AN EXPLORATION AND DESCRIPTION OF THE POSTPARTUM TELEPHONE INTERVIEW

by

Donalda H. Wotton

A Thesis
Submitted to the Faculty of Graduate Studies
in Partial Fulfillment of the Requirements
for the degree of

Master of Nursing

Winnipeg, Manitoba

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ISBN 0-315-77912-8

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ABSTRACT

The postpartum telephone interview is one strategy used by community health nurses to determine the health needs of new mothers and their families once discharged from hospital. The purpose of this study was to explore and describe the use of the postpartum telephone interview as a technique to assess postpartum adaptation. Affonso's conceptualization of postpartum adaptation and the transactional model of stress and coping guided this research. Fifteen women were interviewed about their telephone discussion with the community health nurse. Latent content analysis was used to interpret the data.

Three areas of discussion were identified, namely, "condition", "action", and "reaction". Women were asked about their "general reaction" to their postpartum experience, however, this study indicated that women must be questioned about their "specific reactions" to identify their concerns. Four coping styles emerged during data analysis: "do something", "learn something", "feel something", and "think something".

A significant finding was that the emotional aspects of postpartum adaptation were not addressed during the telephone contact. This brings into question the use of the telephone interview to assess postpartum functioning. The results of this study highlight the need for further research into this community health intervention.

ACKNOWLEDGEMENTS

I would like to take this opportunity to extend my thanks and appreciation to the individuals who have provided support and guidance during the past five years of graduate studies. Firstly, I would like to thank my committee chairperson, Dr. Janet Beaton, for her ongoing patience and support during this research experience. Her time, energy, and scholarly critique of this research were invaluable, but most of all I appreciated her positive and encouraging spirit throughout each step in the research process.

I thank Annette Gupton for serving as committee member. Her comments and questions provided a fresh analysis of my work and contributed greatly to the practical aspects of this thesis.

Dr. Dan Albas, from the Department of Sociology, served as my external member. I thank him for his expertise in qualitative analysis and his encouragement to examine phenomena from a theoretical perspective.

My sincere thanks is also extended to my colleagues and friends who provided support and encouragement to me as I juggled work, school, and home. A special thanks to Jane Sanders and Chung Mi Yim who were always flexible and willing to provide coverage for my requests of vacation and overtime around university classes.

I thank my parents and family for their patience and understanding. I realize that most of the time they didn't know just what I was doing or why it took so long but they were polite enough not to ask.

Finally, I would like to thank my husband, Terry, and my daughter, Jenniece, for their positive encouragement and continuous support. Your willingness to make sacrifices to provide me with that uninterrupted time were appreciated. Words cannot express my gratitude and love.

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STATEMENT OF THE PROBLEM

Childbirth represents the beginning of a new life and, for most women, the beginning of motherhood. The time after birth, the postpartum period, presents a complex series of challenges and changes for the woman and her partner as they strive to integrate a new being into their family. These adjustments can evoke stress and increase vulnerability to crisis (Affonso, 1987) which in turn may effect the health of the postpartum woman, her newborn, or her family.

The physiological changes in the puerperium are numerous. Labor and delivery causes blood loss and physical fatigue. Hemorroids and vaginal lacerations, with possible sutures, cause pain and interfere with elimination. Breast engorgement may cause discomfort, along with the fatigue of breastfeeding around the clock. Sleep hunger, sleep deprivation and sleep disruption plague the new mother's physical recovery during the first postpartal month (Rubin, 1984).

The emotional changes are no less intense. The postpartum woman must integrate her childbearing experience and resolve any unmet expectations (Affonso, 1987). She must create an attachment to her newborn and develop the confidence and skills to care for her baby. The birth of a child causes changes in the woman's relationships with her partner and

family. Responding to family adjustments drains emotional energy from the new mother.

Postpartum adjustment is both a unique and universal experience. It cannot be properly understood outside the context of the broader life course of the woman (Gloger-Tippelt, 1983). Some women may experience childbirth and parenthood without difficulty. Others may find the adjustment overwhelming. Any assessment of postpartum adaptation must include the individual woman's evaluation of her physical and emotional recovery. The woman's appraisal of her postpartum experience will impact on her coping skills (Donaldson, 1981) and, ultimately, on successful adaptation (Blumberg, 1980).

The contextual aspects of our society influence and impact upon the postpartum woman's adaptation to motherhood. At one time, birth represented an event which mobilized extended family supports that were accessible and available to assist the new mother in her unfamilar role. Today, families may live at a distance from their extended families. Subsequently, there is often no one to assist the new mother who must assume total responsibility for the infant whose need for mothering in the early months is most intense (Leifer, 1977). Confinement to the home to perform 24 hour a day infant care can result in intense feelings of isolation and aloneness (Affonso, 1984; Power & Parke, 1984) which may lead a deterioration of family relationships and postpartum depression (Oakley, 1980).

Besides isolation, a mother may feel overwhelmed and confused by her new role. This is particularly significant for women previously in the workforce. A first time mother has to adjust to two job transitions, housewife and mother, and then balance the responsibilities and demands of both jobs simultaneously for the rest of her life (Oakley, 1980). Often, this juggling act has to be accomplished with a third job: employment. In 1986, 56% of Canadian women with children under three participated in the workforce (Torjman, 1988). Thus, a new mother is often expected to master her maternal role during the course of her maternity leave and then return to "work". Such expectations create role strain and role conflict for many women (Majewski, 1985).

"Today's smaller families and the real possibility of planning the birth of each child place a great resonsibility for a successful outcome on women because each child takes on increased importance" (Heller, 1986, p. 24). These societal demands, coupled with the very real physiological and emotional changes, present immense challenges for the postpartum woman. Fiscal limitations in contemporary health care delivery result in the discharge of mothers and their babies home from hospitals earlier than ever. Medical follow-up for the woman usually consists of one appointment with her physician at four to six weeks postpartum. Community health nurses often triage postpartum women in order to provide more intensive services to women having difficulties. Such

circumstances leave women to cope in new and stressful circumstances with little support or information from health care professionals.

In Canada, services to postpartum women have changed due to consumer demand and the economic constraints imposed by shrinking health care budgets. Consumer demand has been strongly influenced by the women's movement and the growth of self-help groups. Feminists have strongly argued that pregnancy, for most women, is a normal event and not a disease (Sherwen, 1987). They have openly challengd medical control over childbirth. As women and their families became increasingly aware of the problems associated with medicalized birth, they began to demand different types of services to "humanize" their birth experience (Romalis, 1981). Early postpartum discharge is one example of such an alternative which allows mothers and babies to recover from the birth experience in their home environment rather than in an unfamiliar hospital setting. Since hospital birth and postpartum care in hospital is expensive, early discharge also represents an economic solution for hospital administrators attempting to stretch their health care dollar (Romalis, 1981).

As postpartum hospitalizations continue to shorten from days to hours, there is an increased demand on community health services. The proportion of nursing resources devoted to community health services has remained relatively constant

over the past two decades (Jones & Craig, 1988). Consequently, community health services have been forced to alter their standard postpartum services, which routinely consisted of home visits to all new mothers, to provide care to mothers and babies discharged shortly after birth.

In Manitoba, postpartum care was addressed in a recent review of health services. Recommendations include the reduction of the cost of in-hospital postpartum care by the provision of a minimum level of medical and nursing care for normal postpartum patients; shortening hospital stays to 48 hours for the majority of uncomplicated vaginally-delivered primiparous women and all uncomplicated vaginally-delivered multiparous women; and upgraded and updated skills and knowledge for community health nurses in the areas of obstetrics and neonatology (Manitoba Health Services Review Committee, 1986). The report failed to acknowledge that hospital replacement services to provide more intensive postpartum care were not readily available in the community (Community Task Force on Maternal and Child Health, 1982) and further, that both fiscal and labor resources must be redistributed in order to adequately service the community (Jones & Craig, 1988).

In Winnipeg, shortened hospital stays for postpartum women have placed increased demands on community health services. Intensive postpartum care previously provided by hospital nurses has to be provided by community health nurses.

As a result, provincial community health nurses now use telephone contact as one way to assess and intervene with postpartum women rather than the traditional home visit. Every woman receives a postpartum telephone interview within the first two weeks following birth. Based on the nurse's telephone assessment, postpartum concerns are addressed by telephone or by a home visit. Telephone contact may represent a viable alternative since 98% of Manitoban households have telephones (Statistics Canada, 1990) and telephone data has been shown to be reliable in community health surveys (Aneshensel, Frericho, Clark, & Yokopenic, 1982). However, there has been little scientific evaluation of the use of telephone contact with postpartum women (Hampson, 1989).

Research evaluating the use of telephone contact with postpartum women is particularly applicable to community health nursing since the nurse is often the first health professional to reach out to the postpartum woman once she is discharged from hospital. Maternal/child health is a major community health focus and nursing assessment of mother and infant are vital nursing functions (Jones & Craig, 1988). Comprehensive postpartum care in the community impacts on the health of childbearing women and their families. Thus, determination of whether the postpartum telephone interview is an effective community health service is crucial.

Purpose

The purpose of this study was to explore and describe the use of the postpartum telephone interview as a technique to assess postpartum adaptation. Postpartum adaptation was defined as "the woman's perceptions of her abilities to cope and adjust to motherhood responsibilities and tasks" (Kutzner, 1984, p. 3).

Research Questions

1. What aspects of postpartum adaptation are addressed during the postpartum telephone interview?
2. What is addressed regarding the woman's appraisal of her postpartum experience during the postpartum telephone interview?
3. What is addressed regarding the woman's coping abilities during the postpartum telephone interview?

Conceptual Framework

This study, designed to examine the postpartum telephone contact and postpartum adaptation, was based on two conceptual frameworks; Lazarus's transactional model of stress and coping

(Lazarus & Folkman, 1984) and Affonso's conceptualization of postpartum adaptation (Affonso, 1987).

Affonso (1987) has conceptualized postpartal adaptive issues into five categories: daily activities; impact of childbirth events; mother-infant interactions; social activities and supports; and self-assessment. This framework incorportates the biological, psychological, and sociological considerations in maternal adaptation.

In Lazarus's transactional model of stress and coping, the person and the environment are viewed as having a mutually reciprocal, bidirectional relationship. This relationship takes into consideration the characteristics of the person on the one hand and the nature of the environmental event on the other. Stress is neither in the environment, nor in the person, but a product of their interplay. Stress is defined as a "particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his/her resources and endangering his/her well-being" (Lazarus & Folkman, 1984, p.19).

Cognitive appraisal is a vital component to this model. It is the "continuous evaluative process that determines why and to what extent a particular transaction or series of transactions between the person and the environment is stressful" (Lazarus & Folkman, 1984, p. 19). Three types of cognitive appraisal occur within this model: primary appraisal, secondary appraisal, and reappraisal. Primary

appraisal is judging that an encounter is irrelevant, benign-positive, or stressful (Lazarus & Folkman, 1984). Secondary appraisal consists of judgments about the coping options and consequences and reappraisal is simply a changed appraisal based on new information from the environment (Lazarus & Folkman, 1984).

Cognitive appraisal influences the type of coping response. "An encounter judged as requiring acceptance is associated with a greater emphasis on emotion-focused coping, whereas an encounter the person felt could be acted upon is associated with a greater emphasis on problem-focused coping" (Lazarus & Folkman, 1984, p. 44). Hence, the evaluative process of cognitive appraisal determines the type of coping response, whether that be an emotional response or behavioral one.

Coping is a process of "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (Lazarus & Folkman, 1984, p. 178). Coping ability is determined by the individual's resources which include health and energy, existential beliefs, committments, problem-solving skills, social skills, social support and material resources (Lazarus & Folkman, 1984). The purpose of coping is to manage or alter the problem with the environment causing distress as well as regulate the emotional response to the problem (Lazarus & Folkman, 1984).

Lazarus's transactional model of stress and coping has been used to conceptualize postpartum adaptation (Donaldson, 1987). Donaldson (1987) proposed a conceptual model which suggested relationships between maternal postpartum adaptive demands, effective coping and adaptive outcomes. Based on the findings of Donaldson's research (1987), the conceptualization of postpartum adaptation as a process appears valid.

The transactional model of stress and coping recognizes the relationship between the person and environment. This is especially important to the postpartum woman whose environment has been altered externally, by the addition of a new family member, and internally, by the physiological and emotional changes accompanying childbirth. Affonso (1987) recognizes these changes by identifying a number of adaptive issues related to the changed environment, including daily activities, mother-infant interactions, and social activities and supports. The recognition that the stress is not simply caused by the birth of an infant or the postpartum woman, but rather is a product of their interplay signifies the complexities in the transition to parenthood.

Blumberg (1980) believes that the subjective perception of the mother may be a subtle but crucial factor in maternal adaptation. The manner in which the postpartum woman views her situation impacts on her adjustment. The concept of cognitive appraisal supports this contention. The woman's perception of her reality, or her cognitive appraisal, is

vital. As a result the health care provider must attend to what is actually happening in the specific context, not what usually happens (Lazarus & Folkman, 1984). The perception of stress has a large subjective component and needs to be seen through the individual's own experience (Larsen, 1966). Affonso's (1987) emphasis on self-assessment and integration of the birth experience are consistent with these principles. The concept of reappraisal supports the processes of evaluation and reassessment which occur during maternal adaptation.

Coping is defined as both behavioral and cognitive efforts by the individual to manage stress. This definition of coping is not limited by traditional conceptualizations of stress and coping which have treated coping as a behavioral trait, style, or automatic response (Donaldson, 1987). Donaldson (1981) advocates behavioral efforts, such as strengthening situational supports, and cognitive efforts, such as strengthening the effectiveness and adequacy of maternal cognitive perceptions, to cope with the postpartum period. Coping behaviors of parents are significant indicators of family adaptation to new parenthood (Ventura, 1986). Thus, this concept is relevant to the postpartum situation.

In summary, Affonso's (1987) conceptualization of postpartum adaptation presents an overview of the major issues confronting the new mother. Lazarus's transactional model of

stress and coping is a framework to examine the process of postpartum adaptation. By blending these two perspectives, a more comprehensive understanding of the postpartum experience is possible.

Summary

The need to examine the effectiveness of the postpartum telephone interview is evident. In 1982, the Manitoba Community Task Force on Maternal and Child Health recommended the evaluation of existing program activities to assess the extent to which they are efficiently and effectively meeting the needs of the public. Telephone contact represents one activity which requires investigation. Besides the contribution to knowledge in the field of maternal/child health, research in this area has the potential to impact on community health nursing practice. Further, the results may be generalizable to other areas in community health.

CHAPTER 2

REVIEW OF THE LITERATURE

Postpartum adaptation is one of the first challenges of motherhood. Historically, the disciplines of psychology, sociology, and nursing have proposed conceptualizations of maternal adaptation as a means of understanding the new mother's experience. These ideas will first be described. Then, postpartum adaptation literature will be reviewed by examining five general postpartum stressors: daily activities; impact of childbirth events; mother-infant interactions; social activities and supports; and self-assessment (Affonso, 1987). The consequences of postpartum maladaptation will also be discussed.

