pregnant, sharing housework, buying groceries • build competence in babycare skills, e.g. settling techniques
Theme two: *Women's perceptions of their losses experienced with birth of the first baby:* • loss of previous lifestyle, loss of time, loss of freedom and independence • loss of self concept with the mother role, requiring profound reconstruction • loss of self esteem, feeling negative, feeling a failure at mothering • very real losses, with no apparent gains in the early weeks of mothering	**Women's suggestions:** *Relevant antenatal education to address these losses:* • discuss incorporating the baby into lifestyle and family relationships • discuss societal perception Vs reality of life with a new baby • acknowledge that becoming a mother takes time • provide opportunities for women to express ambivalent feelings associated with motherhood • talk with and observe experienced mothers interacting with their infants

Theme three: *Women's thoughts and feelings about failing at mothering:* • isolation • expected to manage by oneself • too tired to ask for help • constant learning • can't live up to expectations of mothering	**Women's suggestions:** *Counteracting failure at mothering during antenatal education:* • keep antenatal classes small, build social networks while pregnant • describe the nature and availability of support agencies, community facilities, and ways of networking • emphasize the importance of seeking help as a strength • describe what happens after birth, to balance the content of antenatal education • examine common myths of motherhood

4.8 Recommendations

In response to the findings of this study into the facilitation of coping strategies of women with a new infant, it is recommended that:

- Antenatal education be redeveloped to meet the information needs of women and their partners by providing a realistic picture of early motherhood, so as to facilitate her *maintaining belief* in herself, *knowing*, and *enabling* her in the transition to motherhood.
- Antenatal education topics should include opportunity for women to discuss and reflect on the concept of losses associated with motherhood from the perspective of enabling her to re-allocate time, adjust to life-style changes, think about societal perceptions, express feelings, and interact with other mothers so as to *know* and *maintain belief in herself.*
- Antenatal education should aim to prevent women from thinking and feeling they are a failure at mothering. Classes should be small to provide for the participant interaction, give information relating to community support agencies, describe what happens after the birth, discuss the myths of motherhood, thus facilitating women's *maintaining belief* in themselves, *knowing, being with, doing for and enabling.*

Research should be conducted in order to validate the three identified themes of:

- women's opinions on antenatal education
- women's perceptions of their losses experienced with the birth of their first baby
- women's thoughts and feelings about failing at mothering.

4.9 Conclusion

In order to better facilitate the coping strategies of new mothers, antenatal education should be user-friendly by offering educational programs incorporating a realistic picture of motherhood. Programs should address the losses associated with the birth of the first child, and provide information to empower women with mothering. Further research of the *lived experiences* of coping strategies used in early motherhood needs to be conducted to explore the three identified themes.

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