The profession of nursing has always been intimately involved in promoting the health of childbearing women. Following birth, new mothers receive postpartum care in hospital settings. After discharge, community health nurses provide postpartum care in the woman's home environment. At present, community health services to postpartum women consist of either a telephone call or a telephone call and a home visit. Thus, a comprehensive critique of nursing research assessing the impact of telephone contact on maternal adaptation will be presented. Methodological considerations significant to postpartum research will also be identified. For the purposes of this review, postpartum adaptation will be

defined as "the woman's perceptions of her abilities to cope and adjust to motherhood responsibilities and tasks (Kutzner, 1984, p. 3).

Historical View of the Puerperium

From the psychoanalytic perspective, maternal adaptation is a process related to the resolution of psychologic conflicts arising from the loss of a narcissitic state associated with pregnancy (Deutsch, 1945). Deutsch's (1945) focus on maternal intrapsychic adaptation linked optimal adaptive outcomes to the unconscious reservoir of each mother's own experience with her mother. Deutsch believed that giving birth involved far more than the physical act of childbearing. The emotional issues which the new mother had to resolve required both time and energy. Consequently, Deutsch (1945, p. 274) described the postpartum period as a time of "reconstruction" for a woman.

Benedek (1956) examined psychodynamic tendencies which motivate maternal behavior and concluded that the complex maturational incorportation of emotional passive-receptive tendencies and mothering activities were influenced by the relationship which a mother had experienced with her own mother. This Freudian perspective of motherhood (Gay, Edgil, & Douglas, 1988) emphasizes the psychological experiences of

the woman, completely ignoring the possible influence of the newborn or partner. Benedek (1956) describes the "pathology" of motherhood as the woman's inability to resolve these psychodynamic issues which results in rejection of the child and depression. This conceptualization of postpartum adaptation places the sole responsibility for adjustment on the shoulders of the new mother, ignoring her external environment.

Another group of researchers (Bibring, Dwyer, Huntington, & Valenstein, 1961) introduced the concept of pregnancy as a crisis or a turning point that leads to acute disequilibria. Under favorable conditions, the birth of a child results in specific maturational steps towards new functions. This process of maturation evolves slowly in reciprocity with the child's development and with the growth of the family as an independent family unit (Bibring et al., 1961). Bibring's (1961) developmental perspective, which was based on indepth case studies of women during pregnancy and the postpartum period, provides a beginning conceptualization of postpartum adaptation as a complex process involving other family members. Further, Bibring acknowledges that successful postpartum adjustment has the potential to impact on the growth of the entire family.

From a sociological perspective a somewhat different interpretation of the transition to parenthood emerges. The sociological point of view is that the family is an integrated

social system of roles and statuses. Therefore, the addition of a new family member necessitates rearrangments in role and status interrelations within the family system. In some instances, these changes may be sufficiently stressful to some group members to be classified as a crisis experience (Hobbs, 1968). The field of family sociology had previously examined the impact of change on the family system (Lemasters, 1957). Consequently, sociologists began further investigation of the transition to parenthood.

LeMasters(1957) studied 46 middle class couples whose first child had been born within the previous five years. He assisted couples in deciding the degree of crisis they experienced following the birth of their firstborn. His findings revealed that the birth had precipitated an extensive or severe crisis for 83% of the sample. Dyer(1963) replicated this study with 32 middle class couples whose firstborn was not over two and found 53% experienced an extensive or severe crisis and 38% experienced a moderate crisis. These studies remain classics in the transition to parenthood literature despite the small non-representative samples used and the probable experimenter effects in the LeMasters study.

LeMasters' and Dyer's results have not been replicated with probability samples using questionnaires (Hobbs, 1965) or questionnaires and interviews (Hobbs, 1968). Russell (1974) investigated transition to parenthood using a large random urban sample. Her results indicated that the transition to

parenthood was viewed as only a slight or moderate crisis. Further, a number of parents reported gratifications arising from first parenthood.

Many sociologists criticized the entire conception of parenthood as a crisis (Jacoby, 1969; Rossi, 1968). Rossi(1968) questioned the incongruity of the term crisis; "if the transition is achieved, and if successful reintegration of personality or social roles occurs then crisis is a misnomer"(p. 28). Parenthood as crisis research provided little opportunity or stimulus to report affectively positive or neutral attitudes towards the adjustments required by parenthood (Jacoby, 1969). Thus, the view of the puerperium as a crisis is narrow, since this view would fail to acknowledge the pleasures and satisfactions which many new mothers experience.

Reva Rubin, a nurse, studied the psychological processes of early motherhood. In her classic 1961 paper, she described two transition phases between dependency and independence after childbirth: "taking in" (dependency) and "taking hold" (independence). The "taking in" phase, the first one or two days, was marked by a time of deep sleep before a process of regeneration began. The mother was described as passive and dependent and as having a tremendous appetite while expressing concern for her infant's oral intake and wishing to review her labor and delivery experience (Rubin, 1961). Maternal dependence evolved into independence during the "taking-hold"

phase, which usually occurred during the third postpartal day. During this period, the mother had a sense of immediacy and anxiety in regaining control of body functioning and developing maternal concern for the infant (Rubin, 1961). Frequent and rapid mood swings were common until about 10 days postpartum, at which time psychological equilibrium was restored.

Nursing researchers and practioners have practiced on the assumption that Rubin's concepts are valid (Ament, 1990). Her concept of "puerperal change" is a major theoretical basis for postpartal nursing in many current maternity textbooks (Clausen, Flook, & Ford, 1977; Miller & Brooton, 1977; Reeder, Mastroianni, & Martin, 1983; Strickland, 1983). Ament's investigation (1990) demonstrated "taking-in" and "taking-hold" behaviors and attitudes consistent with the underlying principles of Rubin's concept of puerperal change. Thus, Rubin's ideas may still be applicable for nursing practice today.

However, Gay and associates (et al., 1988, p.398) caution that "much of the information on which Rubin based her observations is obsolete today". Other researchers (Martell & Mitchell, 1984; Walker, Crain, & Thompson, 1986a) have reexamined and challenged the validity of these early findings in light of shortened postpartum hospitalizations and the societal view that the successful postpartal woman regains her independence as soon as possible.

Rubin herself has modified her ideas and no longer discusses the postpartum period in such definitive terms as "taking-in" and "taking-hold" (Rubin, 1984). Instead, what she formerly called the "taking-in" phase of the postpartum period is now discussed as a subjective maternal experience that occurs during the first three weeks after delivery. A "taking-hold" phase is never mentioned. Consequently, the importance of the concepts in question must be reevaluated and possibly redefined (Ament, 1990).

Interactionism has provided yet another perspective from which to study maternal adaptation. Acknowledgment of the infant's contribution to new mother's postpartal experience was a vital consideration which had been previously ignored. Mercer (1981, p.74) believed the infant was "an active partner in the maternal role-taking process, who affects role enactment as well as is affected by the role enactment". This perspective has served as the theoretical foundation for many studies (Broom, 1984; Leifer, 1977; Mercer, 1981, 1985). Leifer (1977, p. 92) suggested that "reactions during pregnancy are usually indicative of future mothering behavior". No previous research had traced the development of maternal feelings through pregnancy or explicated the relationship between attachment to the fetus and actual maternal behavior. Thus, the interaction between the mother and baby, even in utero, was considered to have a significant impact on postpartum adaptation.

An assessment of the conceptualizations of postpartum adaptation reveal a complex phenomena which includes biological, psychological, and sociological considerations. The discipline of psychology describes maternal adaptation as a process requiring emotional energy to resolve the psychological tasks inherent in the adjustment to motherhood. Sociologists view postpartum adaptation as a process with a profound impact on the family system. Nursing theorists emphasized the changing psychological tasks during adaptation and the importance of the mother-baby relationship. Affonso (1987) has incorporated these multidimensional facets of postpartum adaptation in her framework.

Affonso (1987) has conceptualized postpartal adaptive issues into five categories: daily activities; impact of childbirth events; mother-infant interactions; social activities and supports; and self-assessment (Affonso, 1987). These five adaptive issues reflect the psychological and emotional processes of motherhood; consider the sociological impact of birth on the family; incorporate the concept of interaction between mother and baby; and yet acknowledge the basic realities of life, that is, managing daily activities. Affonso's adaptive issues will provide a framework to review the literature on postpartum adaptation.

Adaptive Issue: Daily Activities

The postpartum period is a time of biological and physiological upheaval. Physical changes, such as involution, establishing lactation, and perineal healing, create immense fatigue and impact upon the postpartal woman's ability to perform daily activities for herself and her family. Shortened hospital stays compound those demands with less time provided for physical recovery and a greater emphasis on returning home to resume full household responsibilities. The ability to manage daily activities is an indicator of postpartum adaptation (Affonso, 1987). If a woman exhibits enduring changes from her routine functional level, such as her ability to eat, sleep, or be active, she may be more prone to unfavorable adaptation (Affonso & Arizmendi, 1986).

Affonso (1987) describes daily activities as adequate eating and sleeping habits, self-care, mood stability, and increased energy levels for managing household, infant, and family members. Primiparous women identify difficulties performing daily activities (Gruis, 1977; Harrison & Hicks, 1983; Larsen, 1966; Sumner & Fritsch, 1977) and multiparous women experience even greater demands on their time and energy. The problems of housework and routines within the family multiply with each increase in family size (Larsen, 1966) and the desire to meet everyone's needs at home remains a difficult physical and emotional task for even the most

experienced mother (Gruis, 1977; Harrison & Hicks, 1983; Larsen, 1966; Moss, 1981).

Adaptive Issue: Impact of Childbirth Events

Affonso (1977) proposed that a necessary part of maternal postpartum adaptation was the psychologic task of integrating the childbearing experience into a valuable life event. This may entail the search for "missing pieces" - certain events a woman cannot understand or cannot remember from her birth experience (Affonso, 1977). Rubin (1961) suggested the assimilation of these events occurred during the "taking-in" phase, the first three days postpartum. However, one study of postpartum support groups revealed that 48% of women under six months postpartum and 80% of women over six months postpartum identified "feelings about labor and delivery experience" as an important discussion topic (Cronenwett, 1980). The sequelae of the inability to adequately assimilate the birth experience is unknown, but it may be a significant factor in postpartum psychological distress and depression (Affleck, Allen, McGrade, & McQueeney, 1982; Affonso, 1977, Blumberg, 1980) and/or it may impact on maternal role (Mercer, 1981).

Adaptive Issue: Mother-Infant Interaction

Establishing and maintaining a healthy relationship with the infant is a major aspect of postpartum adaptation (Affonso, 1987). Benedek (1949) suggests that the mother has

an instinctual need to fulfill the physiological and emotional requirements of the neonate and further, that if such a process is surpressed the enforced changes may disturb that "psychosomatic balance which is the source of motherliness" (p. 648). Early maternal-infant separation, infant temperment, and infant illness, all factors which could affect mother-infant interaction, impact on maternal role (Mercer, 1981). Mothers who perceive adaptation to motherhood as difficult have a tendency to demonstrate fewer maternal attachment behaviors (Curry, 1983). Evidence suggests that optimal parent responses are related to optimal infant behaviors and ultimately to the coping strategies used by family members (Ventura, 1986).

Adaptive Issue: Social Activities and Supports

Affonso (1987) believes that the network of human resources that provide guidance, encouragement, and services must be activated and resumed soon after childbirth to facilitate successful adaptation. The birth of a child forces adjustment in the relationship between the woman and her partner. This transition requires balancing individual needs and new parent-child relationships with the continuing needs of the relationship between the parents (Broom, 1984). Studies have found significant associations between the quality of the marital relationship and the ease or difficulty experienced by couples in their transition to parenthood

(Hobbs & Cole, 1976; Russell, 1974). Belsky (1984) contends that the marital relationship is the first-order support system with the potential for exerting the greatest effect on parental functioning. Support from the spouse has proved to have the most general positive effects on maternal attitudes (Crnic, Greenberg, Ragozin, Robinson, & Basham, 1983) and does play an important role in postpartum adaptation (Curry, 1983; Power & Parke, 1984).

The birth of a first child affects both the social network structure and the content of the social relationships themselves (Cronenwett, 1985b). More women than men perceive an increased need for support postpartum (Cronenwett, 1985b). Often mothers are so burdened by infant and household tasks, that they sacrifice adult socializations which are seen to be of least importance amidst the many priorities in the parenting situation (Affonso, 1984). The access and utilization of social supports, such as a parents group, is a coping strategy which may influence mothering ability (Affleck et al., 1982; Miller & Solie, 1983) and have a positive effect on psychological outcomes in the postpartum period (Cronenwett, 1985a).

Adaptive Issue: Self-Assessment

The evaluations and judgments a woman makes about herself following childbirth is the process of self-assessment (Affonso, 1987). This includes considering body image, self-

confidence, hopes for the future, and perceptions of being healthy or ill. The physiological changes which accompanied pregnancy are no longer welcome to the postpartum woman who often longs for her prepregnant state immediately postdelivery. Concerns about body-image have been well documented (Donaldson, 1981; Gruis, 1977; Harrison & Hicks, 1983; Moss, 1981) and may have a profound impact on a woman's self-esteem. Indeed, the "immediate and pervasive fatigue...combined with a bulging fundus and engorged breasts, presents a disquieting picture to the woman when standing on the scale or gazing in the mirror" (Donaldson, 1987, p.23).

The woman's perceptions of her ability to respond to her infant and her confidence in that ability can also impact on postpartum adaptation. One study identified self-confidence as the most salient subjective correlate of sensitive mothering behaviors during feeding among primigravidas in the early weeks of motherhood (Walker, et al., 1986b). During the early postpartum period, many women experience a decrease in confidence regarding their mothering abilities (Leifer, 1977). This lack of confidence may generate anxiety, irritability, and emotional tension which may interfere with the use of coping behaviors (Ventura, 1986) and maternal role attainment.

Maternal role attainment is a process which was initially described by Rubin (1967a, 1967b). She posited a continuous active sequence of cumulative maternal intrapsychic and interactional operations in establishing maternal identity

including: mimicry, role-play, fantasy, introjection-projection-rejection, grief work, and identity. Mimicry and role-play are early tentative forms of taking-on the maternal role. Mimicry is the adoption by the mother of simple behavioral manifestations that are recognizable symbols of the status the mother wishes to maintain (Rubin, 1967a). Mimicry is expressed in action, such as wearing maternity clothes, or in expectations, such as birth expectations. Role play is somewhat similar to mimicry but differs from mimcry in that it goes beyond the outward symbolic manifestations of status into an acting out of what a person in this position does in a particular situation (Rubin, 1967a). An example of role play is the expectant mother participating in child care.

Fantasy and the circular process of introjection-projection-rejection occur later and are more discriminating processes of taking-in the role (Rubin, 1967b). Fantasies include wishes, fears, daydreams and dreams about the self as a mother, and about the baby. Leifer (1980) also reported prenatal and postpartum fantasy and dreaming as essential components of anticipatory preparation for maternal role-taking. Introjection-projection-rejection (I.-P.-R.) is a process in which an action begins within the mother, a model is found outside, and then the behavior of the model is matched for "fit" with the behavior or event that the mother is experiencing (Rubin, 1967a). The "fit" is then evaluated

by the mother. These processes occur as the mother redefines her role fit.

As the mother assumes the maternal role, Rubin (1967a, 1967b) states that grief work is necessary for former roles that must be relinquished. "Grief work is a review, in memory, of the attachments and associated events of a former self (role)" (Rubin, 1967a, p.243). Further, it entails a letting-go of a former identity in some role(s) that are incompatible with the assumption of the new role. Identity is the end point or goal in role-taking. It occurs when the woman has a sense of being in her role as a mother and a sense of comfort about where she had been and where she is going (Rubin, 1967a).

Mercer (1985, p. 198) defined maternal role attainment as "the process in which the mother achieves competence in the role and integrates mothering behaviors into her established role set, so that she is comfortable with her identity as a mother." Mercer (1981) maintains that maternal identity marks the endpoint of maternal role attainment, however, other researchers have found that maternal role attainment and identity demonstrate both stability and change (Walker, et al., 1986a). In Walker's study (1986a), mothers became more self-confident and positive towards themselves from birth to four to six weeks later. However, their attitudes were moderately stable across the postpartum period in that each

mother maintained the same relative position within the sample from the first to the second testing (Walker et al, 1986a).

Psychological adjustment to the maternal role undoubtedly affects the nature of a woman's interactions with her infant (Power & Parke, 1984). Those women who experience more role conflict have more difficulty in making the transition to the maternal role (Majewski, 1985). Thus, maternal role attainment is an important aspect of self-assessment, however, it is not indicative of postpartum adaptation in and of itself.

Consequences of Postpartum Maladaptation

Affonso (1987) has identified five postpartal adaptive issues incorporating the physical, psychological, and social changes which confront the new mother. A mother's ability to deal with these issues impacts on her postpartum adaptation. In some circumstances, the postpartal woman may not be able to cope with the extensive changes occuring in her life. The physical aftermath of birth, lack of rest due to the demands of the newborn, and increase in housework predisposes a woman to physical exhaustion. Having to deal unaided and unprepared with the demands characteristic of newborns may erode the new mother's self confidence. This lack of confidence coupled with isolation and confinement to the home may create

psychological distress and possibly postpartum depression (Oakley, 1980). The adjustments necessary during the postpartum period may affect the relationship between a woman and her partner resulting in marital disagreement. These possible sequalae of postpartum maladaptation impact on the health of the postpartal woman at a time when her ability to cope is limited.

Women experiencing postpartum maladaptation are often not comfortable with their baby, have negative emotions while with the baby, and cannot ward off the concern that "something bad might happen to their baby" (Affonso & Arizmendi, 1986). These feelings may result in avoidance of the baby and neglect in providing infant care. Power and Parke (1984) state that a woman's psychological adjustment to the maternal role undoubtedly affects the nature of her interactions with her infant. Contingent and appropriate maternal interaction with the infant fosters the growth and development of the infant (Donaldson, 1987). Further, Mercer (1986) reported that maternal stress had a significant negative effect on infant growth and development. Thus, postpartum maladaptation represents a threat to the infant's health.

Postpartum maladaptation may significantly affect a woman's partner as well as other family members. Stress experienced by a woman will impact on her relationship with her partner who may be unable, or unwilling, to understand her experience. Consequently, negative interactions between a

woman and her partner may occur . Power and Parke (1984) speculate that negative interactions between spouses may be generalized to interactions with the infant. Since women carry the major responsibilities for the health of their families (Heller, 1986), postpartum maladaption may also result in a woman being unable to carry out her "health guardian" function. Thus, postpartum maladaptation may jeopardize the health of other family members.

In summary, the postpartum period involves biological, psychological and sociological issues which impact on the woman as an individual, her infant, and her family. The consequences of postpartum maladaptation are both significant and far reaching. While at once universal and individual, the adaptive experience varies from birth to birth and from woman to woman (Bibring et al., 1961; Deutsch, 1945; Gloger-Tippelt, 1983). "In effect, the process of pregnancy cannot be properly understood outside the context of the broader life course of the woman" (Gloger-Tippelt, 1983, p. 135). Thus, maternal adaptation must be viewed from the perspective of the individual woman yet take into account the adaptive issues that must be resolved in order for her to function optimally within her family.

The Postpartum Telephone Interview: Impact on Postpartum Adaptation

Until recently, women had a three to four day period of postpartum hospitalization following uncomplicated births. This provided a woman with recovery time from the physical exhaustion of birth and access to health professionals, primarily nurses, for assessment, intervention, and support in adaptation to motherhood. After discharge, community health nurses visited new mothers at home to again assess their postpartum recovery and intervene as indicated.

Shortened postpartum hospitalizations have placed increased demands on community health services. Community health nurses now provide immediate, intensive postpartum care to women discharged within hours of birth as well as care to those women with hospital stays over 48 hours. Additional nursing resources to cope with the increased demands in community health have not been forthcoming (Jones & Craig, 1988). Consequently, community health nurses now use telephone contact as one strategy to assess and intervene with postpartum women rather than the traditional home visit.

There has been very little research about the postpartum telephone interview. Indeed, there is little documentation to identify even what topics are or should be covered during the telephone contact. Thus, it is possible that the postpartum telephone contact may or may not address aspects of postpartum

adaptation necessary to identify women who require further nursing follow-up.

This review will examine studies which specifically used telephone contact as an intervention strategy for postpartum women. Hotline (Elmer & Maloni, 1988) and helpline (Gosha & Brucker, 1986) evaluation studies will be excluded since they did not involve nurses. Significant methodological considerations of treatment, timing, and instrumentation will also be addressed.

Haight (1977) designed a program in which the hospital postpartum nurses telephoned the family three to seven days after discharge to provide nursing service and evaluate care received in the hospital. After three months, information from 136 calls was reviewed. Sixteen percent of the women contacted were doing fine, however, the remainder had questions and concerns. Two main findings were that the majority of problems identified occured during the first week and the most frequent questions asked, regardless of the feeding method, were about baby care.

Detailed specifics about the methodology were not provided. It is unclear what areas of postpartum adaptation were considered during the telephone contact or further, if all nurses used the same assessment format. No information was provided about the population under study. Mothers primarily asked about baby care and almost entirely neglected their own needs. This may be due to the mother's

preoccupation with the immediacy of the baby's needs; her need for information about baby care; her perception that postpartum nurses are interested and skilled in baby care; or it may be a result of limited psychosocial assessment by the postpartum nurses.

Rhode and Groenjes-Finke (1980) investigated the affect of nurse-initiated postdischarge telephone contacts on maternal concerns and maternal sources of information. They randomly assigned 99 mothers to experimental and control groups. No contact was made with the control group mothers between discharge and the six week postpartum visit. The experimental treatment consisted of one nurse-initiated telephone contact the second day home from hospital. The telephone contact included assessment and information in eight areas: self-care, baby care, family planning, rest, visitors, help, family relationships, and depression. The Utah Test Appraising Mothers, a tool with content validity only, was administered by the hospital nurse on day two postpartum. At the six week postpartum visit, a self-scoring version of the Utah Test Appraising Mothers and a questionnaire were administered as well as a personal interview. Results indicated that the experimental group used a significantly larger number of resources and had significantly more concerns about family planning. Thus, one postpartum telephone contact can impact on the woman's behaviors and attitudes.

Rhode and Groenjes-Finke's study used an experimental design to test the impact of one nurse-initiated telephone call. The randomization procedure was unclear and questionable with 62 in the treatment and only 37 in the control group. Attrition was not mentioned. Aspects of the treatment were explained and the telephone protocol provided. The pretest-posttest design strengthened the credibility of the findings. Sensitization of the sample, a threat to external validity, was avoided by having the hospital postpartum nurse complete the first version of the tool and the mother complete the self-scoring version at six weeks. The tool used had content validity, however, the self-scoring measure had not been previously used. Collection of data at six weeks to test the effect of the treatment at two days postdischarge was inappropriate. Although statistically significant results were found by the researchers, 25% of the treatment group could not even remember receiving a telephone call. Clearly, other intervening variables must have affected the outcome.

Donaldson (1987) designed a randomized controlled trial to examine the effectiveness of telephone contact. Postpartum women were randomly assigned to treatment and control groups prior to hospital discharge. The experimental mothers received six weekly nurse initiated telephone contacts for education and support, based on explicit maternal adaptation objectives. The control mothers received standard postpartum

care which consisted of a clinic visit at six weeks postpartum. At eight weeks, all mothers completed a self-report questionnaire measuring maternal and infant health status, maternal developmental expectations, maternal profile of mood states and maternal sense of competency as a parent. Results showed no significant differences between the two groups.

Donaldson (1987) clearly explicated the design and limitations of her study. The lack of significant findings may be attributed to the small sample size (n=20) and the timing of the data collection rather than the intervention itself (Hampson, 1989). No comprehensive tool was available to tap postpartum adaptation necessitating use of many related instruments with varying reliability and validity.

Significant Methodological Considerations

There is a significant lack of research in the entire area of postpartum telephone follow-up. In the few studies available, comparision is difficult since the treatment varied immensely, from six weekly telephone contacts (Donaldson, 1987) to one telephone interview (Rhode & Groenjes-Finke, 1980) and a telephone evaluation (Haight, 1977). The telephone contact itself varied dramatically in content and structure; an evaluation of hospital services (Haight, 1977);

discussion of eight general postpartum areas (Rhode & Groenjes-Finke, 1980); and a repeated structured nursing intervention (Donaldson, 1987). The hawthorne effect cannot be ignored, especially in studies with multiple contacts with the postpartum women. One study referred to the hawthorne effect noting that "mothers were helped because we cared about them, had confidence in them as mothers, valued their children, and were concerned about their development" (Gutelius, Kirsch, MacDonald, Brooks, & McErian, 1977, p. 196). Finally, the individualization of services to the women may result in a wide variation of treatment among study participants.

Timing of the intervention is a critical factor. Intervening immediately after the mother returns home can simply contribute to the stress of the experience and may, as in the case of one study (Rhode & Groenjes-Finke, 1980), result in women forgetting the intervention entirely. Timing of the measurement is also significant. Researchers (Walker et al., 1986a) have found that mothers' attitudes towards themselves became more positive over the postpartum period, whereas, their attitudes towards their babies became less positive. Therefore, measurement at six weeks represents maturational and historical threats to validity.

Selection and use of appropriate instruments is a crucial aspect of the research process (Wilson, 1985). Valid, sensitive, reliable instruments are necessary to generate

accurate knowledge about the phenomena under study. In postpartum research, many instruments are borrowed from other disciplines or simply created for a specific study. The absence of comprehensive, tested tools makes research about postpartum adaptation a difficult endeavor.

One alternative is to simply choose a tool, despite its limited testing, and use and adapt it according to the study requirements. Another technique is to measure postpartum adaptation by using a combination of instruments which results in a less comprehensive view of the complexities of postpartum adaptation. Affonso (1987) has developed an inventory of postpartum adaptation in an attempt to measure the phenomena in its entirety. However, continued revision is required for improvement of the tool.

Recently, a study was conducted to examine the relationship between women's self-reported feelings during the postpartum period and scores from observational and paper-and-pencil measures of maternal adjustment (Flager, 1990). Although the sample size was small (n=20), results provide evidence of relationships between new mothers' descriptions of how they feel and scores from observational and written instruments. "The words a woman uses to describe how she feels can provide nurses with cues regarding areas in need of further assessment" (Flager, 1990, p.415). Consequently, interviewing represents an appropriate research methodology for postpartum women.

The available research about telephone contact to postpartum women lacks comprehensiveness. Firstly, studies have attempted to demonstrate the impact of the telephone interview on postpartum adaptation. Such research is premature. One must first discover what aspects of postpartum adaptation are addressed during telephone contact. Once this question is answered, the effectiveness of telephone contact as an intervention strategy may be indicated. Secondly, despite the voluminous literature on the puerperium, little research has been devoted to the development of sensitive instruments to measure postpartum adjustment objectively. The subjective perception of the woman remains the most valid measure of postpartum adaptation. Finally, none of the available literature has attempted to elicit the woman's perspective on the service she received. If health care professionals want to implement effective programs they must seek out the consumers of the service, namely postpartum women, and request their input. The woman's perspective is a vital consideration in the investigation of the postpartum telephone interview.

Summary

Postpartum adaptation represents a complex phenomena affecting many women. Adaptation to parenthood frequently entails stress even for those women who appear to be optimally prepared for motherhood (Leifer, 1977). Postpartum stress has a large subjective component and needs to be seen through the individual's own experience (Larsen, 1966). Since no reliable and valid instrument has been developed to measure postpartum adaptation comprehensively, the postpartum woman's descriptions may be the most valid measure of her postpartum adaptation.

Because the consequences of postpartum maladaptation are both significant and wide reaching, comprehensive postpartum assessment and intervention must be available. Postpartum care in the community now consists of home visits for some women and telephone interviews for others, despite the paucity of research demonstrating the value of telephone contact. Thus, the postpartum telephone interview requires scientific investigation (Donaldson, 1987; Hampson, 1989; Rhode & Groenjes-Finke, 1980) to insure the delivery of adequate health care. Before investigating the impact of postpartum telephone contact on maternal adaptation, research to examine what aspects of postpartum adaptation are addressed during the postpartum telephone interview is indicated.

CHAPTER 3

METHODOLOGY

The methodology used in a research study must be consistent with the aims and purposes of the research as well as the conceptual framework. This discussion will detail the specific aspects of the research design; data analysis; reliability and validity; ethical considerations; and limitations of the study.

Research Design

A central theme in this research study is the woman's perspective of the postpartum telephone interview. Qualitative research "gives us the opportunity to step into the mind of another person, to see and experience the world as they do themselves" (McCracken, 1988, p. 9). It is indicated when few studies have been conducted in a particular area. The literature review revealed that there has been limited investigation of the value of the postpartum telephone interview. Since research in this area is limited and investigation of the woman's perspective is desired, qualitative research is appropriate.

The purpose of this study was to explore and describe, from the woman's perspective, the value of the postpartum

telephone interview as a technique to assess postpartum adaptation. The conceptual frameworks used to guide this investigation emphasize the importance of the postpartum woman's cognitive appraisal of her situation and the phenomena of postpartum adaptation. Because there are no valid, reliable instruments to measure these constructs, an interview with the postpartum woman represents the method most appropriate to gather this type of information. From the interview transcripts, latent content analysis could be used to identify the relevant concepts necessary to address the research question. Morse (1989b) views this type of investigation as "legitimate qualitative research".

An exploratory design was used to address the research questions. Exploratory designs use qualitative data collection methods, small samples, and a variety of forms of content analysis. They are purposefully flexible, to allow the discovery of new phenomena or gain new insights into know phenomena (Brink, 1989a). Since the postpartum telephone interview has not been examined from the postpartum woman's perspective, an exploratory design to study the topic from the participant's point of view is appropriate (Brink, 1989a). Further, the postpartum woman has participated in and experienced the telephone contact which makes her perspective especially valuable. Brink (1989a) identifies the subjects's knowledge and personal experience regarding the research topic as a consideration in the choice of an exploratory design.

Sample

In this study, the population of interest was postpartum women who have received one postpartum telephone interview from the provincial health department.

A non-probability, convenience sample was recruited from community health offices. Sample size was 15 subjects. Since the objective of this study was to explore and describe the perspectives of individual women, inclusion criteria permitted as broad a sample as possible to reflect the target population receiving this type of postpartum service. Women volunteering for the study met the following eligibility criteria:

1. Received only one postpartum telephone interview from community health services.
2. Able to read, write, and speak English.
3. Had access to a telephone in order to arrange interviews.
4. Lived within 20 miles of the city of Winnipeg limits.
5. Both primiparous and multiparous women.
6. Women who had delivered a healthy newborn.
7. Both mother and baby discharged home from hospital together.
8. Participation in the study occurred as soon as possible after the postpartum telephone interview. No women was interviewed more than three weeks after the telephone contact.

One subject indicated that she had had two telephone contacts from the community health nurse. The mother said she did not know why the nurse had called her back. Data analysis did not reveal any significant difference between her postpartum interview and any other subjects and therefore this subject was included in the sample.

Convenience sampling was used to direct data collection. Subjects whose experience was considered typical were chosen (Morse, 1989a). An upper limit of 20 participants was identified, however, the sample was deemed sufficient at an earlier point in time since the amount of new information provided per unit of added resource expenditure reached the point of diminishing returns (Lincoln & Guba, 1985). Seventeen subjects, all of whom initially agreed to be interviewed, were recruited by community health nurses. Two subjects changed their minds prior to the interview and decided not to participate. Reasons for attrition are unknown, except that both subjects (one a multiparous women and one a primiparous women) said they were simply "too busy". Fifteen subjects were eventually interviewed between the months of July and October, 1991. A methodological log was established which included sampling decisions and accompanying rationale.

The sample was obtained through Manitoba Health (provincial department of health). Once written approval was granted by the Ethical Review Committee at the University of

Manitoba, a written formal request to the Manitoba Health was submitted with verification of ethical approval and a detailed outline of the study. Revisions were made to the interview schedule (Appendix D) and "request to release potential subjects' telephone numbers" (Appendix A).

Recruitment of Participants:

During the postpartum telephone interview, the community health nurse asked the postpartum woman for permission to release her name and telephone number to the researcher (see Appendix A). If the woman agreed, her name and telephone number were given to the researcher. Subjects were contacted by telephone and invited to participate in the research study (see Appendix B). All women recalled the postpartum telephone contact. During the telephone call, an appointment was made for an interview to take place at the subject's home. Prior to the actual appointment, a telephone call was made to confirm the women's decision to participate. Before the interview, womem received a written explanation of the study, (see Appendix C) and had their questions answered.

Data Collection:

May (1991, p. 188) notes that "interviewing is the predominant mode of data collection in qualitative research". Its purpose is to get information in the respondent's words, to gain a description of situations, and to elicit detail

(Lofland, 1971). During the interview process, the researcher emphasized that the respondent's views were acceptable, valued, and important (Schatzman & Strauss, 1973). As well, the researcher took time to establish rapport with the subjects based on reciprocal sharing and trust (MacPherson, 1983).

This study used a formal, semi-structured interview procedure. The interviews were formal in that they were prearranged with informants for the purpose of detailed conversations (May, 1991). Semi-structured interviews are defined as those organized around a particular interest, in this case the woman's experience with the postpartum telephone interview, while still allowing considerable flexibility in scope and depth (Polit & Hungler, 1987). McCracken (1988, p. 7) identifies the advantages of this type of interview: "It is a sharply focused, rapid, highly intensive interview process that seeks to diminish the indeterminacy and redundancy that attends more unstructured research processes".

An important challenge in qualitative research interviewing is maintaining enough flexibility to elicit individual stories while gathering information with enough consistency to allow for comparison between and among subjects (May, 1991). Initial questions were open-ended and broad. Probes and follow-up questions were used to encourage depth and substance in responses. The interview experience was

guided by a schedule, however, freedom and variability was allowed so that women could pursue issues important to them.

The intial interview schedule is in Appendix D. The schedule was pretested and revised as dictated by data analysis or interview experience. This was noted in the methodological log. No attempts were made to structure the interview so rigidly that deviation from the questions in sequence or wording was not allowed. Indeed May (1991) notes that consistency does not require that every informant be asked all the same questions; rather, the goal is to assure that questions, which appear to be relevant at a given point in the data collection phase, are asked of as many informants as possible, so that subsequent interviews can be informed by them. One preliminary interview was conducted to determine the suitability of the questions, and acquaint the researcher with the research process. These data were not included in the analysis.

The majority of women (14/15) were interviewed once. The only exception was an instance in which there were technical problems with the equipment. As a result, that subject was reinterviewed within the specified time constraint. Interviews lasted approximately one hour and were tape-recored and transcribed by the researcher shortly after the interview. Self-transcription assisted in the analysis of the data (Swanson, 1986). Closure of the interview was tenative to allow the researcher the opportunity to telephone the

informant at a later date to clarify questions, validate analysis, or collect additional data. No additional contact with any of the study participants was necessary.

In addition, data were collected from field notes completed by the researcher immediately following the interview. These notes included nonverbal communication and contextual aspects of the interview (see Appendix F). At the end of the interview, participants were asked to complete a demographic data sheet (see Appendix E).

Schatzman and Strauss (1973) recommend the use of three types of notes as data sources for analysis. These include observational, theoretical, and methodological notes. Observational notes are statements about the events experienced through watching and listening. They contain as little interpretation as possible and are as reliable as the observer can construct (Schatzman & Strauss, 1973). In this study, the observational notes included the interview transcripts and field notes. Theoretical notes consist of statements made by the researcher to derive meaning from any of the observational notes. These notes represent the interpretations, inferences, and hypotheses made by the researcher (Schatzman & Strauss, 1973). Methodological notes are instructions to oneself, reminders, and critiques of one's tactics (Schatzman & Strauss, 1973). These different types of notes were filed accordingly to facilitate data analysis.

Data Analysis

In exploratory research, data analysis requires a "fluid, flexible, somewhat intuitive interaction" between the investigator and the data (Brink 1989a, p. 151). Qualitative data analysis involves the nonnumerical organization and interpretation of data to discover patterns, themes, forms, and qualities in unstructured data (Wilson, 1985). Analysis began with the first interview. This study used latent content analysis which is a technique to determine the underlying meaning of units of analysis within the context of the entire text (Woods & Catanzaro, 1988). The units of analysis consisted of words, phrases, or sentences from the interview transcripts. The specific units of analysis were determined during analysis.

In preparation for analysis, Wilson (1985) suggests establishing three types of files. Initially, organizational files were created. These files included observational notes, demographic data, telephone numbers, and so on. Analytic files, a second type of file, included the codes or categories developed in the analysis, theoretical notes, and the emerging analytic scheme. A methodological file was also established and included the methodological notes and methodolgocial log. This organization assisted in data analysis.

Data analysis was an evolving process. Initially, transcript data were analyzed individually, ignoring

relationships to other aspects of the text. Data from the transcript were reviewed and observations were generated in a process commonly called coding (McCracken, 1988). In the second stage, these codes were developed, first, by themselves and then according to the evidence in the transcript. Codes were renamed and collapsed into categories. Next, the interconnections and relationships between the categories were determined. In the fourth stage, the categories were defined and analyzed to determine patterns of consistency and contradiction. In the final stage, the categories were subjected to a final analysis which resulted in a synthesis of the data and conclusions by the researcher.

This analysis process was assisted by computer technology. The computer software program, Ethnograph (Qualis Research Associates), was used to assist in coding the data and for data reduction. For the purposes of this study, inductively generated codes or categories were developed based on themes appearing in the data (Wilson, 1985). Categories were evaluated according to the following criteria: homogeneity; inclusiveness; usefulness; mutual exclusiveness; and clarity and specificity (Wilson, 1985).

Reliability and Validity

Reliability and validity are vital considerations in the design of a research study. Inherent in reliability and validity is the idea of error. "Error that occurs anywhere during the research process compromises the outcomes of the study and limits the usability of the data" (Brink, 1989b, p. 153). During the design phase, the researcher established specific measures to address issues of internal and external validity; reliability; and objectivity.

Internal validity is the extent to which findings in a study are characteristic of the variables being studied and not of the investigative procedure itself (Sandelowski, 1986). Specifically, internal validity represents the truthfulness of the findings. Lincoln and Guba (1985) have proposed truth value as a means of determining internal validity in qualitative research.

The truth value of a study refers to the accuracy of the descriptions and interpretations of the experience under study (Lincoln & Guba, 1985). Lincoln and Guba (1985) suggest that credibility be the criterion against which the truth value of qualitative research be evaluated. The credibility of this study was enhanced using a number of strategies.

Firstly, in-depth interviews were tape recorded to ensure accuracy. All interviews were transcribed verbatim. Participant checks, whereby findings can be validated with

subjects, were built into the design, so that the researcher could contact the subjects following the interview if necessary. Triangulation of data sources was also used, specifically verbatim transcriptions of the interview and field notes from the interview. Lastly, a reflexive journal was established and maintained throughout the study to provide information about the researcher's involvement in the research process. This journal included a daily schedule and logistics of the study and a personal diary that provided the opportunity for catharthis, for reflection upon the research process, and for speculation about insights. Sandelowski (1986) suggests that credibility is enhanced when investigators describe and interpret their own behaviors and experiences as researchers in relation to the behavior and experiences of subjects.

Sandelowski (1986, p.31) refers to external validity as the "generalizability of findings and the representativeness of subjects, tests, and testing situations". "Since qualitative studies seek to describe and explain phenomena, the point of the research is not generalizability" (Brink, 1989b, p.157). In keeping with this principle, Lincoln and Guba (1985) suggest that applicability be considered in qualitative research. Applicability is the extent to which findings of one study are transferable to other subjects or contexts (Lincoln & Guba, 1985). This criteria was met by

providing complete and clear description of the subjects, context, and sampling procedures.

Reliability refers to the consistency, stability and repeatability of the informants' accounts as well as the investigator's ability to collect and record information accurately (Brink, 1989b). Consistency determines whether the study findings would be repeated if the study were replicated with similar subjects in similar circumstances. Lincoln and Guba (1985) propose that auditability be the criterion of merit relating to the consistency of qualitative findings. "A study and its findings are auditable when another researcher can clearly follow the "decision trail" used by the investigator in the study" (Sandelowski, 1986, p. 33). In this study, the researcher documented methodological decisions in a log. As well, the decision trail used by the researcher was verified by the thesis chairperson.

Brink (1989b) suggests that equivalence is the reliability check of choice. Equivalence was established by using alternative form questions within the interview; by transcribing field notes from the interview; and by tape recording the interview. These measures enhanced the researcher's ability to collect and record information accurately.

Objectivity is a final consideration in the research design. Qualitative researchers refer to neutrality rather than objectivity (Lincoln & Guba, 1985). Neutrality is the

freedom from bias in the research process and product (Sandelowski, 1986). Lincoln and Guba (1985) suggest that confirmability be the criterion of neutrality. Confirmability is achieved when auditability, truth value, and applicability are estabilished. The major technique for establishing confirmability was the confirmability audit. This audit uses a trail of raw data, data reduction and analysis products, data reconstruction and synthesis products, process notes, and materials related to intentions and dispositions (Lincoln & Guba, 1985). The provision of a scheme for data analysis enhanced auditability. In addition, the audit trail was supervised by the researcher's thesis chairperson.

Ethical Considerations

Measures were taken to ensure the rights of all participants in the study. Detailed written and verbal explanations of the research project were provided in advance. A written disclaimer was included in the written explanation (see Appendix C). Subjects' agreement to be interviewed was indicative of their consent. Participants were informed that they might withdraw from the study at any time, and that refusal to participate in no way influenced any future community health services which they might require.

Study participants who agreed to participate were told that they need not answer any questions with which they felt uncomfortable, and that the tape recorder could be turned off at their request. At all times, confidentiality and anonymity were maintained. Identifying data was not included in field notes, transcripts, or tapes. Participants were identified by code numbers only, with only the researcher having access to the identifying data/code number combinations.

All information sources - including tapes, transcribed notes, consent forms and demographic data sheets- were kept in a locked filing cabinet. At completion of the study, all tapes and transcripts were be destroyed. Publication of research results will maintain the anonymity of all study participants. A written summary of the results was provided to participants who indicated an interest.

Limitations

This exploratory study has limitations. Despite attempts to control for the trustworthiness of results, validity may be in question due to the single cross-sectional nature of the interview (Brink, 1989b). Common to all exploratory designs, there is a lack of replicability. No single researcher could return to the same subjects, ask the same questions, and receive the same answers (Brink, 1989a). Lastly, women were

being asked to retrospectively evaluate their experience with the postpartum telephone interview. Consequently, there is a risk that the woman's memory of the experience was inaccurate or her perceptions were altered by events which occurred after the telephone contact. These limitations will be considered in the final analysis of the study.

CHAPTER 4

RESULTS

In this chapter, the findings of the study will be presented. Following a description of the sample, the three research questions are discussed. They are: what aspects of postpartum adaptation are addressed during the postpartum telephone interview; what is addressed regarding the woman's coping abilities during the postpartum telephone interview; and what is addressed regarding the woman's appraisal of her postpartum experience during the postpartum telephone interview. Categories which emerged during data analysis will be defined and presented in relation to the appropriate research question. A summary will conclude the chapter.

Description of the Sample

The sample consisted of 15 women, ranging in age from 22 to 35, with a mean age of 28.8 years. Fourteen of the fifteen women were married. All of the women had completed high school. Seven subjects had acquired additional formal education, including two women with baccalaureate degrees and three women with technical training. The majority of the women (11/15) were employed outside the home, six full time and five part time. Ten women planned to return to work, four

full time and six part time. All subjects were Canadian citizens and 13/15 spoke English in their home. One subject spoke French at home and the other subject reported English and Italian as languages spoken in the home.

Three primiparous and 12 multiparous women were interviewed. One subject had a planned cesarean birth, the remainder delivered vaginally. The majority of the women breastfed their babies (9/15), three women exclusively bottlefed, and three women breast and bottlefed. Ten of the twelve multiparous women had other preschoolers to care for on return from hospital. The amount of help subjects received on return home from hospital varied from none (n=3) to two months with an average of 10 days.

In summary, the sample consisted of well-educated women who experienced relatively uncomplicated births. The majority of these women (12/15) had additional family responsibilities and the majority (10/15) planned to resume an active role in the workforce.

Aspects of Postpartum Adaptation

During the interview, subjects were asked to recall the entire pospartum telephone interview and were then questioned about specific aspects of postpartum adaptation which might have been discussed. The researcher's objective was to gain

as much information about the interview as possible. Women recalled information they provided to the nurse and information the nurse provided to them as well as questions the nurse asked them and questions they asked the nurse. Interview transcripts were analyzed to identify the various topics discussed and their relationship to one another. These topics were coded by category. Categories were defined and each coded piece of data was compared to the category definition to insure consistency and to qualify the definition if necessary.

From the subjects' description of the interview, three main categories were identified as aspects addressed during the postpartum telephone interview. These were: condition, action and reaction. Each category will be described and discussed.

Condition

During data analysis, the category "condition" emerged most frequently. A condition was defined as a status report of present and past states experienced by the mother-baby dyad. The physical condition of the mother and the baby was a major focus of the postpartum telephone interviews and was often a starting point of conversation between the mother and the nurse. Mother #5 described the discussion initiated by the nurse:

> She asked different things like how my nipples were doing, if they were cracked...She asked if I had hemorroids and the bleeding, how the bleeding was going.

In another interview, Mother #8 summarized:

> She pretty well asked me everything about my recovery from whether I had had a bowel movement to how I was doing physically...how my bleeding was...

As well, women initiated conversation about their physical recovery. Mother #14 recalled:

> I mentioned that it [the episiotomy] was really itchy... I mentioned that I was still bleeding fairly heavily ... I thought after a week I should have slowed down.

In five cases the nurse asked about past states, specifically about childbirth events. These questions focussed mainly on the physical nature of the labor and delivery.

> [The nurse] asked if it was a natural delivery and it was very fast and she asked how I felt after and how long it took me to get back on my feet and basically how my body felt and aches and pains and anything like that (Mother #5).

At times it was difficult for the researcher to determine the depth of discussion between the nurses and the women about their condition. For example, Mother #6 described a past

condition which she reported to the nurse, however, it was unclear if she reported the effect of that condition to the nurse.

> I had a problem... I had clots in the cervix... and every time they came to check me I was bleeding like crazy and then the blood pressure machine went off... so when I came home my iron and my hemoglobin was just down to almost nothing and I was exhausted. I was crying on the snap of a finger. It was really tough. I couldn't do anything basically but sleep (Mother #6).

The discussion Mother #12 recalled about her episiotomy was limited to the physical effects of the condition:

> The episiotomy was quite bad so she was asking about ... how it was ... its getting better all the time but it was quite bad because he was a big baby. He was 9'10 oz...

The debilitating effect of this condition was not shared with the nurse:

> The first few days at home were hard because I was really sore and we have a lot of stairs ... his room was upstairs of course so the first couple of days were difficult (Mother #12).

The category condition also included the physical status and behavior of the newborn. In this interview, Mother #9

recalled the discussion with the nurse about her newborn's feeding behavior:

> One thing [the nurse] did ask about was about the number of times she was pooping and peeing and that sort of thing per day. And I said that she had at least six diapers per day ... that's the guideline isn't it? And she said yes it is. And I asked her about the color of the poop. And I told her it was kind of a yellowy color and she said yeah with a breastfed baby that's normal. And she was describing what diarrhea would look like...

Mother #11 asked the nurse about her baby's behavior:

> I said she seemed to have a lot of gas and would cry for hours...

Mother #14 questioned the nurse about her newborn's appearance:

> She had some bloodshot lines in her iris or in the whites of her eyes and I mentioned that.

During an interview with Mother #9, the nurse asked about the past condition of the baby:

> [The nurse] mentioned that she had heard that the baby had a collapsed lung when she was born and she was wondering if that was all rectified and I said yes that we had been for another xray this past week and her lung was fully expanded and the same as the other.

Conditions were discussed in every postpartum telephone interview and are obviously viewed as important considerations by both the nurses and the mothers. Conditions were very specific events. Women recalled the identification and discussion of various conditions, but frequently the condition was dealt with as an individual state rather than in the context of postpartum adaptation.

Action

During the postpartum telephone interview, conversation often centered around what the mother was "doing". Further analysis of the data revealed discussions about the activities and behaviors of the mother and her family. These behaviors merged to create a second category - action. Action was defined as purposeful present and future behavior to meet the needs of the newborn, postpartum woman, and her family. Actions of the mother were most frequently discussed. Breastfeeding was one example:

> It was more the concern with feeding and that. I know that because I was breastfeeding. It was is she taking the nipple fine and that kind of thing...(Mother #1).

[The nurse] asked if I was nursing and how that was going and if it was going good and all that... And I told her I was waking him up and she was wondering why...(Mother #3).

Actions related to newborn care were another topic of conversation. Mother #1 stated:

> [The nurse] did bring up taking the temperature and how to do that which, like I said, it was a good reminder.

Mother #4 described the discussion about the baby bath:

> [The nurse] had asked if they had gone into detail in the hospital, if they had shown me how to bath him and that kind of stuff. I just basically said actually I never really went into any bath demonstrations or anything in the hospital because its something you don't really forget.

Often the nurse would ask the mother about behaviors used to meet her own physical needs:

> [The nurse] asked if I was getting enough rest... and if I was eating well...(Mother #3).
>
> [The nurse] asked me if I was getting enough rest definitely... if I was eating enough...(Mother #6).

These previous examples of action are behaviors performed by the mother. However, action also included behaviors performed by the partner or extended family. Again, the behavior is purposeful with the goal of meeting the needs of the entire family. For example, Mother #9 described the actions of her own mother and spouse:

> I had told her [the nurse] that my mom had come for a week and she stayed and did pretty well

> everything so basically I only had to look after [the baby]. And my husband was also on holidays so he was around to do things as well.

Multiparous women described the actions of their partners in relation to caring for the older child:

> Well [the nurse] asked if my husband was helping. And he had some time off while I was in the hospital taking care of my older one but then he had to go back...but [my husband] comes home and he takes care of [my older child] after work (Mother #10).

> [The nurse] asked if I had any help during the time I came home and I did. My husband was off for a week that next week...and was just taking [the older child] for a while (Mother #15).

There were also examples of future action in the interview transcripts. Mother #1 talked about child care:

> We discussed me going back to work... and whether I had had somebody to look after the baby already ... and because I had done it with [my other child] it seems like it is just the way it's supposed to go.

Two of the three primigravidas recalled discussions about future contraceptive/sexual behavior.

> [The nurse] asked whether or not my husband and I had discussed birth control and what we were going to do about that (Mother #11).

> [The nurse] asked about when to resume sexual intercourse and I had mentioned we covered all of that in our prenatal...and it was quite thorough and very good (Mother #13).

Action was a major category addressed during the postpartum telephone interview. Present activities, such as newborn feeding and self care, were regularly discussed whereas future behaviors, such as contraception and child care, were the exception. As well, conversation focussed on the actions of the mother with only vague reference to help or the presence of the partner. The actions of the woman's partner were generally neglected.

Reaction

During data analysis, a general category labelled reaction emerged. Reaction was defined as a response to an experience. There was a great deal of variability in the depth and specificity of each reaction. Thus, reaction was divided into two sub-categories, namely, general reaction and specific reaction. A general reaction was defined as the woman's assessment of her postpartum experience. A general reaction included women's responses to questions like "how are things going?" and "do you need a visit?". As well, questions about postpartum blues were coded under general reaction because women responded to those inquiries in a very rhetorical manner. An inquiry like "have you had any baby

blues?" ellicited a "yes" or "no" response. Every transcript had at least one example of general reaction. Mother #2 provided an example of the nurse soliciting a general reaction:

> [The nurse] asked me how things were going with the baby and I said things were going fine. And she asked if I needed her to come down. If I felt that I needed her to come down and I said no, not reallly... If I was feeling down at all and I said no, it hasn't hit me yet, not like it did with the other two. I don't think it will because so far everything is going good.

Mother #1 summarized her experience:

> It was basically did I want her to come out or was I comfortable and at the time I felt comfortable. I felt fine with myself, nothing physically wrong ... so I didn't need or I didn't feel I needed a visit.

Women's general reactions varied. Mother #13, a primigravida, gave this reply when the nurse asked about how she was "doing overall":

> Tired. I was just tired...

This response was coded as a general reaction, instead of a condition, since it is the woman's assessment of her postpartum experience. Fatigue overwhelmed this mother in her first few weeks at home:

> I was finding it hard to sleep because I wanted to do things. But eventually I was feeling really tired ... I was getting too tired ... I guess I thought I could do it all (Mother #13).

General inquiries about emotional adjustment were also coded under general reaction. This included questions about "postpartum blues".

> [The nurse] also talked about postpartum blues which I said I had no problem with... She only asked if ... I was feeling depressed or any crying or anything like that. And I said no and that was about it (Mother #3).
>
> [The nurse] was asking about postpartum blues and things like that but I really was familiar with that already or can't say I really had any problem with it the first time or the second time (Mother #12).

Specific reaction is a sub-category of reaction. This category included the specific reactions of both the postpartum woman and the siblings of the newborn. In every case where there was another child present in the family, the nurse asked about the specific reaction of that child to the new family situation. The specific reaction of the sibling was defined as the behavioral response to the addition of a family member. For example:

> [The nurse] asked about jealousy and things like that and just if there was any reaction there ... he's been very good... oh, she wants to know how he reacts with less attention (Mother #5).

Mother #1 recalled:

> One thing we did discuss was how to handle sort of the sibling rivalry kind of thing because I was concerned about, you know, what would happen or what could happen and that kind of thing.

Specific reaction of the woman was defined as the mother's emotional response to particular aspects of her postpartum experience. Women expressed a wide range of specific reactions from anxiety and guilt to joy and comfort. Mother #7 described how the reaction of her older child affected her emotional adjustment:

> [The nurse] asked me how I was doing emotionally and everything. And I said, oh I was okay, but, you know, the odd burst of tears ... a lot of it was over just feeling bad ... because we'd had a lot of visitors and then [my older child] would get excited and hit the baby or hit the other kids who were over here and it was getting to me...

Mother #6 recalled her conversation with the nurse about considering bottle feeding instead of breastfeeding:

> I was feeling really guilty about considering not nursing at all when I had nursed the first. I had

> this real fear about not doing kind of the same for both of them.

In another interview, the nurse inquired about the parents' emotional response to their newborn's behavior:

> She asked if we were having a lot of anxiety in dealing with her when she was crying...like that can get on people's nerves...(Mother #11).

During the telephone interview, women shared positive emotions about their postpartum experience. Mother #4 described her feelings about her relationship with her newborn:

> I felt very comfortable with him, very confident with him and you know he's a good baby. No problem.

Mother #5 conveyed similar feelings to the nurse:

> I'm much more relaxed with this one. This one is actually probably a little more enjoyable in that way...you know you just don't fear everything, everything is not so scarey. It's a lot more enjoyable that way.

General reactions of women to their postpartum experience were always solicited by the nurses. Additionally, in every case in which a sibling was present the nurse asked about the specific reaction of the sibling to the new baby. Rarely, however, did the nurse ask about the adjustment of the father (1/15). Specific reactions of the mother were often revealed

in general discussions with the nurse. In most cases, women did not recall specific questions about how they were feeling about postpartum issues. Consequently, fewer specific reactions were revealed during the postpartum telephone interviews.

Coping Abilities

The second research question was, what is addressed regarding coping abilities during the postpartum telephone interview. Women were asked to recall what suggestions were given to them by the nurse to help them cope with a particular issue. As well, women were asked how they were coping with certain issues. The transcripts revealed coping styles encouraged by the nurses as well as coping behaviors reported by the mothers. These data were further condensed into four categories: do something; learn something; think something; and feel something. Each category will be further discussed.

Do something

"Do something" was a dense category which emerged during data analysis. It was the most common response given to mothers by nurses to help them deal with concerns such as baby care and sibling rivalry. "Do something" was defined as implict or explicit directions to the mother. Explicit

directions to mothers about their own physical recovery were frequent. For example:

> [She told me] not to do too much of course because, as I said, I felt fine so I [was] running around ... it was sort of to slow down, not to over exert yourself and wear yourself out. With the stitches care it was just more like, if they do end up getting sore, you want to sit in a hot bathtub or shower or that kind of thing (Mother #1).

In another case, the nurse instructed the mother about circumcision care:

> She told me just to soak him in warm water and that it would slowly come off but not to pull it off or anything like that (Mother #3).

The nurse provided advice to Mother #6 to cope with fatigue:

> Well definitely a lot of rest...[the nurse] suggested lots of fluids just to make sure with the nursing and just to relax because I needed my energy for nursing...

Suggestions to cope with sibling rivalry were common.

> [The nurse] said to just read her a book if I could and have her sit with me while I was feeding that that tends to help, which I have done (Mother #14).

Implicit directions were actions on the part of the nurse which provided the mother with a cue to future action. Mother #1 recalled:

> [The nurse] left her name and that and sent a card.

Both the nurse's name and her card are cues to prompt the mother to call with questions or concerns. In Mother #3's case, the nurse provided cues and explicit directions.

> [The nurse] said that if ever there was a problem I'll leave a card with my name and number that you can always call whether its convenient or not, days, or weeks, or five years.

Again, the basic message is "do something" such as call if questions arise.

"Do something" was a common direction given to mothers. It was a frequent response by nurses to a troublesome "condition" or "action". Women were very receptive to the advice given to them during the postpartum telephone interview, especially if it was congruent with their current behavior, and they frequently followed the suggestions. At other times, however, the advice contradicted their current behavior. In those instances, women accepted the advice on the telephone but did not "do" what was suggested.

Learn something

"Learn something" was another common coping strategy given to mothers during the postpartum telephone interview. The category "learn something" was defined as direct or indirect education to increase the mother's knowledge of various aspects of postpartum adjustment. Direct education

was teaching about a specific postpartum concern. In the following interview, the nurse provided teaching about self-care:

> [The nurse] told me that if ... [the lochia] smelled any different than normal menstrual flow then it was something to be concerned about in case there was infection (Mother #14).

Frequently, the nurse was asked questions about infant feeding.

> I had asked [the nurse] about food ... like is milk all he needs and for how long and she says well up to four months my milk is all he really needs and if I lived in a place without air conditioning she could see him needing some water but, if its air conditioning and so forth, my milk is enough...(Mother #13).

Experienced mothers also inquired about feeding. In the next example, a mother of three tries to discriminate between the teaching she received in the hospital and the teaching she received during the postpartum telephone interview.

> Oh, and the feeding. How much he's supposed to have ... I said to [the nurse] ... he wants to eat every two hours and she said to me it ranges from two to four...She said very seldom do you get a baby that goes every four hours. And basically it is more two to four but more like two to three.

> So, anywhere in there...They said in the hospital a bottle fed baby is supposed to be every four hours and no more than that (Mother #2).

In another example, the teaching by the nurse had a warning tone:

> If you get yourself too run down with [caring for your other child] sometimes your milk will stop (Mother #6).

"Learn something" included indirect education to the woman. Indirect education was defined as the provision of educational materials and opportunities for the new mother. Mother #7 provided an example of indirect education:

> [The nurse] offered, you know, do you want this or that or this type of information? ... She gave me some information on toddler feeding because she knew I had an older one and on the baby's feedings and on birth control.

Mother #3 had a similiar experience:

> She asked if I wanted any other information. [She said] that she would mail [it] out to me and so she did, on siblings and jealousy and discipline and breastfeeding...

The underlying message was for the mother to "learn something" from the resources provided.

The nurse provided Mother #13 with a learning opportunity in the form of a class about infant feeding. This was another example of indirect education.

> [The nurse] mentioned that there is a class or something that I can go to on [infant] feeding.

Women were very willing to "learn something" about an issue which was a concern for them. During the postpartum telephone interview, women were provided with information about infant feeding and postpartum recovery. As well, mothers were offered written materials on a variety of related health topics, such as child health, and accepted the information eagerly.

Think something

During the interview with the researcher, women were asked about how they were coping with specific aspects of their postpartum experience. At times, women identified coping strategies to the researcher which were not always discussed during the postpartum telephone interview. These comments were included in data analysis and were particularly significant in the identification of a less dense category labelled "think something". "Think something" was defined as rationalizations made to alter the mother's perceptions. These rationalizations were internal, namely made by the mother herself, and external, meaning made by anyone else. There were many examples of women "thinking something" in

order to cope with their postpartum experience and few examples of the nurse encouraging the mother to "think something". Following is an example of "think something" in which Mother #7 explained to the researcher her thoughts about taking time out for herself away from her children.

> The first time it was very, very hard to let go. And now I know you can let go and things are still fine ... you need to give yourself that time. You need to live your own life too.

Mother #13 described to the researcher how she coped with her fatigue by altering her perceptions:

> I was finding it hard to sleep cause I wanted to do these things. But eventually I guess I was feeling really tired ...I guess I thought I could do it all you know, but that's just what you have to do. Relax when you can.

In another case, a mother who experienced what she called "postpartum depression" with her second child rationalizes a difficult day after the birth of her third child.

> Yesterday I would have to say, since the baby's been home, was the worst day. Because the baby was up basically from eight til three and I had started getting frustrated because kids were in the house all day [saying] "Mom this Mom that" ... [but] yesterday it wasn't even like a depression it was

> just a hard day trying to satisfy all of them at the same time (Mother #2).

Indeed, Mother #15 endorsed the idea of controlling your thoughts to cope with the demands of motherhood.

> I guess I'm what you call a natural mom...if you're not handling things fine and you're getting all stressed out you're going to make the baby worse, so I just let things just flow...I don't panic.

Women would "think something" to deal with negative feelings and experiences. Mother #6 explained how she coped with guilt:

> I was finding I was feeling really guilty. I thought I should be bathing [my baby] every single day and I got myself to the point where I figure he's not outside playing in the mud and I clean him well when he goes to the bathroom so I figured every second day to give him a bath was good enough.

Mother #12 described a horrifying birth experience of pain and lack of attention and then attempted to rationalize it.

> It probably wouldn't have been so bad I if I had had something for the pain you know. But ... a lot of women have it a lot worse I'm sure, so 27 hours isn't as bad as some people.

These were all examples which were shared with the researcher but were not discussed with the nurse during the postpartum telephone interview.

Sources external to the woman may direct her to "think something" to deal with a particular situation. In one situation, the nurse encouraged the mother to "think something" in order to cope with newborn crying.

> Instead of trying to run around doing something for [the baby] just accept her crying and try putting up with it (Mother #11).

In a final example, Mother #6 described to the researcher her use of an external source "they", meaning other people, to provide rationalization for her lack of immediate maternal feelings.

> Those maternal feelings didn't just come flowing out when he was first born like they did with [my daughter]... I think it's like they say sometimes with some of your children you just love them from the very minute and some of them it takes you a little while to get into it and with him I think it took me a couple of times or a couple of hours or whatever.

It is evident that new mothers use cognitive restructuring to cope with a variety of postpartum issues. The rationalizations of the mothers illustrates that process. Nurses, however, rarely encouraged women to "think something"

to deal with a postpartum concern even though that might have been an effective intervention.

Feel something

A fourth coping ability which emerged during data analysis was "feel something". This category was identified from descriptions by the mothers about the postpartum telephone interviews as well as from the women's conversation with the researcher. "Feel something" was defined as statements or behaviors which provoked a positive emotional response in the mother. This coping response had both internal and external sources. Internal sources were behaviors and statements from the mother. For example, Mother #4 discussed with the researcher how she coped with a very trying childbirth experience.

> This time when I look back on it I didn't feel guilty because I did my best, I did my breathing, I tried as long as I could and then I took it when I really needed it so I didn't feel bad at all at about having had something you know.

The goal of this rationalization is a positive emotion or to not "feel bad".

Mother #5 explained to the researcher the importance of taking time out away from the children (a behavior) so that one can feel good about their family life (an emotion).

> [It is] very important to get out ... because then you come home and you appreciate things more. If you're stuck inside with two kids all the time ... you have to be away from someone to be able to appreciate them when you come back.

Sources external to the mother also played an important role in generating positive feelings which helped the mother cope. Mother #5 explained the effects of her spouse's behavior:

> You know, it helps having a supportive husband too, up in the middle of the night with you, so you don't feel like you're all by yourself ... like he'll burp him after I feed him ... so it's not like ... it's all my responsibility sort of thing. That helps an awful lot. Mentally and physically.

Frequently, women recalled statements the nurse made during the postpartum telephone interview which generated positive feelings. In one conversation, the nurse discussed newborn crying:

> Well, she said, I think the thing with the baby crying was that you have to realize that it's not your fault and that there may be nothing wrong with her. It's just that she feels like crying (Mother #11).

In another interview, the nurse was empathic with a woman's concern about becoming bored amusing her two year old:

> And [the nurse] said, you know, its very hard to find what you do with small children mentally stimulating. You know, when you see them stimulated, great ...I mean 1-2-3 is stimulating for them but its not very stimulating for you (Mother #6).

In this same discussion, Mother #6 expressed her concern to the nurse about not enough love for two children. Mother #6 recalled the nurse's response:

> She also said some people have five, six, and seven kids and all the kids are very happy and very loved, ... so you don't have to worry about it.

Often, as a result of teaching by the nurse or "learning something", women would also report positive feelings. These statements were also coded as "feel something" since the result was a positive feeling which enhanced coping. Mother #3 discussed newborn feeding with the nurse and "felt better". She was reassured. She continued:

> So then when he wanted [to eat] every two and a half hours I was a little concerned but after [the nurse] said not to worry about it (Mother #3).

Mother #14 was relieved by the nurse's explanation of her three year old's response to the new baby:

> [The nurse said] that it was fairly normal and that [my daughter] would eventually come around.

Reassurance and normalizing behaviors by the nurse often produced positive feelings in the women.

Although the majority of the sample were experienced mothers, emotional support during postpartum adjustment was both valued and accepted. Statements made by the nurses during the postpartum telephone interviews produced positive feelings in the mothers. As well, women made conscious efforts on their own behalf, in both thought and behavior, to "feel good" about their postpartum experience. Thus, "feel something" is a legitimate focus for intervention with postpartum women.

Women's Appraisals of Their Postpartum Experiences

The final research question was what is addressed regarding women's cognitive appraisals during the postpartum telephone interview. Data about cognitive appraisal were gathered from two sources. Firstly, all subjects reported that during the postpartum telephone interview the nurse attempted to solicit a "general reaction" from them. This was one example of a cognitive appraisal. A second source of data about cognitive appraisal came from the interview with the researcher in which mothers were asked how they were coping with specific postpartum issues. These two data sources and the concept of cognitive appraisal will be further examined.

In every postpartum telephone interview, subjects reported discussions with the nurse about their general reactions to motherhood. In addition, the majority of the women reported that the nurse asked them how they were doing and if they needed a visit. Using this approach, the nurse attempted to solicit the woman's appraisal of her postpartum experience and allow her a choice about further intervention. No subject reported difficulties with postpartum adjustment which would require a home visit. In a few instances, however, women recalled circumstances which would make it difficult for her to ask for help. For example, Mother #4 stated:

> She just basically asked me just how I was doing ... we really didn't go into a lot of detail about it cause she seemed to think I was getting along fine so we really didn't get into a lot of detail.

Mother #5's experience was similar.

> She asked if she needed to come out and ... she said by the sounds of it she doesn't have to.

Conversations such as these may make it difficult for women to ask for assistance since the message they receive from the nurse is that they are coping well.

During the interview with the researcher, women were asked about specific issues, generated from the literature and based on Affonso's conceptualization of postpartum adaptation, which may have been discussed during their telephone

conversation with the nurse. Although these women were "doing fine" in a very general sense, many had concerns. Women identified emotional issues related to feelings about childbirth, resuming relationships with other adults, and feelings about their relationship with the newborn. Occasionally, the nurse was able to identify and discuss the issue with the woman, however, frequently no discussion occurred.

Resuming relationships with other adults was one area neglected during the postpartum telephone interview, however, 9/15 women expressed their specific concerns to the researcher. Here is one example:

> I feel a desire to get out of the house ... after he was born I was feeling a bit smothered being at home all the time, not getting out... But there was no adults to talk to because all my friends were at work and there are lots of people on the street with lots of babies but they all had them last year. They're all at work so there was actually not really anybody to talk to (Mother #4).

This theme of isolation from other adults continued to surface during the interviews. Mother #6 explained:

> I feel like sometimes an intellectual conversation would be wonderful. You get a little bit tired of the goo-goo gaa-gaa. And you know playing with the toys and stuff like that. That part of its tough.

Being inside all day long was particularly trying on women whether or not they had been working outside the home previously. Mother #5, a "stay at home mother", talked about her situation:

> Just to be able to go to Safeway or ahh, oh, can I do the shopping please?...I mean its nice to get away from the responsibilities for a little while.

Another mother described her feelings:

> You feel bogged down and it kind of hits you. ... so even just one week [inside] and it kind of gets to you and you think oh boy! (Mother #7).

An experienced mother who had been working verbalized her feelings:

> All of a sudden here I am at home all day. It is a bit of a shock. That I'm finding more difficult to get used to than anything else (Mother #12).

Women's thoughts and feelings about their childbirth experiences were not often discussed. Women did recall questions about length of labor, medication used, medical interventions etc. but rarely did women recall discussions about their feelings about their labour and delivery. One third of the sample expressed extremely negative feelings about their birth experience. Mother #13, a first time mother, explained:

> I found it hard really hard ... I didn't expect [the labor] to go on so long... I didn't know how

> long [the pain] was going to go on. But [the labor pains] were so bad I was surprised at how long [the labor] did go on...[it was] bad in the sense like it's great and everything when he's born but just like that whole time sort of turns you off.

The theme of pain was evident in other descriptions of difficult childbirths.

> The labor was extremely difficult...[the contractions] were just absolutely unbearable and with my first one they weren't unbearable until an hour and a half before he was born. And the pain was just absolutely unbearable, I didn't want to lie on my back cause I had back labor... [this labor] was a lot worse, about a thousand times worse (Mother #4).

Another woman expressed her feelings about her medical care during childbirth:

> I felt that I wasn't really given the attention that I should have. Like I was in labor for 24 hours and then finally after 24 hours I was 10 centimetres dilated and he said the baby's head was really big and they'd have to use forceps and then I didn't see him for 2 hours...it just seemed like I was left alone too long I felt (Mother #12).

Unfulfilled expectations complicated women's interpretations of their experiences. In a final example, Mother #14 explained:

> I was a little disappointed. I figured it would be easier. Just the delivery took just about an hour to push her out and that and I got really really tired... like I just didn't think I could do it. [I felt] just helpless... I figured it was going to be a little easier this time but it wasn't.

Two subjects expressed specific concerns about their relationships with their babies. In one instance, a first time mother struggled with her newborn's crying:

> I said the baby was screaming for hours and I think...I think when she called I think in one 24 hour period she had slept six hours (Mother #11).

In this particular example, the nurse was able to intervene and assist the family. In the other case, an experienced mother had a very difficult time with her newborn.

> She's driving me nuts... Cause it's like she stays up more than my first one. My first one was like sleep four hours, eat, and go right back to sleep. This one eats and she stays awake. Then she eats some more. She's constantly nursing...I don't know if she wants to nurse all the time or if she just wants to suck cause she has a soother but she spits

that out half the time... It is still hard to know what she wants (Mother #10).

Again, this mother reports "all is fine" to the nurse but expresses specific difficulties coping with her newborn.

The category "general reaction" indicates that the woman's responses to her postpartum experience were considered. Despite reporting favorable general reactions, however, many women have specific issues which may require further exploration and possibly intervention. A positive general reaction only indicates that at that particular time the mother may not require intensive intervention. A positive "general reaction" does not distinguish between women who are coping well in all aspects of postpartum adaptation and women who are having difficulty coping with specific aspects of their postpartum experience.

Theoretical Relationships

The categories which have been discussed were derived from the subject's recollections of their postpartum telephone interview. Another aspect of the findings was the development of order between the categories. This order was most evident among the richest categories. During analysis of the transcripts, it appeared that when mothers discussed a "condition" or an "action" nurses were likely to suggest that

the mother "learn something" or "do something". When a "reaction" was identified, "feel something" or "think something" was the more likely response. These suggested relationships between the categories require further study and investigation.

Summary

Analysis of the responses of the participants indicated that: 1) "conditions", "actions", and "reactions" were discussed during the postpartum telephone interview, 2) four coping strategies, namely, "do something", "learn something", "think something", and "feel something" were used during the interviews, and 3) that women's cognitive appraisals were assessed by determining their "general reaction" to their postpartum experience. In the final chapter of the thesis, these results will be further discussed.

CHAPTER 5

DISCUSSION

In this final chapter, the results of the study will be analyzed in relation to the current literature and the two conceptual frameworks which guided the research. The implications of the study for nursing education and practice will be discussed. The limitations of the study and recommendations for future research will be presented as well as a summary.

Discussion of the Findings

The purpose of this research was to explore and describe the use of postpartum telephone interview as a technique to assess postpartum adaptation. Affonso's (1987) conceptualization of postpartum adaptation and the transactional model of stress and coping (Lazarus & Folkman, 1984) provided a theoretical lens through which to view the process and experience of motherhood. The three research questions were a reflection of these conceptual models. The research questions were: what aspects of postpartum adaptation are addressed during the postpartum telephone interview; what is addressed regarding the women's appraisal of her postpartum experience during the postpartum telephone

interview; and what is addressed regarding the woman's coping abilities during the postpartum telephone interview. The categories identified during data analysis will be discussed. In addition, the relevance of the conceptual models to the findings will be examined.

Aspects of Postpartum Adaptation

The aspects of postpartum adaptation which were addressed during the postpartum telephone interview were coded into three categories: condition, action, and reaction. Each category will be examined in relation to the current literature and its relevance to the postpartum telephone interview.

"Condition" was defined as present and past states experienced by the mother-baby dyad. Conditions were primarily physical aspects of the mother's recovery, such as the healing of the episiotomy, energy level, and the color and amount of lochia. "Condition" also included the physical aspects of the newborn, such as the baby's appearance, feeding, and behavior.

Health care providers frequently focus on monitoring physical changes in the maternal reproductive system (Affonso & Arizmendi, 1986). Following birth, the woman's body must undergo major physiological changes to return to a nonpregnant state. The fatigue level of the postpartum woman is an especially significant variable. Affonso and Arizmendi (1986)

contend that a woman is at risk for postpartum maladaptation if she is unable to maintain her energy level. Hansen (1991) argues that "postnatal exhaustion" may contribute to the development of severe postpartum depression. Fatigue was identified as a concern in studies of primiparous and multiparous women (Gruis, 1977; Harrison & Hicks, 1983). Conversely, another study (Moss, 1981) reported that 66% of experienced mothers did not have concerns about themselves. During the postpartum telephone interview, the "condition" of the woman was usually discussed in detail, however, there was no in depth questioning about fatigue and energy level.

The study confirms that "conditions" can be addressed by telephone. Postpartum women reported discussion about various "conditions" and were often able to recall the advice and suggestions provided by the nurses. In general, new mothers were receptive to information about their "conditions" although they did not always follow the advice. The inclusion of specific questions about fatigue and energy level is indicated since this data is especially significant in the assessment of postpartum adaptation.

"Conditions" of newborns are also concerns for postpartum women. Sumner and Fritsch (1977) documented telephone calls from new parents in the first six weeks of life. Feeding questions were most common followed by gastrointestinal (colic, constipation, spitting up, diarrhea), skin, and other (face rash, diaper rash, and cord care). Elmer and Maloni

(1988) documented calls to a helpline for parents with babies aged 0-4 weeks. Feeding and infant behavior were the most common concerns of parents. Postpartum women seek out help most frequently for needs and concerns related to the baby (Gruis, 1977). Thus, the findings about the "condition" of the newborn during the postpartum telephone interview is consistent with other research studies. New mothers may have questions about their babies which can be addressed by telephone.

"Action" was a second aspect of postpartum adaptation addressed during the postpartum telephone interview. "Action" was defined as purposeful present and future behavior to meet the needs of the newborn, postpartum woman and her family. Examples of "actions" in this research were activities performed by the mother such as breastfeeding, newborn care, self-care; as well as "actions" by other family members, such as help provided by a spouse or relative. "Actions" were primarily in the present tense, however, future actions such as contraceptive behavior and return to work were occasionally discussed.

The ability of each woman to care for herself is a baseline requirement for adequate postpartum recovery. Affonso and Arizmendi (1986) indicate two self-care activities needed for postpartum adaptation: sleeping and eating. As well, effective breastfeeding is necessary for the growth and development of the neonate. "Actions", such as regulating the

demands of housework, husband, and children, are major concerns for postpartum women (Gruis, 1977; Harrison & Hicks, 1983) and require assessment. Nurses recognized the immense behavior changes demanded of the mother. During the postpartum telephone interview, women were frequently asked about their own "actions" and the "actions" of others available to assist them in their home situation. Questioning new mothers about their behaviors and the behaviors of support people is appropriate and necessary during a postpartum assessment.

Despite the fact that the majority of the sample were experienced mothers (12/15), questions about newborn care were frequent. Moss (1981) reported that baby care "was not a concern" for 58% of her sample of multiparous women. Gruis (1977) and Harrison & Hicks (1983) both noted that fewer than one quarter of their mixed samples of primiparous and multiparous women were greatly concerned about the overall area of infant care. Discussions during the postpartum telephone interview reflected an emphasis on "actions" regarding infant care. This may be due to the focus on infant care by the nurse or the mother's perception that the community health nurse is interested only in concerns about infant care (Harrison & Hicks, 1983). When assessing the "actions" of new mothers, nurses need to recognize that infant care may not be a concern for multiparous women. As well, the

nurse must consider a wide range of "actions" to determine a mother's postpartum functioning.

"Reaction" was the final category which emerged during data analysis. This category was divided into two sub-categories; "general reaction" and "specific reaction". A "general reaction" was defined as the woman's assessment of her postpartum experience and included questions about how the woman was "doing", if she needed a home visit, and postpartum blues. During these discussions, the nurse asked the woman for her opinion about her postpartum situation.

The literature supports the importance of the woman's assessment of her postpartum experience. The subjective perception of the mother is a crucial factor in postpartum adaptation (Blumberg, 1980). Donaldson (1987) agrees, stating that it is the "subjective assessment of the mother herself that is the ultimate determinant of adaptation" (p. 4). During the postpartum telephone interview women were asked very general inquiries about their individual situations. All of the women interviewed reported that they were "fine", however, when asked about specific postpartum issues by the investigator, many women reported negative childbirth experiences and social isolation. Thus, general questioning about postpartum adaptation will not identify significant concerns of new mothers which may be amenable to nursing intervention.

A sub-category of reaction, "specific reaction", describes the particular responses of both the woman and the newborn's sibling. A "specific reaction" of a sibling was simply discussion about the reaction of the other child to the newborn. In every case of another child present in the family, mothers reported that the nurse asked about the specific reaction of other children. In a study by Moss (1981), 55/56 multiparous women were concerned about the "specific reaction" of other children towards the baby. During the postpartum telephone interviews, nurses validated this concern by initiating discussion about sibling rivalry. Specific questioning by the nurse about sibling rivalry allowed mothers an opportunity to discuss ways to handle their children's reactions to the birth of the baby.

A "specific reaction" of the mother was defined as an emotional response to particular aspects of her postpartum experience. For example, how the woman was feeling about her choice of a feeding method or her newborn's crying. Affonso and Arizmendi (1986) emphasized the need to assess the woman's feelings regarding specific aspects of postpartum adaptation by stating that "it is not only important to monitor and document the events occurring ... but also how such events are being processed by the woman and her family" (p.29). During the postpartum telephone interviews, women reported that they were not always questioned about their "specific reactions" and consequently emotional issues were often not identified.

There are many possible reasons psychosocial concerns were not identified and discussed with the nurse. Firstly, required documentation which the nurse completes after the telephone contact consists mainly of physical data about the mother and baby. There is little space to document emotional issues and little recognition of their significance. Secondly, nurses may not be aware of the impact of psychosocial issues on postpartum adjustment. As a result, these issues are ignored. Thirdly, nurses may not have the interpersonal skills to ellicit the "specific reactions" of postpartum women. Nurses would have to probe and question mothers much more extensively. Fourthly, a telephone contact may be a poor mode of communication to establish a trusting relationship in which emotional issues could be identified and explored. Finally, the postpartum telephone interview is seen as a time saving measure to deal with heavy caseloads. When resources are inadequate, nurses may not have the time to devote to these women even if issues were identified. Consequently, the telephone contact may become a superficial exchange of information between the mother and the nurse rather than a true assessment of postpartum adaptation.

Coping Styles

Four coping styles for postpartum women emerged during data analysis: "do something"; "learn something"; "feel something"; and "think something". "Do something" and "learn

something" were the most frequent type of coping responses encouraged by nurses during the telephone interview. "Feel something" and "think something" emerged from women's descriptions to the researcher about how they coped with their postpartum experience. These coping strategies were infrequently encouraged by the nurses. Each coping response will be further examined.

"Do something" refers to implicit or explicit directions given to the mother by the nurse. This coping response was frequently encouraged when women reported a troublesome "condition", such as a sore episiotomy, or difficulties with an "action", such as breastfeeding. Providing direction and advice to new mothers is a common nursing intervention. Affonso (1987) notes that community health nurses are primary informants on mothering skills. Consequently, it is not surprising that this "do something" coping strategy was frequently suggested by the nurse.

"Learn something" was a second type of coping response encouraged during the postpartum telephone interview. "Learn something" is provision of direct or indirect education to increase the mother's knowledge of various aspects of postpartum adjustment. Teaching was provided on topics such as self-care and infant feeding. White (1982) highlighted education as a critical intervention in public health practice. Nurses can and do provide factual information to new parents (Gruis, 1977). Besides direct education, mothers

were frequently mailed written materials. Books and pamphlets were cited as needed resources for postpartum women (Harrison & Hicks, 1983; Moss, 1981). Consequently, the provision of written educational materials to new mothers may enhance their postpartum adaptation.

"Feel something" and "think something" were coping strategies identified from mothers' descriptions of the postpartum telephone interviews as well as from the women's conversations with the researcher. "Feel something" refers to statements or behaviors which provoke a positive emotional response in the mother. During the postpartum telephone interview, statements by the nurse, such as reassurance and encouragement, made women "feel better" about themselves. This type of emotional support and the expression of caring, acceptance and understanding help women cope with maternal adaptation (Donaldson, 1981; Gruis, 1977; Rhode & Groenjes-Finke, 1980). In a few cases, women recalled nurses' statements that particular feelings or concerns were common during the postpartum period. Normalizing ambivalent feelings can provide reassurance to new parents (Miller & Solie, 1980). In addition, women reported behaviors by their partners, such as getting up at night or providing childcare, as helpful because they "felt better" emotionally. These types of behaviors and statements which provoke a positive emotional response in the mother are valuable in the promotion of maternal adaptation.

"Think something" describes rationalizations made to alter the mother's perceptions. The sources of these rationalizations were internal, emanating from the mother herself, and "external" indicating anyone else including the nurse. Mothers used this strategy "think something" to cope with "intangible" situations which they were unable to control, such as a very irritable baby or a negative birth experience. This strategy was rarely suggested by the nurse as a means of helping the mother cope.

Altering perceptions is one way to cope with a stressful experience such as parenthood. For example, one study identified adaptability as an important coping behavior for new parents (Miller & Solie, 1980). Learning patience, being more flexible and more realistic are examples of adaptability. These strategies require changes in perception rather than specific behaviors. Donaldson (1981) states that strengthening the effectiveness and adequacy of maternal cognitive perceptions enhances maternal adaptation. Developing realistic expectations and helping women gain insight into their feelings and experience are other strategies to promote postpartum adjustment (Affonso & Arizmendi, 1986; Donaldson, 1981; Rhode & Groenjes-Finke, 1980). Thus, coping strategies which target the mother's perceptions may be effective in enhancing postpartum adaptation.

Discussion of Conceptual Frameworks

Affonso's (1987) conceptualization of postpartum adaptation and Lazarus's transactional model of stress and coping guided this research. Each model will be evaluated in terms of its usefulness and applicability to this study about postpartum adaptation and the postpartum telephone interview.

Affonso's (1987) conceptual model identified five areas to consider in the assessment of postpartum adaptation. They are: daily activities; impact of childbirth events; mother-infant interactions; social activities and supports; and self-assessment. During the study, women were asked specifically about each area to determine if it was explored with the woman during the postpartum telephone interview. The mother was then asked specifically by the researcher how she was coping with that particular issue.

Daily activities was one area of postpartum adaptation thoroughly assessed during the postpartum telephone interview. The categories of "action", "condition", and "reaction" addressed most aspects of daily activities. Advice, direction, and education was provided to women with concerns about daily activities.

The impact of childbirth events was rarely discussed during the postpartum telephone interview. Women were occasionally questioned about the events of their labor and delivery experience but were rarely asked about their feelings

regarding giving birth. When asked by the researcher how they were feeling about their childbirth experience, five women reported very negative experiences. Pain, unmet expectations and powerlessness were common themes in their descriptions. Other studies have documented the impact of childbirth events as an important issue for postpartum women (Affonso, 1977; Cronenwett, 1980; Mercer, 1981). Women may need help to resolve conflicts surrounding their childbirth experience. "Unresolved conflicts can precipitate negative affect and cognitions which interfere with healthy adaptation" (Affonso & Arizmendi, 1986, p. 26). In this study, the impact of childbirth events was a significant issue for one third of the sample although it was not addressed during the postpartum telephone interview. Nurses may not be cognizant of the impact of the childbirth experience on postpartum adaptation and further, that the birth experience is significant for multiparous women.

Mother-infant interaction is identified by Affonso (1987) as an important aspect of postpartum adaptation. Two women identified concerns in this area, one of whom was an experienced mother. During the postpartum telephone interview, difficulties in mother-infant interaction surfaced in discussions about feedings, coded as "conditions", and general infant care, coded as "actions". One primiparous woman discussed at length her concerns about her baby's behavior. Another woman did not have her concerns about her

baby's behavior addressed. This woman was "experienced" and either it was assumed she knew how to cope with newborn behavior or she felt uncomfortable expressing her concerns to the nurse.

Affonso (1987) suggests that the resumption of social activities and supports is an important issue for postpartum women. During the postpartum telephone interview, women were not questioned about resuming relationships with other adults in their life. In this study, however, participants (9/15) verbalized feelings of isolation and loneliness and a desire for adult conversation. Confinement to the home to provide infant care 24 hours a day was a very lonely experience. In Affonso and Arizmendi's (1986) study, 95% of the women reported difficulties in resuming social activities after childbirth and felt isolated from other adults. Other research has reported similar findings (Gruis, 1977; Power & Parke, 1984). Isolation and loneliness are significant factors which predispose mothers to postpartum depression.

The risk of postpartum depression for this sample of women may be compounded by societal factors. Lack of cultural support and a deficiency of practical assistance, role modeling, and support by extended family may contribute to the development of depression in new mothers (Boyer, 1991). Handford (1985) identified loneliness as a common emotion in women who are experiencing postpartum depression. Further, she proposed a profile of the woman at risk of developing

postpartum depression: "she is about 28 years old, in a stable relationship and has had approximately two years post-secondary education" (Handford, 1985, p. 30). This profile describes the population of women likely to receive only telephone contact. Thus, the postpartum telephone interview must include in depth questions about the mother's emotional status to determine her risk for postpartum depression.

Self-assessment is the final aspect of postpartum adaptation in Affonso's model. No women reported difficulties in the area of self-assessment when questioned specifically. This result is hardly surprising when one considers that these women represent a group of experienced (12/15 were multiparous women), well educated women who were deemed to require limited nursing intervention. An addition, this finding is consistent with the women's reports of their "general reaction" as "fine". However, questionnaire design may have also contributed to this result. The concept of self-assessment includes feelings about oneself, predominant mood, future outlook, and body image. The interview questions about self-assessment focussed on the woman's feelings about herself as a mother and were perhaps too general. Specific questions about body image were not included in the interview. Consequently, it is possible that the interview questions did not accurately assess this concept.

Affonso's conceptual model identifies five aspects of postpartum adaptation. During the postpartum telephone

interview, mothers reported that nurses focussed on the concrete physical aspects of postpartum adaptation and infrequently questioned mothers about psychosocial issues. This study, however, confirms the validity of each of the issues and reinforces the importance of attending to each factor during a postpartum assessment. Further development of this model may provide practioners with a holistic perspective of adjustment to motherhood.

Lazarus's transactional model of stress and coping was used in the study to examine the process of maternal adaptation. Cognitive appraisal and coping are the two main processes which occur when one is faced with a stressful situation. Each process will be discussed in terms of its applicability to the postpartum telephone interview and the woman's adjustment to motherhood.

Cognitive appraisal is defined as the continuous evaluative process that determines why and to what extent a particular transaction or series of transactions between the person and the environment is stressful (Lazarus & Folkman, 1984). Cognitive perceptions are a combination of knowledge and expectations and are influenced by the woman's unique definition of stressor significance (Donaldson, 1981). During the postpartum telephone interview, the nurse asked the mother for her "general reaction" to motherhood. Questions like "how are you doing" and "are you having any postpartum blues" did not identify stressful experiences for the postpartum women.

Rather, statements were answered with a polite "fine". This result is not surprising. Women tend to underreport depressive feeling for fear of being stigmatized as having mental problems (Affonso & Arizmendi, 1986). Consequently, little valuable information was gained from this approach.

During the interview with the researcher, all participants were asked for their opinion about specific aspects of postpartum adaptation or their "primary appraisal". Questions such as "how are you feeling about your childbirth experience" opened the door to detailed stories about women's births. Using this open-ended questioning, many issues were identified as stressful, including negative childbirth experiences and lack of adult socialization.

The woman's cognitive appraisal is vital because it directs the type of coping response. Nurses identified tangible problems for example "conditions" like fatigue or "actions" such as breastfeeding. These issues were handled in a directive manner, encouraging the women to "do something" or "learn something". Affonso & Arizmendi (1986) suggest that postpartum education centers largely on content orientation in terms of "how to do" tasks. As well, an encounter which can be acted upon, such as a "condition" or "action", is associated with a greater emphasis on problem-focussed coping (Lazarus & Folkman, 1984).

When "specific reactions" such as anxiety or guilt were identified during the postpartum telephone interview, two

different coping responses were used by postpartum women: "think something" and "feel something". This is consistent with the conceptual framework. "An encounter judged as requiring acceptance is associated with a greater emphasis on emotion-focussed coping" (Lazarus & Folkman, 1984, p. 44). During the postpartum telephone interviews, these coping strategies were rarely suggested by the nurses. Possible reasons that these coping strategies were not encouraged include: the inability of the nurse to identify the emotional issue confronting the woman; a lack of interpersonal skills on the part of the nurse to intervene in this manner; or an emphasis in nursing on telling clients what "to do" rather than exploring other less directive alternatives. Women themselves used both "feel something" and "think something" to deal with postpartum issues. Thus, these mechanisms are valid coping strategies.

Lazarus and Folkman (1984) define coping as process of constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as stressful to the individual. The results of this study lend support to this definition of coping. "Do something" and "learn something" are behavioral efforts to cope with stress and "feel something" and "think something" are cognitive strategies. These mechanisms were used to cope with external demands, such as sibling rivalry, and internal demands, such as feelings of guilt and anxiety, of the postpartum period.

The transactional model of stress and coping is relevant to the process of postpartum adaptation. During the postpartum telephone interview, specific aspects of the model, namely cognitive appraisal and coping, revealed valuable information about the process of maternal adaptation. As well, the model reconfirmed that maternal adaptation is a physical and emotional transition for the woman and her family which requires a wide range of skills for even those individuals who would seem best able to cope. Further use of this model in the investigation of maternal adaptation is indicated.

Implications

The study results have implications for health care professionals providing services to childbearing women. Recommendations for nursing education and practice will be presented as they relate to the research findings.

Recommendations for Nursing Education

During the postpartum telephone interviews, mothers reported that nurses did not explore the range of issues which confront new mothers. There was an emphasis on the physical

recovery of the mother/baby dyad and on telling women what "to do". The present education of nurses must reflect a broader perspective of the adjustment to parenthood and psychology of motherhood. Psychosocial issues must be considered as important as the physical recovery from childbirth. Every postpartum assessment must include information about the new mother's perceptions of her birth experience, her interactions with her newborn, and her support systems (Hans, 1986; Hansen, 1991).

Nurse educators must develop practioners with a wide range of interpersonal skills. These skills are essential to identify and intervene with postpartum women facing difficult emotional challenges. One study found that a nurse may not recognize a depressed mother even though the mother herself will admit that she feels depressed if asked (Scott, 1987). Thus, nurses must be able to conduct a therapeutic interview which probes beyond the general level of feelings in order to identify significant issues for new mothers.

Based on the findings, it is recommended that agencies providing postpartum care to women in both the hospital and community educate their staff regarding current literature and research about postpartum adaptation and effective nursing interventions. Community health agencies in particular need to recognize the additional skills required to assess postpartum women by telephone and provide inservice education to their staff to enhance service delivery. These measures

will improve the knowledge and skills of health care providers which in turn will improve the delivery of health care to new families.

Recommendations for Nursing Practice

In this study, nurses seemed to be "condition" focussed. Postpartum women recalled discussions about the concrete physiological changes during the pueripeum. For study participants, however, emotional issues of motherhood were more significant. The public health nurse is the health professional most likely to identify postpartum depression (Handford, 1985). Thus, comprehensive postpartum assessments must include discussion about the psychosocial issues which new mothers encounter, not merely a vague inquiry about postpartum blues. Open-ended questions about childbirth experiences and resumption of social activities must become as routine as questions about lochia and breastfeeding. This practice may not result in home visits for all postpartum women. Instead, the postpartum telephone interview will become an opportunity for women to validate and discuss their significant issues related to postpartum adaptation.

Nurses need a wide range of skills in the provision of care to postpartum women. Traditionally, community health nurses have had the benefit of visiting postpartum women in

their homes. This situation provided a face to face personal encounter as well as the advantage of viewing the woman in her own environment. All of this contextual data is eliminated during a telephone call. Consequently, the nurse requires excellent interpersonal skills to conduct a therapeutic postpartum telephone assessment. In addition, it is necessary that community health nurses recognize that many issues confronting mothers are psychosocial in nature and have no prescriptive answer. Therefore, encouraging the use of "emotion-focussed coping" skills to deal with the complex challenges of motherhood may be an effective nursing intervention.

Nurses must examine their own values and beliefs which may impact on their practice. "There is certainly a need to explore the adaptation of those who are labeled by professionals as "better prepared" or "better-educated/experienced - the multiparous, vaginally delivered women" (Affonso, 1987, p. 20). What aspects of their adaptation are nurses ignoring? Careful and sensitive telephone assessment is required to determine the needs of these mothers.

Finally, community health agencies must be aware of the health needs of this group of postpartum women. Pressures on staff to target their efforts to "high risk" clients suggests that there is a group of "low risk" women for whom postpartum services are not needed. This study reaffirms that the

process of postpartum adaptation is never routine or easy. It is significant that the woman who is most at risk for postpartum depression is often the very one who is expected to make a trouble-free transition into motherhood (Handford, 1985). The birth of a child results in adjustments which impact on the health of all childbearing women and their families. Community health agencies must provide their staff with the professional support needed to deliver quality health care services to all new families.

Limitations

A limitation of this study was the retrospective nature of the women's accounts of the postpartum telephone interview. Although women were interviewed within three weeks of the telephone call, some women had difficulty remembering their conversations with the nurse. As well, there was no attempt to validate the woman's story with, for example, the written postpartum referral. Extensive probing and encouraging was used by the researcher to gain as much information about the telephone contact as possible. A threat to external validity may be proposed since concerns discussed with the researcher at three weeks postpartum may have not existed during the postpartum telephone interview at one or two weeks postpartum. Although this is possible, mothers reported concerns raised

with the researcher were never discussed during the postpartum telephone interview. A final limitation is the representativeness of the sample. The number of women who declined and reasons for opting not to participate in the study is unknown. Two subjects who initially agreed to be interviewed and had appointments arranged became "too busy" and were unable to participate. Consequently, the sample represents postpartum women who have had only telephone contact, but in addition the women had the time and energy to participate in a research study in their first few weeks at home.

Recommendations for Future Research

This exploratory study about postpartum telephone interviews is only a small beginning toward practice based research in community health. The findings of the study underscore the need for further research. Recommendations for future research will be presented.

1. The postpartum telephone interview should be studied in its entirety, including a recording of the conversation between the nurse and the postpartum woman, and interviews with both the nurse and the postpartum woman to determine their perceptions of the telephone conversation. Such a design would reveal extensive information about the

interactive processes occurring during the postpartum telephone interview and eliminate the problem of relying on women's reports of nursing interventions.

2. The effectiveness of the postpartum telephone interview, as an assessment strategy with postpartum women, must be determined. Immediately following the postpartum telephone interview, women could be asked to complete quantitative measures of postpartum adaptation to determine their level of functioning. Data analysis could then identify women with inadequate postpartum functioning and retrospectively examine the written referral completed by the nurse. An evaluation of these two data sources could assist service providers in determining the effectiveness of the postpartum telephone interview.

3. Affonso's framework of postpartum adaptation could be further refined and developed to determine key aspects in each area of postpartum adaptation. Larger, more heterogenous samples could be included to determine if these aspects of postpartum adaptation exist in other cultures, socioeconomic groups, and age groups.

4. Lastly, an exploratory research design is needed to examine the coping strategies women use to deal with the "intangible" issues of motherhood, such as negative birth experiences and loneliness and isolation. Sample criteria would be broad and include both primiparous and multiparous women in the first six months postpartum. Qualitative data

analysis could determine the processes used by mothers to cope with "intangible" postpartum issues. Study results may impact on both nursing intervention as well as program development.

Summary of the Study

Childbirth represents a time of change and adjustment for the new mother and her family. During the postpartum period, the new mother is faced with complex challenges which may impact on her health and the health of her family. Contact with health professionals varies immensely. This study examined one such contact: the postpartum telephone interview between the new mother and the community health nurse. Since there was little research about telephone contact an exploratory study was chosen.

The purpose of this study was to explore and describe the use of the postpartum telephone interview as a technique to assess postpartum adaptation. Findings indicated three areas of discussion during the postpartum telephone interview, namely, "condition", "action", and "reaction". Nurses attempted to ellicit women's opinions about their postpartum experience by asking for their "general reaction", however, this study indicated that women must be questioned about their "specific reactions" in order to identify postpartum concerns.

Nurses encouraged women to use various coping styles to deal with a variety of issues. Most frequently, nurses encouraged women to "do something" or "learn something". Less often, women were encouraged to "feel something" or "think something".

The conceptual models used in the study were Affonso's (1987) conceptualization of postpartum adaptation and the transactional model of stress and coping (Lazarus and Folkman, 1984). Both models were relevant and applicable to the study. Study results validated the concepts of cognitive appraisal and coping (Lazarus & Folkman, 1984). In addition, the findings indicated that the impact of labor and delivery and the resumption of social activities and supports (Affonso, 1987) were particularly significant issues for new mothers. Further use of these models in the investigation of postpartum adaptation is indicated.

Study results have implications for health care professionals providing services to childbearing women. Nurses require current knowledge about postpartum adaptation as well as sensitive interpersonal skills to intervene with postpartum women by telephone. Community health agencies need to recognize and respond to the needs of all childbearing women and their families. Further research is required to examine to postpartum telephone interview and the phenomena of postpartum adaptation. These combined efforts on the part of educators, practioners, and agencies will enhance the delivery

of health care to childbearing families during this unique period of the family life cycle.

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APPENDIX A

REQUEST TO RELEASE POTENTIAL SUBJECTS' TELEPHONE NUMBERS

To be read by the Community Health Nurse at the completion of the postpartum telephone interview.

Donalda Wotton, a graduate nursing student, is doing a study about how new mothers manage at home. She would like to contact you in the next few weeks and ask you to participate in the research study. This study will involve a home visit which will take approximately one hour. May I give her your name and telephone number so that she can contact you?

Thank you.

APPENDIX B

INVITATION TO PARTICIPATE IN RESEARCH STUDY: TELEPHONE INFORMATION TO POSTPARTUM WOMEN

Hello, my name is Donalda Wotton. I am a Master's of Nursing student at the University of Manitoba. I am doing a study about the postpartum telephone interview. Do you remember receiving a telephone call from a public health nurse?

Participation in the study would include a tape-recorded interview in your home about the telephone call you received and the completion of a brief form asking for background information about yourself. Would you like to participate?

Thank you for your time. If you have any questions before the interview, here is my home telephone number:

APPENDIX C

WRITTEN EXPLANATION OF STUDY AND DISCLAIMER

Donalda Wotton, a Master's of Nursing student at the University of Manitoba, is conducting a study to describe the postpartum telephone interview. She may be contacted by telephone at during the course of this study. This research will be supervised by three faculty members at the University of Manitoba. The thesis chairperson at the School of Nursing is Dr. Janet Beaton (telephone number:).

Postpartum women who have received one postpartum telephone interview through Manitoba Health are being invited to participate. Participation is entirely voluntary. Refusal to participate will not influence future services received. You will be asked to voluntarily give your opinion about the postpartum telephone interview. By agreeing to be interviewed, you will be giving consent to participate in the study.

All women who volunteer will be asked to fill out a brief form asking for background information about themselves, and to participate in a tape-recorded interview. This interview will take approximately 1-1 1/2 hours, but could be conducted over 2 sessions if desired.

During the interview, the researcher may ask you several questions regarding the postpartum telephone interview and your postpartum experience. There are no right or wrong answers; the researcher is simply interested in hearing your perspective on the subject. You may refuse to answer any questions and may terminate the interview at any time. After the interview, the researcher may need to contact you by telephone to clarify any questions resulting from the interview.

The interview tapes will be transcribed into notes by the researcher. All information will be kept confidential. At no time will your name appear on the tapes or transcripts; a code number will be used to identify all information. Only the researcher will have access to data/code number combinations. Tapes, transcripts and identifying data sheets will be kept in a locked filing cabinet. Upon completion of the study, the tapes will be erased.

The researcher's thesis advisors may read the transcript notes; however, your identity will not be revealed.

Similarly, any publications resulting from the study will be written in such a manner that statements could not be linked to participants.

This study does not involve any direct risks or costs to you. Although it may not have any direct benefits, this information will assist health care providers in planning services for postpartum women.

Would you like to receive a summary of the research results?

No _____ Yes _____

If yes, please indicate your mailing address below:

NAME:

ADDRESS:

APPENDIX D

INTERVIEW SCHEDULE

1. As you know, I am interested in learning about your experience with the postpartum telephone interview. Can you describe the discussion you had with the nurse?

2. Tell me about your discussion with the nurse about your ability to care for yourself? care for your baby? manage the household responsibilities?

How were you coping with the caring for yourself? your baby? the household tasks?

What suggestions did the nurse give you to care for yourself? your baby? the home?

3. During the telephone call, describe the discussion regarding your thoughts and feelings about your childbirth experience?

How were you dealing with your feelings regarding your birth experience?

How did the nurse help you deal with those feelings?

4. Tell me about the discussion with the nurse regarding your feelings towards your baby.

How were you feeling about your relationship with your baby?

What suggestions did the nurse give you about dealing with feelings towards your baby?

5. Can you talk about any discussion with the nurse regarding your relationships with other adults, such as the baby's father, your friends or relatives?

How were you coping with resuming your relationships with other adults in your life?

How did the nurse help you address that issue?

6. Describe for me the discussion with the nurse with respect to your feelings about yourself or about how your felt you were doing as a mother.

In your opinion, how were you coping at that time?

How did the nurse help you adjust?

8. Is there anything else you would like to add about the postpartum interview that we have not discussed?

Thank you.

APPENDIX E

DEMOGRAPHIC DATA

Code Number: _____

1. Age: _____

2. Marital Status: _____

3. Last grade completed in grade or high school: _____
If you have completed education beyond the high school level, please indicate your highest education level attained.

Trade school/vocational training/Community college _____

University degree _____

Graduate degree _____

Other _____

4. Occupation: _____

Are you presently employed?

Yes _____ No _____

Full time _____ Part-time _____

Were you employed before the birth of this child?

Yes _____ No _____

Full time _____ Part-time _____

Are you planning to return to work?

Yes _____ No _____ Unsure _____

Full time _____ Part-time _____

5. Is English the language spoken in your home?

Yes _____ No _____

If no, what language is spoken? _____

Are you a Canadian Citizen? Yes _____ No _____

If no, how long have you lived in Canada? _____

6. Is this your first baby? Yes _____ No _____

If no, how many children do you have? _____

What are their ages? _____

7. When you were discharged from hospital did you have help at home?

Yes _____ No _____

If so, for how long? _____

8. How are you feeding your baby?

Breastfeeding ____ Bottle feeding ____ Both ____

9. Please list the first names and ages of other people in the household and their relationship to you.

APPENDIX F

SUMMARY SHEET

Code Number: ____

Date of contact:

Length of contact:

Context:

Main Themes or Issues:

Comments Regarding Next Contact: