University of Alberta

The Process of Postpartum Adjustment

by 

Stephanie Jeanne Knaak

A thesis submitted to the Faculty of Graduate Studies and Research
in partial fulfillment of the requirements for the degree of

Doctor of Philosophy

Sociology

Edmonton, Alberta
Spring, 2008

Your file Votre référence
ISBN: 978-0-494-45546-3
Our file Notre référence
ISBN: 978-0-494-45546-3

Abstract

This qualitative exploration of mothers' early mothering experiences is organized around two main questions: what do mothers experience in the weeks and months after having a baby; and what are mothers' own understandings of why they experienced and felt what they did? Thirty-three mothers from a range of postpartum emotional states were interviewed, from mostly and mainly happy, to clinically depressed.

Mothers' narratives of their postpartum experiences were foundationally about "adjusting." More specifically, the mothers described variations in their emotional wellbeing according to their own assessments of "how well" they were adapting to the various changes brought about by the birth of their baby.

The analysis revealed that mothers' adjusting efforts are focused on the attainment of a particular goal, that of "feeling adjusted." "Feeling adjusted" emerged as an accomplishment of establishing an integrated maternal identity. The analysis further revealed that "feeling adjusted" occurs through the accomplishment of a variety of adjusting tasks. These tasks emerged as the major components of the postpartum adjustment process. They include: connecting with the baby, developing competence and confidence in one's abilities as a mother, rebuilding day-to-day life, overcoming social isolation, integrating paid work/making decisions about paid work, and reconciling expectations and reality. Further, mothers experience the adjusting process variably, and can have an easier or more difficult time accomplishing the various tasks of adjustment.

Mothers' views about why they had an easier or more difficult time adjusting resulted in the identification of six central themes. These themes emerged as the main resources of the adjusting process. They include: prioritizing self care, having low

situational stress, having enough help, feeling understood, feeling physically and emotionally ready for the baby, and having realistic "core" expectations and beliefs. These resources were described by the mothers as the main things that facilitated their abilities to accomplish the work of adjusting.

The various themes that arose from this analysis—including the goal of the postpartum adjustment process, the main tasks of the process, and the major adjusting resources—are discussed as a theoretical model which aims to provide greater insight into how and why mothers' adjusting experiences vary.

Table of Contents

Table of Contents (cont.)

List of Tables and Figures

List of Tables

List of Figures

Introduction

What do mothers experience in the weeks and months after having a baby? Is there a common process or set of experiences that characterizes this period in a mother's life? In what ways do mothers' postpartum experiences vary? What, if anything, might the exploration of mothers' *varying* postpartum experiences teach us about the phenomenon of postpartum depression? This study was designed to address these kinds of questions by qualitatively capturing the diversity of mothers' postpartum experiences, as indicated by differing states of postpartum emotional wellbeing.

The configuration for this project was inspired, in part, by a concluding remark made by Kathy Berggren-Clive (1998), in her illuminating article on mothers' experiences with postpartum depression (PPD), in which she stated the following:

> a more in-depth qualitative study that explores the differences between women who have experienced postpartum depression and those who have not...would be useful (Berggren-Clive 1998: 117).

Indeed, there is a rich body of qualitative literature on the experiences and processes of postpartum depression and emotional distress following childbirth (e.g., Berggren-Clive 1998; Mauthner 1998; Nicholson 1999; Taylor 1996; Rodrigues et al. 2003; Chan et al. 2002). However, Berggren-Clive's comment speaks to the fact that there has been little research on how these mothers' experiences compare to those of mothers who *have not* suffered severe emotional distress after childbirth.

As well, there are relatively few studies on "normal" postpartum processes and experiences (Green & Kaftersois 1997; Hopkins et al. 1985; Eagan 1985), a comprehensive knowledge of which is an important prerequisite for properly

understanding postpartum depression. As Chrisler and Johnston-Robledo (2002: 181) state in this context, for example:

> the question of differentiating PPD from normal adjustment is more difficult to address as there are so few data available on "normal" new mothers.

This research was organized around two main questions: what do mothers experience in the weeks and months after having a baby; and what are mothers' own understandings of why they experienced and felt what they did? Using a grounded theory methodology (Glaser & Strauss 1967; Glaser 1978; Strauss 1987; Strauss & Corbin 1998), this study was designed to capture mothers' own interpretations of their experiences. I interviewed a total of 33 different mothers from the city of Edmonton and surrounding areas. These mothers ranged in parity from one child to four, resulting in interview data on 45 different postpartum experiences.

Given the central problematic of this study, mothers from a range of postpartum emotional states were recruited. This included mothers who had been clinically diagnosed with postpartum depression (by a family physician, obstetrical specialist, psychiatrist or psychologist), mothers who experienced significant distress but who were never "officially" diagnosed with postpartum depression (PPD), mothers indicating mid or moderate levels of postpartum distress, and mothers who experienced little or no postpartum distress (i.e., mothers who were generally quite happy). This sampling framework, and the subsequent analyses, relied primarily on mothers' own descriptions and assessments of their state of emotional wellbeing. Additional details about the study's methodological approach and research activities are described in Chapter 3.

This study was primarily interested in understanding how mothers described and made sense of their own postpartum experiences. What emerged through the course of my interviews with these mothers was that their interpretations of their experiences were fundamentally tied to a narrative about "adjusting." Basically, the mothers described variations in their emotional wellbeing according to their own assessments of "how well" they were coping and adapting to the various changes brought about by the birth of their baby. In this respect, the analytical focus of this research became increasingly centred on the concept of "adjustment"—in understanding what "adjusting" meant for the mothers in this study, and in how mothers' varying emotional wellbeing could be understood as manifestations of varying adjusting experiences.

As such, the analysis presented in this dissertation focuses on the explication of this process of postpartum adjusting as the general framework through which mothers' experienced varying states of emotional wellbeing. As such, Chapter 4 positions mothers' experiences within this broader narrative of adjustment, defines what the process of postpartum adjusting is all about, and delineates its major stages. Chapter 5 describes in detail the main components of this process—the main tasks that the mothers in this study needed to accomplish in order to "feel adjusted." These include: connecting with the baby, developing competence and confidence as a mother, rebuilding day-to-day life, overcoming social isolation, making decisions about work, and reconciling expectations with reality.

Chapter 6 describes the main factors that the mothers in this study articulated as central to their own understanding of why they felt and experienced what they did. Mothers' own views about why they believed they had an easier or more difficult time

adjusting resulted in the identification of six central themes. These themes emerged as the main *resources* of the adjusting process—those things which the mothers felt helped or hindered their ability to successfully accomplish the work of adjusting. They include the following: prioritizing self care, having low or manageable situational stress, having enough help, feeling understood, feeling physically and emotionally ready for the baby, and having realistic "core" expectations and beliefs.

In Chapter 7, the various themes that arose from this analysis are brought together and discussed as a theoretical model which can be used to better understand mothers' varying postpartum experiences. I conclude by discussing some implications for policy and programming that arose from my interviews, and outline some directions for future research.

Chapter 2:
Background to the Study

This chapter provides a general overview of the current state of the literature on postpartum depression (PPD), and on the processes and experiences of postpartum adjustment more generally. Through this review, this chapter frames and describes the purpose of the current study.

It is worth noting that the following review concentrates most heavily on research in the area of postpartum depression. The reason for this is two-fold. The first reason is that an interest in understanding mothers' experiences of postpartum depression was where this project first originated. Specifically, the design for the current project developed from particular queries that from reading qualitative literature on mothers' experiences with PPD. For example, I began to wonder about the extent to which many of the emotions and experiences that characterized the narratives of mothers with PPD, like the emotions of guilt and anger for example (see Taylor 1995) might also be shared—albeit perhaps in different ways and with different intensities—by mothers who did not suffer from PPD. I also made note of the current debates around how PPD is defined and diagnosed, and began to wonder about how variations in these criteria might influence the actual range of experiences being captured in various PPD studies.

From here, my literature search thus expanded to include research on mothers' postpartum experiences more generally. However—and this is the second reason that this literature review concentrates most heavily on a discussion of PPD—it quickly became apparent that the phenomenon of postpartum depression comprises the vast majority of research literature on mothers' post-childbirth experiences. There are, as Green and Kaftersios (1997: 141) argue, comparatively few data on the "normal range of

experiences" of early motherhood, and virtually no data on how the experiences of mothers from a wide range of emotional states after childbirth converge, overlap, and/or differ. It is in this context that Kruckman and Smith (2003:16) make the following statement about the current state of the literature on mothers' adjustment experiences more generally:

> there is currently very little field research on how people organize and experience their lives in this critical (postpartum) period. We know very little about what occurs after new mothers return home after giving birth in hospitals.

Thus, the "weighting" of the following discussion should be considered as being largely reflective of where the emphasis lies regarding the current literature on general postpartum adjustment experiences and processes, as well as of PPD.

2.1 Defining Postpartum Depression

According to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (4th revised edition, 2000)—known shorthand as the DSM-IV-TR—postpartum depression is not qualitatively different from depression that occurs at other times, although debate does exist on this issue.[1] Its primary distinction from other forms of depression is that PPD is defined as beginning within four weeks after childbirth. As such, it is located in the DSM-IV-TR under the major heading "Depressive Disorders," under the specifier "with postpartum onset." As stated in the DSM-IV-TR (2000:423), "'with postpartum onset' can be applied to the current or most recent Major Depressive, Manic, or Mixed Episode in Major Depressive Disorder, Bipolar I Disorder,

[1] For example, those who argue for a biological etiology believe PPD to be distinct and directly attributable to the hormones of pregnancy and childbirth (e.g., Hamilton & Harbinger 1992; Dalton & Holden 2002). Also, those who see postpartum depression as a direct manifestation of oppressive motherhood discourses and unrealistic expectations placed on mothers (e.g., see Verta Taylor's 1996 research on the attempts of PPD self-help groups to get PPD recognized as a distinct illness) argue that PPD should be treated as distinct from other forms of depression.

or Bipolar II Disorder, or to Brief Psychotic Disorder: onset of episode within 4 weeks postpartum."

At first glace then, it appears that defining postpartum depression is straightforward—either one has PPD according to its established characteristics or one does not. Unfortunately, this kind of simplicity exists only in theory. First of all, some researchers have argued that restricting the definition of PPD to only that specific postpartum time period is an inaccurate reflection of women's actual situations. Namely, many women are *already* experiencing symptoms of depression during pregnancy, while others do not experience these symptoms until *after* the four week period indicated in the DSM-IV-TR (Evans et al. 2001; Green 1998; Romito 1990; Whiffen 1992). As Whiffen (1992: 496) argues in this context, perhaps "the term postpartum depression...should be replaced with a more accurate term, such as childbearing depression...researchers need to be aware of the continuity between pregnancy and postpartum depression." Romito (1990: 10) makes a similar argument:

> a high percentage of mothers in general are distressed and unhappy....is there any theoretical or practical reason then, for trying to identify (or better, to construct) different categories of suffering, labeling what happens in the first year after birth as "post-partum depression" and what happens later as "mental distress in mothers of pre-school children"?

As well, the main symptoms of PPD are highly overlapping with those of depression occurring at other times in people's lives (Thurtle 1994).[2] These symptoms include high levels of anxiety, crying for no apparent reason, immense sadness, insomnia, cognitive impairment, feeling overwhelmed, an inability to care for oneself and/or the baby, a lack of feeling for the baby or others, exaggerated mood swings, feelings of

[2] Given the many apparent similarities between PPD and depression at other times of onset, it is interesting to observe that there is little overlap in the literatures between PPD and depression that occurs at other times.

inadequacy, numbness, helplessness, and in some cases, suicidal ideation (see Table 2.1). These overlapping characteristics in terms of onset, duration and general symptomatology suggest that the definitional boundaries between postpartum depression and depression more generally are not completely clear.

Table 2.1: Major symptoms of postpartum depression

Crying for no apparent reason which continues beyond one week.
Inability to sleep.
Loss of appetite or overeating.
Extreme anxiety regarding the baby's health or safety.
Feelings of inadequacy, numbness, helplessness, and profound inexplicable sadness.
Exaggerated mood swings.
Lack of feeling for the baby or others.
Inability to care for the baby.
Fear of being alone.
Confusion.
Inability to concentrate.
Feeling overwhelmed and unable to make decisions.
Inability to sit still, talking incessantly.
Physical complaints which suggest a panic attack.
Uncharacteristic silence or reclusiveness.
Experiencing bizarre thoughts or frightening dreams.

Source: Harberger et al. 1992; p. 47. "Table 4.3. Symptoms suggestive of postpartum psychiatric illness."

That said, however, some depressive symptoms do tend to appear more frequently among women with PPD than among other depressed individuals. Valerie Whiffen's (1992) review of the literature noted that postpartum depressed women were more likely to report feelings of fatigue (92% versus 64%), guilt (72% versus 42%) and agitation (40% versus 20%) when compared to other depressed women. In contrast, they were also less likely to have suicidal thoughts (16% versus 60%). Interestingly, however, the emotions of guilt, fatigue, agitation, and anxiety tend also to be commonly occurring

experiences *more generally* after having a baby (Oakley 1979, 1980; Villani & Ryan 1997; Beck Irland 1986).

Similar overlaps appear when examining the qualitative research on the experiences of postpartum depression in relation to research on mothers' more general experiences of adjusting to a new baby. Such experiences as loss, anger, guilt, anxiety, feeling overwhelmed, isolation and exhaustion, for example—all characteristic of the experiences of mothers with PPD (Beck 1992; Berggren-Clive 1998; Mauthner 1998; Nicholson 1998; Taylor 1996)—have also been highlighted in research on "normal" or "typical" postpartum experiences (Barclay et al. 1997; Miller 2005; Mausart 1999; Barrett 1990; Rossiter 1988; Villani & Ryan 1997; Wilson 1982). Barclay et al. (1997:726), for instance, in their study of postpartum adjustment among first-time mothers, conclude that "the experience of new motherhood involves 'losses' which are accompanied by...resentment." Similarly, Berggren-Clive's (1998: 110) analysis of mothers' journeys through postpartum depression articulates that "recurring themes of loss emerge through the women's stories."

The existence of such analytical overlaps again points to a certain conceptual "fuzziness." In particular, it points to a lack of clarity about what distinguishes the experiences of postpartum depression from characteristics of "normal" postpartum experiences and emotions. The question of defining postpartum depression—and distinguishing these characteristics from those of generally "emotionally healthy" mothers has been further complicated by methodological differences in study designs, particularly with respect to the question of determining what "counts" as postpartum depression.

For instance, while general estimates of prevalence suggest that approximately 13% of women suffer either major or minor forms of postpartum depression (O'Hara & Swain 1996),[3] there is considerable variability around this estimate, depending on the method of assessment used. For example, if the criterion used is that set out in the Diagnostic and Statistical Manual of Mental Disorders, the estimated prevalence is about 7%. But if estimates are based on the widely used screening tool known as the Edinburgh Postpartum Depression Screening (EPDS), the estimated rate is 12% (O'Hara & Swain 1996). Further, if the criterion used is the assessment of "emotional problems" by family physicians and obstetricians, estimates can run as high as 30% (Gordon et al. 1965).

This variability is also reflected in the PPD research literature. Research designs differ considerably in terms of how they define what constitutes postpartum depression for the purposes of any particular study. For example, some studies rely on the Edinburgh Postpartum Depression Scale (EPDS) or other questionnaire-based assessment devices (e.g., Georgiopolous et al. 2002; Green 1998; Rodrigues et al. 2003), while other studies recruit women from counseling or self-help groups (e.g., Berggren-Clive 2002; Taylor 1996) or recruit those who have received an official diagnosis from a physician or other qualified health professional (e.g., Mauthner 1998). Other studies again rely on mothers' own self-assessments of whether or not they suffered postpartum depression (e.g., Nicholson 1998). These methodological differences raise some important questions about what exactly is being captured in these studies, especially considering the fact that the various assessment tools and diagnostic criteria *themselves* produce different measures of

[3] This overall estimate was calculated by taking the average of rates given from eight major assessment/diagnostic tools.

what counts as postpartum depression and what does not (Romito 1990; O'Hara & Swain 1996).

Mauthner (1998) and Barclay & Lloyd (1996) have also spoken to the issue of definitional boundaries in noting that, while a technical distinction does exist between the experiences of "sadness" and actual "depression," (see Stiver & Miller 1988) this distinction is often difficult to delineate, whether in clinical settings, in research designs, or in more common uses of the term "postpartum depression." As Barclay & Lloyd (1996) argue in this context, the term "postpartum depression" is often used—by health professionals, mothers, and others alike—to describe an array of distressing emotions following childbirth, including such experiences as the transitory "baby blues" and other feelings of low mood:

> the term *depression* is used to describe any distress experienced by new mothers; confusing clinical depression with the unhappiness, anxiety and frustration that may occur in many women after the birth of a baby (Barclay & Lloyd 1996: 136).

In short, then, the definitional boundaries of what constitutes "postpartum depression" and what does not have not been clearly delineated in everyday and professional dialogue, nor have they been conceptualized consistently in academic research.

This definitional "blurredness" indicates that the constitutive boundaries of PPD have not yet been firmly delimited or "black-boxed" (Latour 1987).[4] And as sociological theory teaches, the very establishment of the boundaries between "normal" and "abnormal"—as well as the categories used to distinguish one disorder from another—are fundamentally social processes (Busfield 2000). Illnesses—how they are defined,

[4] Latour uses the term "black box" to mean that debate on a particular knowledge claim has occurred and been resolved to the point that it has become "fact". All questions have been answered and all counter/opposing arguments have been discounted.

attended to, and experienced—come into being through human dialogue and debate, and through the processes of labeling and categorizing (Latour 1987; Thoits 1985; Brown 1990). Romito (1990: 8), in this context, cogently argues that "the phenomenon labeled postpartum depression, rather than being a natural entity, is defined and actually constructed by the very instruments used to measure it, and in more general terms, by the very process of research." It is also constructed by and through the actions of mothers themselves; how and when they choose to seek help for emotional problems after childbirth, the extent to which they accept and/or resist particular diagnoses and treatments, and the way they make sense of their own experiences (Thoits 1985; Taylor 1996; Kushner 2005).

These debates over the characteristics and boundaries between PPD and "normal" adjustment experiences—as well as those that exist between PPD and other forms of depression—point to a need for research that seeks out the experiences of *all* mothers, from mostly and mainly happy to clinically depressed. This is the design employed by the current study. Importantly, this kind of research design allows for an examination of the various connections and departures across a more complete range of postpartum experiences, not only those experiences pre-defined as being "normal" or "abnormal." Further, including the spectrum of emotional wellbeing within a single study ensures that exclusion of various "borderline" experiences (between normal or abnormal, for example) is not at issue. As well, it allows for the possibility of bridging bodies of literature which, despite analytical similarities, currently remain quite separate.

Further, the design of a study which actively attempts to capture a more complete range of emotional wellbeing and postpartum experience overcomes the problematic

tendency of dichotomizing experience into two relatively homogenous categories—namely the categories of "healthy or "normal," versus those of "unhealthy" or "abnormal." The importance of guarding against a dichotomous conceptualization of PPD has been persuasively argued by many who have found mothers' postpartum experiences to exist more on a general continuum of emotional wellbeing than according to dichotomies (Green 1998; Romito 1990; Nicholson 1998). In this context, it has been argued that the distinction between PPD and other postpartum experiences may have more to do with the intensity of feelings rather than something one does or doesn't have—that "postpartum depression seems rather to be a process in which women can be more or less involved according to the changing circumstances of their lives" (Romito 1990: 8-10).[5]

In this respect, assuming those who have PPD are homogenous and distinct from those who do not have PPD does not appear to be an accurate framework for capturing the actualities of mothers' experiences. As such, the design for the current study emphasized the importance of seeking out the stories and experiences of mothers from a range of postpartum emotional wellbeing. In taking the position that this kind of inclusion is of central importance to ongoing debates about the very definition and conceptualization of mothers' postpartum experiences and emotional wellbeing, this study intentionally aimed to capture a continuum of emotional wellbeing.

2.2. Models of PPD: Causes, Contributors and Characteristics

[5] Debate does exist on this question, however. For example, those who conceptualize PPD as an etiologically and qualitatively distinct illness tend not to emphasize the continuum model of emotional wellbeing (e.g., Dalton & Holden 2001; Hamilton & Harbinger 1992). However, in the absence of research that actually captures and explores a full range of "healthy" and "unhealthy" experiences, it is difficult to ascertain the extent to which this continuum model of emotional wellbeing helps (or fails to help) enhance our understanding of PPD and postpartum wellbeing more generally.

There are three main models or frameworks in which the literature on PPD fits. Each of these approaches attempts to understand and explain the main causes, characteristics and contributors of postpartum depression. These three models, broadly stated, might be termed the bio-medical, the psycho-social, and the cultural-feminist approaches to understanding PPD. The main contributions of each of these fields of study are outlined below.

2.2.1 The role of the biological: characterizing PPD

While biological and hormonal factors have been argued to play an important role in postpartum depression, it is unlikely that the illness is solely of an organic nature (Cooper & Murray 1998; O'Hara 1997; Miller 2002). As Hendrick & Altshuler (1999: 77) state, for example:

> for the majority of...biological variables thought to be etiologic, including progesterone, prolactin, cortisol, and B-endorphins, studies have been negative or contradictory and have yielded no clear evidence that these hormones play a part in postpartum depression....The literature does not consistently support a hormonal etiology for postpartum depression.

Importantly, however, this contention is still under debate, as the hypothesis that PPD is purely a hormonally-based illness of childbirth continues to be investigated (Dalton & Holden 2001), and many within this tradition do favour a conceptualization of PPD as a "hormonally and biochemically-induced reaction to the body's upheaval in giving birth" (Dix 1985: 8).

Some of the lines of research that currently show promise for enhancing understanding of the role of biological factors in the characterization and/or development of PPD include the hypothesis that estradiol or estriol plays a role in postpartum mood changes (Hendrick & Altshuler 1999), and that estrogen therapy may be beneficial in

severe and chronic cases of PPD (Gregoire et al. 1996). As well, it has been found that, for some, PPD may be related to thyroid dysfunction (Cooper & Murray 1998; Hamilton 1992; Harris 1994). It has also been noted, however, that the "thyroid dysfunction could be secondary to immunological changes brought about by stress" (Cooper & Murray 1998: 885).

Although the question about what and how biological factors play a role in PPD remains uncertain and debated, medical professionals often describe the illness in organic terms to patients. The logic is that explaining PPD in biological terms increases a patient's ability to "come to terms" with the illness, and makes her more receptive to treatment (Fernandez 1992; Hickman 1992). Interestingly, however, when asking mothers themselves about the role of biological factors, sufferers are often ambivalent about the centrality of biological factors as being underlying causes of their illness—while some interpret their depression as being largely organic, others do not find biological explanations sufficiently convincing to explain their experience (Lewis 1995; Nicholson 1998). However, mothers do feel that framing postpartum depression as a biological or organic illness provides it with a legitimacy and acceptability that they feel would not be there if it were framed more as a socially or culturally-based phenomenon (Taylor 1995, 1996).

One line of research which requires further attention—particularly for the purposes of a more integrated understanding of what causes and characterizes PPD—is the extent to which biological factors are affected by, and integrated with, broader environmental contexts (Fremont & Bird 1999; Link & Phelan 1995). For example, we now know that vulnerability for many illnesses—as well as the ability to heal—is

mediated by environmental factors such as psychological stress and social support, both of which interact with bodies to lower immune system function (Cohen et al. 1997; Keilcolt-Glaser et al. 1995). Similar considerations with respect to the interplay of biological and environmental factors are important to the development of comprehensive theoretical models of postpartum depression, particularly given that such factors as situational stress, social support and marital problems have been well-established to be significant risk factors in the development of PPD (Dennis & Kavanagh 2003; Cooper & Murray 1998; O'Hara & Swain 1996; Berthiaume et al. 1996)

Secondly, as research into the biological mechanisms of postpartum depression continues to develop, it is important that attention be directed to the question of proximity. Specifically, it is important that we ask and examine whether a particular biological factor is a *marker* of PPD, making up part of its symptomatology or definition, for example, or whether it occurs temporally prior, indicating a causal or contributing connection to its development.

Research into the phenomenon of depression more generally, for example, has found that parts of the prefrontal cortex in the brain among depressed individuals have lower numbers of glial cells and neurons than among non-depressed persons (Rajkowska 2000; Cotter et al. 2001), and that depressed individuals also show a larger degree of shrinking of the hippocampus (Sheline et al. 1999). Importantly, however, as Kramer (2005: 54-55) acknowledges, these biological features are part of what helps to define or *characterize* the actual illness:

> these findings…suggest that depression is a brain disease characterized by distinct cellular pathology.

These biological features are thus part and parcel of the illness of depression, helping to distinguish and define *what it is.* These findings, however, cannot necessarily be conceptualized as underling causes, which, according to established scientific criteria, must occur temporally prior to the phenomenon in question (Babbie 2005).

2.2.2 The psychosocial model of PPD: the factors of risk

The psycho-social understanding of postpartum depression typically interprets PPD as one possible response to the stress of the specific life event of having a child and becoming a mother (Nicholson 1998). In this context, PPD is conceptualized as an absence of adaptive behavior, which occurs when people feel powerless to control a stressful situation (Chan et al. 2002).

In contrast to the biomedical approach, which tends to emphasize biological abnormalities to explain and understand PPD, the psychosocial approach tends to adopt more of a continuum model of PPD, which Ball (1994: 14) articulates as follows:

> postnatal depression is one end of a whole spectrum of emotional reactions to motherhood. At the other end is the happy, fulfilled and well-adjusted mother who delights in her new status and role. In-between are the majority of women who calmly adjust to motherhood without experiencing the euphoria of one extreme or the depression of the other.

A major focus of this approach has been to identify the main psychosocial stressors that underlie the development of PPD in particular individuals. As such, it has provided useful insight into our understanding of various contributors or "risk factors" of postpartum depression. First of all, for example, the finding that women with marital problems are more likely to suffer from postpartum depression than those in stable relationships has been well-established (O'Hara & Swain 1996; Romito 1990):

> at least eleven research pieces have reported a significant link between post-partum depression and "marital difficulties"....no one who has looked

> for such a link has failed to find it....even though what different authors call "marital difficulties" may describe somewhat different phenomena, the consistency with which the role of the husband is made evident in post-partum depression is striking (Romito 1990: 12).

Some research has also suggested that single mothers may have somewhat higher rates of postpartum depression (Herz 1992).

Another major vulnerability factor to PPD is a lack of social support (Dennis & Kavanagh 2002; O'Hara & Swain 1996; Miller 2002). Cooper et al. (1996), for instance, found that women who lacked social support were approximately twice as likely to develop postpartum depression as those who had adequate support. Further, Green (1998) found that, among women who scored consistently high on the EPDS both pre- and post-natally, only 25% were getting the support they expected from their partners, and nearly three in ten felt they had no one they could talk to.

Lack of social support has also been iterated in qualitative studies of women's experiences with postpartum depression (e.g., Berggren-Clive 1998; Mauthner 1998, Taylor 1996; Chan et al. 2002; Rodrigues et al.2003). This literature has also illuminated that there is an important difference between objective measures of the existence of support, and personal assessments of the quality and adequacy of support (Oakley 1979, 1980, 1992). As Oakley (1992: 28) states in this context, "having support is one thing; being satisfied with it is another."

While the concept of social support is broad and often ill-defined in studies, it is typically meant to refer to support along emotional (i.e., having someone to talk to), informational, and tangible or material (i.e., "having help") dimensions (Oakley 1992). These three dimensions of support have been articulated by Schaefer et al. (1981: 385-6) as follows:

> *emotional* support includes intimacy and attachment, reassurance, and being able to confide in and rely on one another....*Tangible* support involves direct aid or services and can include loans, gifts of money or goods, and provision of services such as taking care of needy persons or doing a chore for them. *Informational* support includes giving information and advice which could help a person solve a problem and providing feedback about how a person is doing (in Oakley 1992: 29).

Thus, the finding that a lack of support contributes to the risk of PPD also encompasses research which shows that having a poor relationship with one's mother and/or having family members living far away increases vulnerability to PPD (Cox 1996; Herz 1992).

A third factor found to be significant to the risk of getting postpartum depression is that of stressful life events. O'Hara & Swain (1996: 5), in their meta-analysis of the main risks for PPD, conclude the following, for example:

> social stress in the form of relative poverty, obstetrical difficulties and stressful life events during pregnancy is a clear risk factor for postpartum depression.

What is important to note, however, is that the exact constitution of a "stressful life event" varies, as similar events hold different meanings to different individuals under different circumstances. In other words, "change in itself is of no importance–everything turns on the meaningfulness of events" (Brown & Harris 1978: 275).

In the case of PPD, pregnancy itself has been identified as a possible "stressful life event" for the development of PPD in mothers, particularly if the pregnancy was unwelcome (Berggren-Clive 1998; Green 1990). Other examples of stressful life events that have been associated with postpartum depression include: a reluctant change in employment status (Cooper & Murray 1998; Murray et al. 1995), demands related to infant care (Cooper & Murray 1995; Whiffen 1988; Kitzinger 1990; Cutrona & Troutman 1986), an unpleasant birth experience (O'Hara & Swain 1996; Madsen 1994), and

ongoing difficulties such as financial worries or housing problems (McIntosh 1993; Paykel et al. 1980).

With the exception of having a previous history of depressive episodes or postpartum depression (O'Hara & Swain 1996; Cooper 1998),[6] other social and demographic patterns currently remain inconclusive or show only small associations. For example, even though strong class differences are observed in the rates of depression more generally—with working class and poor women having the highest rates of depression (Brown & Harris 1979; Meertens et al. 2003)—there is little evidence to support a similarly strong association in the case of PPD (O'Hara & Swain 1996). Other demographic factors such as age, length of relationship with partner, number of children, education and parity fail to be consistent predictors for postpartum depression (O'Hara & Swain 1996).

With respect to the contribution of specific psychological factors, some researchers have found PPD to be associated with particular cognitive traits, such as having a negative attritibutional style (Hopkins et al. 1984), neuroticism, (O'Hara et al. 1990), anxiety (Hopkins et al 1984), negative or maladaptive attitudes towards the self (Whitton & Appleby 1996), or showing "recurrent maladaption to change in developmental tasks" (Herz 1992: 69). Relatedly, Mirowsky & Ross (1989) have linked low instrumentalism (not feeling in control and unable to manage situations) and lack of cognitive flexibility to high levels of distress and depression more generally.

[6] Specifically, women with a history of depressive disorders or who have previously suffered postpartum depression are more likely to experience postpartum depression (O'Hara & Swain 1996; Cooper 1998). Importantly, however, a family history of depression is *not* associated with increased risk for PPD (O'Hara & Swain 1996).

Also, some have explored the relationship between gendered personality and PPD. Pfost et al. (1989), for instance, found that women who scored high on femininity scales tended to have lower scores for depression. The hypothesis in this context is that perhaps women with more traditionally feminine personalities experience fewer conflicts in their transition to motherhood and feel more confident in their ability to mother (Chrisler & Johnson-Robledo 2002). Another study, however, (Berthiaume et al. 1996) had different results, finding no association between PPD symptomatology and gender orientation.[7]

Overall, the psychosocial understanding of, and research on, PPD has illuminated various factors that contribute to the development of PPD in specific individuals. However, this research has also demonstrated that the very definition of a situation as being a "stressful life event" or as representing a "lack of social support," for example, is subjectively influenced. It thus remains an important avenue for further investigation to understand how *mothers themselves* define, experience and give meaning to these various psychosocial factors.

We currently know, for example, that most husbands reduce their household responsibilities after the birth of a baby and typically offer little help with child care (Oakley 1980; Romito 1990). This suggests that the *majority* of mothers—not just those who suffer from PPD—are getting less help from their partners after the birth of a baby. Further, it is not only mothers who suffer from PPD who are dissatisfied with this scenario: Green (1997) found 21% of new mothers who were not suffering from PPD were unhappy with the level of support provided by their partner, with another 20%

[7] Notably, however, this study did find that lack of social support, increased stress, and poor marital support were strongly associated with the development of PPD.

feeling only "neutral." So, while a lack of support has been clearly identified as a risk factor for the development of PPD, it appears that many mothers who do not suffer from PPD also experience a certain lack of tangible or material support, particularly from their spouses.

We are thus returned to the problem of understanding the *subjective* assessment of how a particular event or situation may become a "risk" or contributing factor to the development of PPD for some women, but not for others. What is still needed is a better understanding of how such things as "social support," "stressful life events," "poor marital relations" and "psychological orientations" are defined by mothers themselves. It is through an analysis of the point of view of mothers themselves—understanding how they identify, contextualize, describe, and otherwise give meaning to these various concepts—that we can better understand how these factors mediate and influence mothers' varied postpartum experiences and their emotional wellbeing.

Further, more research is needed on the questions of why and how particular factors may or may not be related to one another, and how they play out in the development of postpartum depression. As Brown & Harris (1978: 271) note in this context about their findings on women's vulnerabilities to depression more generally:

> the model tells us only that in some way the factors are causally linked to the disorder. It does not tell us how or why.

Thus, if we want a truly comprehensive understanding of how postpartum depression comes about, we need to know *why* and *how* these various risk factors are related to one another and to the illness itself. This points to a need for in-depth qualitative study.

2.2.3 Cultural-feminist contribution: setting the stage for distress

Anthropological, sociological and feminist literatures have been particularly helpful in explicating how the cultural context influences the development of postpartum depression, and postpartum emotional distress more generally. This model tends to place the cultural context of mothering and the social-structuring of the postpartum environment as central to understanding the "hows," "whys" and "whats" of postpartum depression. In short, this approach—noting that the global incidence of postpartum depression seems to vary greatly depending on cultural context (Miller 1999; Cox 1986, 1996)—tends to conceptualize postpartum depression and postpartum emotional distress as an individual reaction to a socially-based problem.

As such, many within this tradition tend to problematize the very interpretation of postpartum depression as "abnormal" or pathological (Jelabi 1993; Nicholson 1998; Romito 1990; Mausart 1999). Specifically, it is often argued that postpartum depression is "normal" in as much as its underlying causes and symptoms are rational manifestations and reactions to oppressive and inherently "distress-creating" social and cultural conditions. Nicholson (1998) argues in this context, for example, that postpartum depression should be understood as part of the normal experience of most women when they become mothers, and that depressive symptoms are not features of a 'syndrome' or pathology, but are associated with the shared problems surrounding the conditions of motherhood that exist in North America today. Mausart (1999: 22; 107), similarly, argues the following:

> motherhood is the most powerful of all biological capacities, and among the most disempowering of all social experiences...there is a "trauma of reorganization" which is a predictable and utterly "normal" response to the demands of new motherhood. Yet our reluctance to name the experience (except in diagnostic, stigma-laden terms such as "PPD" or "baby blues") remains monumental, and our efforts to ready ourselves for it, negligible.

Of key importance to our understanding of PPD, this line of research has illuminated that postpartum depression, while not exclusively limited to non-Western societies, does occur mostly and mainly in advanced industrial societies (Kruckman 1992, Harkness 1987, Stern & Kruckman 1983; Cox 1996; Zelkowitz 1996). Why might this be? The main finding is this: cultures with a general absence of PPD socially organize the post-natal period in such a way that meaningful material assistance is provided to new mothers, the role transition associated with having a baby is socially recognized as positive, and the mother's self esteem is maintained (Seel 1986; Fried & Fried 1980; Stern & Kruckman 1983; Wile & Arechiga 1999; Barrett 1990). As Mausart (1999: 105) argues in this context:

> the lack of reintegration rituals for new mothers [is] a major cause of postpartum depression....The problem [in Western societies] is not the enormity of the transition. It's that the transition is experienced as enormous in personal terms, yet it remains socially invisible.

Although specific practices and rituals vary, societies with little or no incidence of postpartum depression tend to structure the postpartum period according to the following general practices: 1. recognition of a distinct period in which the mother's regular duties are interrupted (typically ranging between three to eight weeks); 2. mandated rest for the mother; 3. some degree of social seclusion; 4. social recognition of the mother's new (typically elevated) status; 5. social practices to protect the perceived vulnerability of the new mother; and 6. assistance with tasks (Stern & Kruckman 1983).

The importance of these rituals is that they protect the health and emotional wellbeing of new mothers. They do this by solidifying social roles, serving as a learning process for new mothers, providing an important form of support, and helping to channel

powerful emotions such as grief, ambivalence, anger and fear (Fried & Fried 1980), emotions which have been identified as common to the experience of having a baby and becoming a mother more generally (Parker 1995; Oakley 1979; Villani & Ryan 1997; Barclay et al. 1997).

A study cited by Stern & Kruckman (1983), for instance, compared Chicana women living in Chicago on the basis of whether or not they practiced the traditional Mexican postpartum ritual known as "la cuarentena." This custom involves a rest period of approximately 40 days, eating of special foods, assistance from other female relatives with household tasks and child care, restrictions on visitors, as well as bathing and hair washing restrictions. The women who practiced "la cuarentena" had lower incidences of postpartum depression and more positive responses to their pregnancies.

What this line of research thus indicates is that the relative lack of cultural recognition and support provided to mothers in Western countries during the postpartum period creates a fertile environment for the proliferation of major emotional difficulties:

> the role transition following the mother's return from the hospital appears to be the most vulnerable of the stages in becoming a parent for American women. The general social isolation, financial pressure, lack of status, and dearth of supportive activities for the urban American new mother provide fertile ground for the development of depression (Wile & Arechiga 1999: 89-90).

What this body of literature does not adequately attend to, however, is the question of individual vulnerability.

A second key contribution of this body of research is the finding that societies with little to no incidence of PPD tend to place a high value on mothers and on the activities that mothers do. In these cultural settings, the transition to motherhood involves a *positive* status passage, with additional children bringing increased reverence and

respect (Harkness 1987). This represents a different cultural context than that of Western countries, where market-driven ideologies deem the activities of motherhood to be inherently "non-productive" (Crittenden 2001). Christine Jelabi (1993: 59) points this out as a central paradox of contemporary Western motherhood, that "to bear and raise children is often a fundamental part of a woman's life, yet to be a mother is to occupy a low status position in our society."

The cultural dominance of the "motherhood mystique"—an idealization of what mothering is all about and how it should be experienced (Chrisler & Johnston-Robledo 2002)—has also been argued to be a major contributor to the development of postpartum emotional difficulties and postpartum depression (Mausart 1999; Rossiter 1988; Villani & Ryan 1997; Nicholson 1998; Kendall-Tackett 2005).

Specifically, idealistic cultural beliefs about mothering and motherhood create *unrealistic* expectations about what the experiences and realities of mothering "should be" like (Thurer 1995; Bernardez 2003). Unfortunately, when reality does not meet the standards of such expectations, it can contribute to the development of postpartum depression (Mauthner 1998; Beck 2002; Rubin 1984; Berggren-Clive 1998; Mauthner 1998):

> it is the disparity between the expected and the real, between the ideal image of the self as woman, wife and mother and the experience of self in body post-natally that...results in depression (Rubin 1984: 110).

And as Beck (2002: 458) has also found:

> myths of motherhood created by our society set expectations that are impossible for mothers to attain and place women's mental health at risk...the studies...focused on the key role conflicting expectations and experiences played in the development of postpartum depression....Women experienced conflict between how they expected to mother and their own experiences as mothers. They became disillusioned

> with motherhood, as they perceived that they failed to fulfill their expectations of themselves as the perfect mother.

One of the tenets of current mothering ideology is that motherhood *by definition* is a happy and joyful experience. This cultural climate thus discourages women to voice (or even admit having) feelings of ambivalence, disappointment, or other negative emotions associated with mothering (Mausart 1999). Another tenet of dominant mothering ideology is what Jelabi (1993) calls "the myth of maternal instinct," which goes hand-in-hand with the fallacy that mother-baby bonding is an instant and innate experience. Third, Western ideals of independence and control are promoted though an image of successful motherhood as one who "does it all," and does so without help (Hays 1996). As Thurer (1995: xvi) argues in this context:

> the current standards of good mothering are so formidable, self-denying, elusive, changeable, and contradictory that they are unattainable. Our contemporary myth heaps upon the mother so many duties and expectations that to take it seriously would be hazardous to her mental health.

These idealized discourses create, in Berggren-Clive's (1998) words, a "culture-wide conspiracy of silence about the realities of motherhood." She goes on to argue in this context that, as such, "postpartum depression is not a pathological disease but a natural response to the myths of motherhood [which] have established certain expectations of motherhood that are impossible for women to maintain" (Berggren-Clive 1998: 105). And, as noted above, a marked disconnect between mothers' *expectations* and their actual experiences is a major theme in this body of PPD literature (Beck 2002; Mauthner 1998), thereby illuminating another potential vulnerability or "risk factor" for postpartum distress.

Notably, however, acceptance of the motherhood mystique and broader ideals about mothering *is not* unique to only those who suffer from postpartum depression. In a survey of 1,100 pregnant mothers, for instance, Genevie & Margolies (1987) found that 70% of their respondents had extremely idealistic expectations about motherhood. The experience of disconnect between the expectations and the realities of motherhood has also been noted in other research on "normal" experiences of adjusting to motherhood (Mausart 1999; Barrett 1990; Oakley 1979; Mercer 1995; Lewis 1989). As Bernardez (2003: 301) argues in this context, for example:

> women are shocked at the difficulties inherent in mothering and feel themselves to be failures when measured against the mythical standard. The expectations of omnipotent and exemplary motherhood have been internalized, preventing women from an accurate assessment of the task at hand.

Thus, what remains unclear is just how and why women's experiences of this disconnect between expectations and reality might or might not be connected to variations in mothers' postpartum emotional wellbeing.

Idealistic "motherhood mystique" discourses, motherhood's devalued status, a lack of social structure during the postpartum period, and the lack of meaningful cultural recognition for the identity and role transition thus all work together to create a cultural environment ripe for the proliferation of emotional difficulties after childbirth. In this context, we might consider them "fundamental" to the existence of PPD (see Link & Phelan 1995). Importantly, however, *all* mothers are influenced by this same broad cultural context, but only some mothers suffer postpartum depression. As (Mauthner 1998: 348) thus reminds us, "one important question remaining is why, given that mothers live in the same cultural context, some become depressed while others do not."

2.3 Framing the Current Study

Postpartum depression, in short, is best conceptualized as a bio-psychosocial phenomenon, meaning that a complex combination of cultural, psychosocial and biological factors implicate its development and expression. The literature on postpartum depression across these three general research foci has made significant contributions to understanding this phenomenon. The bio-medical approach, for example, strongly hypothesizes that there is a qualitative, organic distinction between the postpartum depression and the experience of "sadness" or milder levels of postpartum distress. This suggests that, in as much as there *is* a continuum of postpartum emotional wellbeing (see Green 1998; Green & Kaftersois 1997; Whiffen 1992), certain biological characteristics of mothers at the extreme end of that continuum may very well be qualitatively distinct from mothers experiencing postpartum "sadness" or less severe levels of distress.

Secondly, the psychosocial approach has shed light on some of the main vulnerabilities for developing postpartum depression, which include such factors as a history of depression or other mental illness, particular cognitive or personality styles, marital problems, a lack of social support, and stressful life events. This approach has also provided useful insights into the continuum of mothers' postpartum emotional wellbeing, and the relationship between stress, coping, and emotional health.

Thirdly, cultural-feminist models have illuminated how and why certain cultures—advanced industrial societies particularly—have significantly higher incidences of postpartum depression than other parts of the world. Specifically, this approach has illuminated the broader cultural and social-structural conditions—a lack of social-structuring of the postpartum period, idealistic and unattainable motherhood discourses,

motherhood's devalued status, and the lack of meaningful recognition and support for the identity and role transition of becoming a mother—that put *all* mothers at an increased risk for postpartum depression and postpartum emotional difficulties more generally. In short, this model suggests that the very process of adjusting to a new baby and becoming a mother is *in general* more difficult because of the cultural and structural factors outlined above. This model also brings to the fore the significance of experiencing dissonance between expectations and reality in the development of postpartum depression.

There are, however, still considerable gaps in our knowledge. Most importantly, given that mothers' postpartum wellbeing reflects more of a continuum of emotional health than a dichotomy (normal or healthy versus depressed), it is crucial that more research is directed to capturing, analyzing, and seeking to understand this continuum. As Barclay et al. (1997: 720) persuasively argue, "unless 'normal' is understood, it is impossible to recognize or manage the problems women face at either a therapeutic or social level." In other words, it is only through a *drawing together* of the range of postpartum experiences that we can better understand how and why some mothers suffer more than others.

Indeed, this approach—employing a single study to examine the range of postpartum emotional wellbeing —has been identified by many as an important line of inquiry (Green & Kaftersois 1997; Berggren-Clive 1998; Mauthner 1998; Barclay et al. 1997; Christler & Johnston-Robledo 2002). As Barclay et al. (1997: 727) note, for example, "what is missing...is a framework that draws together women's experiences of

early motherhood, conceptualizes the magnitude of the change required and provides strategies to help women negotiate this experience."

This was thus the approach employed for this study, which I undertook using a qualitative methodology. This approach was undertaken with the aim of capturing mothers' own interpretations for why they experienced whichever emotions they did after childbirth. As well, by contrasting and comparing these mothers' stories and histories against the backdrop of the existing PPD literature, this project aimed to move us one step further towards the development of a comprehensive theoretical understanding of postpartum depression.

Chapter 3
Methodological Approach and Research Activities

The methodological orientation of this study was that of grounded theory (Glaser & Strauss 1967; Glaser 1978; Strauss 1987; Strauss & Corbin 1998). The main features of this qualitative method are inductive theory-building, constant comparison of data (to each other and to the emerging theory), and the discovery of a core category or basic social psychological process around which the entire study revolves. Grounded theory is a process of theory building, meaning that theoretical ideas emerge from the data itself, with the continuous generation of new hypotheses and ideas to be further explored, until the point of theoretical saturation has been reached.[8] Further details on the grounded theory methodology are provided below

3.1 The Methodology of Grounded Theory

Grounded theory is part of the qualitative tradition of research. In general, qualitative methodologies are best suited to research problems requiring in-depth study, exploration and inductive thought. Given that my interest was in exploring mothers' experiences, histories and personal interpretations—and trying to understand how these are related to postpartum emotional health—a qualitative approach was favored over a quantitative one, which is more oriented to testing and verification.

Within the qualitative tradition, grounded theory distinguishes itself from other major traditions such as phenomenology and ethnography with its strong emphasis on the building of theory. The goal of phenomenological research, for instance, is to understand the true "lived experience" of a particular phenomenon. By contrast, ethnography is concerned with description, "thick description" being the ultimate research goal and

[8] That is, until the basic social psychological process or core category is identified and no new information is emerging from subsequent interviews.

criteria upon which an ethnographic study is judged. In these other traditions theory generation does still occur. However, there is less relative emphasis on the development of conceptual models or explanatory theory—the ultimate research goal of a grounded theory study. In other words, grounded theory studies aim towards the generation of theory that explains or has some predictive power for the phenomenon in question. (Morse & Richards 2002; Morse 1992)

According to Morse (2001), there are a number of other qualities that distinguish a grounded theory study from other forms of qualitative inquiry. The first is that grounded theory typically focuses on process and trajectory: a shared problem or change that has occurred in the people's lives one is studying. Secondly, grounded theory favours the use of gerunds (see Glaser 1978) for coding and analysis, again reinforcing a focus on action and process. Third, grounded theory studies are centered on a core category or basic process, which could either be a basic social psychological process (BSPP) or a basic social structural process (BSSP) (Strauss 1987). It is this core category or process which forms the centerpiece of the eventual theory. Finally, Morse (2001:2) notes that the theory produced in grounded theory is "unique in that it makes the synthesis of descriptive data readily apparent through its concepts and relational statements."

The philosophical foundations of the grounded theory approach are rooted in the sociological tradition of symbolic interactionism, making the study of meaning central to inquiry (Strauss 1987; Charmaz 2006). According to symbolic interactionism, the extent to which people within society share meanings is what gives a measure of stability and pattern to social behaviour (Blumer 1969). Thus, an understanding of human action requires the study of meanings:

> if individuals base their actions on their interpretations of meaning, it is essential to discover the actors' meaning in order to understand and explain the behavior. Thus, to understand human conduct requires study of the actors' overt and covert behavior. This is the chief methodological implication of symbolic interactionism that is directly addressed through the use of grounded theory (Milliken & Schreiber 2001; 178)

Thus, in as much as grounded theory is based in this tradition, this methodology emphasizes the importance of grasping actors' implicit and explicit meanings of behaviors and events. Grounded theory also adopts from this tradition the assumption that change is a constant feature of social life, and that studying social interaction and social process are of central importance to understanding human behavior (Strauss 1987).

Grounded theory's main technique is that of constant comparison, meaning that the process of theory building involves continuously moving among the data, and from the data to the emerging theory and back again. Through this on-going analytical process, concepts and categories continue to emerge and take shape as they are compared to one another and against the data. The end result is the development of an integrated theory that "fits" and "works:"

> by "fit" we mean that the categories must be readily applicable to and indicated by the data under study; by "work" we mean that they must be meaningfully relevant to and be able to explain the behavior under study (Glaser & Strauss 1967: 3).

Other dimensions of rigor are that the generated theory should have practical relevance to the substantive area, it should be readily modifiable, and it should have the ability to transcend the data at hand.

3.2 The Role of the Literature Review in Grounded Theory

The literature reviewed prior to the undertaking of this study was done so with a belief that the existing literature provides usefulness as a set of "sensitizing concepts" for

the research, not as a particular framework to be validated or enhanced (Glaser & Strauss 1967). In using a grounded theory approach, the methodological thrust is that of theory *generation*, not verification (Glaser & Strauss 1967; Glaser 1978; Strauss & Corbin 1998). As such, the existing literature was used as an initial orientation, and a launching pad for further exploration. Adhering to the central tenet of the grounded theory approach, the way in which—or even whether or not—any of the existing models or findings within the existing literature are ultimately addressed, elaborated, challenged, or added to must only emerge through, and be determined by, the data themselves.

That said, some grounded theory texts (e.g., Glaser & Strauss 1967; Glaser 1978) advise against engaging in a literature review, opining that doing so could result in preconceived ideas being brought into the research, thereby hindering the inductive process. Others (e.g., Charmaz 2001, 2006; Morse 2001; Schreiber 2001), however, argue against the pragmatics of this (that one needs to know *something* of the relevant literature in order to develop a proposal aimed at providing something new), and point out that one *always* brings preconceived ideas and existing theoretical proclivities into a study. It simply cannot be helped. The key, they argue, is to use existing knowledge and literature with vigilance. As Dey (1993: 63 in Schreiber 2001: 59) notes, "there is a difference between an open mind and an empty head....the issue is not whether to use existing knowledge, but how."

Thus, the existing literature—as summarized in Chapter 2—was used primarily as a point of departure into the research. In this context, Schreiber (2001) points out that sensitizing concepts—existing ideas or understandings the researcher brings into the research—"must be carefully scrutinized and *only* brought into the study if support is

found in the data" (Schreiber 2001: 59, emphasis added). Also, Morse (2001) suggests that information and ideas generated from the literature review be "bracketed" and used for later comparison with emerging concepts. It is with this orientation that the literature on PPD was reviewed. Throughout the process of conducting this research, the goal was to make explicit any existing proclivities, ideas and conceptualizations—through the process of memo-writing—in order to ensure that the data itself provided the primary analytical thrust. As such, existing literature and ideas were brought into the analysis only through the process of ongoing comparison with the data, and with the emerging theoretical ideas emerging out of these data.

3.3 The Research Problem

The main thrust of any grounded theory study is to isolate the investigation's core category or basic social process, which is not expected to be known ahead of time. Indeed, it is important that this emerges *through* the process of the research and is based on the data itself. The core category or basic process is the analytical concept that holds the study together (Glaser & Strauss 1967; Strauss & Corbin 1998). Once the core category emerges, all other categories and codes generated through the research should be working to explain and illuminate this core category. It is through this process that we are able to discover "what is really going on" for the phenomenon in question. It is what Rita Schreiber (personal communication August 8, 2003) calls "the red thread rule," finding and integrating that key "red thread" that holds the whole study together.

Given this characteristic of the grounded theory approach, my initial research problem remained necessarily broad. My main intention was to explore mothers' postpartum experiences, interpretations and personal histories—from the point of view of

mothers themselves—trying ultimately to understand how and why some mothers experience greater postpartum distress than others. As such, my research focus was broken out into two general research questions.

Broadly stated, the first question was: *"what do mothers experience in the weeks and months after having a baby?"* Key to this exploration was the construction of a theoretical sample that included mothers from differing postpartum emotional states, from mostly and mainly happy to clinically depressed. Thus, my first aim was to undertake a qualitative exploration of mothers' postpartum experiences and their narrative constructions of those experiences. The second broad question followed directly from the first and asked: *"what are mothers' own understandings of why they experienced and felt what they did?"* Thus, the second analytical task of this research sought to capture mothers' own attributions of their varying experiences.

3.4 Main Research Activities

Grounded theory uses the technique of theoretical sampling. This means that one's sample size or sample characteristics cannot be determined ahead of time, but that sampling evolves through the process of the research itself. The sample is based on the concepts emerging from the analysis or previous interview, and which appear to have relevance to the emerging theory. As Strauss & Corbin (1998: 202-203) state, "the aim of theoretical sampling is to maximize opportunities to compare events, incidents, or happenings to determine how a category varies in terms of its properties and dimensions....each event sampled builds from and adds to previous data collection and analysis." Thus, in a grounded theory study the key question for sampling is "where do I go/who do I talk to *next*?" Sampling is purposive, cumulative, arises directly out of the

ongoing data analysis process, and seeks variation (e.g., what are the dimensions, characteristics, or conditions of x? How, when and where does x work in this or that way?). In this context, Milliken & Schreiber (2001: 183) note that a "fully developed grounded theory will account for broad variation in the experience and perspectives of participants."

A theoretical sampling approach was thus used to recruit participants for this study. First of all, given the study's central problematic, mothers from a range of postpartum emotional states were recruited. This included: i) mothers who had been formally diagnosed with postpartum depression; ii) mothers who experienced significant distress but who were never formally diagnosed with PPD; iii) mothers who indicated mid or moderate levels of postpartum distress; and iv) mothers who experienced little or no postpartum distress (i.e., mothers who were generally quite happy).

In all, I interviewed a total of 33 mothers from the city of Edmonton and surrounding areas. The mothers ranged in parity from one child to four, enabling the collection of information on a total of 45 different postpartum experiences. Interviewing mothers with more than one child proved especially fruitful to the analytical process, as these mothers' narratives were full of reflections and comparisons regarding the various "whats" and "whys" of their different experiences.

As well, the mothers ranged anywhere from approximately three months postpartum to five years after the birth of their last child. As such, this study captured mothers' stories from a range of temporal vantage points. Some mothers' stories provided a more immediate or "present-tense" account of their experiences, for example, while others' stories were more reflective in nature. This range of temporal vantage points was

useful for capturing both detail and breadth. Mothers who were still in the midst of their adjustment experiences, for example, were able to provide vivid detail about the particularities of their day-to-day situations. On the other hand, mothers who were more removed from the immediacy of their postpartum experience were able to incorporate into their narratives a more comprehensive interpretation of their experience as a whole.

Mothers were recruited for this study through advertising in various locales. A copy of the recruitment notice used is included the Appendix. Recruitment notices were placed at the university campus, at a local daycare centre, at a local YMCA, and at four parent resource centres/community health centres at various sectors in the city of Edmonton. The specific locations for posting advertisements about this study were chosen because of the demographic variability of the clients serviced by these organizations. It was my aim to recruit mothers from a variety of age, income, education, and ethnic positions. And while the final sample did include mothers of varying ages (from 20 to 36 at the time their first child was born), income levels (ranging from dependence on social assistance to a household income of over $100,000 per year), and education levels (from uncompleted high school to doctoral candidates), my final sample included only one mother who was not of Euro-Canadian origin.

As well, while my final sample did not include any mothers who had been widowed, the sample contained considerable variations in mothers' marital status. It included married mothers, those in common-law unions, single mothers, and mothers who were divorced/separated. Among the married/common-law mothers, some described their relationships as strong, while others characterized their relationships as considerably less stable. All the mothers in this study were heterosexual, all were able-bodied, and two

mothers noted that they had a chronic illness. Also, some of the mothers in the final sample had suffered from periods of depression previously in their lives.

Interviews took place between the months of May 2004 and February 2005. In general, the interviews lasted approximately one hour and a half, although they ranged in duration. The shortest interview was 45 minutes long, and the longest was just under three hours. All interviews were conducted in person, typically in the mothers' homes. In some cases, however, participants felt more comfortable meeting at a coffee shop, restaurant, or campus boardroom/classroom. All interviews were tape recorded, with the mothers' permission.

The interviews were unstructured, open-ended, and in a conversational style. I invited the mothers to "tell their stories," and used prompts where necessary. I asked them to talk about their birth experience, their postpartum experience, and their pregnancy. I invited them to talk about their life before the birth of their baby, as well as the relationships in their lives and other things significant to their own personal biographies. Key to the aims of this research, I also asked them to explain—in their own words—how they felt in the postpartum, and why they believe they felt the way they did after childbirth. A copy of the general interview guide used for this study is included in the Appendix.

Research Ethics Board (REB) approval was granted for this study. In keeping with REB requirements, all interviews were conducted with full consent from the participants. As well, interviewees were assured of the confidentiality of our interview together, and were promised anonymity. As such, all interview excerpts included in this dissertation rely on the use of participant pseudonyms. Copies of the letter and consent

form that mothers were given are also included in the Appendix. Interviews were transcribed into a word processor, and then into the qualitative software Atlas-ti for aid with analysis. All data files remain password protected. An audit trail was also compiled for this study. This audit trail consisted of records detailing my activities throughout the research process. A journal of activities was maintained primarily for this purpose. Analysis of the interview transcripts was ongoing throughout research process. More details on coding and analysis are provided below.

3.5 Coding and Analysis

In grounded theory, coding is the "pivotal link between collecting data and developing an emerging theory to explain these data" (Charmaz 2001: 341). As such, procedures for the coding and categorizing of data are well-established in the grounded theory literature (Charmaz 2006). Coding, at all levels, involves asking questions of the data. It begins by going through the interview transcript on a line-by-line basis and creating codes to "name" the data. Line-by-line coding is a crucial first step because it breaks up the data in such a way that allows the analysis to move beyond the descriptive (Strauss 1987). Charmaz (2001: 342) provides the following as a guideline for this first phase of coding:

> look for and identify what you see happening in the data....What is going on? What are people doing? What is the person saying? What do these actions and statements take for granted? How do structure and context serve to support, maintain, impede or change these actions and statements?....Make your codes active. By being specific and active you will begin to see processes in the data that would otherwise likely remain implicit.

While initial coding helps to break into the data and begin to see categories and processes, the next level of coding is more focused. It is often referred to as axial coding

(Strauss 1987; Strauss & Corbin 1998), because analysis revolves around the axis of one category at a time. In other words, axial coding involves a focused analysis of the emerging categories in order to saturate its properties. Questions continue to be asked of the data, questions like the following: under what conditions does this category/process develop? What are the dimensions of this category/process? When, why and how does this category/process change? What are its consequences? How do research participants talk about, think, feel and act in relation to this category/process? (see Charmaz 2001, 2006). Key to the ongoing analytic process is seeking to understand how each emerging category is related to other categories.

The final stage of coding is what Strauss (1987) calls selective coding. This stage involves coding in relation to the core category or basic process, explicating its dimensions, characteristics, variability, and conditions. Through this process, the other categories become integrated with one another and with the core category or basic process. It is this general process of coding and analysis that was undertaken for this study.

On-going memo-writing of ideas and thoughts was also a main activity of this study. Memo-writing provided ongoing details and considerations about the various research activities, and also provided authentication and direction for the emerging analysis. It also provided a way to "track" the process of idea-generation and theory building so central to this methodology. Memo-writing is a central activity in any grounded theory study, as it provides the crucial link between coding and the first draft of the completed analysis–the theory itself:

> memo-writing spurs you to start digging into implicit, unstated and condensed meanings....Begin as soon as you have some interesting ideas

> or categories that you wish to pursue....Memo-writing should free you to explore your ideas about your categories. Treat memos as preliminary, partial and immanently correctable (Charmaz 2001: 347-8).

Memo-writing is thus the analyst's workbook of thoughts, ideas, hypotheses to pursue, understandings, misunderstandings, and insights. As such, it is the key mechanism through which the process of coding and data analysis led to the development of the theoretical model explicated in this dissertation.

3.6 Rigour

As highlighted above, Glaser and Strauss (1967) outline two primary criteria of rigour for grounded theory; that the theory generated from the data "works" and "fits." The criteria that the theory "fits" with the data, and that it "works" in its ability to relevantly describe or explain the phenomenon under study are criteria that speak most directly to the issues of validity in qualitative research; namely, the extent to which the analysis and conclusions from the research are supported by the data (internal validity), and the extent to which the findings have applicability with other subjects and in other settings (external validity) (Mayan 2001).

For this study, internal validity was ensured through the analytical process of constant comparison, which emphasizes continuous "back and forth" movement between the mothers' narratives, and the process of coding. This process ensured that the analytical categories were always directly tied to, and emergent from, the data themselves. As well, throughout the analytical process, I made a point to employ the words and phrasings used by the mothers themselves as much as possible in articulating and elaborating the analytical categories and concepts. Furthermore, all interviews were completed in-person by the researcher, and were tape recorded and transcribed. This

ensured that the authenticity of the original verbatim interviews was preserved throughout the analytical process.

Memo-writing was another technique used to ensure the rigour of this analysis. Memos were ongoing throughout the interviewing, coding and writing process. These memos—all of which were dated and titled—were used to express thoughts, uncertainties, evolving ideas, and other details about the analytical process. As such, this memo-writing tracked the evolution of the theoretical interpretation, thereby providing a "roadmap" of the analytical process—how the analysis generated out of, and also connected back to, the mothers' own narratives and perspectives. In other words, memo-writing was a key tool in ensuring that the emerging theory was "working" to relevantly explain the process of adjustment, and the ways in which this process was variably experienced among the mothers I interviewed.

External validity or "the degree to which the audience or the reader of the report is able to transfer the research findings to contexts outside the study situation to other settings," (Mayan 2001: 26) can only ultimately be determined by those who read the findings and conclusions described here (and/or through future research with mothers in other settings/contexts). However, assurance of external validity in qualitative research depends highly on the extent to which the data are saturated or "thick" (Mayan 2001). This dimension of rigour was supported through the process of theoretical sampling—of ensuring, for example, that the experiences of mothers from a wide range of postpartum emotional states following childbirth were captured and represented in both the data itself and the resulting theory—as well as by continuing to interview mothers to the point of saturation.

Assessment of saturation was made based on established guidelines (see Morse and Richards, 2002), such as noticing considerable replication within established categories, and noticing when new "data offer[ed] no new direction, no new questions." (Morse and Richards 2002: 174). Saturation for this study was reached at the completion of 33 interviews, representing a total of 45 postpartum experiences. This represents hundreds of pages of interview data that were used in the development of the theoretical model summarized in Chapter 7. As well, every effort was made to provide as much "thick description" to readers as possible in the analysis that follows.

3.7 Analytical Categorization the Sample

Because of this study's interest in capturing a range of experiences—as delineated primarily by varying states of emotional health—the analytical framework which emerged from this research categorized mothers' experiences into four general groups of experiences. This study relied primarily on mothers' own descriptions and assessments of their emotional wellbeing and their postpartum experience.

In my interviews, I asked mothers to describe their general state of postpartum emotional wellbeing. Mothers used their own words to describe how they felt, and also provided a self-rating of their emotional wellbeing at different points throughout their pregnancy, birth and postpartum experience, and to indicate how they would describe their overall state of postpartum emotional health. For this self-rating scale, mothers described their emotional health on a scale of zero to ten, with zero being the worst they could possibly imagine, and ten being the best they could possibly imagine.

Certainly, this kind of self-rating was not an "objective" measure of emotional wellbeing. However, used in concert with mothers' more in-depth and detailed

descriptions of their experiences and feelings, it provided—for the purposes of this study—a vivid and workable picture of mothers' general state of postpartum emotional health. As highlighted in the table below, mothers' experiences were categorized into four general groups, according to their own descriptions of how they felt, emotionally, in the postpartum.

Table 3.1: Categories of Postpartum Emotional Wellbeing

Categories of postpartum emotional wellbeing	**Number of experiences captured**
Group A: • Mostly and mainly happy (emotionally very healthy)	14
Group B: • Low to moderate emotional distress (emotionally healthy, but wellbeing compromised)	11
Group C: • Moderate to high emotional distress (emotional wellbeing significantly compromised: mothers suspected possible PPD)	10
Group D: • Diagnosed with PPD (emotional wellbeing severely compromised; officially diagnosed with PPD)	10

n=45

As noted, I did not rely on the use of questionnaire-based devices, such as the Edinburgh Postpartum Depression Screening (EPDS), as my method of categorization. This was my intention at the outset of the study. However, as I proceeded through the research process, it was revealed—by the mothers themselves—that many declined to complete these questionnaires at the time they were offered.[9] As well, for those mothers who did complete the EPDS at their six-week immunization appointment, many felt that

[9] All mothers are asked to complete the EPDS when they bring their babies in to receive their first set of immunizations. This is a questionnaire-based screening tool, commonly used to screen for symptoms of postpartum depression. These immunization appointments generally occur at about six weeks postpartum. Mothers go to a community health centre for this appointment.

their EPDS scores did not adequately capture their overall experience or emotional state. As the table highlights, however, I did make a general distinction between mothers who had received a *clinical diagnosis* for postpartum depression, and those who thought that they might have had PPD but did not seek and/or receive an official diagnosis. This was done, in part, in response to ongoing debates about where and what the actual boundary is between "depression," "sadness," and otherwise "normal" adjustment experiences.

The different kinds of experiences captured in each of these categories are described in greater detail in the following chapter, in the context of this study's main analytical concept—that of "adjusting."

Chapter 4:
The Basic Process: Postpartum Adjustment

As described above, stories from across the spectrum of emotional wellness—from mostly and mainly happy to clinically depressed—were sought for inclusion in this research. Given such diversity, the analytical question became focused on understanding what, if anything, might be common about these mothers' experiences. As also described above, grounded theory studies aim for the discovery of a core category or process.[10] This basic process or core category is the central analytical theme: it connects with all the other analytical categories generated from the data, and provides unity to the theoretical model. The emergence of this study's basic process—"postpartum adjusting"—is described below.

4.1 The Emergence of the Basic Process: Postpartum Adjustment

As noted above, the sample of mothers interviewed for this study was initially categorized according to how they identified and described their overall state of postpartum emotional wellbeing. Through the process of interviews and analysis, however, it was increasingly revealed that the mothers' descriptions of their postpartum emotional health were intimately connected to a broader narrative about "adjustment." In this context, mothers' descriptions and understandings of their postpartum emotional health were very much situated within a story about their challenges and successes in adjusting to their new realities and responsibilities as mothers.

Adjusting, then, emerged as the basic social psychological process for this study. It was the main concept that connected together the varied experiences of the 33 mothers I interviewed. It answered the fundamental inductive question, "what are these mothers'

[10] The basic social process could be either a basic social psychological process (BSSP) or a basic social structural process (BSSP) (Strauss 1987).

stories about?" I adopted the specific term "adjusting" as the main label for this process, as it was the term most commonly used by the mothers themselves to describe what their postpartum experience was all about. As Fiona[11] and Fran articulated, for example:

> you can change anything you want to change about the situation besides the fact that I was giving birth to my first child and I think it would have been the same. I think it was a normal adjustment period. I think that it was just something I had to go through. (Fiona, mother of one; group C)

> it's a big change...when you have a baby. And it was really hard to kind of adjust to it all. (Fran, mother of one; group C)

Regardless of whether it was their first child or their fourth—and regardless of where they placed themselves along the continuum of emotional wellbeing—the mothers in this study spoke of their postpartum experiences essentially as experiences of adjusting.

The main difference among the mothers' narratives of adjusting, however, was that they described having an easier or more difficult time with this process. Basically, mothers who experienced more compromised levels of emotional wellbeing described having "a harder time" adjusting. Conversely, mothers who described overall more positive levels of postpartum emotional wellbeing described their emotional wellbeing in terms of feeling like they were "adjusting well" and/or that they had adjusted without too much difficulty. Excerpts from Danielle and Emily illustrate this connection:

> I've just had a lot of difficulty....felt really a lot of anxiety and a lot of guilt. I started feeling um I thought I was a bad mom....It's been a slow process adjusting and I'm not quite there yet, but definitely feeling better than I was. (Danielle, mother of one; group D)

> I'd say I've adjusted well. I was probably better off than the average mother, just because I do feel everything's gone just so smoothly.....Yeah. It's been pretty easy. (Emily, mother of one; group A)

[11] Pseudonyms have been used to protect the anonymity of the research participants.

Essentially, mothers' assessments of how easy or difficult they found this process to be reflected how "able" they felt in accomplishing the work of adjusting. Having "a really tough time"—a common phrasing among the mothers in this study who experienced considerable difficulties—was a main indicator of their degree of struggle in accomplishing the various *tasks* of adjusting, which are described in the following chapter. "Adjusting difficulty," in this context, was described by the mothers in this study as a function of "how well" they felt they were able to accomplish the work of adjusting.

In this way, the mothers' stories align closely with literature on "the psychology of adjustment," (Miller, Yahne and Rhodes 1990) which focuses on the relationship between stressful life events and coping processes. In this literature, the concept of adjustment is treated as both a process and an achievement. Lazarus (1976: 15) articulates the following in this context:

> adjustment is regarded as an *achievement* that is accomplished either badly or well. This is a practical way of looking at the matter because it permits us to turn to such questions as how unsatisfactory adjustment can be prevented and how it can be improved. The second perspective is adjustment as a *process*. We ask, "How does an individual, or how do people in general, adjust under different circumstances, and what influences their adjustment?

The interest of this field of study is thus two-fold—understanding the processes of adjustment, as well as the outcomes of adjustment. In other words, the interest is to understand the different ways people cope with various situations and stressors, as well as to understand "how well or badly adjustment is accomplished" (Lazarus 1976: 127).

Within this theoretical perspective, depression and emotional distress are treated as expressions of difficulties adapting to particular life events or changes (Brown &

Harris 1978; Mirowsky & Ross 1989; Ball 1994; Lazarus 1976, 1991, 1999; Eckenrode 1991). As Mirowsky & Ross (1989: 181) argue:

> some people are more distressed than others primarily because they are in difficult circumstances which their personal histories have not prepared them to master.

In this context, Mirowsky & Ross (1989: 129) further argue that "distressing events" are those which are interpreted as undesirable and threatening to peoples' sense of control:

> undesirability is highly salient...because it is an evaluation of consequences. *Undesirable events mark transitions to worse positions* ....Some of these represent losses of income, power or prestige....Some of these losses involve emotional support....In each case, it is not the event per se, that is important, but what the event signifies (emphasis original).

Also central to this theoretical framework, then, is the concept of subjective appraisal—that one's appraisal of their situation is central to understanding how they cope with, or adapt to, that situation. As Lazarus (1999: 9) argues, appraisal "has to do with the way diverse persons construe the significance for their wellbeing of what is happening and what might be done about it."

The work of Lazarus (1976, 1991, 1999) is particularly helpful in this regard. Lazarus uses the analogy of a seesaw, where the "environmental load [is] on one side of the balance point or fulcrum and the person's resources [are] on the other side" (Lazarus 1999: 58). In this sense, mothers' descriptions of feeling more or less "able" to accomplish the work of adjusting can best be understood in the context of their appraisals about their situations; in particular about the relative balance between the magnitude of their adjusting tasks (the things they have to do in order to "feel adjusted") and the adequacy of their personal adjusting resources (the things that facilitate their abilities to accomplish these tasks). These two topics are the focus of Chapters 5 and 6, respectively.

4.1.1 Categorization of the sample: Capturing variations in "adjusting difficulty"

As noted in Chapter 3, mothers' postpartum experiences were categorized into four general groups, according to their own descriptions of how they felt in the postpartum. However, these four general categories of emotional wellbeing also emerged as being reflective of mothers' varying experiences of *adjusting.* Specifically, they provided an indication of "how well" mothers felt they had adjusted or were adjusting to their new lives, realities, roles and responsibilities as mothers. This connection is highlighted in Table 4.1, and described in detail below.

Table 4.1: Categories of "Adjusting Difficulty"

Categories of "adjusting difficulty"	**Number of experiences captured**
Group A: • Mostly and mainly happy (emotionally very healthy) • Adjusted well/had little difficulty adjusting	14
Group B: • Low to moderate emotional distress (emotionally healthy, but wellbeing compromised) • Experienced some difficulties adjusting	11
Group C: • Moderate to high emotional distress (emotional wellbeing significantly compromised: mothers suspected possible PPD, but never sought diagnosis) • Experienced considerable difficulties adjusting, but ultimately still able to adjust without medical intervention	10
Group D: • Diagnosed with PPD (emotional wellbeing severely compromised; officially diagnosed with PPD) • Experienced extreme difficulties adjusting /felt unable to adjust without medical intervention	10

n=45

Fourteen mothers had postpartum experiences that fit into the first analytical category, Group A. These mothers described their overall general state of emotional health throughout the postpartum in very positive terms. They generally rated their emotional wellbeing at about an "8" or a "9" out of a possible "10." Typically, these mothers emphasized that, overall, they felt they had adjusted well to the birth of their new baby, and to their new realities and responsibilities as mothers. Notably, these mothers also tended to reflect on their adjustment experiences as being relatively smooth—in comparison to others' experiences or in comparison to what they had expected—and not overly difficult. Emily is an example of a mother whose experience fit into this category of emotional wellbeing. The following excerpt from our interview provides an illustration of the experiences that were included in this category:

> I think probably I've been at an 8 ½ to 9....overall it's been pretty good....There's been no real difficulties....and so yeah, overall, everything that I've experienced I definitely think has been better than average. (Emily, mother of one; group A)

The second analytical category included mothers who described their emotional wellbeing as being in a middle-range, in relation to the full breadth of postpartum experiences represented in this study. These mothers typically rated their general state of emotional health as ranging between a "5" and a "7," on average. Many of these mothers also described swings in their emotional state, explaining that some days/weeks would be quite low—a "2" or a "4" for example, while others would be much better—a "6" or "7," for example.

In general, these mothers described their postpartum emotional wellbeing as being somewhat compromised, but they did not feel that they were depressed. Overall, they still felt able to accomplish the work of adjusting, albeit with challenges. In general, these

mothers described their postpartum adjustment experiences as being more difficult, and/or as taking longer, and/or as being a "bigger" process than the mothers in the first category. Kiera, quoted below, is an example of a mother whose experience fit into this category of emotional wellbeing:

> I would always say I was at the 5 to 10 mark, generally. But, like I said, there were days when you know…you're just upset and exhausted…that I would have gotten to about a 3….that was the hard part. I don't know if you just get so caught up in the moment or you're just so exhausted that you can't even think beyond what's happening in the moment…..I was definitely familiar with the idea [of PPD] and everything like that. But because I often felt successes along with—I was fairly sure that no, I wasn't clinically you know, I wasn't going to be clinically diagnosed with post-partum depression. (Kiera, postpartum experience after first child; group B)

The third analytical category of emotional health included mothers who experienced considerable emotional distress during the postpartum but who *had not* been formally diagnosed with postpartum depression. This category encompassed 10 of the 45 experiences captured in this study. Most of these mothers wondered if perhaps they had had postpartum depression, however, they did not pursue professional intervention or diagnosis. Two of the mothers included in this group had been diagnosed as having PPD, but told me that they disagreed with their diagnoses, stating that they ultimately managed to adjust without requiring medication, and that, by and large, their experiences and situations were "normal."

The mothers in this analytical category typically rated their overall emotional health as ranging anywhere from approximately a "2" to a "5," many again reporting considerable swings in their emotional state. In all cases, these mothers did feel that their emotional wellbeing being improved over time, without requiring professional intervention or medication. These mothers did, however, describe having "a tough time"

in the postpartum, and described considerable difficulties in their postpartum experiences. Mary is an example of a mother whose second postpartum experience fits this category:

> I felt very overwhelmed…I remember when I brought the baby in for his immunization at two months and they do the postpartum screening, and they have a series of 10 questions. And the nurse looked at me and said to me "you scored right on the line, how are you feeling?" Well when she said that, I felt very defensive, and I said I felt fine. And some part of my head said "…something's not right. You should be feeling…better." And I knew that I should be feeling better and I wasn't…..I remember saying to my husband, "I'm so tired." And I was crying at the dinner table, and [the baby] was probably a good six weeks, two months old, and I remember saying, "I'm just so tired, I don't even know why I'm crying, I'm just not happy. I feel like I should be happy, but I'm just so tired…..I think I just didn't feel like I was extreme enough to be able to validate going and getting help. (Mary, postpartum experience after second child; group C)

Fiona was another mother whose experience fit into this general category:

> I found it a really big adjustment….I just didn't realize how hard it would be and how much it would affect every part of my life…..Every day I think to myself, what have I done? What have I gotten myself into? But at the end of the day…I think I just—I think I'm managing. (Fiona, mother of one; group C)

The fourth category derived for this analysis included mothers who *had been* diagnosed with postpartum depression. These mothers typically described their experiences in terms of feeling unable to "handle" all that their new realities brought. These mothers felt chronically overwhelmed and burdened by the magnitude of their new responsibilities. They described very low states of emotional health, generally rating their wellbeing as being between "0" and "4." One of these mothers entertained suicidal thoughts and thoughts of infanticide, and one mother had attempted suicide. In general, these mothers felt that they were *not* coping with their new realities and responsibilities, and described having an extremely difficult time adjusting. Tianna and Chris are examples of mothers whose experiences fit into this general category:

> [I felt] very overwhelmed. Very overwhelmed. I had done lots of reading. I read every book imaginable, you know, giving birth and the first couple of months, and I thought, okay, I can do this. But when she came I was so exhausted—I had no idea. I thought, "what did I do, I shouldn't have done this"....I found being on maternity very lonely. And we had no money. And I felt very depressed. My husband would come home and have a lot to talk about, but I didn't have anything to talk about. My day was unloading the dishwasher. Yeah, it wasn't very positive. But then when I came back to work I felt very overwhelmed with having to come back to a job after a year. Because everyone had gotten used to the new person and then I had to meet with her, get [baby] ready in the morning, and I found that hard, too.....I felt very hyper all the time, like nothing was back to normal, I was crying all the time. And finally my husband said, you know, I think something is wrong. And my mom had noticed it. My best friend had noticed it. So I went in to talk to the doctor and the first time I saw this guy I started crying. So he gave me a prescription. In no time I started to feel like me again....I felt like I could handle things a lot better. (Tianna, mother of one; group D)

> it was like I couldn't handle life....I just really, I just felt very overwhelmed....I didn't understand how come I felt like I wasn't capable of handling it. I guess doing the job of being mother to two babies at the same time and—yeah, I just felt really overwhelmed. (Chris, postpartum experience after second baby; group D)

In all, there were 10 experiences that fit into this fourth category. All the mothers in category decided to go on medication, at least temporarily, after being diagnosed.

In general, mothers' descriptions of having an easier or more difficult time adjusting were articulated as a function of the relative congruence between magnitude of their particular adjusting requirements (the things they had to accomplish in order to feel adjusted—as detailed in Chapter 5) and the adequacy of their adjusting resources (the things that facilitated their abilities to accomplish their adjusting tasks—the topic of Chapter 6). Mothers' descriptions of how easy or "tough" a time they had adjusting also varied according to how long and/or how intensely they experienced the stage of "early adjusting." The main stages of the postpartum adjusting process are described below.

First, however, it is important to note how the mothers also variably described their adjusting experiences in relation to the concept of responsibility.

4.1.2 The concept of responsibility

What, exactly, did the mothers in this study feel that they were adjusting *to* in the weeks and months after having a baby? Obviously, they were adjusting to their new baby and to the various changes that this baby brought to their lives. There was, however an underlying element to mothers' narratives that was especially "weighty" and particularly defining of what their adjusting stories were about. This is the element of responsibility. As Tammy remarked in this context, when you have a baby "there is this amazing fear that you have that I am suddenly in the world alone with this child."

Being responsible for the life of another has been identified by others as a central characteristic of the mothering role and experience (Stern & Bruschweiler-Stern 1998; Bergum 1989, 1997). The act of becoming a mother involves the taking on of absolute responsibility for the survival and wellbeing of one's new baby, a being which is completely dependent and virtually helpless. In this context, mothers' "realization that they suddenly hold ultimate responsibility for someone else's life...[can be] absolutely daunting" (Stern & Bruschweiler-Stern 1998: 11). Tianna's and Tammy's comments illustrate the significance of this realization of their new responsibilities as mothers:

> the responsibility. I'm responsible for this little person. Everything I do and say and every action I do in my life is going to affect this child. And you think about that before you have them but it's not really real until you're having this little baby. (Tianna, mother of one; group D)

> there was just this tiny little thing that I was going to be taking home and responsible for....mentally, it was hard to get my head around the fact that I was now responsible to take care of this child—for like a millennia. (Tammy, mother of one; group A)

And while various significant others—the baby's father or grandparents, for example—may share some of this responsibility for the child, mothers generally identified the "ownership" of this responsibility as principally their own. This was the case for the single mothers interviewed, as well as those who were married or partnered. Jan, one of the married mothers from this study, for example, talked about how this sense of responsibility was so fundamental to her sense of self as a mother, it influenced how she and her husband organized their division of labor with respect to child care. She stated the following:

> see, this is where things become so complicated. Because if I told [my husband] to stay home from work and take care of [baby] because she's sick he would do it. He would phone in and stay home. But I don't want him to. Because I'm her mom and I want to take care of her myself.....so I'm kind of elbowing him out in that respect. (Jan, mother of one; group B)

Mothers, then, interpreted the ownership or acceptance of this responsibility for the survival, wellbeing, and raising of the child as central to what it meant to be a mother.

In this respect, mothers' experiences of adjusting very much involved the experience of accepting and "owning" this new and enormous responsibility. As Eagan (1985: 3) has also noted in this context, "a woman first begins to feel like a mother as she develops a profound sense of being completely responsible for her child." Stern and Bruschweiler-Stern (1998: 16) have referred to the acceptance of this responsibility as the development of "task ownership." They define it thus:

> you own the responsibility, so that any successes and failures, even if they are brought about by others, revert to you.

Importantly, the responsibility of motherhood is a source of both burden *and* pleasure/empowerment (Parker 1995; Genovie & Margolies 1987; Bergum 1989, 1997;

Stern & Bruschweiler-Stern 1998). As Parker (1995) argues, the responsibility of motherhood is an inherently ambivalent experience: it is at the same time both a burden and a blessing. This interpretation of the concept of responsibility as encompassing both a dimension of "burden" and a dimension of "purpose/pleasure" has also been described in the work of Ball (1994) and Parker (1995).

Notably, the mothers in this study described variations in their adjusting experiences in terms of their own understanding of what the responsibility of being a mother to their new child meant to them, to their lives, and to their sense of self. Specifically, mothers' interpretations of how difficult or easy a time they had adjusting reflected how burdened or overwhelmed they felt by their new responsibilities, *as well as how* empowered/joyful they felt by their new responsibilities.

The following table (Table 4.2) summarizes this connection between mothers' interpretations of their new responsibilities and their varying experiences of adjusting. In general, the ways that mothers described their experience of "adjusting difficulty" reflected their own understanding of what the *responsibility* of being a mother to their new child meant to them, to their lives, and to their sense of self.

For example, many of the mothers in this study who experienced PPD or high levels of emotional distress—i.e., who described having considerable difficulties adjusting—described feeling overwhelmed and/or overly burdened by their new responsibilities as mothers. This was how Danielle felt:

> it's the responsibility; [the baby's] dependence upon me. It's really overwhelming. I mean, I knew that he would be dependent on me, but when you actually get into the situation where its just— I'm finding it very, very lonely.....I feel I'm carrying a lot more of it than my husband....I thought that I wouldn't have to be the sole person. (Danielle, mother of one; group D)

Many of these mothers also described their experience of their new responsibility as being more of a "burden than a blessing" (Chris, postpartum experience after second child; group D), indicating that they did not appraise their new responsibilities as providing them with a feeling of purpose/pleasure.

Table 4.2
Adjusting Difficulty as Expressed
through Mothers' Feelings of "Burden" and "Purpose/Pleasure"

Appraisal of Responsibility along Dimensions of "Burden" and "Purpose/Pleasure"	Purpose/Pleasure: "low"	Purpose/Pleasure: "high"
Sense of Burden: "low"	not observed*	Low adjusting difficulty (groups A or B)
Sense of Burden: "high"	High adjusting difficulty (groups C or D)	Mid adjusting difficulty (groups B or C)

* This scenario, which was not observed in this study, would be that of mothers who experience a low sense of adjusting difficulty, and who also experience little sense of purpose from this responsibility. This appraisal—feeling neither burdened nor empowered by the responsibility of motherhood—could be hypothesized to exist among mothers who are not significantly invested in their new roles as mothers.

By contrast, mothers who had an easier time adjusting often talked about how their new responsibilities and realities as mothers provided them with a "sense of purpose," and a feeling of joy. These mothers also tended to feel that the weight of the responsibility for the child *was not* theirs alone to bear. As Ingrid commented in this context:

> I felt such a sense of relief when she was born…because now I wasn't the only one who was responsible for her….The sense that I'm not 100 percent responsible. I mean, I'm 99 percent now, but you know, daddy can go look after her for—you know, daddy can go make sure she's okay or grandma and grandpa, whatever. So suddenly it wasn't all hanging over my head. Because it is such a huge responsibility. (Ingrid, mother of one; group A)

Finally, mothers who described having more "mid-range" adjusting experiences often described feeling considerably burdened by their new responsibilities, but also described how they felt their new responsibilities provided them with an important sense of purpose/pleasure. This was Fiona's experience. Fiona, a sole mother with no family support, often talked about feeling overwhelmed by the magnitude of her responsibility. However, she also described that the weight of this responsibility was offset by the sense of purpose that her baby brought to her life, and the pleasure she derived from her baby. She stated the following:

> [the baby] wasn't planned. So, I'm a single mom. But I just—I really wasn't doing anything worthwhile. You know. Like I was doing the regular partying, you know, nothing meaningful, and now I'm going back to school and raising her, and I have my own place, and I have my things, and I just think that now I want to be somebody because there's someone who hopefully will want to be like me....I think it empowered me. You know, I think that overall it was for the best. (Fiona, mother of one; group C)

The work of Lazarus (1969, 1999) and others (e.g., Brown & Harris 1978, Mirowski & Ross 1989) is again useful, as this theoretical perspective emphasizes the importance of *meaning* (i.e., subjective appraisal) as central to understanding variations in people's adaptive experiences. These authors argue that it is not by "objective" assessments of the stressfulness of a particular adaptive phenomenon that determines personal experience. Rather, it is a person's own *interpretation* of that event —and their interpretation of the adequacy of their resources—which is of primary influence.

In the context of the above table, then, it is valuable to draw on the argument that individuals will appraise a stressful situation based on what that situation means to them. There are three main types of appraisals for any life event or change, including whether a

particular event represents a harm or loss to the self, a threat to the self, or a challenge for the self. Lazarus (1999: 76) distinguishes these three main types of appraisals as follows:

> harm/loss consists of damage that has already occurred. Threat consists of the possibility of such damage in the future...[whereas] people who feel challenged enthusiastically pit themselves against obstacles, feel expansive—even joyous—about the struggle that will ensue. (Lazarus 1999: 76)

Lazarus further argues that the primary factor determining whether a situation will be interpreted as a challenge or a threat, for example, has to do with the adequacy of one's personal and social resources. He states:

> situations vary greatly in whether they pull for threat or challenge. Some clearly impose too much demand on a person's resources to lead to challenge, and they are likely to be threatening, whereas other situations provide much latitude for available skills and persistence, and so encourage challenge rather than threat.....The more confident we are in our capacity to overcome obstacles...the more likely we are to be challenged rather than threatened and vice versa, a sense of inadequacy promotes threat. Because confidence in ourselves varies greatly among different people, individuals differ in whether they are prone to experience threat or challenge. (Lazarus, 1999: 77)

Using this theoretical formulation, then, it would follow that the experience of having a baby could be interpreted as a situation involving threat or harm/loss, or it could be appraised as a kind of challenge. Notably, the mothers in this study also described how various personal and social resources influenced their particular interpretations or assessments of their new responsibilities, and hence, their particular adjusting experience. These resources are the topic of Chapter 6.

4.2 Main Stages of the Postpartum Adjustment Process

Mothers' descriptions of their postpartum experiences revealed adjusting as a process which occurs over time, and which involves three main stages. And while the mothers in this study emphasized adjusting *as a process*, and as something that they "just

had to go through" (Tammy), adjusting was not something that "just happened" as they progressed through the postpartum weeks and months. Rather, the mothers' narratives revealed that postpartum adjusting is fundamentally a process of *self*-change, involving considerable effort and energy. Danielle, a mother of one, illustrates this meaning of adjusting in her following comment:

> what I do say a lot of the time, is that I just have to get used to it. Just change and adjust myself (Danielle, mother of one; group D).

However, while the process of adjusting emerged as being an inherently effortful and intensive process, the mothers talked about how did not always feel intentional or "in control" of their adjusting efforts. In many instances and during many periods, mothers described their main focus as being to "just cope," to "handle," or otherwise "just get used to" their new situations and circumstances. In other words, while they felt they were actively engaged in the work of adjusting, they did not necessarily feel like they were fully *in control* of their adjustment intentions and efforts.

In this respect, mothers' narratives of adjustment typically encompassed three main phases of adjusting activity—a period of "just coping" and of "coming to terms" with their situations, followed by a period of "feeling more in control" and of "making conscious decisions" about their various adjusting needs and activities. The final stage marked the completion of the process, the point at which mothers described "feeling adjusted."

In general, mothers first experienced an early adjusting stage where their adjusting efforts were focused on adapting and initially "coming to terms" with their new realities. The second main stage of adjusting—later adjusting—was indicated by mothers being more intentional in their language and behaviors. The transition between these

stages of adjusting was marked primarily by the experience of control and physical wellbeing. Specifically, mothers described progressing from the early stage of adjusting to the later stage of adjusting as they felt themselves *regaining control* over their day-to-day lives, over their ability to plan and prioritize, and over their own physical wellbeing. Cox (1996: 12) has also noted this general pattern as follows: "women...can be seen as undergoing a rite or passage...[where] they become separated from old roles, go through a limbo-like period of transition and are then incorporated into a new set of roles."

4.2.1 Early postpartum adjusting

In general, the early stage of the adjusting process was marked by an experience of loss of control. As part and parcel of this early adjusting stage, mothers often also described feeling considerably whelmed or even overwhelmed with their situations, feeling frustrated, angry or anxious, and feeling physically very tired. Gabrielle and Bettina provide the following descriptions of this general stage of the adjusting process:

> all of a sudden here's this baby and you have no control over it and you have no control over anything else in your life. Everything's just happening *to* you. (Gabrielle, postpartum experience after first child; group C, emphasis original)

> I was mentally and emotionally and physically exhausted.....And it was just—it was hard....I was too overwhelmed to deal with everything, like to deal with other people. Like all my energy was going towards [baby]. (Bettina, mother of one; group A)

Many mothers also described this stage in such ways as "being in a fog," as "feeling like a zombie," or as feeling like "everything was a blur." As Bettina and Fiona commented in this context, for example:

> like initially it's all a blur. The first few weeks after and in our mom's group they were saying that you're kind of a fog. You stay in a fog and then it kind of clears up and gets better. (Bettina, mother of one; group A)

> the first couple of months I was seriously like I walked around like a zombie. I was like this is crazy. Like I knew it wasn't going to be easy. I never expected it to be easy. But I never in my wildest dreams imagined it being that difficult. Like it just it was crazy. (Fiona, mother of one; group C)

The mothers in this study commonly described this early stage of adjusting—especially as it occurred in the early postpartum weeks and months—as being heavily focused on adapting to, and coming to terms with the immediate demands of their new realities. They spoke, for example, about "getting used to" (Danielle) their new realities and responsibilities, about "figuring out" (Alice) what to do, about trying to "handle" (Chris) all the changes the birth of the baby brought to their lives, and that they often felt like they were "just coping" (Astrid).

Mothers also often characterized this early stage of adjusting as being marked by a general feeling of amplification and intensity—both positive and negative. As Jill described, for instance:

> the post-partum quite magnified the good and bad. Yeah. I guess the immediate post-partum experience was just that, it was a magnification of everything. (Jill, postpartum experience after second child; group D)

For many mothers, this included feelings of extreme joy, coupled with feelings of extremely low mood and sadness. For some mothers, however, this stage was characterized by a general *absence* of feeling—or, as Beth described it, "feeling blah."

These kinds of descriptions from mothers about early adjusting align in certain respects with the literature on the phenomenon of "baby blues," which describes a period of emotional highs and lows immediately after the birth of the baby. Baby blues are believed to affect the majority of mothers, and are understood to be a "normal" part of the experience of having a baby (Miller 2002). Many researchers attribute the baby blues to

the sudden drop in hormones that occurs with the baby's birth (Harris et al. 1994). The literature discusses the baby blues as a generally transitory experience, acknowledging that they tend to diminish after the first few weeks after birth.

Similar to this description of the "baby blues," the mothers in this study generally described experiencing poorer levels of emotional wellbeing during this early stage of adjusting than during the stage of later adjusting. Importantly, however, it *was not* only hormonal changes that the mothers attributed these initial experiences to. The mothers in this study also attributed their lowered emotional wellbeing during the early stage of adjusting to their particular situational realities—circumstances which are highly typical of mothers' postpartum contexts in Western societies today (Villani & Ryan 1997; Barclay & Lloyd 1996). These situational realities included moderate to severe levels of sleep deprivation, a loss of control over routines, time and personal freedoms, and being considerably whelmed or overwhelmed, and frustrated or angry with the strains and difficulties of caring for a new baby. As Annabelle opined in this context:

> it was...stressful, like because the lack of sleep, because the first one was still not sleeping very good, and getting up every three hours with the other one. It was like really hectic. Lack of sleep was the big, was a big factor. (Annabelle, postpartum experience after second child; group D)

As well, many of the mothers in this study felt that their experiences of early adjusting lasted for much longer than just the first few weeks postpartum, the generally agreed-upon parameters of "the baby blues" (Miller 2002). Many mothers characterized this stage as lasting a number of months. As Gabrielle stated about her experience, for example:

> once he was sleeping some at night, things got a lot better at that point. Once he got to be a more settled baby, you know, sort of around six

> months, eight months, things got way better. (Gabrielle, postpartum experience after first child; group C)

Furthermore, these general features of early adjusting—overwhelm and/or frustration/anger, fatigue, and the experience of loss of control—were also experienced by some mothers a number of months *after* the baby's birth. This was Fran's experience. For her, it was her first few weeks postpartum, as well as when her baby reached about six months of age (when she returned to her graduate studies) that she described feeling overwhelmed, frustrated, fatigued, and a loss of control. Figuring out "how to cope" became a primary focus for her at this time. She stated the following about her experience:

> after those initial few weeks, the first six months…it was kind of just really plateauish. It wasn't really a lot of up and downs, she was a good baby. But then, you know, around six months there it went totally downhill. Like there were points where I was an absolute disaster. Like I punched holes in our wall. And kicked holes in our wall. And like, that is not me. I'm so easy-going all the way. But I was just so frazzled. I was burnt out….yeah, from 6 to 12 months was that really difficult…..I was just overwhelmed, I think. Not understanding how to cope with, mentally, with the changes. And not getting sleep and all the things you need to have in mind that your baby needs, I don't know, just so much, so overwhelming. (Fran, mother of one; group C)

In this respect, early postpartum adjusting does not appear to be the same thing as the "baby blues," nor does it appear to be limited to a particular period of time. While hormonal changes certainly would be expected to influence mothers' experiences in the early days and weeks after the baby's birth, this analysis revealed that something else was also going on. This "something else" is what I am calling "early adjusting." It emerged as an integral part of the adjustment process, and was described by the mothers as being focused on "getting used to," "coming to terms with," and otherwise "handling" their new realities, responsibilities and relationships.

In general, mothers who described experiencing greater difficulties adjusting—including those who had been diagnosed with postpartum depression—described this early stage of adjusting as lasting longer and/or as being more intense, as compared to mothers who had "an easier time" adjusting. These mothers experienced greater difficulties in regaining a sense of control, and in being able to engage in more intentional and consciously-focused adjusting work. *In short, mothers who suffered from greater levels of postpartum emotional distress generally felt that they were "stuck" in this early adjusting stage for a much longer time, and that it was more difficult for them to get out of this stage and into the later stage of postpartum adjusting.* This is perhaps unsurprising, given that this stage of adjusting was described by most of the mothers as being associated with lower levels of emotional wellbeing as compared to the stage of later postpartum adjusting.

Mothers' lower emotional wellbeing during this stage had a lot to do with their experiences of physical fatigue and sleep deprivation. As Jan described, for example:

> it's like for me, if I don't get enough sleep at night, I do become mildly depressed. Like I become much more pessimistic. I become more susceptible to feeling stressed out. And that can start a spiral of "okay I'm stressed, I don't feel like doing it, I'm feeling frustrated and angry" and for me a lot of it has to do with just not getting a good sleep. (Jan, mother of one; group B)

As well, the mothers intimately described the emotional and the physical dimensions in such ways as feeling "physically and emotionally drained" (Beth, postpartum experience after first child; group C), or about feeling "physically and emotionally exhausted" (Leslie, postpartum experience after third child; group D), for example. Comments from Beth, Mary and Gabrielle further illustrate the connection the mothers made between their physical wellbeing and their emotional wellbeing:

> I think I wondered, is this post-partum depression or, you know....I slept very little.....that was a big—you know, not getting any sleep at all, well, and I could feel myself—if I don't sleep I cry. (Beth, postpartum experience after first baby; group C)
>
> I didn't know how much of it was depression and how much was exhaustion. (Mary, postpartum experience after second child; group C)
>
> looking back on it, I think I probably did have a bit of what they call post-partum depression. I certainly wasn't myself and you know, whatever causes it...obviously, a big part of it is sleep deprivation for sure. (Gabrielle, postpartum experience after first child; group C)

In this context, the mothers in this study did not feel themselves transitioning out of this early stage of postpartum adjusting until they started "feeling more rested" and physically recovered.

4.2.2 Later postpartum adjusting

The mothers in this study described a point at which they felt themselves feeling more intentional and "in control" of their adjusting efforts. The transition from early to later adjusting was key for these mothers, as it indicated that they were experiencing success in the adjusting process. As Ball (1994: 6) points out in this context, "success in achieving some degree of coping will eventually lead to full adjustment".

In general, mothers' experiences of transitioning from early to later adjusting were marked by two things: they felt that they had regained some control over their day-to-day lives and activities, and they had started to feel physically recovered and rested. The mothers often described this transitioning experience as "a turning point," a "breakthrough," or as the point at which "things started shifting," for example. As Keira's story illustrates:

> I was thinking the turning point for me was around the nine month mark. It was summer at that point that you know, they are getting a bit more independent...and those were sort of the days when I can get a picture of a

> little bit more freedom happening; they're sleeping better – [the baby] had a regular nap time so I *knew* I had a period of time that he would be sleeping. And if I wanted to I could just sit or go sit outside for a little bit or even just take a little bit of a nap, that there's some routine to what he did, so that I could have time for me alone. (Kiera, postpartum experience after first child; group B)

Mothers also often talked about the necessity of feeling connected to or "in love with" their babies before they felt themselves transitioning out of the early stage of adjusting. This was Mary's experience:

> my son was about four months. And I was feeling better by then, because I remember talking to the nurses at the Health Centre and saying "I've had a hell of a four months." And I remember the nurse asking, "well, how are you feeling now?" And I said "I'm feeling like I'm honestly starting to fall in love with my son....I can feel myself waking up." (Mary, postpartum experience after second child; group C)

"Connecting with the baby" emerged as one of the major *tasks* of the adjusting process, and is discussed in the following chapter.

Mothers' experiences of transitioning into the stage of later adjusting occurred more or less gradually. Jan, for example, remarked that, for her, adjusting was "a gradual uphill," while Mary, similarly, commented that her transition "was really gradual." By contrast, other mothers experienced this transition as taking place much more suddenly. Suzanne, for example, described her experience as follows:

> something happened right around when he was three and a half to four weeks old.....I just felt like things shifted. I was sleeping a bit more, and the bonding, and things were really coming. I fell in love with the whole idea of motherhood, and him, and everything, and just all of a sudden I was having fun. (Suzanne, mother of one; group B)

As these excerpts illustrate, the transition from early postpartum adjusting to later postpartum adjusting was indicated by mothers' sense that they (and also their babies) were feeling more settled or rested, and that they were regaining a certain amount of

control over their time, their routines, and their day-to-day lives. As such, this transition was also marked by a general shift in the mothers' stories.

Typically, mothers characterized their later adjusting experiencing as being marked by improved emotional and physical wellbeing, as well as greater intentionality in, and control of, the planning and execution of their day-to-day activities. In this later stage of adjusting, mothers were actively reconstructing their day-to-day lives—and hence, their identities—with focus and intent. As Jill commented in this context, this stage was marked by attempts to "put everything in its place—finding how things fit together best."

Mothers described later adjusting as typically being focused on integration and the search for balance, as well as on "getting back to [their] own things." Conscious decision-making and active reflection on, and renegotiation of priorities, expectations, and activities occupied centre stage for the mothers in this adjusting stage. As Jan, for example, said about her struggles to integrate motherhood with her career, she had to "consciously define, what do I really want to do?" Nancy's comment, below, is also illustrative of the active and intentional character of later adjusting:

> I've done a lot of work making changes in my life, little changes here and there. I now take time for myself. That's been huge for me. To work on identifying my own needs. Communicating to my husband and just being clear about when I need a break. (Nancy, mother of one; group D)

Similar to the earlier stage of adjusting, later adjusting lasted a longer or shorter period of time, ranging anywhere from a number of weeks to many months or even years. As well, for some mothers, it began within a month or two after the birth of the baby, while for others it did not begin until many months after birth, or even after the baby's first birthday.

4.2.3 "Feeling adjusted"

As mothers proceeded through the process of adjusting to their new roles, responsibilities and realities, they reached a point at which they ultimately described "feeling adjusted." Mothers' descriptions of this "settling point" (see Eagen 1985) included such ideas as the feeling of "getting back to normal," and of "feeling like myself again," for example. The following excerpts from Fiona and Fran illustrate how the mothers in this study described the experience of "feeling adjusted:"

> [the baby] came in and she shook everything around, but I think in the end everything kind of fell back in order again. (Fiona, mother of one; group C)

> I think that first year I felt like I didn't know who I was. I lost all my sense of being. That was kind of like how I felt. And when I got back to school, I really—you know, the first semester back when I starting taking care of my life, I felt really uncertain about myself. I didn't know what was going on with me. And then the second semester I just kind of, Okay, yeah, I remember who I am. I remember what I'm doing. I remember what I was doing before. And it all started to feel better. Like I started feeling like myself again. Which was huge because I felt like I'd totally lost that. (Fran, mother of one; group C)

Importantly, the point at which the mothers in this study described "feeling adjusted" varied considerably, ranging from a few months after the birth of the baby to well over a year.

Mothers' experiences of "feeling adjusted" thus marked the achievement or completion of the process of postpartum adjusting. The accomplishment of this process is what Ramona Mercer (1985; 1995) describes as the development of an integrated maternal identity:

> [once] she has integrated the [maternal] role into her self system with a congruence of self and other roles; she is secure in her identity as a mother, is emotionally committed to her infant, and feels a sense of harmony...and competence in the role" (Mercer, 1995:14).

This was largely how the mothers in this study described the experience of "feeling adjusted."

They spoke, for example, of such things as having figured out "how to be fully myself and fully a mom and somehow mesh them" (Jill). Astrid and Ingrid also articulated this point well in their following comments:

> for me it was like, yeah, finally kind of getting things back in order. Getting things going again, yeah, you know. Because I had only gone back to work a couple months before that, at 12 months, so feeling like I was finally getting back into the swing of it. (Ingrid, mother of one; group A)

> for me, it was about having figured out this whole, well, what kind of mother am I and how do I want to mother? And how do I manage all of it? How do I find a life for myself in all of this as well? (Astrid, postpartum experience after first child; group A)

As can be gleaned from Astrid's comments, "feeling adjusted," for the mothers in this study, was about "feeling like a mother" *and* "feeling like myself." Fran and Holly's comments also emphasize this theme:

> for me it was really about trying to integrate the child with my life, and with who I was and who I've become. (Fran, mother of one; group C)

> I don't want to lose myself in being a mom. And being a mom is great. I love being a mom. But to me that can't define the totality of who I am. (Holly, mother of one; group B)

As Block (1990: 3) describes in this context, the postpartum adjusting is, more than anything, about mothers' "struggle to integrate motherhood into their existing identities."

Mothers' descriptions of "feeling adjusted" supports the work of others who have conceptualized mothers' postpartum experiences specifically as culminating in the acquisition of an *integrated* maternal identity (Mercer 1986; Eagan 1985; Miller 2005), as opposed to simply the acquisition of a maternal identity (Rubin 1967a, 1967b, 1984; Ball

1994; Barclay et al 1997; Kurtz Landy & Sword 2006; Lu 2006). Mothers' descriptions in this regard also highlights that this "adjusting goal" is not unique to first-time mothers—an important finding given that the majority of research on this topic is limited to the experience of first-time motherhood (e.g., Miller 2005; Mercer 1986; Barclay et al. 1997; Rossiter 1988; Wilson 1982; Oakley 1979, 1980; McMahon 1995).

Importantly, however, "feeling adjusted" was not described by the mothers as being only about internal changes—about a psychological exercise of "figuring out of who I am." Rather, the mothers talked about how the reconstruction of their identities occurred *through* their day-to-day actions, interactions, thoughts and feelings. In other words, the process of adjusting involves the accomplishment of a variety of adjusting tasks. This aspect of the adjusting process is the topic of the following chapter. First, however, a note about variations in the length of this process.

4.3 Variations in the Duration of the Adjustment Process

Mothers described considerable variation in terms of how long this process took, both as an overall process, and in relation to the accomplishment of any of its major tasks (as described in the following chapter). Among the mothers I interviewed, a time period of approximately one year after the birth of their baby was commonly noted as the amount of time it took them to "feel adjusted." Tammy's experience was one such example:

> I had no idea what having a child would be like...the adjustment to having a child in your life....[and] adjusting to the baby in the first six to nine months was very good, I think when I listen to some other people's stories....By the time he was a year old I was actually getting back to my own things. I was taking time for myself. You knew what it felt like. (Tammy, mother of one; group A)

That said, however, the overall duration of mothers' postpartum adjusting experiences varied enormously, from a few months, to a number of years.

Jan, for example, spoke of the process taking, in all, about two years for her:

> it wasn't until she was about two years old that I finally felt like, okay...I've got my wind back....I think for about two years I was just—I don't know....I definitely was tired and very—in a more negative place than I am now. And that I hadn't been before [she was born]. I found it very difficult. (Jan, mother of one; group B)

As well, Heather, a married mother of two, described her adjusting work as taking considerably longer after the birth of her second baby than her first. She stated the following about her second postpartum experience:

> its been a long time coping....but you know, I started feeling really good about the last year [when my daughter was two]. Now, I feel just great. But there was a lot of change in really three years. (Heather, mother of two; groups A and D)

Other mothers, however, particularly some (but certainly not all) second, third and fourth-time mothers, described "feeling adjusted" after only a few months. These mothers often described their adjusting experiences as being easier the second or third or fourth time around, as they "knew what to expect," and felt that the new baby fit into their existing lives a bit easier.

This was the experience of Gabrielle, a mother of two. Gabrielle described the process of adjusting after the birth of her first child as taking, in all, approximately one year. After the birth of her second child, however, she said she "starting feeling like herself again" after only a few months. The contrast between her two postpartum experiences is highlighted below:

> [after my first child], I'd say probably the first six months, you know, I wasn't really happy. I was just sort of getting along. And after that things improved a fair bit and by the time he was about 10 or 11 months I went

> back to work and it really helped....I was feeling pretty much like myself again. (Gabrielle, postpartum experience after first child; group C)
>
> [after my second child], the first couple of weeks weren't great....It was frustrating again...But um then she started sleeping better. Sleeping a little bit longer stretch.....I'm feeling pretty much like myself again. You know, by a couple months in. (Gabrielle, postpartum experience after second child; group A)

Among the mothers I interviewed, longer adjustment periods were generally more common among those who experienced greater difficulties adjusting. Most typically, mothers who experienced greater difficulties adjusting described being in the stage of "early adjusting" for a longer period of time.

There are two implications from this finding about the variability of this process in terms of "how long" it took mothers to feel adjusted. First of all, this study's finding that mothers' experiences of postpartum adjusting often occur well into, and even beyond, the first year after birth has implications for the conceptualization of the "the postpartum period" as the primary period of adjustment and recovery. The conventional characterization of the postpartum period—defined as including the first six weeks after birth (Ball 1994)—is the time period typically used for assessing mothers' emotional outcomes, particularly whether or not mothers might be experiencing symptoms of postpartum depression. However, as Ball (1994: 15) points out in this context:

> we have no real basis for assuming that there is any period which could be considered to be the "proper" time within which a woman *should* be able to adjust to the demands of motherhood, but social, family and health service patterns do seem to assume that most women should be coping with motherhood within a few weeks of childbirth (emphasis original).

Ball further notes that this standard characterization of the postpartum persists largely because it coincides with the general amount of time it takes mothers' bodies to

physically recover from the birth. She thus argues that there is actually no "evidence that this time is the 'normal' time for adjustment" (1994: 16).

Thus, in as much as we understand the postpartum period *as* a period and process of social psychological adjustment, this analysis suggests a need to rethink our conception of "the postpartum period." Specifically, it requires that we pay closer attention to the length of time it actually takes mothers to accomplish this process. Mothers' descriptions of their adjusting experiences also highlighted that the first six weeks after birth are not always the most challenging for mothers in terms of their struggles to cope with, and adapt to, their new lives as mothers.

Rethinking the concept of the postpartum in this way thus has specific implications for health policy and practice. Health and social service patterns have long attributed an important role to public health in helping, facilitating and monitoring mothers' adjusting efforts (Ball 1994; Edmonton Board of Health et al. 1994). Currently, however, the provision of postpartum support programs is generally limited to the first few months after birth. However, as illuminated here, mothers may encounter difficulties at any point along this process, which often takes up to a year or longer.

Thus, there may be a need for health and support services to be made available to mothers *throughout* the duration of the postpartum adjusting process, not only during the first few weeks and months. This would particularly be the case with programs designed to provide practical and emotional support to mothers in their adjustment efforts, as well as the ongoing assessment of how well they are coping (as measured by the Edinburgh Postpartum Depression Scale, for example).

Secondly, the considerable *variation* in the length of time it took mothers to "feel adjusted" suggests a needed change in our thinking about how this process is best conceptualized. The mothers in this study described considerable variability in the amount of time this process took, both overall, as well as in relation to any of the major adjusting tasks described in the following chapter.

The kind of variation that this analysis captured provides a slightly different lens through which we can understand what might be considered "normal" or at least "normally occurring" adjusting experience. Specifically, this analysis suggests that, in as much as there may be an average or "mean" path through this adjusting process—as articulated by other research (e.g., Mercer 1986; Eagan 1985) and as communicated in various popular baby-care texts (e.g., Eisenberg et al 1996)—the actual variation in adjusting experiences is too great to realistically expect many mothers to actually have what might be deemed the "average" experience.

To date, however, much of the existing research on the process of adjusting to motherhood has described mothers' experiences in a month-by month format, delineated according to the passage of time. This is the case with studies published by Eagan (1985) and Mercer (1986). Mercer, for example, articulates the phases of this process as being delineated according to the following major markers: the first month postpartum; the fourth month postpartum; the eighth month postpartum; and one year after birth. Eagan, similarly, articulates the process of adjustment as occurring in a month-by-month format. Her chapter titles are, for example, Month 1-The Fog; Month 2-Smile: Beginning to Love

their Babies; Months 3 to 4-Symbiosis; Month 5-Hatching; Months 6 to 7-Coming Back to Me; Months 8 and 9-Together Again.[12]

What emerged from this study, however, was that the amount of time it took for mothers to accomplish any of the major adjusting tasks, and to "feel adjusted" more generally, varied considerably according to how difficult and/or how "big" mothers' felt their adjusting requirements to be. Thus, while I do not suggest that this analysis challenges the work of others and their articulation of this process as, *on average*, proceeding according to a general temporal pattern, I do suggest that greater emphasis needs to be given to the considerable variation around this general pattern as part and parcel, and typical of, the process itself. This requires, I would argue, a shift in conceptualization—from models organized primarily by *time*, to models organized primarily according to the major *tasks* of this process. Such a model is presented in Chapter 7, after I discuss the major tasks of the adjusting process (Chapter 5), and the main factors that the mothers identified as being key in facilitating their abilities to accomplish the tasks of this process (Chapter 6).

[12] In this respect, the studies undertaken by Mercer and Eagan represent two examples of a commonly-employed research design for the study of mothers' postpartum experiences. In this type of design, mothers are interviewed at set intervals throughout the period of research interest. Analyses then reflect the findings or general themes at each interview point. In this respect, the final analysis often provides a comprehensive picture of the "average" or "most common" experiences at each of those interview points. This kind of study design is an effective way to capture and understand process, and to capture experience as mothers are going through it. However, it tends to underemphasize variation.

Chapter 5: The Tasks of Postpartum Adjustment

The mothers in this study talked about their experiences of adjusting in two main ways. On one hand, they spoke of adjusting in a "big picture" sense, referring to the process as a whole. Danielle, for example, talked about having a baby as being "a really big adjustment." Fran, in a similar vein, stated the following:

> it's a big change...when you have a baby. And it was really hard to kind of *adjust to it all.* I don't think my husband had a problem at all. But yeah, I did (Fran, mother of one; group C, emphasis added).

The second main way the mothers talked about their experiences of postpartum adjusting was in reference to the various particularities of the process—the various things they had to adjust to, and/or the various adjustments they had to make in order to "feel adjusted."

This connection in the mothers' narratives finds support in the work of others (e.g., Burke & Tully 1997; Mercer 1995) who argue that the reconstruction of identity involves not only the internalized view of the self, but also the external behaviors and roles that are performed. Mercer (1995: 5), for example, describes how identity work occurs through "action in and interaction with the physical and social world." In this respect, mothers' adjusting experiences—the ultimate reconfiguration and integration of their identities as mothers—must be understood as occurring *through* the particularities of their day-to-day lives in the weeks and months after the birth of their babies.

In this respect, the mothers in this study often talked about adjusting as being about various smaller, and more specific activities, such as adjusting from working to being at home, for example, or of having to adjust to the loss of routine and structure, or adjusting to taking care of two children instead of one. Comments made by Alice and Penny provide examples of some of these particularities of the adjusting process:

> I was a career girl for the longest time, ten years—since I was 18. I was a manager, high paid, challenging environment and just absolutely on the go all the time. To go to staying at home. To just taking care of a baby. You almost feel like you're cut off from human contact. So that was a hard adjustment. (Penny, mother of one; group B)

> now you're organizing yourself, you're organizing [the baby], you're trying to adjust to their schedule and they don't have a schedule so you don't either....So to go a situation with suddenly no structure I sometimes feel a little lost.....So, yeah, so that's been a really tough adjustment. (Alice, mother of one; group A)

Mothers' descriptions of these different "specifics" of adjustment revealed that the adjusting process is comprised of various components or tasks. In other words, the analysis revealed that *the accomplishment of adjustment occurs through the achievement of various adjusting tasks or components.*

The tasks that proved integral to mothers' sense of feeling adjusted occurred across numerous dimensions. For example, mothers often spoke of the centrality of the relational dimension, especially with respect to the process of building intimacy and learning to "fall in love" with their new babies. They also talked about having to adjust to building new relationships, and of having to attend to changing relational dynamics with their spouses/partners, and others, including other children.

As well, mothers spoke of having to make a number of occupational adjustments. Most immediately, they described their experiences in learning how to take care of their new baby, and in developing a sense of competency and confidence in their abilities in this regard. Hand-in-hand with the need to learn how to care for their baby, mothers also talked about how they needed to find ways to balance or reconcile their baby care responsibilities with their other, existing, responsibilities.

Moreover, mothers spoke of having to adjust to the routine changes that accompany the birth of a new baby, even if these changes prove to be temporary. These changes included coping with and overcoming various situational realities of the postpartum environment, such as social isolation and the general loss of routine. For many mothers, there were also adjustments relating to the termination or alteration of employment situations. Typically, adjusting to these various kinds of day-to-day and routine changes ultimately involved a *rebuilding* of day-to-day activities and routines, and of *overcoming* such things as the detrimental effects of social isolation.

Mothers also talked about adjusting on a personal level. They spoke, for example, of needing to find new ways to care for themselves, both physically and emotionally. They spoke frequently of their struggles and successes in trying to find new ways to balance their own personal needs with the needs of their child(ren). Another common theme in the mothers' narratives of adjustment was how they found they needed to re-evaluate their priorities and revise their expectations, both of themselves and of the world around them. The ideological dimension was thus also central to mothers' experiences, as they often described how their own beliefs, expectations and behaviors were influenced by broader cultural discourses, and also by the opinions, expectations and actions of others.

These different themes in mothers' narratives have been articulated in this analysis as encompassing six general adjusting tasks or properties of the adjustment process. According to the mothers' narratives, these were the primary activities through which they ultimately came to (re)construct their identities as mothers, and came to integrate their new identities with the rest of their life. The main tasks of the process of

postpartum adjusting are described in detail below and are as follows: connecting with the baby, developing competence and confidence in caring for the baby, rebuilding day-to-day life, overcoming social isolation, integrating paid work/making decisions about work, and reconciling expectations with reality.

Importantly, each of these tasks emerged as processes in and of themselves. They all informed, reinforced, and contributed to one another, as well as to mothers' overall sense of "feeling adjusted." Further, as discussed throughout this chapter, mothers described having an easier or more difficult time accomplishing these various tasks. Each of these main adjustment tasks varied in terms of how long they took to accomplish, and how salient or momentous they were to mothers' overall adjustment experience. Mothers also found certain adjusting tasks to be larger in magnitude than others.

5.1 Connecting with the Baby

Perhaps the most fundamental of all the adjusting tasks that emerged from this analysis was the process of connecting with one's baby. Mothers variously talked about this experience as one of "connecting," "bonding," "feeling attached," and/or "falling in love" with their babies. Mercer (1977: 16) has defined this process as follows:

> attachment is the process in which an affectual and emotional commitment or bonding to an individual is formed, and is facilitated by positive feedback to each partner through a mutually satisfying interactive experience.

The mothers in this study described the accomplishment of this process as feeling needed and loved by the baby, of experiencing a sense of reciprocated intimacy between mother and baby, and of experiencing joy and pleasure from their interactions with their babies. The description given by Alice illustrates the accomplishment of this adjusting task:

> as the weeks go by I just find myself I love him even more. You know? And I'm able to experience him more. That I'm less guarded about what could happen to him and more willing to live in the moment…I think that's a feeling that you just get by living it, not necessarily by reading about it (Alice, mother of one; group A)

This process emerged as being both interactive and developmental. As such, it was not something that necessarily occurred immediately or instinctually, but that developed over time. It also required an emotional openness, or, in the words of Alice, a willingness to be "less guarded." Among the mothers I interviewed, interaction and reciprocation formed the basis of this relationship-building process. Mary, for example, stated the following about her experience connecting with her second child:

> I had these little moments where I remember looking at [baby] and thinking "you really *do* love me". And it just blew me away….And once he started to smile and once he started to interact…when he started to do his spontaneous laughter, and it was bonding, like a bonding laughter. Like when you could start to see that he was really making the connection and seeing "oh there's my mom" and he'd smile, and I'd be like "ohhh" and it was just like these little gifts he gave me, and it would just be these little things that would happen, just these little gems. (Mary, postpartum experience after second child; group C)

The centrality of receiving reciprocation from the baby was noted by all the mothers in this study, even those who *did not* feel that connecting was a particularly difficult or lengthy process.

Some mothers, like Mary, quoted above, described this intimacy developing gradually, while others mentioned that their feelings of connection towards their babies happened "all of a sudden." Either way, their connection with their babies developed and strengthened as their babies began to show more positive responsiveness and affection. Smiling, laughing, reaching out, and recognition of their mothers' voices were all commonly mentioned examples of responsiveness that helped mothers feel connected

with their babies. Mary's and Holly's stories both illustrate the interactive nature of this process:

> its funny the things that stick out in your mind, because my son was playing in the exer-saucer and he called out to me and he put his arms up and started to cry. And I picked him up and he was happy and he was content. And I remember thinking as I picked him up that he was comforted. I remember looking at him and thinking "I really am your mom and you really do love me…you really do love me." That's when I felt myself starting to fall in love with him. (Mary, postpartum experience after second child; group C)

> when I first went to work that was my biggest fear. That I would come home and he would forget who I was….So I remember the first night I came home from my first shift, I walked in the house and I think he heard me, and he woke up in his crib, and I went in to check on him, and he got up on his elbows and he looked up and gave me a great big smile. And it melted my heart (Holly, mother of one; group B).

The mothers in this study also spoke of their babies' increasing abilities to show affection as adding to the enjoyment of their day-to-day mothering experiences. As Violet remarked:

> it was just a gradual getting adjusted to the whole thing. Figuring out what to do, and slowly connecting with her, right, like watching her develop and stuff like that. (Violet, mother of one; group B)

As such, mothers' accomplishment of "connecting" with their babies interacted and overlapped with their experiences of developing competence and confidence in undertaking their mothering roles.

5.1.1 Key variations

In general, the mothers in this study described this adjusting task as being a primary focus of the early stage of adjusting. In other words, mothers did not describe themselves transitioning from the earlier to the later stage of adjusting until this task had been accomplished. That said, the mothers in this study described the accomplishment of

this task as occurring anywhere from the time of birth to several months afterwards. The following excerpts illustrate the variations in mothers' experiences with respect to the duration of this task:

> you want to meet this little person that you've been carrying around for like nine, ten months....As soon as they put him in my arms...it was pretty cool. Like I fell in love with him right away. So for me it was a really good experience. (Holly, mother of one; group B)

> I didn't really feel like the baby was a human at all. Like I think it took me five weeks before I sort of went, "Oh, okay, you're a real person. I think I might love you". It was really surreal. I didn't really feel a sense of attachment to her for awhile. Which I thought was really weird. And you know, you always feel guilty, not having things the way you think they should be. So it took me a while like to form a bond with her. (Fran, mother of one; group C)

> I didn't feel like I really had a relationship with her for quite awhile...it was like that for months. (Jill, postpartum experience after second child; group D)

Many of the mothers in this study, for example, described this process as beginning during pregnancy, and as being accomplished immediately upon, or within a few weeks of, the baby's birth. The mothers who had this experience often talked about how they took time in their pregnancies to experience the baby's movements, how they talked or sang to the baby in utero, how they felt like they were already "getting to know" the baby while pregnant, and how they "felt bonded" to the baby even before it was born. They also described the anticipation and excitement of being able to meet their babies for the first time. Alice had this experience, as did Mary after the birth of her first child:

> I was very attached to him and felt I loved him even in utero, I loved the baby, and then now once you have him, I found that I just loved him so much more and was, you know, so happy. (Alice, mother of one; group A)

> he came out my son - I didn't need to get to know him. I knew who he was immediately. (Mary, postpartum experience after first child; group A)

For 9 of the 32 mothers who participated in this study, this process of connecting took much longer, from several weeks to several months after birth. Three of these mothers described this process as taking one to two months to develop, while six of these mothers described it taking considerably longer than that. Mary's story—the experience she had after the birth of her second child—is an example of the latter experience:

> I remember thinking, "I love you because you're my baby, my son, but I don't *feel* for you like I do for [older son]". I felt so guilty. And I just thought "what do I do with you? Like I love you because your mine, but I just can't seem to enjoy you like I did with [older son]." And it was horrible. And this went on for months. (Mary, postpartum experience after second child; group C)

The mothers also experienced variations in terms of when they felt this adjusting task began for them. While some mothers felt that this process began during their pregnancies, for example, many of the mothers for whom this process took longer to accomplish described that, either consciously or unconsciously, they had not allowed themselves to get "too attached" to the baby during their pregnancy. In this respect, the process of relationship-building did not begin for them in pregnancy, like it did for many of the other mothers in my study. Rather, it began mainly *after* the baby was born.

Many of the mothers who described "not letting themselves get too attached" to their babies while pregnant had experienced concerns about the viability of their pregnancies. Heather had this experience:

> I pretended I wasn't pregnant until I got the [amniocentesis] results. But you know, obviously I was, and this child started kicking at 17 weeks, you know—before I got the results…so I think there was an initial bonding issue right there. (Heather, postpartum experience after second child; group D)

Another common concern described by many of these mothers was feeling worried that the new baby would necessitate taking attention *away from* their other children. In

addition to Mary, quoted above, Chris, Jill, and Heather all described this concern as being central to their experience. Excerpts from some of their stories are provided below:

> I had a real grieving period…because I realized my relationship with number one was going to change. And I was really afraid that I wasn't going to have enough love for both of them. (Jill, postpartum experience after second child; group D)

> I think just having a two year old child and he was really, a really easy baby, very happy little boy…..I did everything for him. You know, I did everything for him and when I was going through my labour with my daughter, all I could think about was him. My maternal drive went the wrong way…..I was so connected to [my older child], and I had a lot of bonding issues with my daughter. (Heather, postpartum experience after second child; group D)

As well, some mothers described the connecting process more difficult and/or as taking longer because of challenges in caring for their babies. Colic, health issues and difficulties with (breast)feeding were commonly-mentioned issues for these mothers. Heather's experience speaks to this issue. She compared and contrasted her two postpartum experiences as follows:

> [with the first baby], I just couldn't believe that I had a baby. You know. I never saw myself in my whole life was having a baby, and I've got this perfect little guy and he's so sweet. And then um you can bring him along anywhere, and you know, he just uh follows his routines well, and he's really an affectionate little guy. And the opposite with my daughter. Like you could not cuddle her. I remember when she was about six or seven weeks old and her colic was so bad we were invited out for dinner, and she had a diaper rash, and just trying to hold her, and I gave her to my husband, and you know, he'd leave and come back and she was screaming in her car seat. He couldn't hold her anymore. You know, she's seven weeks old and she's rolling and her arms are writhing…her whole infancy, like I never held her and gazed into her eyes. I couldn't make eye contact with her. She would cry and get upset. Um. None of that was recreated. Like you know, with my boy those eyes you could swim in them. (Heather, mother of two; group 1 and group 4)

Heather's comments provide further reinforcement to the idea that this task is fundamentally an *interactive process*, as does the very poignant statement made by Mary that "it is so hard to love somebody when you can't see that they love you back."

Illuminating these variations in the length of time it took for this relational intimacy to become established also underscores the importance of understanding this adjustment task as developmental, as interactive, and *as a process* (see also Eagan 1985; Mercer 1995; Stern & Bruschweiler-Stern 1998; Robson & Moss 1970). This finding provides empirical data directly in contrast to popular ideological and cultural beliefs about mother-baby intimacy, particularly to the idea that this connection occurs instinctually and instantaneously (Eyer 1992, 1996). Specifically, these mothers' experiences confirm that "our real lives belie the myths made about [maternal instinct]. Love at first sight, whether for a handsome stranger or a newborn baby, is rare indeed." (Eagan 1985: 12).

Importantly, however, the idea that mothers instinctually and instantaneously "fall in love" with their babies is not a benign construction. The mothers in this study for whom this process took longer and/or who described experiencing greater difficulties in accomplishing this task generally described feelings of guilt in connection with this experience.

Typically, the intensity of mothers' guilt varied in accordance with the length of time it took them to feel connected with their babies. For example, Jill, Chris, Heather, and Mary all experienced severe guilt about the many months this process took for them. As Heather stated:

> and then the guilt, because—um tremendous guilt because I wasn't bonding with her....it was very wearing. (Heather, postpartum experience after second child; group D)

For these mothers, the length of time it took them to develop a connection or feeling of attachment to their babies was of key saliency to their overall postpartum experience. These mothers all described their overall adjustment experiences as difficult, and also described high levels of emotional distress.

By contrast, when this task of "connecting" was accomplished immediately or shortly after the baby's birth it barely felt like an adjustment at all. As such, many mothers for whom this task was accomplished relatively quickly and "easily" did not experience this relationship-building process as a particularly salient element of their adjusting work. If anything, these mothers talked about the early achievement of this task "gave them strength" and helped facilitate the transition from the earlier to the later stage of adjusting. As Paige noted in this context, for example:

> I was a very happy and proud mom. I enjoyed spending that time with my child.....I think I just really got a lot of strength from that. (Paige, mother of one; group B)

Importantly, however, the ease with which some mothers experienced this process should not obscure the finding that the task of "connecting with the baby" emerged as a developmental and interactive process, a process which can take considerable time.

5.2 Developing Confidence and Competence in Caring for the Baby

The second major adjustment task the mothers in this study described as central to their postpartum experience involved learning and doing the work of mothering. This task emerged as a process whereby mothers came to develop a sense of competence and confidence in caring for their baby. It was a combination of—in the words of the mothers

from this study—"figuring out what to do" and learning/doing "what works best." As Raeanne remarked in this context:

> just trying to figure out so much—and you feel like you're on the hugest learning curve ever. Figuring out what to do. What's best for [the baby], and it seems like every day I was learning new tricks in those first couple of weeks, you know, little hurrahs, right, little—good things, but also feeling like there's so much to learn. (Raeanne, mother of one; group A)

Developing confidence and competence in caring for the baby emerged as a developmental process. It was acquired through mothers' day-to-day interactions with their babies, and through the process of getting to know the baby, his/her needs, wants and preferences.

This adjusting task was revealed to have two main components: learning and implementing current (expert-informed) baby care practices; and developing sufficient confidence in one's mothering abilities to be able to *deviate* from these prescriptions, according to the demands of particular babies, preferences and situations. In many ways, this adjusting task was about developing a personal mothering practice, which, while informed by professional and scientific advice, is not held hostage to the strictures of professional prescriptions. As Penny's comment illustrates:

> a lot of moms follow the book to the "t" you know, of when to do things. And I thought that had to be the way, too. And then I started to realize that you just have to do what your baby wants you to do....I mean, I do read the books a lot, you know, but then I sort of say "okay, how much of that do I really take, you know." (Penny, mother of one; group B)

The process of developing confidence and competence in caring for the baby was generally accomplished through a combination of learning (i.e., reading child care books and other literature, attending pre- and postnatal classes, talking to other mothers, as well as health care and other professionals), experience (both current and previous

experiences), and existing personal beliefs. Alice's comment illustrates how experience, knowledge and personal beliefs all played a part in her experience of this task:

> [I figure things out from] trial and error. Reading for sure…but [the books] have got different philosophies out there on child rearing and that, so trying to find those that fit with your philosophy and like you're trying to kind of follow some of that advice. Um. Some just ignorant belief, just I don't know why, but it just stuck in my head and so that's what I think. You know? Where it comes from I'm not sure. Probably in part just the way I was parented. Um. Other new mothers' advice. Like women my age…..There's an eight week new mom's network course and it provides you with information and an opportunity to connect with other moms and that, so I've done that. To get information. And yeah, I'm just feeling, I mean, yeah, lots of it's just seeing what works and then you just want to know that it's normal. (Alice, mother of one; group A)

Most of the mothers in this study gained some of their child care knowledge from attending postnatal programming and/or by reading one or more of the many popular baby care manuals on the market today. The bestselling *What to Expect the First Year* (Eisenberg et al. 1996) and *The Baby Book* (Sears & Sears 2003) were two examples of books that mothers mentioned reading in order to prepare themselves for learning how to care for their babies. Many mothers also prepared for, and read literature on, specific aspects of baby care that they identified as important to them, such as breastfeeding and/or sleeping, for example.

Perhaps unsurprisingly, this kind of preparation—reading texts on baby care and attending pre- and postnatal programming—was most typical of the experiences of first-time mothers. The multiparas mothers in this study often noted that they tended not to need these resources as much, as they had the benefit of experiential knowledge. As Gabrielle stated in this context, "you know what to expect." Also, Natasha iterated the following:

> I'm not sure maybe if it was because everything I went through with my first one and I sort of learned everything that maybe the second one was easier because of that. (Natasha, postpartum experience after second child; group B)

The benefit of experiential knowledge was also noted by some first-time mothers who had previous experience in caring for babies and small children.

The mothers in this study also talked about learning about baby care by talking to other mothers about their experiences. Typically, mothers solicited the advice and knowledge of other mothers from their own generation. As Raeanne remarked, for example:

> having tips thrown in from other moms or when I would go back to [see the midwives] for his check-up. That's all been really helpful....taking information from my peers. (Raeanne, mother of one; group A)

Interestingly, many of the mothers in this study *did not* feel they could rely on expertise from their own mothers or mothers-in-law. Alice and Raeanne iterated the following on this point:

> I tend to believe the validity of advice [from other mothers my own age] more so than I do parents or grandparents or that, because things change, right, and I question what used to be....I mean, they used to put babies on their tummies and now they don't, right? So, I mean, I just try and filter some of that through um common sense, and whether or not I believe it's true or not (Alice, mother of one; group A)

> and I guess [I take some information] from my mom and [my husband's] mom but I guess I'm a little bit hesitant...because they're dated information. And so right away when my mom's going, "Oh, I had to feed you guys pablum at night so you could sleep through the night." Well, they don't do that anymore. So, yeah, being a little bit cautious about it. (Raeanne, mother of one; group A)

This general lack of reliance on older generations for advice and knowledge about baby care is, at least in part, a result of the dominance of science and "expert" knowledge in influencing contemporary parenting practices (Grant 1998; Thurer 1995; Arnup 1994).

Today's dominant mothering ideology subscribes to the requisite that child care should be expert-guided (Hays 1996), but, as the mothers in this study articulated, this expert knowledge changes frequently. It was for this reason—for a fear of receiving "dated information" (Raeanne) that many mothers hesitated utilizing advice from older generations.

Notably, however, not all mothers hesitated to take advice about baby care from mothers of older generations. Interestingly, those mothers who *did* rely on their own mothers (or other mothers of older generations) for advice and knowledge about baby care often described this as being helpful to them in their own ability to develop confidence and competence caring for their babies. As Penny noted, for example:

> I do think it frustrates me more to see moms following too much of the book, I guess. And I just basically have gotten a lot of advice from my mom and sister. And I pretty much have done a lot of what they suggested, anyway. It doesn't hurt babies to try rice cereal at two months. It's not going to hurt them, you know. Just try it. You know, and if they don't want it, they don't want it. If they want it, then they'll take it. Why not? Just try it....Trial and error, and advice from my mom—that's really helped. (Penny, mother of one; group B)

Arguably, then, in as much as available knowledge about baby care is not being transferred across generations, it could be argued to represent a loss of valuable knowledge. While some of their knowledge may indeed be "outdated" in terms of safety or health (like sleeping babies on their stomachs, for example), much of the knowledge older mothers have to pass on has been successfully "tried, tested, and used."

However the mothers gained their knowledge and information about baby care, the mothers in this study still found that there was considerable "hands-on" learning involved. Specifically, they had to learn how to care for *this* particular baby, within this particular situational and personal environment. In this context, the mothers talked a lot

about learning through trial and error, about figuring things out "on their own," and "as they went along," Raeanne, for example, stated, that "for me I think the biggest thing was just to figure it out for myself."

The issue of normalcy—in terms of what babies do and need, as well as in terms of various approaches or techniques to baby care—was central to the process of developing confidence and competence in baby care. "Knowing what's normal" provided a baseline or acceptable range of behaviors which mothers used in gauging their own baby's development, and in learning appropriate methods of care. "Knowing what's normal" provided a marker for, and confirmation of "doing it right." In this respect, mothers' understandings of "normal" in terms of care practices and in terms of infant development/behavior were central to their experience of developing confidence in their mothering abilities. As Tammy stated in this context:

> [books and expert advice] have given me sort of the understanding that things are okay, that I'm not out there in left field with child care, or you know, it's very normal behavior. I have a lot of questions about whether this is normal or not. So, just being able to find some of those sources of information that made you feel more reassured that you're doing the right thing or that I was doing the right thing, that helps to manage some of the stress. (Tammy, mother of one; group A)

For the mothers in this study, the definition or range of normalcy came from three main sources: expert and professional advice and literature, previous experience, and knowledge of other mothers' experiences. By virtue of previous experience, mothers with more than one child tended to already have more confidence and competence in their abilities to care for a new baby, particularly if their new baby was a generally "easy" baby. For many of these mothers, this adjusting task was often accomplished with less effort, and, as a result, was a less salient part of their overall adjustment experience. As

well, their gauge for defining "what was normal" became less based on expert literature, and more on their own experiences. In fact, many mothers of multiple children talked about becoming more relaxed about expert-invoked standards of "normalcy," and also talked about being less worried about "doing it right." Gabrielle described this experience after the birth of her second child.

> I think I worry less with [this baby]. You know. Partly because I don't have as much time to do so and partly because you know, I see that [older child] does pretty well, you know, for the most part. He's a pretty well adjusted kid and he's pretty happy and he does these things developmentally appropriate for the most part...and I think, yeah, we've probably done an okay job with him, so as long as we can do the same thing with her, we probably should be okay. You know, so I think there's less to worry about. (Gabrielle, postpartum experience after second child; group A)

Concerns about "knowing what's normal" were often more common among the first-time mothers in my study. And as Tammy, opined, the reason for this was because they did not have other children from which to gauge what "normal" might be. She stated that "probably if you had a second child it would be a lot easier because you've seen some range of that before."

5.2.1 Key variations

In general, the mothers in this study engaged in a considerable amount of learning activities ahead of the birth of their babies in order to prepare themselves for "what to expect" in terms of baby care. As such, the task of learning how to care for their new babies—and of developing confidence and competence in this regard—was the adjusting activity that mothers often felt the most ready for, and unsurprised about. The main exception to this tendency was when mothers' preparations for "what to expect" and

"what to do" in relation to baby care *did not* materialize as anticipated or as prepared for. As Gabrielle expressed, for example:

> you know, I was trying everything in the books to get him to sleep, and nothing worked like you expected it to, or like the book said it was supposed to, or like, you know, your mother told you, you know, try this and it will work for sure. It doesn't work. So you got like frustration after frustration and uh I think that's probably, yeah, the best word I could use to describe it. Frustrating. (Gabrielle, postpartum experience after first child; group C)

Thus, the mothers in this study who realized the most benefit from their preparation activities were those for whom their baby's care demands and needs were similar to, or at least not contrary to, their existing knowledge.

The saliency of this task to mothers' overall adjustment experiences was connected most closely with parity and the particular demands of the baby. First of all, this adjusting task was often more salient for first-time mothers. For many first-time mothers, it was their first experience taking care of a baby. As such, the process of developing confidence and competence in taking care of their babies involved considerable learning. Ingrid, for example, made the following comment about the magnitude of the learning process:

> the first day that we brought her home…it was 34 degrees [Celsius]….And so we brought her home and she was basically lethargic. She just wasn't—she didn't want to really wake up. She didn't want to feed. So we panicked and drove right back to the hospital, which was a good half hour away. And took her in and as soon as she was in this air-conditioned office she woke up. She was perked up, she was fine. [laughs] We were embarrassed as hell. And the doctor, who was our discharge physician, said, "well, you know as long as you're here I'll take a look at her". Picked her up out of the car seat, kind of looked at her, looks at us, says, "her diaper's on backwards." "Okay. Well, now we know". I mean, this is the level that we were working at. You know. It was terrible….Like how am I going to pull this off?....So I mean, it's been a huge learning experience for me. (Ingrid, mother of one; group A)

Many first-time mothers also found this adjusting task a particularly salient part of their overall adjusting experience because they were less sure of, and more worried about, "doing it right" and about figuring out what was "normal." Alice and Emily, both first-time mothers, made the following comments in this context:

> you know. Is this normal? As long as it's normal I'm okay. I can manage it. I just need to know if it's normal. (Alice, mother of one; group A)

> and that's sort of why I've been reading and everything so much because I'm like, I want to make sure I'm doing everything right and not making any mistakes. (Emily, mother of one; group A)

Although many mothers of multiple children found this task to be less central to their overall adjusting experience, this was certainly not always the case. This was because of the second important factor connected to the magnitude of this task—the particular care demands of the baby. Whether a woman was becoming a mother for the first time or the fourth time, caring for a baby with challenging or more difficult needs influenced the enormity and the difficulty of this adjustment component. Health concerns, difficulties with sleeping and/or eating, and colic were the most commonly described difficulties described by the mothers in this study that made this adjusting activity considerably more challenging. Two mothers' stories are excerpted below. Heather, a mother of two, found this task especially challenging after the birth of her second child primarily because her baby was colicky. Nancy, a mother of one, described the difficulties of learning how to care for a baby born with serious heart problems:

> with the second one...that was a whole different kettle of fish because I had a two year old and then adjusting to an infant. I had a very tough time....because she was like 12 days old and she started crying. And that lasted about four months. And...even after that, a lot of crying for her first year, and it really only stopped this summer....You know, and I know a lot of people and their second child really enjoyed it a lot more because they were so much more casual and you know, you know a lot more and you

> have a lot more wisdom. But I think it wasn't like that for me…because of the intense crying. (Heather, postpartum experience after second child: group D)

> the heart condition. It was a total shock…..she was in the hospital for 21 days…I felt very unsure about what to do….I think it was worse during those early months when we still dealing with a brand new baby, and when [the baby] got home from the hospital and the whole tube feeding issue. Just all the complications and all the work that I had to do to manage her heart condition. (Nancy, mother of one; group D)

Mothers who had more difficult-to-care-for babies often talked about this aspect of adjustment being more challenging, not only because it often felt that there was no end to their babies' needs or demands, but because they rarely felt a sense of satisfaction that the care they were giving was *good* care. In other words, they often felt like they weren't making their babies happy, or weren't properly meeting their needs. Danielle, whose baby had colic and also suffered from health problems at birth, made the following comment in this context:

> just wishing I could do something to make it better….it hurt me so much more, that I couldn't make it better. [The baby] was in pain all the time. And he wasn't happy…..He was crying. I was crying. (Danielle, mother of one; group D)

By contrast, mothers who described themselves as having "good babies"—babies who were relatively easy-to-care-for—often found this adjusting task to be less emotionally and physically demanding, irrespective of parity. "Good babies," for the mothers in this study, included babies who were healthy and generally contented, who generally ate and slept well, and who developed according to expected milestones. These mothers often described feeling "lucky" to have easy or good babies, because it made the process of learning to care for the baby simpler. Emily's experience was one such example:

> I think I'm pretty lucky. Like I think I have it pretty good....[the baby] is just great....you know, she's a baby. A typical baby. But...she's just so good, and hit most of her milestones so early, and we're just like "oh she's such a good baby." (Emily, mother of one; group A)

As well, for many mothers with more than one child, the process of learning to care for the new baby was not challenging in and of itself. Rather, it was challenging because it required learning how to care for *more than* one child at a time. In this context, what made this adjusting task particularly salient was the need care for a new baby in conjunction with existing care responsibilities. Natasha, a mother of two, spoke to the significance of this to her adjusting experience after the second child was born:

> I just felt a lot more tired and things just felt a lot more stressful. Just faster and busier...because there was one more baby. I felt at times like there was 10 times more to do....I'm running after one and I'm trying to nurse the other one, and it just kind of always felt a little frazzled. (Natasha, postpartum experience after second child; group B)

Among mothers with more than one baby, the saliency of this adjustment task was thus often related to the high volume of their care demands, particularly as they existed in relation to the adequacy of their supports and other resources.

5.2.2 The significance of breastfeeding

Mothers' experiences with breastfeeding were often central to the process of developing competence and confidence in caring for their babies. Virtually all of the mothers (32 of the 33) in this study breastfed their babies—at least initially—a great many of whom experienced challenges in this regard. For these mothers, their struggles with breastfeeding was a central experience around which the accomplishment of this task took place. In other words, a key milestone for feeling competent and confident as mothers was their sense of feeling successful with breastfeeding.

Alice was one of the many mothers from this study who experienced breastfeeding challenges, but who eventually overcame these difficulties and established a breastfeeding practice she was satisfied with. In her story, excerpted below, she talked about how important breastfeeding was to the accomplishment of this adjusting task:

> it's been very difficult—like we've had every problem. I started off with cracked nipples. Ended up with mastitis. Ended up with yeast. And so I found it really challenging. Really hard....We went through it all. And we did it, I mean, I'm really proud. Like we didn't have to use formula at all. Oh, we worked through everything, and it just felt good. And we've gone now finally in a much better place. (Alice, mother of one; group A)

It is worth noting that Alice was a first-time mother. In this context, some of the mothers in this study noted that their *ability* to persevere in the face of breastfeeding difficulties—to invest the time and energy into seeking lactation assistance, for example—was perhaps greater because they only had the responsibility of looking after that one child. For instance, Natasha, a mother of two who experienced considerable difficulties breastfeeding her first baby, opined that her ability to carry on with breastfeeding might have been different had she experienced similar difficulties with her second baby. She stated the following:

> if that had happened with my second, I think I would have probably just lost it as far as just continuing with that. Because then you're dragging -- like it's one thing to drag *one* baby to the lactation consultant for your appointment and things like that, but if I was dragging around *two* children, a two year old and a baby, to do that, like that could have been a whole different scenario. And I think that as well, mentally, it just would have put a lot more strain into things. (Natasha, postpartum experience after second child; group B)

Most (30 of 32) of the mothers in my study who attempted breastfeeding did ultimately manage to establish a breastfeeding relationship that they were comfortable with. Many of these mothers articulated how significant it was for them to have resolved

their breastfeeding problems—not only for the sense of accomplishment, which was pivotal to their experience of developing competence and confidence in their mothering abilities—but because of the potential moral and emotional consequences of *not* being successful. As Natasha stated in this context:

> it got to that point where I could not imagine *not* being successful with it. And that, I just thought, "I can't even go there" with it, because it truly I think would have totally spiraled me into a serious probably state of depression....And so failure—it really seemed to me, I thought, was a real sense of failure in myself and even as a mother. (Natasha, postpartum experience after first child; group A)

Thus, failure with breastfeeding represented for many of these mothers an indication of lacking competence as a mother—an inability to do what was best for their babies. This was Beth's experience. Beth, a mother of two for whom breastfeeding was unsuccessful with her first child, and who experienced considerable breastfeeding challenges with her second, felt that these experiences cast a shadow over her sense of confidence in her abilities as a mother. She articulated her experience as follows:

> I felt so horrible about myself that I couldn't do this for [baby]. I don't know. Even though I was doing everything I could, I mean, everything. I just could not. It just wouldn't happen for us, you know? It was so, I don't know. You feel like less of a person, less of a mother, less of a woman even, you know, that you can't do this for your child.....I feel like I'm always questioning my abilities as a mother. I think you do, anyhow. But when you—when this happened, you know, it multiplies it, you know. (Beth, postpartum experience after first child; group C)

Similarly, Kiera, who was unsuccessful with breastfeeding her first baby, largely because of having had breast surgery three years prior, described the following experience:

> with my son I think I was so—I had tried to breastfeed him and it went horribly and I was feeling quite a failure in that department. And I went to bottles.....It was a difficult time.....I did feel a sense of relief that the problem had been solved. Like, you know, I saw him thriving better [when we went to bottles].....But I felt a sense of failure because breastfeeding

was very important to me. (Kiera, postpartum experience after first child; group B)

In today's maternity culture, breastfeeding *is* something that is strongly promoted, and mothers are well aware of the current importance placed on breastfeeding (Schmeid & Barclay. 1999; Murphy 1999; Knaak 2006; Davies 2004; Wall 2001). Indeed, many mothers described feeling additional pressure because of the importance placed on breastfeeding by the health community. As Beth bluntly stated, "I really felt pressured." On the other side of the coin, however, Penny, the mother in this study who did not attempt breastfeeding, felt her decision to not breastfeed was respected by the health professionals she came in contact with. Interestingly, however, she still described having to manage feelings of guilt for her decision, and that she got pressure from *others* about her feeding decision. She stated the following:

> I never felt comfortable breastfeeding, but when I got pregnant you get the pressure from *everybody* around you to breastfeed...and then I started to think, well maybe I should, and then I thought, "no, I still feel uncomfortable about this"....but the nurses never pressured me. They never pressured me....Believe it or not, the people who did give me some harsh things about it were men. Like my boss and the guys at work. You know, who were fathers. "You should breastfeed". And I'm thinking, why does a guy have the right to tell me that I have to breastfeed?..... But you need to let go of the guilty things whether you bottle feed or breastfeed. You feel guilty if you don't breastfeed at first. You think that you are not giving them something that they should be getting. And you want to be such a good mom. (Penny, mother of one; group B)

Mothers' experiences with breastfeeding thus represented an important dimension of this adjusting task. For most of the mothers who participated in this study, it represented the best kind of care they could give—that it was the best thing to do for the baby's health, and that it was an important relational undertaking. However, it was also a task infused with significant emotional and moral meaning, and thus represented a key

event in the experiential process of developing a sense of competence and competence as a mother. As such, it is perhaps not surprising that mothers who experienced difficulties with breastfeeding tended also to find this adjusting task a particularly salient part of their overall adjustment experience.

5.3 Rebuilding Day-to-Day Life

A third major task of the adjusting process for the mothers in this study was the process of rebuilding of their day-to-day lives. This included most centrally the need to re-establish a sense of daily routine, and to reclaim some personal time. All of the mothers in this study, irrespective of parity, talked about the process of rebuilding day-to-day life as beginning with the experience of *losing* a sense of routine and a sense of predictability over day-to-day life. As Danielle commented, for example:

> I thought we would be on some sort of a routine. I like routine, schedule, and organization. That's how my life had operated. And there's been *no routine*. There's a bit of one now. But when he had colic, like, whoa. There was no routine at all. So I found that difficult. (Danielle, mother of one; group D)

As well, it was not only this loss of routine and predictability that required adjusting to. Also central to the mothers' experiences was the loss of control over the very ability to plan, organize, and execute day-to-day activities. The mothers talked about the fact that they could no longer sleep when they wanted, eat when they wanted, exercise when they wanted, visit friends when they wanted, and so forth. Their daily activities were now determined primarily by the needs of the baby, which were typically not predictable or "routined." As Fiona recalled, for example:

> the whole change in routine. Like it's not just the lack of sleep. It's that you're not on your routine anymore. You're on somebody else's. And I just—I found it a big adjustment. (Fiona, mother of one; group C)

Most of the mothers in this study described trying to find ways to accept or cope with this change to their day-to-day lives, as opposed to forcing an adherence to a routine or schedules for the baby from early on. The current philosophy of "on-demand" baby care was the main influencer in this regard. This philosophy of child care advocates a practice of on-demand, child-centered baby care, especially with respect to feeding and sleeping (Sears & Sears 2003; Eisenberg et al. 1996; Spock & Parker 1998; Torgus & Gotsch 2004; Douglas 2001). Because most of the mothers in this study believed in allowing babies to sleep and eat "on-demand," it necessitated that they find a way to accept this loss of routine and loss of control over routine until their babies became—in the words of Gabrielle—"more settled."

As such, attempting to "go with the flow," to "relax more," and otherwise "just cope" or "deal with" the loss of day-to-day routines and control over those routines was the most common adjusting strategy for the mothers in this study—at least initially. In fact, only one of the mothers I interviewed, Holly, practiced a scheduled form of baby care. Incidentally, Holly believed that encouraging her baby to learn and follow a regular feeding and sleeping routine was helpful to both her and her baby in facilitating this aspect of adjusting:

> we try to schedule his sleeping and eating....I had him pretty much scheduled. I think from about week two. And I think that really helped him out as far as you know, he doesn't—he didn't have to cry when he was hungry or I didn't have to figure it out because he was on a regular feeding schedule so I didn't have to worry about okay, if he's crying now does that mean he needs his diaper changed or is he tired or is he hungry? Like, um, I didn't have that guess work. (Holly, mother of one; group B)

For Holly, this adjusting task took only a few weeks to accomplish.

For most of the mothers who participated in this study, however, the process of rebuilding daily routines took considerably longer. In general, the mothers did not feel able to accomplish this task until their babies had established more regular eating and sleeping patterns, and had become more predictable in their needs. As might be expected, there was considerable variation in terms of when this occurred. Comments made by Paige and Kiera illustrate some of this variation:

> I was thinking it's around the nine month mark...they are getting a bit more independent...and those were sort of the days when I can get a picture of a little bit more freedom happening....there's some routine to what he did. (Kiera, postpartum experience after first child; group B)

> well, the breakthrough really was after the first five weeks. It became a little easier. I felt we had established a good routine. Um. I was able to get back little bits of time....Yeah, the pace slowed down a bit. A routine kicked in and it was a little bit more predictable on how a day was going. (Paige, mother of one; group B)

Although the mothers in this study often did not feel like they had accomplished this task until their babies had become more settled and predictable, the re-establishing of routines *was not* a passive process. Even though most of the mothers I interviewed followed an "on-demand" philosophy of baby care, they also were continually looking for opportunities to give their days more structure and consistency. As such, mothers often spoke about the re-establishing of routines, not only as part and parcel of what they needed to accomplish in order to "feel adjusted," but as also being a good thing for their babies. It was in this context that many mothers talked about how their babies "depended on their routine" (Fiona) or "thrived on routine" (Jill). It was in this context that Tammy stated the following about the mutual benefits of this adjusting task:

> it's really good for the child to have a routine but it's really helpful for us, too, because once I sort of knew—say, he'd go for a nap and you would have two hours where you could plan and that you might be doing some

> kinds of work and get the dinner ready on time. (Tammy, mother of one; group A)

In this context, the process of re-establishing day-to-day activities and routines was a "push-pull" kind of adjusting task. Mothers struggled to *accept* a loss of routine at the same time as they assertively acted on opportunities to *re-establish* some kind of routine.

The mothers' stories also included discussions about their attempts to regain some control over their *own* personal time. In this respect, the process of finding "me time" emerged as an important dimension of rebuilding daily life. It is in this context that postpartum adjusting as a process of integration comes more clearly into focus. Specifically, it underscores the idea that adjusting is not only about adapting to new responsibilities and realities, it is also integrally about finding a way to re-balance one's own needs, in light of one's new responsibilities and realities.

Again, many mothers' experiences in reclaiming personal time proceeded through an initial stage of "coming to terms" with their loss of freedom, followed by the making of conscious efforts to actively regain some control over their own time and personal freedoms. As such, mothers often described feeling quite angry, frustrated, or resentful about their loss of freedom. Their expressions of anger were often directed at their partners, or at others whose freedoms *had not* been similarly curtailed. It was in this context that many mothers talked about how they no longer had the freedom to attend to even their basic personal hygiene needs, while their partners or spouses had virtually no new restrictions on their personal freedoms or time. As Kiera commented, for example:

> when [my husband] wanted to walk out of the house he walked out of the house. Whether it was get out to go to the store or go to work or whereas I—my life had changed and I couldn't do that anymore. Without packing up the baby and going to like, you know, getting a haircut, like I said, even having a shower. He did all those things. Just as

> he had done before. And my life had changed drastically. (Kiera, postpartum experience after first child; group B)

Interestingly, while the single mothers in this study also described this loss of freedom as a key element of their adjusting experience, they often did not share these same feelings of anger and resentment. While these mothers felt frustrated with the ongoing challenges of being a sole parent, they also talked about how they had generally anticipated and been prepared for that experience. In general, it was among the married mothers—particularly those who had not expected such a difference in the extent to which their daily freedoms and personal time had become curtailed in relation to their spouses'/partners'—that these emotions were experienced the most intensely. Many mothers had expected that their partners or spouses would be more involved in the day-to-day care of the baby, and that this responsibility would lead to similar constrictions on their time and personal freedoms. It was in this context that Astrid made the following comment:

> I think I hoped—we didn't talk about it a lot, which probably wasn't the best idea. But I think I hoped that [my husband] would be more involved in the day-to day-care. Like in the day-to-day responsibilities. So yeah, that was a disappointment....I was hoping that it would be more balanced. (Astrid, postpartum experience after first child; group A)

As mothers proceeded through this adjusting task—as they experienced success in regaining some control over their own time—the intensity and frequency of their anger and frustration tended to lessen. Often, however, their feelings of anger, resentment or frustration did not go away completely. This was especially the case among mothers who either had not raised the issue of shared responsibility with their partner/spouse, or whose spouses/partners were not responsive to their concerns. As Kiera remarked in this context:

> when you're bottle feeding, other people can take on that responsibility. Well, [my husband] wasn't willing, so that was when I resented it at that point, you know. When there are things that other people can do for you and you feel resentment when they don't—you know, it should be partly their responsibility. I mean, and they don't take it on. (Kiera, postpartum experience after first child; group B)

Most of the mothers in this study employed two main strategies in undertaking this task. The first had to do with their babies becoming more settled in their routines. As Paige iterated, for example, once "we had established a good routine, I was able to get back little bits of time." The second main way mothers' described regaining control over their own time was to consciously plan and arrange for opportunities for personal time. As Annabelle described, for example:

> when I want to go out I have to either plan it like two weeks in advance and tell [my husband] every day until that two weeks, or find a babysitter myself, or go out to my parent's place and when they have time off—either my mom or my dad or my sister to watch them and then I go out. I have to plan it. (Annabelle, postpartum experience after second child; group D)

Importantly, this latter strategy emerged as involving a considerable amount of effort and "work." As Danielle iterated in this context:

> to take time myself, it involves a fair amount of planning...I'm going away actually for two days for work. And that involves immense work—of trying to find people to look after [baby]...it's a lot more challenging than I had ever thought it would be trying to find sitters. (Danielle, mother of one; group D)

As such, this latter strategy was not employed as much by the mothers as the former strategy of waiting until their babies' became more settled in their routines.

5.3.1 Key variations

In general, this task of adjusting was experienced as greater or smaller in magnitude—and as taking a longer or shorter amount of time—depending on the needs of

the baby, as well as on the extent to which mothers prioritized this particular adjusting task. It was in this context that Holly—who practiced a scheduling form of baby care—talked about her commitment to this as being a useful strategy. She stated:

> I think that was an easier way for me to go. It seemed to work really well for him, too. (Holly, mother of one; group B)

Basically, the length of time it took mothers to feel like they had re-established a sense of routine in their day-to-day life—and had regained come control over their personal time—was influenced by three main factors, all of which were overlapping and mutually reinforcing:

- mothers' personal preference regarding routine and structure, and how much of a priority this adjusting task was;
- the strictness of mothers' adherence to on-demand baby care, and
- the amount of time it took their babies to become "more settled" and predictable, particularly in terms of their eating and sleeping habits.

Further, the mothers in this study who described themselves as thriving on routine and structure typically found this adjusting task more demanding and, consequently, a more salient aspect of their overall adjustment experience. Penny, for example, a mother of one who self-professed to love schedules and routine, described her experience as follows:

> I think that I overly got concerned with her schedules because I'm a manager in retail. So in my position everything has to be managed down to the hour. And so just as soon as I would think we were on a routine and then she'd throw in a curve and do something and I would actually get annoyed.....So, frustration with the fact that I—we didn't have a schedule or she wasn't sticking to a schedule and I would get frustrated. (Penny, mother of one; group B)

As noted above, a strategy of trying to "relax more" was employed by many mothers as a way of coping with their initial loss of routine. Some mothers found this easier to do than others. Many mothers who found the loss of routine—and loss of control over routine—particularly difficult to cope with attributed their difficulties to their own personality styles. The contrast in experiences between Raeanne and Gabrielle illustrates how mothers attributed their own personality styles to this element of adjusting:

> I think I'm a flexible person—so, you know, I kind of go with the flow, so if I didn't get a good night's sleep prior to baby, you know, I didn't necessarily have a horrible day afterwards. So it was "do what you need to do" kind of thing, and give [baby] what he needs....just doing different things to make it easier for ourselves. (Raeanne, mother of one; group A)

> [The loss of control] just was really a shock. They never warned you about that [in the prenatal classes]. At least I don't remember them ever talking about that kind of thing.....Maybe it's because I'm too anal and I don't go with the flow very well. (Gabrielle, postpartum experience after first child; group C)

5.4. Overcoming Isolation: Building Networks and "Getting Out"

The existence of, and eventual overcoming of, social isolation was another common theme in mothers' narratives of their adjusting experiences. As Beth articulated, for example:

> I found the leap from no children to children so lonely, you know....I just felt so isolated from society, I guess....I was struggling with adjusting to that. (Beth, postpartum experience after first child; group C)

Indeed, in our current culture, the typical postpartum environment is one where mothers are largely isolated from others (Mausart 1999; Rossiter 1988; Oakley 1979, 1980; Kendall-Tackett 2005). Mothers are typically at home with their new babies, many without extended family nearby, and many living in suburban areas, making neighborly

interaction less a feature of daily life (Jacobs 2006). Rossiter (1988: 244) argues the following in this context:

> mothering involves rather extraordinary transformations of identity....in conditions of isolation, this...is experienced as loss of self...mothers are left without the social interactions which construct and produce identity.

In this context, many mothers talked about finding ways to cope with, and ultimately overcome, the experience of social isolation as a central component of the adjusting process. Gabrielle articulated this adjusting task as follows:

> I think that's really a big part of that whole post-partum experience, especially when you're on your maternity leave and you've worked all your life, and I think you desperately need to have adults that you talk to and get together with and you know, even if it is just to talk about your kids because of course that's what the conversation always revolves around. (Gabrielle, postpartum experience after first child; group C)

Mothers employed two main strategies in their efforts to overcome the experience of social isolation: "getting out" of the house, and by creating new, and maintaining existing, social networks.

The value of "getting out" was a central strategy employed by all the mothers in this study. Penny, for example, made the following illuminating comment in this context, saying that "I mostly had the good days when I was out doing something. The bad days were when I was stuck at home all day long." However, given the logistical challenges of going out with new baby, the strategy of "getting out" was described by mothers as requiring considerable effort and energy. In short, "getting out" was work.

In this context, many of the mothers in my study spoke of making "conscious efforts" to prioritize their intentions to get out. Nancy's and Gabrielle's stories illustrate the effort and intentionality that was required by mothers to overcome the experience of isolation by "getting out:"

> at first, I stayed in a lot. Lot more than I should have, yeah. And it was only after sort of that second and third month with him that I really, really—I know I can't go on like this, you know…I *have* to do this. You know. I really don't feel like going to exercise, you know, I really don't want to go, but I know if I go I'll feel better. You know. And to do that was hard sometimes, too. (Gabrielle, postpartum experience after first child; group C)

> I had to start making a point to get out. And that was a big thing for me—getting out of the house and doing things. I'm an active person. I like to keep busy and following through, you know, getting out, but I've really had to make a conscious effort to do that. (Nancy, mother of one; group D)

The second major adjustment strategy mothers employed was to make efforts to connect with others. Mothers' adjusting efforts in this regard were generally geared to towards the building of new social networks, and/or the maintaining of existing ones. In this context, many mothers spoke of the value of connecting with other mothers who also had young children or babies, either through organized pre- and postnatal programs, or through friends who were also mothers. The mothers described how they valued the camaraderie of being with other mothers. They described how connecting with other mothers offered opportunities for friendship, as well as a valuable context through which their own experiences could be validated as "normal." As Emily commented for example:

> strollercize really helped…hanging out with other moms was fun….we get together and hang out, and it's nice to know that the emotions that we go through are normal and we're all doing them. Yeah….it feels good, just when we're around each other, right? (Emily, mother of one; group A)

Importantly, however, not all mothers felt they needed the kind of interaction or connection offered through formal networks. Violet, for example, felt that for her, attending a mothers' group was "more effort…than it was worth." In this context, a number of the mothers in this study felt that formal programs and groups did not provide

the kinds of opportunities they were looking for in terms of (re)building social networks. Raeanne, for example, made comments about how such formal groups—while they did provide for an outing—weren't the right fit for her own social needs:

> I would be concerned about it with some groups, like mom's groups, yeah, I would be concerned that it would be a show of who's the best mom or who's the best kid…these mom's groups, it's just not real. It's phony….I guess that's why I tried to forge my little group, you know with friends and talk to the midwives. (Raeanne, mother of one; group A)

Thus, mothers generally determined on their own whether or not attending postnatal programs or formal groups was a useful strategy for their own adjusting needs. In this respect, access to such groups was, for many mothers, not a key concern. This was particularly the case for first-time mothers, who were at home with their babies for the first year. Access *was* an issue, however, among some first-time working mothers, as well as some multiparas mothers, who wanted to attend these formal groups but couldn't—because of child care issues, or because of the times of day they were offered. Beth made the following remark in this context:

> they don't offer [those networking programs] to you, when you have another child. And that was really disappointing to me. I would have loved to have had a place where I could have gone….That would have been so nice. Because, like I said, I barely moved for two months…..So. It would have been nice to have had that option, you know. (Beth, postpartum experience after second child; group B)

Many mothers also talked about how they drew on existing relationships—with partners/spouses, friends, or family members—to overcome feelings of isolation. As Raeanne, Holly, and Gabrielle commented, for example:

> when I felt really lonely I'd…find somebody to connect with. You know, phone my father-in-law, who's retired, and say "come and let's go for a walk or something." (Raeanne, mother of one; group A)

> a friend of mine had her baby two weeks before me. We would talk on the phone six to ten times a day. Like we were constantly on the phone together, we were both pregnant together and worked together at the same place. (Holly, mother of one; group B)

> if I was having a crappy day. You know, if I was getting up—[son] had been up since four in the morning or something, or he was just crabby and I couldn't figure out why, and you know, it was like I'd call one of my friends up, and "What are you guys doing today? Let's go to the swimming pool." "Okay. Meet you there at ten o'clock." Give you something to look forward to. Something to get out of the house for. (Gabrielle, postpartum experience after first child; group C)

The third strategy employed by some of the mothers in this study to combat the isolationist character of their postpartum realities was to return to work. As many mothers described it, returning to work provided an opportunity to "get out of the house," and also provided opportunities to (re)connect with other adults. While many mothers who retuned to their jobs after their babies were born did wait until the end of their maternity leave (if applicable), some returned to work early. Often one of the main reasons they gave for this was so that they could reconnect with their colleagues and for the opportunity to spend time with other adults. The following comments made by Nancy and Beth illustrate how the strategy of returning to work helped some of the mothers in this study to rebuild their social worlds and overcome the experience of isolation:

> I couldn't stand the isolation of being at home. That was really, really hard for me. I felt very lonely. Very alone. Very isolated. Nothing to look forward to. So I was really excited to go back to work. (Nancy, mother of one; group D)

> I think I stopped feeling isolated more so when I went back to work. At least I was with adults again. (Beth, postpartum experience after first child; group C)

Interestingly, many other mothers contemplated going back to work early in order to combat their feelings of social isolation, but ended up not following through.

Typically, their contemplations about returning to work early were not acted on because they started having successes in their attempts to "get out" more and to build connections with others outside of their work environments. This was Penny's experience:

> I actually contemplated going back to work, too. Early. I thought "I can't handle it. I can't take it. How come [my husband] gets to get out of the house and go to work, and I have to stay home." I actually thought that I might have to go back to work early. I mean, I decided not to go back. I started feeling better. Things started getting easier. (Penny, mother of one; group B)

It is worth noting that returning to work and making decisions about work was not only a strategy used by some mother for overcoming social isolation. It also emerged as an adjusting task in and of itself, and is described in section 5.5.

5.4.1 Key variations

The task of overcoming isolation was often quite salient among first time mothers, particularly those who were leaving a relatively social work environment. By contrast, many mothers of multiple children described on-going activities and responsibilities with their older children as providing continued opportunities for them to get out of the house, and to interact and socialize with others. This was Kiera's experience:

> I don't know how to say it. I think [the two postpartum experiences] were similar, although when you have one child already there are more demands of going out and being more of a part of the community. So you don't isolate yourself as much when you do have that older child....So I think I felt a lot more isolated with the first one. Because I didn't have those or feel those responsibilities that I needed to get out and be a part of the community. (Kiera, mother of two; group B)

Notably, however, mothers of multiple children still did experience situations of isolation, of which they needed to overcome. Leslie, for example, a mother of three, described the issue of isolation as being more salient to her adjusting experience with her third child than it was with her first. For her, the experience was not about the changing

social context that went along with transitioning from work to being at home with a baby for the first time, but to changes in her own social relationships. She described her experience as follows:

> after [my first baby] was born, things were tough. I felt overwhelmed, but it was okay because I still had my friends. I still had my social life. My life still kind of ticked along. And so I guess I felt that it was going to be okay. But after [my youngest] was born, I felt very isolated. Very alone…And, you know, I was kind of estranged from my friends, not in touch with them. I was having problems with my family. Yeah, I felt isolated. (Leslie, postpartum experience after third child; group D)

As well, many mothers in this study—whether mothers for the first time or the fourth—found it quite difficult to "get out" or "get involved" in those early days, weeks and months, mainly because of baby care needs and/or because of a lack of physical energy to undertake the logistical work associated with getting out or getting involved. Beth, for example, a mother of two, talked about how her challenges with baby care—breastfeeding specifically—contributed to her experience of social isolation. She stated the following in this regard:

> I was so relieved when the nursing finally was working, because then I could leave the house with him. Before, all I did all day was—poor [older child] was playing in the living room and I was in there with [baby]—nursing on and off, on and off….so I basically just sat there for months, so that was, again, really isolating. I couldn't do anything…..So once he finally started to nurse I got to leave the house with him. Which was so wonderful. But then it was hard to go anywhere or for any length of time, because he still needed to nurse a lot. (Beth, postpartum experience after second child; group B)

Along similar lines, many mothers whose babies were born during or shortly before winter talked about the difficulties that living in a northern climate at that time of year presented to their abilities to "get out." This was part of Beth's experience with her first child, and Fran's as well. They stated the following:

> [I felt] like there was no where for me to go and nothing for me to do, you know? Because it was winter, too. She was born in September, so that time when you want to be outside or being out with your child, you're so limited. I remember it was so cold that year I couldn't leave the house with her, it was so isolating. (Beth, postpartum experience after first child; group C)

> I really felt alone and frustrated and was—I hate sitting still all the time and I felt like I was constantly breastfeeding. And never got my butt off the couch....and it was during those winter months, too, you know, from October to December that it was, you know, cold out and frustrating because you want to go out but you've got this baby to bundle up all the time. (Fran, mother of one; group C)

Lastly, mothers' experiences with social isolation varied according to their own personalities. In particular, mothers who described themselves as sociable and outgoing often found the isolating features of the postpartum environment as more central to their overall adjustment experience, and hence, overcoming this isolation became a more important focus of their adjustment work. On the other hand, mothers who described themselves as less social or as needing less social interaction and stimulation were often much less focused on this aspect of the adjustment process. The contrasting experiences of Violet and Kiera illustrate how this element of adjusting was differently experienced:

> the other thing that was kind of a surprise to me is I thought, oh yeah, "I'll meet with other moms and go to these moms' groups and that kind of stuff". But, I had a very low desire to do that. And at that point none of my friends really had kids...Um. So I did go once to like a moms' thing at a health clinic and just didn't particularly enjoy it....So we just kind of went and came home and I never did that again...You know, it was more effort to me than it was worth. So I'd stay home and we'd go for a walk or do whatever kind of thing...you know, for the most part it was fine. It was nice...I really like going for walks. (Violet, mother of one; group B)

> I think with my first child I was just feeling like I needed more contact with adults....I mean, I'm a very social person. I love to talk. I had tons of time talking with adults when I was working and at university before, and I lost a lot of that, at that point. It was a big change. And definitely just feeling the need to express any feelings I was having was all. So

> with [my second child] I went into the La Leche League, and so we had meetings and things like that and that really helped compared to my first one. (Kiera, mother of two; group B)

Again, the accomplishment of this task varied considerably in terms of how long it took, ranging from a few weeks to up to a year.

5.5 Integrating Paid Work/Making Decisions about Work

The arena of employment exists as a central aspect of most women's lives, and is a focal point for the construction of their identities (Eagan 1985; Miller 1995; Richardson 1983). It is also central to the postpartum adjusting process. As Stern & Bruschweiler-Stern (1998: 202) describe in this context:

> this is what the adaptation phase of motherhood is all about; bringing your many identities into balance with your life as a mother....Perhaps the hardest place of all to find harmony is the bridge between the two roles of mother and career.

As such, for the mothers in this study, making decisions about paid work—whether or not to return to work; if so, in what capacity; how best to integrate or "balance" the often conflicting demands of mothering and paid employment; and how to organize child care—emerged as a key aspect of their adjusting experiences. The process of making decisions about work—and the process of integrating paid work, if applicable—thus emerged as a major task of the adjusting process itself.

The mothers in this study made a variety of different decisions about work. First of all, among the mothers who returned to work, not all waited until the end of the standard one-year maternity leave.[13] While many of the mothers in my study did return to

[13] Through the Employment Insurance program in Canada, eligible women are entitled to a total of 50 weeks of maternity and parental benefits. The basic benefit rate is 55% of one's average insured earnings, up to a yearly maximum insurable amount of $40,000 CAD. This translates into a maximum taxable payment of $423 per week. In order to be eligible for benefits, women must have worked a minimum of 600 hours since their last claim or in the previous 52 weeks. (Service Canada 2007)

work at this time—either on a full-time or part-time basis—many also returned to work earlier.

Sometimes mothers returned because of particular opportunities (this was Beth's situation after her first child, as she was offered a promotion), sometimes because of necessity (this was Indri's situation after her third child, as she was employed on contract and therefore not eligible for maternity leave benefits), and sometimes because they found it helpful to their overall adjustment efforts. This was Danielle's situation. Danielle, a mother of one, returned to work on a part-time basis after her baby was approximately six months old. She tells the following about the value of returning to work early as an adjusting strategy:

> I've been going back to work once a week, an afternoon a week, and I want to keep that up. I feel like I need that....there, I can control what's going on. I can be really organized. Adult contact. I enjoy it. I miss it. (Danielle, mother of one; group D)

As well, a few of the mothers who participated in this study were in graduate school. These mothers often talked about how they returned to their studies before their baby's first birthday. Typically, this was because current maternity leave policies did not adequately support their situations.

At the other end of the spectrum, some mothers decided not to return to their existing jobs upon completion of their maternity leave, opting instead to stay home longer or permanently, or deciding to search for alternative employment situations—something that would be more suitable to their new realities. Two of the mothers in my study, for example, Leslie and Mary, did not return to their existing jobs, but decided to open up day-homes, thinking this might be a good way to balance their desire/need to work, alongside their desire to be with their children during the day.

More often than not, mothers' choices and considerations about work were not one-time decisions. In many cases, mothers made different decisions about work after the birth of each new baby. For example, both Leslie and Mary who opened day-homes—Mary opened her day-home after the birth of her first child while Leslie opened hers after the birth of her second—subsequently closed their businesses after the births of their next babies. Both of these mothers commented on how running a day home was exhausting work. Once they became pregnant with their next babies, their day home operations no longer provided the balance they needed. Rather, the running of their day homes became too physically and emotionally difficult. As Mary described, for example:

> when [my first child] turned six months old, I opened up a day home, here at the house. I wanted to stay home with him, so I wasn't going outside the home to work. And it went well. The family—I had two children here that I looked after, and there was a big discrepancy in parenting styles, and it was not a perfect fit, but it went okay. I knew it wasn't going to be forever. When my son was about 16 months old, I got pregnant again. And his was a more difficult pregnancy from the get-go. I was very tired. I had [oldest son], who's not two yet, and I'm looking over these other kids too....just looking after my son, and looking after these two others, and I was finding it harder and harder to enjoy. (Mary, experience with second child; group C)

Also, as mothers proceeded through this adjusting task, some changed their minds from what they initially had planned. Emily, for example, had originally intended to return to work after the birth of her child. At about six months through her maternity leave, however, she decided to remain at-home after her maternity leave ended:

> I'm not going back to work...and it's not what I expected at all. Because I totally thought, I can't imagine *not* going back to work. I love it so much. I love being a mom just so much more.....I do miss work, but I've taken on like different little projects to do, like design and communications and stuff....it gives me something to do and that's why I have my little fill of doing work so I actually feel fulfilled and that's all I need. (Emily, mother of one; group A)

Beth, by contrast, initially envisioned herself staying at-home, but then decided to return to work:

> I didn't expect to go back to work, I don't think. But I'm happy now being at work. I'm really lucky where I am....I like working. (Beth, experience with first child; group C)

Bettina was another mother who expected to return to work, but then considered changing her decision. She expressed her feelings as follows:

> I don't want to [go back to work]. I never thought I'd be—I always thought of myself as a career woman. But I can't imagine like one day without seeing [baby]....when it comes closer I know that things will hopefully get better. (Bettina, mother of one; group A)

Mothers' decisions and experiences about employment also varied with each individual experience. In this context, the process of making decisions about work emerged as an integral part of the adjusting process *every* time one became a mother. Indri, for example, a mother of three, had different returning-to-work experiences after each of her three children:

> my job now isn't the same one I've had with all three kids. I was working before I had [my first baby]...with a TV station and it's just too hard a job to do with little kids. If you look at any newsroom, people don't have children in that newsroom. Especially the women. Because it's just too hard a job to do with kids. I mean, I used to sleep with the scanner under my pillow and get up in the middle of the night and go do things, so it was just not feasible. And I tried to go back to work when he was nine months old. I got a different job, working with just a local cable station. And he – I lost three babysitters because they wouldn't take him anymore because he was crying so much. And then I just said, screw it, and I quit my job and I did freelance work...and then I kept doing that and when I had—when [second baby] was a year we moved to Edmonton and I got this job. And it's still a contract with my company...but because I'm on contract I don't have time off, so I'm still working full-time and looking after the kids full-time. (Indri, mother of three; groups A, B, and C)

Waverly, a mother of four, also made different decisions about work after the birth of each child, ranging from being at-home to working full-time.

Largely, mothers' thoughts, plans, decisions and experiences with respect to returning (or not retuning) to work emerged as part of a more ongoing process. Indeed, mothers' experiences of adjusting to their new work-family arrangement, whether it involved returning to work in some capacity or being at-home, was central to their achievement of an integrated maternal identity—to the accomplishment of the process of postpartum adjusting. However, these initial decisions and experiences did not necessarily represent the accomplishment of *permanent* work-life balance. As Eagan (1985: 191) has also noted, for example:

> the settling point…is at the same time real and illusory. What is real is the achievement of an integrated self and this will persist until she has another child. Of course the sense of settling is also an illusion because…the balance achieved is not stable. Ahead, and not very far, are new challenges and new contradictions that will dislodge this newly won equilibrium.

Thus, for many of the mothers in this study, the various strategies and changes they made in their lives to create an initial sense of balance or integration often needed to be revisited again at a future time. Natasha, whose children were four and six at the time of our interview, illuminated this issue in her following comment:

> I don't know how long post-partum period goes, but I sometimes wonder now, at the ages they're at now, six and four, some days I'm like having more postpartum than I ever did when they were first born….you get into that whole superwoman concept. Honestly, I almost feel like it's more postpartum now than when they were even smaller. And I think it's just because more things are incorporated into that ideal…because there's the working part of me and then there's "I'm mom" and the home life and I have other extracurricular activities that I really enjoy that I like to stay involved in. (Natasha, mother of two; groups A and B)

In this respect, then, this task—as it pertained to the process of postpartum adjusting itself—dealt primarily with the *initial* decisions and integration activities that mothers undertook with respect to their employment situation: conscious decisions about what to do at *this* particular time, and in *this* particular context, in order to adjust to their new reality and set of responsibilities.

5.5.1 Key variations

Mothers varying decisions about work, and their struggles and successes in integrating paid work with mothering, revolved around four main themes: personal circumstance and need, the availability of child care and appropriate employment arrangements, and the issues of time and energy, and personal beliefs and preferences.

With respect to the theme of personal circumstance and need, mothers talked about their particular lifestyle and situational circumstances and how these influenced their decision-making process about if and how they returned to work. As Natasha and Tianna remarked, for example:

> I work-full-time.....to maintain the house that we're living in, and you know, to have the lifestyle that we have. (Natasha, mother of two; groups A and B)

> I knew I would have to work. Working part-time was not really financially feasible for us. I knew I would have to go back full-time. (Tianna, mother of one; group D)

For the mothers in this study, "needing" to return to work did not present a difficulty in and of itself. It was only when mothers described needing to work but not *wanting* to work that they also tended to describe this adjusting task as being more difficult and/or salient to their overall experience. As Waverly aptly noted in this context, "there's

nothing worse than having to work because you have to as opposed to because you want to."

Mothers also talked about the willingness of their employers to meet their particular needs—and the availability of suitable child care—as influencing their decisions, and as contributing to the ease or difficulty of their adjusting experiences in this regard. The contrasting experiences of Gabrielle and Fran reflect how the extent to which employers and institutions plays an important role in influencing mothers' experiences:

> I've worked for [the company] since 2000. So when I moved here they agreed to let me work from home. Part time from home. Which is great. And I should be able to continue doing that almost anywhere in the world that I go.....and so I went back three days a week. And that seemed to work out really well. (Gabrielle, mother of two; groups C and A)

> the challenge was...finding that balance....trying to find my place as a mother and an academic. Because the academic world isn't really friendly to moms. Well, my department particularly. I find it really sad that I can't go to a conference because there's no way that I can arrange day care or stuff like that. Like I think that's really important. (Fran, mother of one; group C)

Another major theme in mothers' adjusting stories with respect to this task dealt with their own personal preferences about combining paid work with mothering. Many mothers described their personalities as being central in this regard. Specifically, they described that their decisions were based—at least in part—on what best suited their own personality styles. As Natasha commented, for example:

> having that part of my life separate from my children, I enjoy it. I enjoy having the adult feeling. My professional life....I think the bottom line is that's just who I am and I recognize in myself that I'm not just able to stay at home...it's part of who I am. I mean, I'm a [professional]. I went to school for six years. To do that....and although I love my children dearly, I think, okay, it's time for mommy to go back to work, you

> know, because just something about just 24/7 being immersed with the children it's just not—I don't think it's best for me personally. And then it's not best for them, either. (Natasha, mother of two; groups A and B)

The other major theme central to mothers' experiences with this adjusting task was the issue of time and energy. Many mothers talked about the time and energy challenges associated with combining paid work and mothering. It is in this context that many mothers contextualized this concern in terms of "juggling," or in terms of "feeling torn." As Waverly and Holly remarked in this context:

> I hope not to go back to work. Because it's just too hard to juggle everything. 'Cause I want to give 110 percent. And if I'm not doing that, then I feel like really bad. So hopefully I won't have to go back. But it depends on the financial situation. (Waverly, postpartum experience after fourth child; group C)

> I'm at the tail end [of my Master's]. But then I'm also planning on going on to my Ph.D. I'm really torn about that, too…that I'll spend all that time at school and I'm going to miss out. And we want to have more kids….And so trying to balance that, plus working part-time, plus getting a Ph.D. I don't know if I can juggle all those things. You know, I have to be realistic….But, the area I'm in, I absolutely love. I love learning about my area and getting more—it would be a huge career advancement for me, too. It would just open a ton of doors for me. So I really, really—I just really want it to work out. I really want to be able to juggle everything. (Holly, mother of one; group 2)

Perhaps unsurprisingly, for many mothers, this initial resolution to the issue of integrating paid work and mothering meant making compromises to their own expectations about what all they could "handle" and what they could expect to accomplish in a certain amount of time. The following excerpt from Jan's story highlights how mothers often resolved this conflict by changing (i.e., lowering) their perspectives or expectations of themselves with respect to their career ambitions:

> I had to say, "I'm interested in this and this is what I want to do and this is where I'm going to put my energy and focus on". And you know, making those clear choices…I actually had to say to myself, "Do I want

> to do this as my job, as my career?" And if I do want to do it then how do I want to do it?....And I realized my expectations of myself were higher than they needed to be. If I lower my expectations a lot of stress would go. (Jan, mother of one; group 2)

Some mothers, like Holly, for example, temporarily resolved this dilemma by exploring options for part-time work:

> that's one of the reasons why I'm thinking, okay, maybe we can get a position that I can job share after the second one. Instead of going back full time. Having to juggle full-time work plus school plus kids. I can't do that. I mean, I know that now. I just can't. (Holly, mother of one; group B)

Other mothers again decided to leave the labor market altogether, at least temporarily. This was both Mary's and Heather's experience. Comments from Heather are excerpted below:

> at times when I've had like a lot of job stress, you know, I work twice as hard or somebody asks for something and I volunteer and stuff up to the plate, I'll be the one to work the overtime, or...I would keep trying harder and harder and, you know....So I'm not going to go back this time. I'm done. I won't be going back for a good couple of years, like they're gonna have to be in school....I'll work again some day. But right now it's just a very intense period as you well know, with young children, but you know, it's just lie low right now. (Heather, postpartum experience after second child; group D)

One of the most central themes in the mothers' stories with respect to how they described this task as more or less difficult had to do with the extent to which mothers "felt torn" about their decisions and experiences. In short, mothers who "felt guilty" or "felt torn" about returning to work tended to describe this adjusting task as being more difficult to accomplish. Jan was one such mother. She described her experience as follows:

> I'm always feeling either guilty that I'm not spending time with my daughter or guilty that I'm not spending time on my thesis and going back and forth. No matter what I'm doing. One or the other, I want to be

> doing the other...the two things happen at the same time and it's very difficult to feel like you're putting enough resources into each of these things without completely draining yourself. (Jan, mother of one; group B)

In this respect, greater difficulties in accomplishing this task were reflected in mothers' experiences of "feeling torn" about how best to meet both their work/career priorities and their mothering priorities. As Fran described about her experience, for example:

> I think it's funny about between who I am and who I want to be and as a good mom. And to me, like a good mom being one that takes the time to spend with my child. Like to have that one-on-one time....there's nothing more that I wanted to give her than me. I want to give her me....And that's maybe why I feel guilty when I leave [to go to work]. I want her to have, understand, and feel that I am there, I'm committed, you know, totally committed, I mean, but also feel that I have a sense of self and feel like I can do what I want to do, and yeah, just have a balance. I think that's the biggest challenge. Is being me and being a mom. (Fran, mother of one; group C)

The experience of guilt was also central to the mothers' experiences who described considerable difficulties in accomplishing this adjusting task. As Beth described in this context:

> I just can't imagine going [back] to school and the guilt I would feel for leaving them for even an hour, you know. Right now, I see [older child] every day on my break at lunch time, you know, you don't want to leave them. You feel guilty. (Beth, mother of two; groups C and B)

In short, mothers who held a "core" belief about needing to "be there completely" for their children, but who also wanted or needed to return to paid work often described having more difficulties in accomplishing this task. The role of "core" beliefs in helping to facilitate (or hinder) mothers' adjusting abilities is described in Chapter 6.

5.6 Reconciling Expectations with Reality

The last major theme that featured prominently in mothers' adjustment stories had to do with the degree of congruence between their beliefs or expectations, and their experienced realities. Specifically, mothers described needing to *realign* their expectations, priorities and beliefs about their babies, about motherhood, and about themselves in accordance with their new realities. Adjusting, in this context, required that mothers find ways to reconcile the "disconnect" between the ideal and the real. As Alice's comment illustrates, this adjusting task involved figuring out "how…you balance your ideals with what the reality is of the situation."

Interestingly, all the mothers in this study described their postpartum experiences to be different from what they had expected. Indeed, many mothers opined that there was no way to ever be fully prepared for "what to expect" with a new baby, because every baby is different, as is every mother, and every postpartum situation. Mothers often described the various things that came unexpected to them as "shocks" or as "surprises." As was mentioned by Astrid, for example, "I experienced a lot of different things that I hadn't been prepared for, things that came as kind of a shock to me." A comment made by Jill further illustrates how mothers described their experiences of "disconnect" between expectations and reality:

> I read a book in the library and I don't know if you would have read it or not, but it was just a really good one on this whole topic and it was called "Mother Shock". I liked it….[the author] takes the whole concept of culture shock and parallels it to mother shock…..that one summed up a lot of stuff for me and you know, how you change. (Jill, postpartum experience after third child; group D)

Mercer (1986; 1995) has referred to this aspect of adjusting as the process of harmonizing one's ideal self with one's actual self or self-image. According to Mercer (1995:5), the ideal self is the self of expectation, where "desired attributes…are

incorporated into the cognitive structure as a guide for behavior." Mercer acknowledges that ideal selves will vary, as they are heavily influenced not only by societal customs and values, but also by personal histories and individual contexts. The actual self, or "self-image," by contrast, is described by Mercer (1995: 5) as "a mirror and evaluator of the self."

In this respect, the process of reconciling any disconnect between one's expectations and one's reality emerged as a central part of the adjusting process, and was one of the key activities whereby mothers cultivated and integrated their new identities as mothers. As Mercer (1995: 13) also notes in this context, "feeling adjusted" thus requires that mothers experience an "internal harmony with the [mothering] role and its expectations."

The mothers in this study described three main activities as being central to this process. The first was to change elements of their day-to-day realities so that their routines, activities, and parenting practices better coincided with their expectations. Largely, these "reality changes" included the various adjusting activities that have already been discussed in this chapter. This included such things, for example, as the creation of new social networks, routines and activities, the re-establishment of existing roles, activities and relationships, learning to feel confident and competent as a mother, and feeling connected with one's baby.

Another way mothers worked to reconcile their expectations with their experienced realities was through a process of "putting things in perspective." As Ingrid stated for example:

> I think that trying to put things in perspective is important.....I think I try to be a bit pragmatic and look at it like "you do the best you can, and no

> one's going to be perfect," and I think too....I kind of look at things that my parents have done and I got into a big fight with my dad a couple of weeks ago, and he said basically "yeah well, obviously I wasn't a perfect parent, but I tried," and now I can really understand that....I have a sense of you do the best you can and you know, you try not to fall too short. In any one area. But uh but it's inevitable that you're going to. And hopefully you try and explain to them what's going on. (Ingrid, mother of one; group A)

Putting things in perspective, for the mothers in this study, involved two strategies: making comparisons between their personal situations and the real or imagined situations of others; and focusing on the "big picture" with respect to their responsibilities, roles and realities. Basically, the activity of "putting things in perspective" emerged as a cognitive strategy that mothers used to rationalize the "hows" and "whys" of their particular situation. As Holly described, for example:

> I think overall, considering what I'm exposed to on my job, I think I've got a skewed scale of you know what makes a good—like, I'm not a drug dealer. I'm not a prostitute. You know like. Like I'm not saying I'm like, oh, yeah, I guess I am, I'm saying I'm a better mother than they would be. Um. So I think maybe that helps me put some things in perspective. (Holly, mother of one; group B)

The mothers described this strategy as a way to reconcile unfulfilled expectations while still building their sense of self as a (good) mother. This strategy has been described by others as an effective means of coping and adjustment (Eckenrode 1991; Wills 1987; Pearlin & Schooler 1978; Lazarus 1969, 1991, 1999). As Eckenrode (1991: 4) describes for example, a "person may compare him- or herself to others who are experiencing the same stressor by who are worse off and in this way enhance their own self-image."

The third strategy the mothers in this study described to reconcile their expectations with their new realities was to actually change or alter their expectations and beliefs about their new lives, roles and responsibilities. The strategy of changing one's

expectations has also been described in psychological literature as a form of "positive reappraisal" whereby individuals change their perception or way of viewing a problem or stressor in order to help resolve the disconnect they are experiencing (Clark & Hovanitz 1989; Lazarus 1999).

In this context, many of the mothers in this study described having to actively change various expectations about themselves, about motherhood, and about their new lives. As Gabrielle remarked, "lowered expectations about life" were central to her adjusting experience in this regard. Jan also made the following comment in this context:

> I've learned how to just talk to myself a little bit better. So in that respect...I'm not as hard on myself as I used to be. My expectations—I've lowered my expectations of myself now. (Jan, mother of one; group B)

Typically, mothers described this process of as one of becoming "more realistic" and/or "less idealistic" about things, and renegotiating their adherence to the largely unattainable image of the "supermom."

In general, mothers described having to alter their expectations in three main areas. First, they talked about needing to adjust their expectations about themselves as mothers. For many, this meant renegotiating their relationship to personally-held mothering beliefs and ideals. As Penny remarked in this context:

> I used to think that the perfect parent existed. I think I'm a lot better now....I've lightened up on myself...thinking that you're supposed to do it this way or that way and but then getting into the reality of the situation a lot of that has been tossed out. Now I think that the perfect mother doesn't exist. You just do the best you can. (Penny, mother of one; group B)

Secondly, as noted earlier, many mothers described having to alter their expectations about their careers or work ambitions in order to feel adjusted. Tammy made the following comment in this context:

> you feel like you're torn, wanting to spend 24 hours a day with my child versus trying to find that two or three hours where you have to do some work. But I guess I just changed my perspective. Where school had been really important to begin with, then I had the child…and I finally just decided that if it would take another year in the Ph.D. program in order to take care of the baby then that's how it's got to be. (Tammy, mother of one; group A)

Thirdly, many mothers talked about having to lower their expectations of their spouse or partner, especially in terms of their involvement with childcare and other domestic responsibilities. The following comment from Astrid illustrates this theme:

> I was hoping that it would be more balanced. But it's okay. I've worked through that now, and kind of accepted it and lowered my expectations about it so it doesn't upset me so much. (Astrid, postpartum experience after first child; group A)

In this context, the mothers in this study described the role played by their spouses/partners in their adjusting experiences in two main ways. The first was in regards to the above—specifically, in their need to reconcile any disconnect between their expectations about what their spouse/partner would be like as a father and partner (and therefore also what they would be like as a source of material and emotional support), and their experienced realities in this regard. Specific to the process of postpartum adjusting, then, the mothers typically described changes or adjustments in their intimate relationships with their spouses/partners as taking place within this context of "reconciling expectations with reality."

The second main way that the mothers' described their spouses/partners as playing a central role in their postpartum adjusting experiences had to do with the extent to which they felt they provided a source of emotional and material support; in other words, the extent to which mothers felt their spouses/partners helped or hindered their

abilities to adjust. The role played by spouses/ partners as forms of support is discussed in greater detail in Chapter 6, The Resources of Postpartum Adjustment.

Another main area where the task of reconciling expectations with reality emerged as being a particularly important activity was with respect to mothers' birth experiences. This was particularly the case for mothers' whose birth experiences had not gone as hoped or as expected. As Gabrielle commented, for example:

> I spent much more time thinking about how I felt then than I probably ever have...around the birth of my son. I felt like I let myself be pushed around by the medical bunch at the hospital and I'm just not that kind of person usually. I sort of had to delve into why did all of that happen and what could I have done differently. Again, focusing on the—you know, as opposed to really focusing on the emotions more on what I could have done differently...I didn't really want that to happen again. So I was trying to sort of think through that, too, and you know, think about how I had really felt about the whole situation, and why, and again, was there something I could have done differently. (Gabrielle, postpartum experience after first child; group C)

As Gabrielle's story illuminates, mothers' issues with their birth experiences—when their experience did not go as hoped or as expected—were not necessarily about the fact that things had not gone as expected. More centrally, when mothers described how they needed to make sense of and "reconcile" their birth experience, they often spoke of the fact that the experience had left them feeling disempowered or "pushed around." This is a finding that finds support in the work of others—that mastery or a sense of control is key to mothers' satisfaction with their experience of birth (Humenick & Bugen 1981; Bramadat & Driedger 1993; Beck 2004), and that an important element of mothers' adjusting experiences is the need to clarify and make sense of the events of the birth (Rubin 1984; Madson 1994; Arizmendi & Affonso 1987).

In general, mothers who described having fewer expectations about their birth experiences tended to find this reconciliation process less difficult and/or salient to their overall experience. The contrasting experiences of Holly and Suzanne illustrate this variation:

> you know, they tell you in the birthing classes, like have a birthing plan, how do you want your birth to go, and I think that's really naïve, and looking back on it now, I think that's really ridiculous to even have one going in there. Because so many things can happen. Like ideally, yeah, I didn't want a C-section. And fortunately, I was able to not have one. But to have a preconceived notion, no, I want to go through it with no drugs, or I don't want them to break my water, or I don't want to be induced. Well, I was nine days overdue. I had to be induced. He already pooped inside of me. So he had to come out. My water wasn't breaking. He had to break my water. Or else he may not have come out as good as he did. So I think its a little naïve to have all these preconceived notions of how we want the birth experience really to be. (Holly, mother of one; group B)

> I guess I just never really thought that [a C-section] would happen. I expected it would be a normal induction. I mean, I felt so healthy and thought that everything would be normal and great. And nothing would go wrong. So, probably for the first several weeks after his birth I felt like I did something wrong and felt like I didn't have the right kind of birth. With the C-section. It was a strange mixture of inadequacy almost....like I felt like I was robbed of a normal birth experience. Yeah, that was a bit crappy. Now I'm just at this point where I don't think about it anymore—it doesn't matter. I'm just happy that everything went well....but yeah, I was very, I was shocked, both physically and mentally. I was in shock (Suzanne, mother of one; group B)

Other examples of how this task was experienced variably by the mothers in this study are discussed below.

5.6.1 Key variations

Perhaps unsurprisingly, mothers' experiences of the magnitude and saliency of this task were directly related to the relative amount of disconnect between their expectations and their realities. Ingrid and Holly, for example, experienced little dissonance between their expectations of motherhood and of themselves as mothers, and

their experienced realities. As such, they did not experience this adjusting task to be particularly difficult to accomplish. They made the following comments this context:

> I think in a lot of ways I am the kind of mom that I expected that I would be. (Ingrid, mother of one; group A)

> for the most part I think I'm pretty comfortable with where I am as a mother and how I'll be raising my child and that type of thing....the transition to motherhood was what I expected, for the most part. (Emily, mother of one; group A)

As well, these mothers tended to describe that their most important expectations had been materialized. Their babies were born healthy, and their situational circumstances were largely what they had anticipated or prepared for.

On the other hand, the mothers in this study who experienced a greater degree of disconnect between their realities and their expectations typically found this adjusting task to be more difficult to accomplish, and more salient to their overall adjusting experience. This was Beth's experience. Beth described experiencing a considerable amount of disconnect between her expectations and her reality, and described the process of reconciling this "disconnect" as being particularly defining of her overall adjusting experience.

Beth was an early childhood educator who worked extensively with babies and small children. As such, she had expected that mothering would feel and come "naturally." It didn't. She described this experience as follows:

> I'd really feel, oh, it just comes natural, you know? And then I felt this whole stigma with that it's not coming natural. And I remember being angry about that.....I mean, I worked with it every day, but when you have your own, you struggle with them and it wears you out. And I don't think anybody told me the horror stories, you know? You always just hear the good things.....I thought, Oh, my gosh, I must be horrible. To not be so excited all the time.....And I didn't know how to respond to her needs right away. You just don't know those things before. And I thought for

> sure it would be so quick for me, because I work with children, and because I love children so much, and it wasn't. I think that was the biggest shock, that it didn't come naturally, like I thought it would you know. (Beth, postpartum experience after first child; group C)

For Beth, the task of reconciling her expectations with her experienced realities felt particularly difficult to accomplish because it required a change to her beliefs about the "naturalness" motherhood and mothering:

> I guess now I can look back and know it was okay with [daughter] to not be okay all the time, you know, to be, yeah, to not be so ecstatic all the time, and that it doesn't always come natural, that it can be really hard, you know...there has to be a way to know that kind of thing, you know, and because now I realize it doesn't come naturally to every baby or every mother. (Beth, postpartum experience after first child; group C)

In general, the mothers who described this adjusting task as taking longer or as being particularly difficult to accomplish were those who described needing to find a way to ultimately *lower* their expectations about themselves as mothers and/or the experience of motherhood. As Jill remarked in this context, for example, "my expectations are too high of myself." This was experience was also described by some mothers—like Danielle and Nancy, for example—in terms of needing to reconcile "perfectionist" expectations with "less than perfect" realities.

> I was wanting everything to be so perfect and then when it's not perfect, I was kind of blaming myself. Feeling lots of guilt. Guilt about working, guilt about staying home, guilt about the baby's heart condition, guilt about many things....I'm managing better now. And I'm feeling better. I don't really compare myself anymore to that ideal image of the good mother. I used to but now I think that that was a misconception. And now I'm better about say, for example, if the house isn't clean, I'm willing to let it go. Like, tonight, we ate frozen pizza for dinner, whereas early on I would have thought that was a terrible thing, but now I say okay, if [daughter] has pizza once in a while, it's not a big deal. (Nancy, mother of one; group D)

> I wasn't really a flexible person. A go-with-the-flow kind of person...I like things being perfect. (Danielle, mother of one; group D)

The extent to which mothers' experienced a gap between their expectations and their reality emerged as central to understanding mothers' varying experiences with respect to this adjusting task. As such, this analysis provides additional support to the argument that incongruence between expectations and reality plays a central role in the experience of adjustment difficulty (Rubin 1984; Mercer 1995; Mauthner 1998; Beck 2002).

5.7 Summary

The focus of this chapter has been to describe the various tasks of the process of postpartum adjustment. These tasks—connecting with the baby, developing competence and confidence as a mother, rebuilding day-to-day life, overcoming isolation, integrating paid work/making decisions about work, and reconciling expectations with reality—were described by the mothers in this study as the main activities they had to undertake in order to adjust to their new realities and responsibilities. The accomplishment of these tasks culminated in mothers' experiences of "feeling adjusted." As this chapter emphasized, however, there was considerable variation in how mothers experienced these various tasks of the adjustment process—in how long it took mothers to accomplish these tasks, in how salient various tasks were to mothers' overall adjustment experiences, and in how "big" or how difficult various tasks felt to the mothers in this study.

Of particular interest to this analysis, however, was how "able" mothers felt to accomplish these various tasks, however big or small, difficult or easy they were perceived to be. In this context, mothers' varying experiences of "adjusting difficulty" reflected the particular relationship between the magnitude of their adjustment demands

(i.e., the tasks they needed to accomplish) and the adequacy of their adjustment resources (i.e., the factors that enabled them to effectively accomplish those tasks).

Mothers' varying experiences of "adjusting difficulty" were thus connected to six main resources. These resources—which were articulated by the mothers in their own narratives about their adjusting experiences—were described as the main things that facilitated their abilities to accomplish these various tasks. In other words, the mothers in this study felt that their abilities to accomplish the various tasks of adjusting hinged on the quality of their personal resources. These resources include the following: prioritizing self-care, having manageable or "low" situational stress, having enough help, "feeling understood," feeling "ready" for the baby, and having realistic "core" beliefs and expectations. These resources are the topic of the following chapter.

Chapter 6:
The Resources of Postpartum Adjustment

A central problematic of this study was to understand why mothers themselves believed they experienced and felt what they did. As this chapter explicates, there were six main themes that encompassed mothers' explanations of why they experienced what they did. These themes emerged as the main resources that enabled mothers to successfully accomplish the work of adjusting. They include the following: prioritizing self-care; having manageable or "low" situational stress, having enough help, "feeling understood," feeling "ready" for the baby, and having realistic "core" beliefs and expectations.

These themes figured prominently in the experiences of all of the mothers I talked with, and in their explanations of why they had an easier or more difficult time accomplishing the various tasks of adjustment. In general, the mothers in this study who experienced fewer difficulties adjusting described having all or most of the following resources:

- they prioritized their own self care, especially in terms of getting rest or sleep when needed and in being able to get a break;
- they had low or manageable levels of situational stress,
- they had enough "help" in meeting their day-to-day demands and responsibilities;
- they felt emotionally understood by, and connected with, others,
- they generally felt "ready," both physically and emotionally, for the baby and all that that entailed.

- that they had realistic "core" beliefs and expectations about mothering and motherhood.

By contrast, the mothers in this study who described having greater difficulty adjusting attributed their compromised abilities (and their poorer emotional health) to experiencing deficiencies in these resources. In general, mothers' varying experiences with adjusting to their new baby were closely associated with *how many* of these resources they described as being operant. This general pattern is highlighted in the Table below.

Table 6.1
The Cumulative Impact of Adjustment Resources on "Adjusting Difficulty"

Categories of adjusting difficulty	**Number of resources**
Group A: • Mostly and mainly happy (emotionally very healthy) • Adjusted well/had little difficulty adjusting	5-6
Group B: • Low to moderate emotional distress (emotionally healthy, but wellbeing compromised) • Experienced some difficulties adjusting	3-5
Group C: • Moderate to high emotional distress (emotional wellbeing significantly compromised: mother suspected possible PPD, but never sought diagnosis) • Experienced considerable difficulties adjusting	1-3
Group D: • Diagnosed with PPD (emotional wellbeing severely compromised; officially diagnosed with PPD) • Experienced extreme difficulties adjusting /felt "stuck" in the process	0-2

This pattern was a general tendency that revealed itself in this particular study. Other than the observation that these six factors tended to be cumulative in their influence

on mothers' varying adjusting experiences, more precise conclusions about the cumulative influence of these variables on mothers' adjusting experiences and outcomes cannot be drawn from this observation. Quantitative research would be needed to determine how and if this general pattern holds up in larger population samples.

The following sections elaborate on the six main themes the mothers identified as being central to their own understandings of "why they felt and experienced what they did." Importantly, these themes were not described by the mothers as being mutually exclusive of one another but as highly overlapping and interdependent themes.

6.1 Prioritizing Self Care

One of the most commonly-given explanations given by the mothers in this study about why they felt and experienced what they did pertained to the prioritization of their own self care. In general, the mothers described that an ability to prioritize their own self care *facilitated* their adjusting efforts, while poor self care tended to hinder their abilities to adjust. As the following comments made by Tammy and Natasha illustrate:

> I just have to—I go to sleep and then I'll feel better tomorrow....I also try and do things physical that help me relax. Make sure I get physical exercise. Or I'll go for a bath or I'll meditate or I'll read a book. After the baby's gone to bed, I try to take some time for myself. Try not to be jumping onto e-mail right away or getting on with the housework. Taking five or ten minutes just thinking of my health type of thing. (Tammy, mother of one; group A)

> [my activities] are part of what keeps me sane, you know. I run. I'm a runner and I do marathon running and...and that has been, I think, just an absolute savior for me. Like huge. I literally feel the stresses and stuff lifting away at least for that hour that I'm out running and what not....I think it can be dangerous if women do start giving up some of the things they enjoy being involved in because that can be very much a sanity break, and then what do you have, if you start giving those things up? (Natasha, mother of two; groups A and B)

As suggested by these excerpts, the most important dimensions of self care identified by the mothers in this study were: getting sufficient sleep and rest; eating nutritionally and getting adequate exercise and activity; and "getting a break" when needed.

6.1.1 Dimensions of self care

The first, and perhaps most central, dimension of self care articulated by the mothers in this study was the ability to get adequate sleep. Over and over again, mothers related their experience of fatigue and "tiredness" to how well they were adjusting. Ingrid, for example, commented that "waking me up over and over again really deteriorates my performance and my ability to cope with anything (mother of one; group A)." In this respect, sleep deprivation and physical exhaustion was, for virtually all of the mothers in this study, one of the most central themes in their explanations of why they had an easier or more difficult time adjusting.

Holly, for example—who described her emotional wellbeing as generally mid-range but fluctuating (she rated her emotional health as being between a 5 and 8 out of 10)—explained that the "worst times" for her came when she was overly tired. She stated the following in this context:

> the worst times for me are when I'm really, really tired. When I'm absolutely out of my mind exhausted. I don't like that mind numb feeling of being so tired. And when I'm that tired, the baby still needs me…And at that time, no, I don't like being a mom. Because I don't feel I have anything to give. (Holly, mother of one; group B)

Holly then described how "getting sleep" was essential for her ability to recover:

> once I've had a little bit of sleep I feel better. And I think that's a big part of it—is knowing that if I can just sleep a little bit then I'll feel different when I wake up. So yeah, I think, and if it wasn't for my husband to be able to give me that time to just go and have a nap every once in a while, I don't know how I would get through it. That would be tough. (Holly, mother of one; group B)

Mothers' ability to "get enough sleep" was thus described as a central mechanism of adjustment. In this respect, mothers described that "not getting enough sleep" and/or and feeling "so tired" curtailed their abilities to "cope" and "deal with life." As Jan described in this context:

> I was surprised at how intermittent sleep can make the rest of your life so difficult....and I was expecting tired, but I hadn't thought, I hadn't been aware, or been prepared for how much that comes to influence every other element of your life. It's not just that you're tired. It's just you're too tired to do so many other things that—that would make things better. Or that you should be doing or that needs to be done. (Jan, mother of one; group B)

Jan described her adjusting experience as encompassing approximately two years in total. She described her emotional wellbeing during this time as generally ranging from a four to a six (out of ten). One of the main reasons she gave for why she experienced what she did—and why it took that amount of time before she "got [her] wind back"—was that she was not adequately meeting her own self-care needs. She stated the following:

> it was a very short term that I didn't get tons of sleep. But it seems to me that I was tired for a lot longer than that. Just physically...I was just exhausted. Mind you, I was nursing. And I wasn't looking after myself very well. I was eating a lot of—I wasn't eating very balanced and so when I'm tired I start to crave high sugar high fat type foods that only perpetuate your sluggish feelings. And so I wasn't eating—I wasn't worried about my own nutrition very well and so I had gained weight. (Jan, mother of one; group B)

For Jan, self care meant getting sufficient sleep and rest, as well as adequate nutrition and exercise. As illustrated in the excerpt below, Jan's understanding of her experience was once she started to prioritize her own self care, her ability to "deal with life" improved:

> I know that once I started exercising again and started eating healthy and my attitude has changed....and I feel much more positive about my ability to deal with life than I did. (Jan, mother of one; group B)

Similar to Jan, there were a number of mothers in this study who commented on the negative effects that not eating nutritiously enough—or not eating regularly enough—had on their ability to cope and adjust. Danielle, for example, whose baby spent five weeks in the NICU and who spent most of her waking hours at the hospital during that time, is one such example. Danielle, who was diagnosed with PPD and had considerable difficulties adjusting, felt that a large part of her experience could be explained by the fact that she had not been able to prioritize her own self during this period:

> I think what triggered a lot of it or at least aggravated it—is I wasn't getting enough sleep. I was spending a lot of time at the hospital. I wasn't eating properly (Danielle, mother of one; group B)

Similarly, Waverly made the following comment about her adjusting experience:

> one of the symptoms I recognize when I'm feeling depressed is that I don't eat. I just don't want to eat. Which isn't good because it's a vicious circle. Because it makes you feel worse. Right? So I know when I do force myself to eat, like breakfast or lunch, that I actually do see the benefit. (Waverly, postpartum experience after fourth child; group D)

Other mothers, like Alice for example, who described more positive adjusting experiences, often identified that their ability to eat nutritiously was of central importance:

> [my husband's] mom, she's been a Godsend really.....We came home from the hospital and we had like almost an entire week of food in the fridge for us. And not just like junkie food. Like, you know...nutritional stuff....And, you know, she did that every week, for, I don't know, for the first month. She came over every week. Yeah, so, I mean that was just so helpful. (Alice, mother of one; group A)

In addition to the role played by eating and nutrition, many mothers identified exercise and activity as central to their particular adjusting experience. Specifically, the mothers in this study who engaged in exercise and other forms of physical activity all described this as being directly—and positively—linked to their adjusting experience. In

fact, none of the mothers in this study who engaged in regular physical activity or exercise suffered from PPD. And while many did describe experiencing lower or more mid-range levels of postpartum emotional health, they specifically emphasized that, were it not for their ability to exercise and be active, they would have experienced even greater difficulties accomplishing their adjusting tasks. As Tammy described, for example:

> I certainly always found emotional strength because of some of the physical activities that I do. Like whenever I swim, in some sense it's like meditation because you're doing laps and you keep your mind on the water…you're just concentrating on breathing or swimming or getting from A to B. And so that helps calm things down. (Tammy, mother of one; group A)

The last main dimension of self care that mothers described as being central to their adjusting experience had to do with their ability for respite—to "get a break" when needed. "Getting a break meant being able to take some time away from the baby as well as getting temporary relief from other responsibilities. Further, as Alice described, the value of respite lay not so much in what mothers actually *did* during that time, but in the actual "getting" of that break when needed:

> there'll just be a day when like, enough, enough, I don't want to hold [the baby] anymore. I don't want to see you until it's time to eat. [laughter] But so, yeah, just getting my husband to take care of him, look after him for a few hours so I can go and have a bath or read a book or pretend to read a book. And just take some time out and not have anything to do with the baby for an hour or two, you know, go surf on the computer or like, you know. Clean the bathroom [laughter] Anything. (Alice, mother of one; group A)

The value of "getting a break," as described by the mothers, was that it functioned as a strategy for physical and emotional recovery or preservation. As Indri explained in this context:

> if you can get a break when you really need it, that keeps it down. Yeah. And I think that's why I didn't feel it as much [with the first baby], is

> because I had that. But if you don't get that break the stress just keeps adding and adding and adding up and I don't think in our society, I think we've set up certain expectations that we shouldn't need [the breaks]. (Indri, postpartum experience after third child; group C)

Important, however, in order for mothers' respite opportunities to properly function in this manner, they needed to provide mothers with palpable relief from their responsibilities, not just a "pushing off" of responsibilities to a later date. As Indri commented about her most recent adjusting experience:

> there's no break. There's no—you know, even through you know [the kids are] gone for awhile, you know what you have to deal with when they get back. So then that time that you have to yourself really doesn't mean a thing. Like when you're on your own, um, it's a fight to get out the door and it was a fight to even have the opportunity to do it. And you know what's happening back at the house. Boy, that's sure not a lot of fun! So you don't get a break there, either. You know? (Indri, postpartum experience after third child; group C)

In this context, many mothers who described having more positive postpartum adjusting attributed their experience, at least in part, to their ability to "get a break," and to take some time for themselves. As Ingrid opined about her experience, for example:

> I think I'm like tremendously lucky, because you know...I have people who look after [the baby], you know, four days a week. Um. And so you know, even if I'm not at work I can run and get something done. I've got some of that private time, and that, I think, makes a world of difference. (Ingrid, mother of one; group A)

Prioritizing and engaging in self care—getting adequate rest and sleep, "getting a break" when needed, and eating well and exercising/being active—were thus identified by the mothers in this study as central adjusting resources. Adequate self care, in other words, emerged as a central mechanism of the adjusting process itself. As described, however, not all the mothers felt that they were able to prioritize and engage in self care activities adequately. There were three main reasons mothers gave for this, all interconnected: a

lack of "naturally-occurring" opportunities for self care; not having enough support or "help," and/or feeling a lack of entitlement to prioritize self care.

6.1.2 Factors affecting mothers' abilities for self care

First of all, mothers' abilities to engage in self care depended on the circumstances of their day-to-day lives, particularly the needs and demands of the baby, as well as their various other responsibilities and situations. In other words, mothers' "naturally occurring" opportunities for self care were determined by their day-to-day circumstances and the various demands on their time.

Indeed, a few of the mothers in this study did feel that they had sufficient naturally occurring opportunities in their days and nights for adequate rest and sleep and other self-care necessities. These mothers, more often than not, were first-time mothers who described having relatively "easy" babies (i.e., babies who weren't too fussy, who slept for decent intervals, who ate at fairly regularly-spaced intervals, etc), and who also described having low levels of additional life stresses or responsibilities (in addition to those of the baby). Emily was one such example. She described her situation as follows:

> I never felt totally sleep deprived, even though I was tired. But, you know, I had nothing to do, so I was like, well, I'll get up with her. And then I napped when she napped during the day, and so it was all fine. (Emily, mother of one; group A)

Perhaps unsurprisingly, most of the mothers did not experience this kind of situation. Mothers with more than one child, for example, and mothers whose babies were more demanding in terms of their care needs (either because they were described as "fussier" or "more difficult" to care for, or because of parenting styles that were particularly demanding and labour-intensive), did not have sufficient "naturally

occurring" opportunities to adequately engage in self care. Waverly, a mother of four, commented about her situation in this context, and talked about being "spread too thin":

> when [my last baby] was born, I was really depressed. Really, really depressed. And I think now I'm finally kind of coming out of it. But it was just so hard. And it still is hard. Because it's just that I never get a chance to just be. Just be with myself. I'm always looking after one child or the other and running around, and my sister put it one day, she said, "Oh, it's like Groundhog Day". You ever seen that movie, Groundhog Day? You know, it was the same thing over and over again. Well, that's what it's like, you know. I'm cleaning the house over and over and over again, and you can see, it's not like the cleanest house by any means, I mean, *[laughs]* it's livable, shall we say. I never really get ahead. And that's the worst of it. I feel that I can't look after any one of my children the way I would like to look after them. Because I'm just spread too thin. (Waverly, postpartum experience after fourth child; group D)

It was in this particular context that the mothers in this study articulated the role of support or of "having help." Specifically, the issue was whether mothers had enough help or assistance with childcare or other responsibilities so that sufficient opportunities for self care could be *created*. Many of the mother who were able to adequately engage in their own self care described how they "had help" with childcare and other responsibilities. "Having help"—from their husbands/partners, from other family members or friends, or by utilizing forms of paid care—enabled the creation of opportunities for mothers to address their self care needs. As Holly and Alice iterated in this context:

> I think if it wasn't for my husband to be able to give me that time to just go and have a nap every once in a while, I don't know how I would get through it. That would be tough. (Holly, mother of one; group B)

> [my husband] will come home and make dinner, and you know, ask me if I need a nap or a bath, like, you know, he's really supportive and I think understands that it's a difficult adjustment.....I've had lots of help too, you know, from his family, from my family. Like I feel really fortunate with that....[my mother-in-law] would come over and she'd just clean the house. Spend the entire day. Things like washing my floors, and just, you

> know, she did that every week, for, I don't know how long....and she'd watch [the baby] if I wanted to go have a nap. She'd - you know, make sure he was doing okay and look after him. (Alice, mother of one; group A)

Some mothers felt they did not have enough support or "help" in this regard. These mothers often noted that they could not rely on their partners (or the baby's father), on other family members or friends, or on paid care for this kind of assistance. Simply put, they didn't have the support resources they needed to enable them to "get a break," to get proper rest and sleep, and to otherwise attend to their own care needs. This was Fiona's situation and Indri's as well. Excerpts from their interviews are provided below:

> when [the baby] was two months old I got the flu. And I've never been so ill in my life and pretty much I was told by family members, you know, you got yourself into this...So you're going to have to, you know, stick through it. And I really thought I was going to die. (Fiona, mother of one; group C)

> [people often tell me] "oh, you're doing such a good job with the kids." Yeah, but I could do even better if I could just get a break. Or, you know what? If someone would just help *me* out a little bit. But you can't say that....it's fear that the help wouldn't come anyway. That it wouldn't come anyway. So if it's not going to come anyway then why bother saying it? Because then it's even more disappointment. (Indri, postpartum experience after third child; group C)

Notably, however, many of the mothers who raised the issue of support in this context did not describe it mainly as a problem of the support not being available. The issue, rather, was that mothers often *did not feel entitled* to ask for the help they needed in order to properly attend to their own self care needs. As Beth articulated in this context, for example:

> I was just so physically tired and so emotionally drained all the time....so horrible how it affected me. Even to get a nap in the afternoon, you know, it just wasn't possible....That was a big, you know, not getting any sleep at all....[but] I felt bad asking for help a lot of the time, from anybody—family or whatever. 'Cause you feel you have this responsibility of this

> little child, you know, and it's *yours*. You're all by yourself, totally. (Beth, postpartum experience after first child; group C)

Thus, while the relationship between the demands on mothers' time and the adequacy of their supports was certainly a concern, mothers' sense of entitlement to actively prioritize their own self care was perhaps the most predominant theme in this regard.

This resource, then, emerged largely as hinging on mothers' sense of entitlement to prioritize self care—whether mothers felt entitled to prioritize their own need for sleep and self care, particularly if it meant soliciting and relying on various forms of help or assistance in order to do so. A number of mothers did not. There were two main reasons mothers gave for this, both organized by broader cultural ideals about "good mothering" (Hays 1996).

First of all, many mothers described feeling uncomfortable about the idea of claiming an entitlement to their own self care as a top priority. These mothers talked about how the thought of prioritizing their own needs felt somehow "wrong" or inappropriately "selfish," especially if it meant relying on help from others to do so. These mothers also described how, if and when they did attend to their own self care needs without there being a "naturally occurring" opportunity to do so, it induced feelings of guilt. As Leslie remarked about her experience, for example:

> guilt has been a huge issue for me. The biggest one, the one I felt most guilty about, was having my son watch TV in the afternoon so I could go have a nap. I'm not one who advocates TV for children, so that was a problem....I'd feel really guilty about that. I felt so guilty, and guilty for feeling so tired, for not having more fun with the kids and stuff. (Leslie, postpartum experience after third child; group D)

Secondly, for many mothers the very idea of relying on "help" from others—whether it was the baby's father, paid babysitters or daycare, or other family members or

friends—induced feelings of guilt. In this respect, many of the mothers felt that needing and asking for help was somehow "wrong". They expressed a belief that they really "should" be able to handle things on their own. As Mary described of her experience, for example:

> I tried to organize things in a way so that I didn't need assistance....And I think I did them and myself a big disservice, because I think I would have been better off if I'd been able to have someone come in for a while so I could, say, go get groceries. Or, you know, drop the kids off....I think I made things very hard on myself. I look back on it now, and I don't know. I just think I made things really really hard on myself, but I felt guilty about it. You know, I'm the mom. I should be the one doing it. (Mary, postpartum experience after second child; group C)

In this context, the idea of "getting help" for many of the mothers I talked to, felt like an admission of inadequacy—of not properly living up to what was expected of them as mothers, as wives, as women.

Notably then, the subtexts in these mothers' narratives reflect an adherence to broader ideological tenets about "good mothering"—namely, that "good mothers" don't have high needs for self care, and the needs they do have should only be attended to around the edges of daily life, when opportunity naturally presents itself. Further, it reflects an adherence to an ideological tenet which holds that "good mothers" do the work of mothering without help; that mothers really *should* be able to handle everything on their own, without needing to "have help" with childcare and other responsibilities.

For these mothers, the ability to engage in adequate self care was primarily described in terms of their own feelings about "good mothering" and about the appropriateness of prioritizing self care—feelings and beliefs that reflect broader cultural ideals about mothering in contemporary Western societies. As such, many of these mothers described that before they were able to adequately meet their own self care

needs, they had to "overcome" their belief that prioritizing self care went against the grain of "good mothering"—especially if this meant taking time away from the baby, utilizing paid forms of care, or compromising their preferred parenting practices. As Leslie described, for example:

> I've learned to manage [the guilt]. And I've learned to focus on me. So, for example, if I put [youngest child] in front of the TV for half an hour or an hour so I can go grab a nap, my husband might say, "Oh, this isn't a good thing. You should be up with him and nobody's watching him." But now I can deal with that and say, "Hey" you know, "we're just going to have disagree on this because I need this and that is that." It does create tension in our relationship but he'll eventually adjust to it. (Leslie, postpartum experience after third child; group D)

Importantly, once these mothers started activating this crucial resource—by claiming their own self care *as a priority*—they also started to describe feeling more able to cope and adjust.

Importantly, the few mothers who described actively prioritizing self care from the outset of their postpartum experience often described how this commitment to self care required critically engaging with these broader mothering discourses and ideas. These mothers typically critiqued the ideal of the "self-sacrificing good mother" by arguing that because prioritizing their own self care was crucial to the preservation of their emotional health and to their ability to cope and adjust, it preserved their status as "good mothers." Ingrid, for example, made the following comment in response to my asking her why she thought she had such a positive postpartum experience:

> I know for me, just having time away from the baby. And it sounds like a terrible thing. And I think it goes back to this notion of what is the good mother supposed to be like—that it's supposed to be somebody who never wants time away. Somebody who is so thrilled to be with the baby that they don't need time away. And they don't get mad and they don't get frustrated and tired. As a methodology that's pretty dangerous. Because you know, we're only human. (Ingrid; mother of one; group A)

Raeanne also prioritized her own self care, and described this prioritization as a key reason for why her adjusting experience was, overall, quite positive. Raeanne, however, also described experiencing some ambivalence in this regard, noting that even though she did make a point to prioritize her own self care, she often still felt guilty for doing so:

> I guess [I feel guilty] mostly around doing stuff for myself. Like last week I went for a massage. So I went for a massage and my mom held [the baby] for the hour and yes, he screamed…and so I felt terrible because he was like, you know, so unhappy. But you gotta do some things for yourself. But it's hard to do. (Raeanne, mother of one; group A)

Thus, going against this tenet of "good mothering" and actively prioritizing one's own need for self care was rarely an "easy" or straightforward commitment to make. It was, rather, something that was often experienced with ambivalence.

In general, the mothers in my study from middle and upper-middle socio-economic positions were more likely to talk about feeling "unentitled" to prioritize their own self care than were the mothers from more disadvantaged socio-economic positions. Lower-income mothers, by contrast, were slightly more likely to describe an actual lack of adequate assistance or "help" as being a central factor in their ability to adequately engage in self care activities. Further research with larger samples of mothers would be useful to better establish the general variability of relationship between socio-economic status and access to the resource of self-care.

In sum, then, mothers' abilities to engage in adequate self care—to get sufficient rest and sleep, to eat nutritionally and get adequate exercise, and to get a break when needed—were central to their understanding of why their adjusting experience was what it was. Specifically, prioritizing and engaging in adequate self care was identified by the

mothers in this study as a main resource of the adjustment process—it was one of the key factors that enabled them to successfully cope with their new realities and responsibilities and, ultimately, to accomplish the tasks of the adjustment process.

6.2 Having "Low" Situational Stress

The second major theme in mothers' narratives about "why they experienced what they did" in the postpartum had to do with their level of situational stress, particularly as it existed in relation to the amount of "help" they had in dealing with their various demands and stresses. The mothers spoke about their level of situational stress in reference to the various responsibilities and circumstances that were making demands on them, physically and emotionally. As such, the theme of "situational stress" encompassed the particular demands of the new baby, as well as the various other responsibilities and issues that the mothers had to attend to. The most common demands that mothers in this study identified included: the care demands of the baby, the care demands of other children, marital or other relationship issues and stresses, financial worries, and other stressful events.

In general, mothers who described having an easier or more positive adjusting experience often attributed their experience, at least in part, to having low levels of situational stress. Emily, for example, made the following comment in response to my asking her why she felt she had adjusted well:

> I think I have it pretty good....I have no pressure to go back to work if I don't want to. I have a great support system, and you know, and [the baby's] great...she's just so easy. (Emily, mother of one; group A)

On the flip side, the experience of having "too much going on" was often articulated by mothers as hindering their abilities to adjust. Many mothers also described this

experience in terms of feeling or being severely "overwhelmed." Annabelle, in this context, contrasted her two postpartum adjusting experiences primarily in relation to the amount of situational stress in her life:

> I had a lot of stresses added on [with the second baby]...I had a feeling that was part of [why I had more difficulties]...I had another child. Having to deal with him as well as a newborn....Also, my brother ended up in the ICU in the middle of my pregnancy. And almost didn't make it. And then after my second one was born, he ended up in the neonatal ICU. Because he had some air outside his lungs and had trouble breathing at birth. So I didn't get to take him home until he was 10 days old. Plus relationship stresses. In my relationship. My marriage was a little rocky at the time because of everything that was going on. And my dad's back was getting worse and we also ended up—when my brother was in the hospital—we ended up in a car accident. (Annabelle, postpartum experience after second child; group D)

As indicated in Anabelle's story, her additional stresses did not all begin with or after the baby's birth, but were there already during her pregnancy. Many mothers who described feeling overwhelmed or overloaded with all the things that required their energy and attention described that they were already experiencing a considerable amount of stress from their pregnancies and events that occurred while pregnant. This was Waverly's experience with her fourth child. She stated the following in this context:

> I always get really sick at the beginning of my pregnancies. And for him it just kind of went on till that month five. And then all of this stuff with my father when I was six, seven months pregnant. Plus all the work and everything. It just—it was a year I don't really like to remember. And then when he was born, I was really depressed....[because] I could never get ahead. (Waverly, postpartum experience after fourth child; group D)

For some mothers who described their situational stress as being "too much to handle," their primary source of stress had to do with the care demands of the new baby itself. Typically, these babies were described by their mothers as more difficult-to-care-for. Sometimes, this was related to health issues. Other times, mothers' described the

additional stress of caring for a baby with colic, or who were otherwise "fussy" or "not easy" babies.

Danielle's situation illustrates how the basic tasks of baby care can be overwhelming in and of themselves, particularly when the baby has more intensive needs.

> when I was 33 weeks pregnant I went into premature labor. [The baby] was in ICU for about five weeks....I wasn't getting enough sleep. I was spending a lot of time at the hospital. I wasn't eating properly. Just trying to deal with [the baby] and his diagnosis....I stayed the last four days, actually, right at the hospital. I was breastfeeding and I wanted to try and breastfeed. Twenty-four hours a day. They wanted to know that you could handle that full-time before he went home. So I was actually staying at the hospital as well. Then, probably about a week before we left, he started—the colic started—and really bad, so it was severe....It was all very stressful. And [the baby] wasn't sleeping. At all. So I wasn't sleeping either. (Danielle, mother of one; group D)

Danielle, who had been diagnosed with PPD, made the following connection between her adjusting difficulties and her experience of being overwhelmed with the demands of her baby's care:

> I think I still would have had difficulty with the adjustment from being at work to being at home. About the sense of isolation that I find...I think I still would have experienced those feelings. But without him being early, sort of colicky and so on, I think it wouldn't have been as severe...I think it may have...been a lot milder. (Danielle, mother of one; group D)

Importantly, Danielle's story also illustrates the interconnection between mothers' degree of situational stress and their ability to engage in adequate self care.

6.2.1 The manageability of situational stress as a function of support

Mothers thus attributed the degree of stress in their lives as being a central factor in why they felt the way they did—in whether they had an easier or more difficult time adjusting. Importantly, however, the mothers had different measures of "how much" situational stress was "too much." In other words, two mothers with very similar

situational circumstances and stressors could—and often did—appraise the *manageability* of their situations in different ways. In this respect, the identification of low or manageable situational stress as an adjusting resource did not emerge as an easily identifiable "situational picture." In other words, mothers' understanding of what having manageable situational stress meant was not merely a function of the type or number of stressors mothers were faced with.

While many mothers, like Anabelle, for example, were confronted with a heavy constellation of stressful circumstances—circumstances that they identified as hindering their abilities to adjust—other mothers facing similar stressful life situations *were not* overcome by the demands these situations presented. This was Kiera's experience, whose story is presented in greater detail below. Still others, by contrast, described their main source of situational stress as being related to the demands of the baby, and felt that this alone was "too much to handle." This was Tianna's experience. She stated the following in this context:

> after you have a baby, you know, you're so tired and it's so overwhelming I was petrified to go home with her. So how am I going to do this? I can't take care of this baby....It was the responsibility of taking care of her and not being able to do the things that I wanted to do....You know, and you want to get out and go somewhere. Well, you don't get up and go. You have to get everything ready and then you get there and she's crying and she's messed her diaper, and then where do I go? And you know, I had read all this stuff. And okay, I can handle this, but when it actually happens it's very different. (Tianna, mother of one; group D)

Most typically, the mothers' interpretations of what was "manageable" situational stress varied most directly with how much help and support they had in dealing with their various demands and day-to-day responsibilities. In other words, mothers assessed the manageability of their particular situations largely in terms of the *relationship* between

the intensity of their responsibilities and demands, and the amount of help and support they had in meeting those responsibilities and demands. It was this specific connection between situational stress and "help" that was the crux of how mothers articulated this theme in relation to their adjusting experiences.[14]

Specifically, mothers who felt that they could lean on others for help, assistance and emotional support were much less likely to experience their situations as overwhelming. These mothers, in short, were less likely to feel that "it was all up to [them]" (Tianna, mother of one; group D). As well, mothers' interpretations of their degree of situational stress as being more or less manageable were connected to their abilities to engage in self care (which, as described above, also emerged as being mediated by support). In this respect, these three resources were all mutually reinforcing of one another.

The interconnection of these themes is illustrated well in the contrasting experiences of Chris and Kiera. Both Chris and Kiera had two children, and both were married at the time their children were born. Further, both these mothers left their marriages when their children were of preschool age. Both Chris and Kiera described their relationships with their former spouses as being highly stressful and "toxic." In addition to describing serious relationship difficulties, these mothers both emphasized that their former husbands provided little to no help in terms of childcare or other household responsibilities. As well, their husbands had been physically and/or sexually abusive—in Kiera's case, towards her and another adult woman; in Chris's situation,

[14] Perhaps unsurprisingly, the relationship between the intensity of mothers' responsibilities and demands, and the amount of help and support they had in meeting those demands seemed to connect closely with variations in socio-economic status. Specifically, mothers from lower socio-economic positions were more likely to describe higher levels of situational stress, both as a function of "overwhelming" demands and circumstance, and as a result of inadequate help and support to manage their various demands and stresses.

towards their children. In short, both these mothers described their situations as highly stressful, and as very taxing on their physical and emotional energy.

Chris was diagnosed with postpartum depression after her second baby was born, and attributed her difficulties, in large part, to the circumstances of her particular situation. Kiera, by contrast, rated her postpartum emotional wellbeing as being generally "in the 5 to 10 range" and felt, overall, that she had adjusted successfully. She articulated her adjusting experience as follows:

> I was definitely familiar with the idea [of PPD] and everything like that. Because I often felt successes along with—I was fairly sure that no, I wasn't clinically you know, I wasn't going to be clinically diagnosed with post-partum depression. (Kiera, postpartum experience after second child; group B)

How, then, did these two mothers with similar situational stresses account for their different postpartum experiences? In essence, Kiera and Chris contextualized their stresses in different ways—Kiera interpreted her situation as a challenge that was still manageable, while Chris felt unable to handle the additional stresses along with the demands of new baby. Excerpts from their stories are provided below:

> there were a number of times when I sat in the rocking chair with my son and you know, I would say to him, "I will find a way out of this for us". But it has to be on my terms. You know, I mean, I didn't—I don't know how to explain it, but I knew at the time that I had to take advantage of it. But it knew in the long run that it would be better for my children. (Kiera, postpartum experience after second child; group B)

> why [do I think I felt the way I did]? Because I think I had made a conscious decision that I wasn't going to be with my husband for the rest of my life, so I had to move on with my two girls and make a better life for the three of us....I was, you know, pretty young still. I had a lot of things that I had wanted to do in my life and I just felt that if it had just been [oldest child] and I, it would have been so much easier to accomplish those things. But, you know, with [second child] coming into my life, at such a soon interval after [first child], I just basically felt that there was so

> much more that I would have to do in order to make things happen for the three of us. (Chris, postpartum experience after second child; group D)

As can be gleaned from these excerpts, these mothers appraised their situations in terms of their ability to cope with the stresses and demands of their particular situations. This assessment of coping ability, in turn, was heavily influenced by the quality of their support resources. In other words, the critical difference in these two mothers' situations hinged on the mitigating influence of their support systems. Chris felt she had no help or support. More than that, Chris described her intimate relationships as a source of "negative support," which *added* to her sense of stress. She stated the following in this context:

> there was no real family support. I just had to depend on me....we stayed with mom and dad I think for about six months...and my dad always made comments, "well, my mother raised five kids, how come you're having such a hard time with two?"....that didn't help. (Chris, postpartum experience after second child; group D)

By contrast, the support Kiera received from her family mitigated the stress of her circumstances by providing a "cushioning" effect (Oakley 1992; Lazarus 1969; Ball 1994). In this way, Kiera talked about the positive support of her family as being instrumental in her assessment of her situation stress as manageable. Kiera stated the following why she felt she was still able to adjust successfully, particularly given the magnitude of her situational stress:

> my family was my biggest source of support....you just always know that you have somebody to fall back on because the family's there and that's what families do. That's you know, no matter what happened, I *knew* they were going to be there. (Kiera, postpartum experience after second child; group B)

In sum, then, mothers' assessments of situational stress emerged as a central theme which explained their varying experiences of "adjusting difficulty." In short,

having low situational stress emerged as a central resource for the process of postpartum adjustment. It was a central theme in mothers' own understandings of why they experienced greater or fewer difficulties accomplishing the various tasks of adjustment. Importantly, this resource did not emerge as something which could be objectively defined or measured, but as a subjective and contextually-dependent assessment, based on the adequacy of mothers' supports. As Caplan (1964 in Ball 1994: 9) notes in this context, "crisis...is helped or hindered by the persons around them [sic]."

6.2.2 "Negative" support as a key factor in situational stress

As discussed in greater detail below, the concept of social support emerged as a key resource for the adjustment process, facilitating mothers' abilities to accomplish their adjusting tasks. "Social support," in this context, is often assumed to exist along a continuum, which moves from "little or no support" to "lots of support." What emerged in this analysis, however, is this continuum extends farther. Specifically, the concept of support also involves the experience of "negative support." As it was experienced by the mothers in this study, negative support referred to the presence of intimate personal relationships that, in theory, *should be* supportive, but which, in actuality, *added to mothers' situational stress*, draining their emotional resources.

In this study, these kinds of relationships most commonly involved mothers' spouses/partners, but also sometimes involved mothers' parents or other family members or friends. The significance of negative support was two-fold. On one hand, these relationships were described by the mothers as failing to provide them with the emotional and material support they needed. As Indri commented about her relationship with her husband, for example:

> I was expecting that he would be doing more. And that he would be more involved with the kids....and the expectations always lead to disappointment don't they? But, I mean, we'd always talked about the fact he would....and he doesn't think he's doing little. I mean, he thinks he's doing enough. And it's just there's a big fight and it's more stress and sometimes it's just easier to do the damn thing rather than talking about it and getting stressed about it. Just do it myself. (Indri, postpartum experience after third child; group C)

In this way, negative support functioned as an obstacle to mothers' being able to "get enough help" or to "feel understood."

More centrally, however, these negative relationships were described by the mother in this study as *adding* to their day-today responsibilities, strains and demands. As Carla noted, they were relationships that "dragged them down:" Chris and Carla's stories illustrate how having "negative support" was described as hindering mothers' adjustment efforts:

> my husband, of course, was no help whatsoever, which is why we're no longer together.....Just before [baby] was born, he committed credit card fraud. And cheque fraud. And I knew at that point that I was never going to be able to depend on this man to provide for us. Because I would never be able to depend on him for anything, really, because he was so untrustworthy in that sense that you know, this is our family, and look what he's done to us. He's taken food out of our mouths....Yeah, I knew at that point in time that I was never going to be with him. (Chris, postpartum experience after second child; group D)

> my mom and my friend...are the ones that are dragging me down and saying "I should do this and I should do that. And you should do this to improve yourself, or you should do this". Saying "you should leave [boyfriend]. He's controlling." And I try to shrug it out of my head and say, why can't they see that I'm happy with [boyfriend]? We have our arguments but everybody does when they're in a relationship. They hate him. My dad loves him...he says that he's a keeper. And sometimes he gives him a bad time at times, too, but not as bad as my mom and my friend. (Carla, postpartum experience after fourth child; group D)

Notably, Carla was in much more frequent contact with her mother than with her father. During our two-hour interview together, for instance, Carla's mother phoned three times.

Carla answered her mother's call the first time only. The other times her mother telephoned, Carla remarked to me that she wished her mother would "just leave her be." Carla went on to express how her mother's "negative support" was a pervasive presence in her day-to-day life, undermining the impact of any "positive" emotional support she was receiving from others (like her father, for example) and adding to her situational stress.

Thus, as can be gleaned from these mothers' experiences, the *manageability* of the situational stress created by having negative support relationship(s) was particularly evident when this "negative support" was not adequately offset by other, *positive* emotional and material support relationships. Indeed, existing research has well established the role of "marital problems" as a contributing factor in the experience of postpartum difficulties (Romito 1990; O'Hara & Swain 1996). This analysis confirms this finding, but in a broader form.

For one, the concept of "negative support" extends this issue to *any* intimate relationship that is functioning negatively. Secondly, it highlights that these kinds of relationships not only represent a source of situational stress, *but also* represent an obstacle to mothers' receiving adequate material and emotional support. The role of social support as an adjustment resource is discussed in more detail in the following two sections.

6.3 Having Enough Help

As noted, the mothers in this study identified the adequacy of their support resources as playing a key role in their adjusting experiences. In general, the mothers in this study identified two main dimensions of support as being integral resources for

adjusting: emotional support and material support. This section describes the dimension of material support as a resource for mothers' adjusting experiences, while the following section focuses on the role of emotional support.

The mothers in this study heavily emphasized material supports as playing a key role in their adjusting experiences. Most commonly, mothers described this resource in terms of "having enough help." As Emily articulated, for example:

> I've never felt totally overwhelmed. Because I do know that I do have that support and if I ever got to the point where I was like okay, I need a break—that I have so much support that I could get it through my husband, through his family, through my family, so there's no question that, yeah, I've got lots of help. (Emily, mother of one; group A)

As part and parcel of the experience of "having enough help," the mothers in this study also identified informational support as being important. Specifically, mothers talked about this aspect of support in terms of their ability to gain information, knowledge and skills to successfully undertake their day-to-day responsibilities. Yasmine, for example, described the value of this kind of support in the following context:

> I looked into [parenting support program] because I was feeling like I was starting to crack up. Things were just nuts and [older child], it seemed like she was out of control, and I thought, "you know, if I can't handle her now, what's going to happen when she gets older?" You know. So we needed some skills....because, I mean, I was raised—my mom yelled and hit. She didn't really—she didn't play with us really. She didn't show us a lot of compassion. And uh it was just—it's hard. And I don't want to do that with them. So that was the idea. Fix things now. And [once I started in the program] things got almost immediately better, both in my emotions and in her behavior. (Yasmine, postpartum experience after second child; group C)

The resource of "having enough support," as it was articulated among the mothers in this study, served three main purposes. First of all, as described earlier, "having help"

was often identified by mothers as necessary for them be able to attend to their own self care needs. As Indri articulated in this context:

> without the support, you don't get a chance to kind of regroup and feel like, "okay, I'm okay now. And move on". You just don't get that. Like with the first one I had that chance, right? When…I was feeling tired I could have a nap. I had my parents to help. I didn't have that with the second one or with this one. (Indri, postpartum experience after third child; group C)

Secondly, as also described above, mothers described the adequacy of their supports mitigating the intensity and amount of situational stress in their lives. As Kiera and Yasmine described, for example:

> I had incredible support from my parents. And had I not had that things would really be hard. Like I would say if they had lived out of town or far away, there would have been a point where I would have just flipped, because you know, I just would have had absolutely no support. (Kiera, postpartum experience after second child; group B)

> with [first child] you know…we were still living with my husband's parents, so I still had someone else around that could help me out if I was feeling stressed. So we had my husband's parents for support and it was a lot easier. (Yasmine, postpartum experience after first child; group A)

Third, mothers talked about material forms of support as providing them with valuable information or knowledge, which they said helped them in their adjusting efforts, especially in terms of learning and figuring out "what to do" or "where to turn" for help.

The various ways in which mothers relied on and utilized material forms of support fulfilled a crucial function with respect to mothers' adjusting experiences: it helped mothers feel that their day-to-day stresses and responsibilities were not "all up to them." For the mothers in this study, "having enough support" enabled them to feel that they were not alone—that, at least on some level, their feelings, experiences, and responsibilities were shared by others.

In this context, Indri described how she felt that her three different adjusting experiences could be largely understood in relation to changes in her support system. Specifically, Indri attributed her steady loss of support—especially that of not "having enough help"—as a main deficit, making it more difficult to adjust:

> I think it's for me it was the losing support that was a big one. So with each progressive baby I lost a little bit more support.... [Without the support], you don't get a break. I don't get a break. And I know I don't have any history of depression in my family. There's none of that. So I don't think for myself it's a chemical imbalance but I think it's just that I shouldn't have so much to do....It was much easier with my first. I had my mom and dad there. And my mom, well, it was so nice. Because she was always there for me but not telling me to do this or that. Which was nice because you feel like you're supported....And I made new friends through our parent group there, and they were very good and very helpful, and again, you know, okay, we're all going through this together. There was a lot of support there. And that made a big, big difference. (Indri, postpartum experience after third child; group C)

As Indri described, with each child the responsibilities and stresses of her life increased. At the same time, however, the amount of help she had progressively diminished.

Most commonly, the mothers in this study described their husbands/partners, as well as their own mothers or other family members as their main sources of material support. Notably, the mothers in this study who described more positive postpartum experiences often attributed their experiences, at least in part, to their spouses'/partners' active involvement in childcare and/or household responsibilities, and to the fact that they had many people in their lives "helping" them to meet their daily responsibilities and demands. As Paige remarked in this context, for example:

> sometimes I feel a bit overwhelmed with doing everything by myself but still with this strong feeling that yes, it is manageable....because I probably have more supporting friends than lots of happily married couples have. (Paige, mother of one; group B)

Another source of support identified by many of the mothers in this study was that of institutional or more formal forms of support. These kinds of supports were identified most commonly among the lone mothers in this study and/or mothers who felt their existing material support were not adequately meeting their needs. This was Fiona's experience. Fiona was a younger, lone mother of one child. She was not in contact with the baby's father, she had lost touch with her friends (expressing little regret, however, noting that her former friends were "not really the kind of people [she] wanted around the baby"), and her parents had made it clear that they were not to be considered a source of support. As Fiona recalled, her parents informed her that "you got yourself into this, you're going to get yourself out of it and through all the obstacles." Fiona, in this context, described drawing on various community supports as her main support resource. She stated:

> on the plus side, like [baby] goes to Classroom on Wheels and we go to Parent Talk to interact with other children, and in that sense, I think the support is there. Like I think for parenting concerns and growth and development, I think the support is there. But as for if I'm having a bad day or if there's something I want to do or something, can I kind of pawn her off on somebody for a day?, no. So. But I think in the other sense there is the support there. (Fiona, mother of one; group C)

Fiona also made specific mention of one service as being particularly valuable to her in terms of "having enough help:"

> and then there was, what do they call it, after a C-section or if you have multiple births, or if you have post-partum depression, they will have somebody come in and help you out. And I had a girl come in for a couple of weeks, and she helped out with the cleaning. That was great. (Fiona, mother of one; group C)

In general, friends were only occasionally identified as a source of material support or "help. However, when mothers' friends were also mothers, they were often

also described as being a valuable source of informational support. Most commonly, mothers identified friends as fulfilling the role of confidant or emotional support (see below). Lastly, some mothers mentioned using available literature as a source of informational support, to gain necessary knowledge and skills.

Importantly, many mothers who felt they "had enough help" described relying on *multiple* sources of support. Holly, for example, identified both her mother and her husband as providing help in terms of childcare and with various household responsibilities. Ingrid, as well, described her situation similarly. Ingrid talked about how she drew heavily on her husband, her own parents as well as her in-laws for "help" with childcare and other things. She stated the following in this regard:

> we wound up moving I think when [the baby] was about six months. But that actually made it easier on us because we moved closer to our parents.....me, my folks and his folks, we live within a fifteen, I'd say, a ten block radius. And they're very helpful. Because my mom babysits two days a week and his mom babysits two days a week....It might be different if I didn't have sort of a social support. (Ingrid, mother of one; group A)

The various factors identified by the mothers in this study as affecting their ability to "have enough help" are discussed below.

6.3.1 Factors affecting mothers' abilities to "get enough help"

A number of mothers described deficiencies in their material support resources as central to their understanding of why they had a more difficult time adjusting. These mothers identified a variety of obstacles in relation to their abilities to receive the support they felt they needed and wanted in the postpartum. These obstacles included issues pertaining to access, availability and quality of support; and feelings about entitlement to support.

First of all, some mothers in this study who felt they were unable to "get enough help" described having "negative support" relationships with their spouses/partners. As described above, negative supports were described by the mothers in this study as relationships that should be supportive, but are not. They are relationships that, if anything, are considered as a source of additional situational stress. This was Indri's experience. She made the following important comment in this context:

> yesterday I was talking to my neighbor across the street. And I told her that I was coming here this morning to do a postpartum study. She said, "you don't have postpartum [depression], dear" and I said, "yeah, you know, some days I feel really down." And she goes, "is that postpartum [depression] or is that just because your husband's a burn-off?" That's interesting. Quite honestly. It's much more the latter than the first, I think…..I'm actually considering leaving him. And one of the things I realize is that...it might actually be better because the expectation won't be there that he should be helping out and that he should be doing stuff. I just will know that I'm on my own and I just have to do it on my own. And then the perception from the outside world is different. That now they look at a two parent family and they think, "oh yeah, she's getting help and support from her husband. She doesn't need anything extra." Whereas if I'm on my own and the single mother of three then other people will—it will be easier for them to say, "hey, do you need help with this or help with that?" (Indri, postpartum experience after third child; group C)

Secondly, access to material support was an issue among some mothers. These mothers typically identified experiencing challenges in accessing formal forms of material support, as they were largely unaware of what was available, and unsure about how to go about finding it. As Danielle noted in this context, "I found it really difficult to get all my supports together….it seems really difficult to access help." These mothers thus talked about not knowing where to look, who to call, or where to go in order find the help they needed.

A major theme in the context of mothers' challenges in accessing support had to do with the amount of effort and energy required. In short, for many mothers, the process

of *figuring out how to access* the support they needed simply took more energy and effort than they had available. Tianna, made the following comment in this context:

> I know enough to know that there are resources out there that I could have found. But I didn't...when you're feeling too tired and so low—when you feel like there's so much on top of you as it is, that to go out and have the energy to go out and find these things out for yourself, maybe that's why I didn't, too. Because it did take so much energy. (Tianna, mother of one; group D)

Without question, accessing and mobilizing support—whether personal or institutional—*does* take energy and effort. As such, mothers who felt able to put in the required energy and effort generally felt that access was not a major obstacle. As Fiona emphasized, for example:

> I opened the phone book. And I just started—I called people and I looked on the internet for the community services programs and you know, I didn't let any doors close. And I kept my ears open.....If you want the support and if you want the help and if you need anything, it's out there. *You just—you know, you gotta put your effort into it.* (Fiona, mother of one; group C; emphasis original)

It is worth noting that Fiona described feeling fortunate to be living in a major city, stating that, "I don't think I could have done this in [the town I used to live in]...They just—they don't have [the programming]."

Some of the mothers who described lacking material support felt that the amount of support they needed was largely unavailable to them. As Danielle and Indri both commented for example:

> [its so hard to] get a break for me. Like I said, if we had a nanny full-time that would be great. But we just can't afford it. (Danielle, mother of one; group D)

> first thing in the morning, when the kids get up, I'm up with them even if I've gone to bed at four o'clock.....and in our society now we don't have anyone really helping you through it. There's no one older who lives with us—around us, even, that you can count on. Someone who—when the

> baby wakes up at three o'clock in the morning or when they're teething, crying all night—can take the baby and say "okay, you're not doing it anymore." (Indri, postpartum experience after third child; group C)

Waverly, a mother of four, spoke of her recent challenges in "getting enough help" as an issue of availability. Specifically, she felt that a general lack of affordable childcare is a major obstacle for many mothers in this regard. Waverly contrasted this most recent postpartum experience with her previous one, when she lived in Quebec and was able to make use of their universal day care system:

> In Quebec it was five dollars a day daycare at the time. So the two girls were in daycare all day [after my third bay was born] because we could afford that…and so that made it easy, even though [my husband] was away and I was selling the house by myself...mentally and emotionally I felt fine…..I think, in Quebec, what was good is that it was affordable for all. Like just because my husband makes a make a good wage doesn't mean that we have money to burn. And the fact that I was able to put my children in, when [my third child] was born, I was able to put [the older ones] in the daycare, and it was very structured. It was very much a teaching environment. Even for newborns, like the six month olds, they're teaching them songs and they're doing, they've got a whole program, and it's like, I could relax, well, I knew they were okay, and I could get my life back together again. (Waverly, postpartum experience after third child; group B)

> And here they don't have that. There's nothing. Absolutely nothing. (Waverly, postpartum experience after fourth child; group D)

The other major issue mothers talked about in terms of being able to get enough help had to do with their sense of *entitlement* to receiving help with childcare and other responsibilities. As Danielle remarked in this context:

> I had friends and family around, but never seemed really like a support to me…..that's where my guilt comes in and I feel, I don't want to overuse [my supports], burn them out. Or have them think that I'm taking advantage of them. I feel quite nervous and difficult to ask for help. (Danielle, mother of one; group D)

As indicated by Danielle's comments, the mothers often described this in terms of "feeling guilty" about the idea of asking for help. Guilt, as an expression of moral digression or moral "wrongdoing" (Lazarus 1991), was a reflection of mothers' low sense of entitlement to material forms of help or assistance.

Mothers, then, often felt guilty at the idea of soliciting or making use of available supports because they worried about "imposing" on the people in their lives. As Heather's comments illustrate, for example:

> and now looking back at that time, I would have let a lot more people help and I would have hired somebody professional and at arm's length....I find it so strange, because I do have great support. More than adequate...but you know, somebody would say, "Oh, if you ever need help call me" but you never do. You know, it's not like they said, "I'll be there Wednesday for..." And when I would ask somebody, I would always go at high speed, you know, run errands, come back as fast as I can, make sure I've got coffee and lunch for them there and you know, so whereas I should have just said "I'm losing it. Come take this child from me". (Heather, postpartum experience after second child; group D)

Also, as described in Section 6.1, many mothers also hesitated in soliciting more material support or "help" because they believed that they should, in fact, be able to handle things "on their own."

Many mothers articulated this belief by comparing their own situations to those of other mothers, real and hypothetical. These comparisons to real or hypothetical "others" tended to be either mothers who faced greater day-to-day challenges and therefore warranted a need for the help they got, or they were mothers who appeared to be "handling it all on their own" without a lot of help or assistance. Heather made the following comment in this context:

> this is really a stupid thing, but you put yourself in other people's shoes and...in my life I have three people with disabled children.....so you know, I just felt so much empathy for all these other people that, oh, how

> dare I complain? You know, it had nothing to do with me at all whatsoever, but that was one of the things that was holding me back. It was like I was supposed to get my act together and be kind of you know, suck it up, look at what these people are going through and they've still go it together kind of thing. (Heather, postpartum experience after second child; group D)

Similarly, Tianna commented that "other people have kids, have numerous children, work full-time, go to school, and work full-time and seem to be able to handle it" (Tianna, mother of one; group D).

Thus, for many mothers who faced obstacles in "getting enough help," the primary issue was not one of access or availability of support, but about a more deep-seated sense of entitlement to material support. As discussed earlier, these beliefs have their roots in broader cultural discourses about motherhood and mothering—specifically, in the idea that "good mothers" shouldn't need to depend on the assistance of others; that they should be able to "handle" things all on their own.

In short, then, mothers' abilities to "get enough help", in as much as it emerged as pivotal to their adjusting experiences, was often hampered by a low sense of entitlement. As Yasmine remarked, these mothers often described that they had to "learn to ask for help" (Yasmine, postpartum experience after second child; group C). Penny's experience also highlights this point:

> that's one thing I had to learn. I make myself conscious of it. Its that if I didn't tell people how I felt *every day*, even my own husband, then I probably would have stayed in it, thinking that, you know, *I* have to deal with it. But then I realized that *I* didn't have to deal with it. Everybody else was going to help me deal with it. You know, like I had to tell my husband if I was mad at him. I had to tell him if he wasn't helping me out. I had to tell him I was feeling miserable and I needed adult time. I had to tell my mom that. And then once I told everybody that, then I had the support system, you know. (Penny, mother of one; group B)

As also noted earlier (see Section 6.1), the issue of entitlement was a more central theme in the narratives of mothers from middle and upper-middle class positions. Lower-income mothers who struggled with "getting enough help" were more likely to describe issues of lack of access or availability to the help and assistance they needed as being more central to their experiences.

6.4 "Feeling Understood"

The fourth major resource of adjustment that the mothers identified was that of "feeling understood." This resource is also often referred to in the literature as "emotional support" (Oakley 1992). Holly emphasized the centrality of emotional support as an adjusting resource in the following comment:

> a friend of mine...had her baby two weeks before me. We would talk on the phone six to ten times a day. Like we were constantly on the phone together, we were both pregnant together and worked together at the same place, and personally, I think if it hadn't been for that I probably would have been a basket case. I think I probably would have been on like antidepressants or something like that. (Holly, mother of one; group B)

This resource was articulated by the mothers as feeling able to "reach out" to others emotionally, about them "feeling connected" with others emotionally, and about "feeling safe" in sharing their feelings and experiences. As Indri articulated in this context:

> sometimes that's what we need to hear....when you hear someone else tell you that it's okay, you don't feel like you're the only one. (Indri, postpartum experience after third child; group C)

Emotional support, for the mothers in this study, fulfilled a similar function to that of having enough help: it helped them feel that there were not alone—that, at least on some level, their feelings, experiences, and responsibilities were shared and/or understood by others. And, as Harrison et al. (1995) also describe, emotional support functions as a resource for adjusting because that it gives mothers someone to talk to and

learn from as they problem-solve. The contrasting support experiences of Holly and Indri highlight this function of emotional support and of "feeling understood"

> I personally don't know how new moms get through that time without someone you can call ten times a day. And someone who can totally understand what you're going through. So, I mean, for me I can't even put a price tag on that. That was just amazing for me. So and we still talk on the phone like three times a day kind of thing. So that was probably the most important thing for me getting through the first six months. (Holly, mother of one; group B)

> you feel like you totally are alone. You are the only one...because a lot of people brush it off. People in society don't want to hear stuff like that. You know. "How are you?" "I'm just fine." And "oh, isn't your baby adorable? you must love being a mom." Well, yes, I do. But I think it's really hurtful that they don't hear the other side of things. When you don't talk about it at all, it builds up and like there's no one to vent toward, because you can't talk about it with your kids, and really, they're the only ones you see all day long. And like I say, in my case, my husband comes home and...we'll eat supper and I'll go to work...so there's no time to talk about it in the evening and like really no one wants to know about it. (Indri, postpartum experience after third child; group C)

While many mothers relied heavily on their husbands/partners for help with childcare and household responsibilities, some also described their husbands/partners as confidants. Notably, the mothers in this study who described more positive postpartum experiences often attributed their experiences, at least in part, to the fact that their husbands "understood" what they were experiencing. Alice made the following remark in this context:

> I think one of our strengths as a couple is that we talk about all that and we talk about the various things that come out of all these things, so at least we're both aware of where each other is at. (Alice, mother of one; group A)

Many mothers also relied heavily on their own mothers or other family members as sources of emotional support, a finding that has also been described by others as being an important factor for understanding mothers' postpartum experiences (Welburn 1980;

Brown et al. 1994). Penny, for example, made the following remark about the significance of the emotional support she received from her mother and her sister:

> I would call my mom pretty much every day or she would call me....I had a really good support system. And my sister would say, bring the baby over to the house for the day, because she had two kids....they were the ones that really helped me. To be happy again and make me more relaxed. (Penny, mother of one; group B)

Further, some mothers, like Holly, gained emotional support primarily from their relationships with friends. Emily, for example, described how she had become close friends with the women she met in her postnatal support group. She said the following about the benefits of those relationships:

> [its] nice just to have people to talk to who are going through the exact same thing and you know, like if I have just something off in my day or something. And I could tell my husband...but he wouldn't really understand, because he's not the one with the baby all day and stuff, so it's nice to have just the other whole support group who's going through the exact exact the same. (Emily, mother of one; group A)

In this context, many mothers identified friends *who were also mothers* as being a particularly valuable form of emotional support. Specifically, the mothers talked about how it "helped knowing that somebody else was feeling the same way" (Beth) and that others were "going through the same thing" (Gabrielle).

Often, mothers who described feeling supported emotionally—by their husbands/partners, mothers or other family members, or friends—noted having relationships characterized by frank and open communication. As Ingrid described, for example:

> I don't think [my relationship] with my mom changed too much. Like we've always had a...very kind of frank and open relationship...I think if anything, it brought us a little bit closer, just because you can empathize a little bit more with what they've been through. I don't know if it changed

> any of the dynamics. It intensified what was already there. (Ingrid, mother of one; group A)

In this context, it is important to note that *not all* intimate relations or friendships were considered by the mothers in this study as adjusting resources in this regard—as adequate sources of postpartum emotional support. Specifically, mothers tended *only* to reach out emotionally to their husband/partners, friends or family member if they felt confident that their feelings and experiences would be understood and validated. As Fran remarked, for example:

> I did have a hard time. I felt like, you know, a lot of people that I was close friends with we didn't—we still haven't regained a bond back…..I think everybody in the department was like, "Whoa. Weird." That I was the only one really with a kid there. I met just one other girl, lady, she's 50, she has two older, older kids, and she was like the only one that I could ever really relate to. She could relate to me a little bit more. But you know, so her kids were so much older, but there was nobody in the department. And everybody who did relate to me as a mom, they just couldn't believe it, and there's still that separation. I think they didn't grasp what I was feeling at all. (Fran, mother of one; group C)

The last main source of support identified by the mothers in this study was that of institutional or formal forms of support. These kinds of supports were identified most commonly among the sole mothers in this study and/or mothers who felt their existing personal relationships were not adequately meeting their support needs. Kiera, for example, who identified the support of her parents as being a key resource for her, also mentioned that she went to see a counselor after the birth of her first child. She explained this as follows:

> it probably took six months or so before I started to go and see a counselor. There were so many things I felt like I couldn't and didn't want to discuss with my mom and dad, you know what I mean? There's only so much you talk to your mom and dad about your marriage and even friends, sometimes I felt they understood; sometimes I felt they didn't. And so I

> went to talk to a counselor. And that really helped a lot (Kiera, postpartum experience after first child; group B)

This was also Fiona's experience. When I asked Fiona which source(s) of support she found the most valuable in helping her through the adjustment process, she identified a counseling service she accessed. Fiona noted that her counselor helped her to "put things into perspective," validated her experiences and feelings, and provided her with some much-needed reassurance to her that she was a "good mother" to her new baby. Fiona described this experience as follows:

> The City, their family counseling I went to, and my counselor there was phenomenal. Like I just I was so lost when I walked into her office. [Baby] was two months old and she helped me work through things and be like you know, you got to take the good and learn from the bad. Actually, I think without that I might still be wallowing in my sorrows and all of that stuff. It was a free service provided by the City and it was unbelievable. (Fiona, mother of one; group C)

The various factors identified by the mothers in this study as affecting the adequacy of their emotional support are described below.[15]

6.4.1 Factors affecting the adequacy of mothers' emotional supports

A number of mothers described encountering obstacles with respect to their abilities to reach out emotionally. First of all, many mothers' expressed concerns about a lack of formal programs and services geared to the emotional support of new mothers. The main concern voiced in this regard, was that current postnatal programs do not generally fulfill this function. In short, many mothers did not feel that these were emotionally "safe" environments. As Nancy commented in this context, for example:

> I was very good at putting on a show in the moms' group. So, I talked, you know, to the new moms' group, but I didn't really talk to any of them about my feelings. It was very superficial in that respect. I just didn't feel

[15] The factors affecting the adequacy of mothers' emotional supports did not vary markedly by socio-economic status.

> comfortable talking to them about how I was really feeling. (Nancy, mother of one; group D)

For many mothers, these programs would be much improved if they would provide better opportunities for mothers to share their feelings and to connect emotionally. The following comment made by Beth speaks to this issue.

> [in the postnatal classes] we would talk about—you know, we'd talk about what your child should be eating, or you know, but we really didn't talk about emotional needs at all. We didn't talk about - you know, we would - - oh, how cute the babies were, we let them play together, that kind of thing. So there was never really talk about anything...and it probably would have helped. If I knew somebody else was feeling the same way I was, that would have helped. (Beth, postpartum experience after first child, group C)

The second concern expressed by some mothers in terms of their ability to receive adequate emotional support was that of experiencing "negative support." This was Kathy's experience. Kathy described actively reaching out to various confidants in her life, including her husband and her mother. However, she felt that her experiences were not being heard or understood. As she described it, she felt like she "was trying to dig [her]self out of a hole, and everybody is pushing [her] back in." She stated the following in this context:

> going to [husband], my mom, the mental health nurse, I just felt like nobody was helping me....That just made me feel worse. (Kathy, postpartum experience after second child; group D)

The third major issue mothers talked about in terms of being able to get the emotional support they needed had to do with their *hesitancy* about reaching out emotionally, an issue that has also been identified in the work of Harrison et al. (1995). In this study, many mothers described not reaching out emotionally out of fear that they would be "judged as bad mothers," (Anabelle, postpartum experience after second child;

group D) or seen as "failing as a mother" (Beth, postpartum experience after first child; group C). These mothers talked about how they feared that their experiences and feelings were somehow "wrong." Again, the emotion of guilt was central to mothers' experiences of *not* reaching out. Nancy made the following comment in this context:

> you know, I was communicating a bit with my husband, but I didn't feel like he really understood. And he was frustrated with me. So I don't know how helpful that really was. It was just that, I felt like there was no real strong support network or people to turn to to talk about my feelings and what I was going through. One of my friends who does have kids, well she's very much that "perfect mother" type and so I felt very hesitant about talking to her about anything. I thought she wouldn't get it. (Nancy, mother of one; group D)

Thus, for many of the mothers in this study who did not feel comfortable asking for help, or felt unable to emotionally "reach out" to others, their hesitancy stemmed from feelings of inadequacy. They worried that they were failing as mothers, and felt their difficulties and struggles were indications of personal deficiencies. As Tianna explained about her experience, for example:

> there were a couple of my friends that were on maternity leave the same time I was. And my one friend said, "Oh, yeah, I feel like that, too. It's no big deal. You know. It'll pass". And my other girlfriend had no problem at all. She was well into her forties so she had gotten used to doing her own thing even more than I had. She was adapting to it fine. I thought, okay, it must just be me that I can't handle this. (Tianna, mother of one; group D)

These mothers generally did not interpret their difficulties as being "normal," or as being part of a more commonly-shared adjustment process. As such, many of these mothers worried that talking to others about their feelings and experiences would not result in increased understanding, but would result in a validation of their own sense of inadequacy. A comment made by Annabelle illustrates this point:

> [my family] give me a lot of support, but I seemed to during my depression wanting to talk to other—somebody else. I don't know why I

> felt that way, but I didn't want to talk to them as much....I just seemed to want to talk to other people more because I didn't think [my family] would understand the way I was feeling. Because a psychologist or a counselor—that's their job to listen....I think I felt misunderstood. I thought [my family didn't understand the way I was feeling and at the time....I thought they thought I was just a bad mom. You know. So that's another reason why I just wanted to talk to somebody else. Because I thought [my family] thought that I was a bad mom. That's what I thought during that time, too, is that I was a bad mom. That I shouldn't have had [the children] and blah blah blah, on and on and on. (Annabelle, postpartum experience after second child; group D)

Beth described having a similar experience after the birth of her first child. Beth explained how she felt uncomfortable "reaching out" emotionally because doing so would confirm her fear that her experiences and feelings were not those of a "good mother." Beth responded as follows to my asking her why she choose not to complete the EPDS screening questionnaire at her six-week postnatal meeting with the community health nurse as follows:

> I didn't want to think that I was—I didn't want anybody else to think that I was failing or not a good mother.....It seems like—it seems like everyone else is and you're not. (Beth, postpartum experience after first child; group C)

Tianna also worried about being judged by the world around her, saying that "it was pride that kept me from reaching out. The pride. How people would judge me and 'why can't you handle this?'"

In sum, then, inadequate emotional support was not only a function of access or availability. For many mothers who described lacking emotional support, the primary issue was that they didn't feel "safe" reaching out emotionally. They expressed their hesitancy as stemming from a fear that their experiences would not be validated as "acceptable" or as "normal." In other words, they feared that everyone else was happy and adjusted, and living up to the standards of "good motherhood"—just not them.

Importantly, however, once these mothers *did* begin connecting with others emotionally, they described this as key in helping them cope and adjust better. As Danielle remarked in this context, for example:

> the general therapy group that I've been going to, it's been helpful just in terms of my self-esteem. Just getting together with other mothers and what other moms have been thinking and feeling, because a lot of what they've been feeling I'm also feeling. One day a mom said that she doesn't always enjoy being a mom. And I'm like, "wow, I can relate to that. I can relate to that." And I thought I was the only one that didn't enjoy being a mom all the time....I was relieved. I was feeling guilty about not enjoying being a mom. I felt a sense of relief. Like the guilt kind of went away a little bit. (Danielle, mother of one; group D)

These experiences about the value of the emotional support these mothers eventually did start receiving reinforces the idea that "feeling understood" is an important resource for the adjustment process.

6.5 Feeling "Ready" for the Baby

The fifth major theme that emerged from this analysis had to do with how prepared or "ready" mothers felt for their new realities and responsibilities. Readiness, in this sense, encompassed two main dimensions: emotional readiness and physical readiness. These two dimensions emerged as being highly interdependent, and as such, mutually informing of one another. For the mothers in this study, their sense of readiness was a central factor in their own understandings of why they experienced and felt what they did. Mothers who felt emotionally and physically "ready" for their new babies articulated this sense of readiness as one of the main things that helped facilitate their abilities to adjust.

First of all, physical readiness was described by the mothers in this study as being central to their postpartum adjusting experience. Similar to the centrality of postpartum

self care (discussed above), mothers spoke of the importance of preserving their physical health, and of getting adequate rest, sleep, and "down time" while pregnant as crucial to their ability to adjust after the baby was born. As Mary remarked in this context:

> with the first baby, even though I was working fulltime, I still stopped to rest. I remember just stopping, taking time to rub my belly and think about the baby. I remember I felt physically much better [than I did during the second pregnancy]. With the second, I was just on the go all the time, and felt I just didn't have a chance to do that. I think that was a big part of it. (Mary, mother of two; groups A and C)

Mary went on to say the following in response to my asking her why she thought her second postpartum experience was so much more difficult than her first:

> [second pregnancy] was a more difficult pregnancy from the get-go. I had bad heartburn, morning sickness right through to the fifth or sixth month. I was just so tired....having the exhaustion, plus the stress of the job, it primed me I think. (Mary, postpartum experience after second child; group C)

Another way that mothers talked about feeling ready physically for their new babies was in being able to "get things ready" for the baby's arrival. This included a number of different preparatory activities such as preparing food that could be frozen and reheated, having the baby's room or sleeping area completed, arranging for help with child care and/or household responsibilities for the first few days/weeks postpartum. As Holly's experience illustrates:

> It wasn't too bad. I did a lot of preparing beforehand. Like to have like a bunch of food and stuff prepared. So that I wouldn't have to cook...I had enough food in the freezer to last us for about 2 ½ weeks. I didn't have to cook at all. So that was a lifesaver. Because if I had to cook forget it. We would have been eating Kraft Dinner or Kentucky Fried Chicken or something. So that was a good big thing for me. So - yeah, and we didn't have a whole lot of people over, either. So we didn't - you know, we made it really clear to everyone *before* we had him that call before you come, because we don't want a million people here. So that really helped. (Holly, mother of one; group B)

In keeping with this, mothers who had not been able to adequately "get things ready" described how they felt unprepared in this regard, and felt that this "lack of readiness" added to their postpartum situational stress. Many of the mothers who felt unready in this regard were often those who experienced unexpectedly early labors. In this respect, physical readiness was closely connected to mothers' assessments of their postpartum situational stress.

Physical readiness, in this context, could also be understood as a component of the theme "prioritizing self care." In the same way that the mothers described their abilities for *postpartum* self care as being integral to their adjusting experience, their ability to care for themselves physically *during pregnancy* also emerged as an important theme in mothers' stories. And like the theme of postpartum self care, mothers' feelings about their physical readiness for the baby mostly had to do with how "tired" or "exhausted" they were. Similarly, mothers' sense of physical readiness for their new babies—how tired, exhausted or "not tired" they were going into the process of birth—was influenced by the stresses of their day-to-day life, including such things as pregnancy, work, and childcare responsibilities; and their feelings of entitlement to prioritize their own self care.

The second main dimension of readiness described by the mothers this study was that of emotional readiness. "Feeling emotionally ready" was articulated by the mothers in this study in terms of a feeling of anticipation and eagerness about the birth of their new babies. Feeling ready was about looking forward to, and feeling prepared for, one's new responsibilities as a mother. Mothers who described feeling emotionally ready felt that this helped them in their adjustment efforts. The following excerpt from my interview with Paige illustrates this point:

> Interviewer: So, why do you think you felt so well? You said you've experienced depression other times in your life and some might say you might have been at risk for suffering depression post-partum, being a single mom, not having an income, and living in a foreign country.
>
> Paige: I think I just really got a lot of strength from the fact that I really had wished for this baby....just the wanting of the baby and appreciation of this gift in my life....there was never a question that I would not want the baby. That was never a question...I knew that I do want to have a child. So single motherhood didn't scare me. (Paige, mother of one; group B).

Tammy also illustrates the resource of "feeling emotionally ready" in her following comment:

> I was ready for motherhood. I found the right person. Which helped. And then both of us have been together since '91 and done quite a bit of traveling. Done a lot of things that we personally wanted to do in terms of experiencing different cultures and a lot of places. And decided that at this stage in my life especially being here in Canada and back in Edmonton, it was the best place to have a child in terms of not just child care, but also health, and opportunities for [husband] to find work....And I knew what I wanted to do now...the maturity and it seemed like a lot of things were coming together, colliding, in terms of family and school as well, even though my husband was going to be traveling and doing a lot of work overseas (Tammy, mother of one; group A)

Another way that the mothers talked about feeling ready had to do "knowing what to expect." In this context, adequate knowledge and information provided the mothers with a sense of comfort and reassurance that "if you know what to expect, you're better prepared to handle what comes along" (Astrid, mother of two; groups A and B). Emily noted the following in this context:

> I just totally prepared myself for the worst, especially because my pregnancy had been so bad....another thing that I was concerned with. I might - actually, [husband] and I both had thought that maybe I would be hit by like post-partum depression or whatever, because I have such severe PMS, and my sister is clinically depressed....you know, it's very possible. So we were fully prepared for it but nothing ever came of it (Emily, mother of one; group A)

Thus, the value of informational preparation was that it functioned as a resource—a tool box of skills, knowledge and understanding—that could help them in their adjustment efforts. For this reason, the mothers in this study whose preparations about "what to expect" encompassed a wider range of possibilities and scenarios—including the possibility of experiencing negative realities, emotions and outcomes—generally described feeling "more ready" in this regard. In other words, feeling ready meant also learning about, and preparing, for "the worst" as well as the best (Glass 1983; Mercer 1995).

As might be expected, the mothers in this study who felt emotionally "unready" for the entry of the new baby into their lives experienced greater difficulties adjusting. This theme of feeling emotionally "unready" featured prominently in the interviews I had with Mary, Nancy, Annabelle, Chris, and Waverly for example, all of whom struggled considerably in the postpartum. In these mothers' stories, their experiences of feeling emotionally "unready" were closely tied to their assessment their own ability to handle the responsibilities of being a mother to a new baby, *given all of their existing responsibilities and demands*. Interestingly, these mothers also described adjusting experiences whereby the task of "connecting with the baby" took longer, and was more difficult to accomplish.

In many of these experiences, the mothers noted that their pregnancies had been unplanned, and had come as a shock to them. Nancy's experience was one such example:

> I got pregnant right after we got married. It was a total surprise. And I remember that I felt very emotional during the pregnancy although I only really noticed it in hindsight....I think I was ambivalent about the pregnancy even though we decided we were going to have kids. Just the shock of it, because it was unexpected. Even though it was expected eventually. (Nancy, mother of one; group D)

For many of these mothers, even though they felt blessed to have their children, they experienced considerable ambivalence about the *timing* of their pregnancies. They felt, in short, unsure about whether they had enough physical and emotional resources to take on the responsibility of becoming a mother to a new baby at that time. As Chris stated in this context:

> yeah, I think that's just it. I think it is that emotionally, I think that I was ready for the *birth*, but I wasn't ready for *a baby*. (Chris, postpartum experience after second child; group D)

In many ways, the concept of readiness—as it was described by the mothers in this study—was essentially an articulation of their pre-birth state of physical and emotional wellbeing. In this respect, the connection mothers made between their own sense of physical and emotional "readiness" and their resulting postpartum experience adds support to existing research which shows that mothers' state of emotional wellbeing in pregnancy is correlated to their postpartum emotional wellbeing (Dennis & Kavanagh 2003; Green 1998; Evans et al. 2001). Unlike some of the other adjusting resources discussed above, the resource of feeling "ready" for the baby did not tend to vary by socio-economic status.

6.6 Having Realistic "Core" Beliefs and Expectations

The last major theme that mothers described as being of central importance to their adjusting experience had to do with whether "core" beliefs and expectations about themselves, their lives, their relationships, and about the experience of motherhood were either reinforced or threatened. Mothers who described having fewer difficulties adjusting often attributed their experience to the fact that their "core" expectations were preserved through their experiences. By contrast, mothers who described greater difficulties

adjusting often attributed their experiences, at least in part, to the fact that key or "core" expectations and beliefs about themselves and their experiences had been threatened or violated.

In this context, what emerged from this analysis as a key adjustment resource was being "realistic" in one's core beliefs and expectations. Ingrid and Yasmine articulated how having "realistic" expectations functioned as a resource for their adjusting efforts in the following comments:

> I mean, maybe men particularly, have this really romanticized notion of what it's like to be a mom and you know, I mean, I've been realistic and pragmatic about what I expected out of it. (Ingrid, mother of one; group A)

> I don't believe in those [images or ideals of "the perfect mother"] you know. I know you do the best you can and hope it works. And I think that you have to take advantage of whatever opportunities you get. You know. To do the best for them that you can, because there are a lot of things you just can't do on your own. (Yasmine, postpartum experience after second child; group C)

Similarly, Paige made the following comment about how her "realistic" or pragmatic beliefs about how best to mother functioned as an important resource.

> my philosophy has become whatever works is the approach I take. Whatever makes my life—whatever works, whatever makes it manageable....And when I get into a rut where I put myself down I just try to remind myself....as long as he is a happy child who develops normally, there's really no major concern and it's not my goal to have a "super baby." (Paige, mother of one; group B)

Mothers described how "having realistic expectations" was important to their adjusting efforts because it helped them manage a variety of possible realities, not only the positive or the "ideal" scenario.

Importantly, this same theme was central to the narratives of mothers who described having more difficulties adjusting. These mothers, however, often described

that the source of their difficulty lay not so much in the fact that their was a "gap" between their expectations and their realities per se, but that the gap between expectations and reality represented a violation of, or threat to, a "core" belief or expectation. As Kathy articulated in this context:

> that's my problem. I have these expectations that things will be a fairytale. Like I said, oh, we've had our bad, now it's going to be good. And I *really* believed that because I'd already been through so much in my life....But, it wasn't. It wasn't a fairytale (Kathy, postpartum experience after second child; group D)

In this vein, mothers' own understandings of why they felt and experienced what they did in the postpartum had to do with the rigidity or idealism of their "core" beliefs about mothering and motherhood, especially as these beliefs and expectations intersected with their actual realities.

Core beliefs, in this respect, were described by the mothers in this study as deeply-held beliefs and expectations about themselves, and about what "good mothers" do, feel and are. In other words, core beliefs and expectations were those beliefs that were fundamental to their understanding of what good motherhood was all about, *and about what they needed to do and feel and be in order to be good mothers*. As Rubin (1984: 110) argues in this context:

> it is the disparity between the expected and the real, between the ideal image of the self and the experience of the self in the body postpartally that produces...self-disparagement. This self-disparagement results in depression and hostility.

Core beliefs, then, are those which were incorporated into the very construct of mothers' self-concepts as women and as mothers—that were foundational to their own "picture of self" (Mercer 1995: 118)

In short, the centrality of these "core" beliefs and expectations to mothers' adjustment experiences had to do with whether these beliefs and expectations were generally reinforced or upheld through mothers' actual experiences, or whether they were threatened or violated. According to the mothers' narratives of why they felt and experienced what they did, having more "realistic" core beliefs and expectations was helpful to their adjusting efforts because it increased the likelihood that these core ideas about themselves and their experiences *would not* be violated or threatened through the actualities of their new realities.

Having realistic core beliefs thus made the process of "reconciling reality"—one of the major tasks of the adjusting process—easier to accomplish, as this lack of idealism often meant that there was less adjusting work required for the accomplishment of this task, and that any changes in expectations or beliefs that were required by mothers in to successfully accomplish this task, were likely not "*core*" expectations and beliefs.

There were a number of different kinds of core beliefs and expectations that the mothers in this study articulated as being central to their adjusting experience. First of all, some mothers identified core beliefs about their lives as mothers more generally. They held certain fundamental beliefs about how their lives as mothers should and would be. Importantly, mothers who described having less rigid and/or idealistic expectations about what their experiences and feelings would be like articulated this as being helpful to their overall adjusting experience. As Jan articulated, for example:

> I don't think I went into it with huge expectations. When I was a teenager I never found it interesting. I didn't like babysitting. Um. I didn't grow up in one of these—I didn't grow up having a huge desire to be around kids a lot. It wasn't a big part of my—I knew I wanted to have children, but I was more curious about the experience of pregnancy. I was very curious about pregnancy but less curious about children…and so I knew I wanted

> to have a baby and have a family with my husband, but I think my expectations for what it would be like were kind of—they were very undefined and just well, whatever happens, happens. And I know babies cry and that it's going to be difficult. So I think I had kind of low expectations, sort of...yeah, I wasn't disappointed. (Jan, mother of one; group B)

By contrast, mothers who described having more idealistic expectations in this regard—and whose expectations were threatened or violated—described this as a key reason for why they experienced greater difficulties adjusting.

Kathy's story provides an illustration of this kind of experience. Kathy was in a life-threatening car accident approximately five years before our interview. After a grueling recovery, she and her boyfriend (who was also a victim in the accident) decided to marry and take "full advantage" of what life had to offer. They decided to have children right away. Their first baby was born and Kathy described this postpartum experience positively, and felt that, overall, "everything went fine." During her pregnancy with her second child, Kathy became ill with a virus that put her at great risk for losing her pregnancy. For Kathy, this possibility represented a violation of a fundamental expectation she had about her life that "we've had our bad, now it's all going to be good." In her mind, she had already suffered enough for one life and believed—to her core—that "things will be a fairytale." She stated the following about how this belief mediated her adjusting experience:

> probably the moment I found out my baby—I might lose this baby [was when the depression started]. Yeah. I don't think I could—I don't know. It was too much for me, I think. I think just because, like I said, I had been through so much. That I felt like I was immune to anything more bad. Because I had, you know, I felt like "I'm so young and I've had all this happen to me, and nothing's gonna go wrong now." (Kathy, postpartum experience after second child; group D)

Another kind of "core" expectation or belief that the mothers in this study described as influencing their adjusting experience had to do with their relationships with others, typically their spouses/partners. In this respect, this kind of core belief had to do with the expectation that the tenets underpinning that intimate relationship—trust, honesty, dependability, understanding, or the belief that their spouse/partner would do no harm, for example—would not be transgressed. As such, mothers who felt that core expectations about their relationships had been violated often talked about how this experience made it more difficult for them to accomplish their adjusting tasks.

Again, Kathy's experience is illustrative of this kind of core expectation, and how it played a role in her postpartum experience. Kathy described how she felt her husband had "taken advantage of" her vulnerable state after giving birth (she experienced hemorrhaging and had had other difficulties) in order to get her to agree to a name for the baby she had previously been opposed to. For Kathy, this situation represented a violation of a deeply held belief that her husband would never do anything to hurt her, unintentionally or intentionally. She stated the following in this context:

> I thought that he hurt—like I felt like he really hurt me. Like *really, really, really bad.* And when I married him I was kind of—because he was, he is the main guy and that, I felt like I had that *guarantee* of this guy is never going to hurt me like I thought I was that would never happen, right? And then I felt like well, even somebody you love more than anything could hurt you. You know. Anyone could hurt you. And that was hard for me to accept. (Kathy, postpartum experience after second child; group D)

By contrast, Gabrielle made the following comment about how her expectations of her husband were not seriously violated in the course of her adjusting experiences, because she understood how her husband "is who he is." She stated the following in this context:

> I love my husband dearly. But he really wasn't much help in a lot of ways. .....But, I mean, he is who he is. I don't think there's anything he could

> have done differently. About the only thing I wish is that [after the first baby that] he could have maybe had a bit more empathy and a little less um need to fix it. You know, more ability to just listen instead of trying to fix it. Um. But then again, I've wished that before for him, not just in relation to having kids....so I don't blame him for feeling that way. (Gabrielle, mother of two; groups C and A).

The third and most frequently mentioned form of "core belief" for the mothers in this study had to do with fundamental expectations and beliefs about mothering itself. In this context, "core mothering beliefs" represented beliefs and expectations to that were integral mothers' sense of self as a (good) mother—who they believed they needed to be, what they needed to do, think and feel in order to be good mothers to their child(ren). Again, mothers who felt that their core mothering beliefs were upheld or reinforced through their experienced realities often noted this as being helpful to them in their adjusting efforts. Further, as Ingrid's comment highlights, mothers typically described that having more flexible and/or realistic "core mothering beliefs" was important in this regard.

> definitely, there's an ideal out there about what the perfect mother is. It's not me. And I just accept the fact, I mean, it's the same as knowing there's a perfect woman stereotype and she's like five ten and blonde. And I'm neither of those things. So at some point you go, I'm just different than that. And that's fine. Um. And I think also in my case it's been trying to take the good things that my mom—that I got from my relationship with my mom. Because again, she was working from the time I was only four months old. And yet we have a very close relationship and I look up to her a lot. So I know you can be different than this perceived ideal. And still be a great mother. You know, that's never been a question to me.....I think in one way, with my mom working, it developed the sense of it's okay to be selfish sometimes.....it also teaches you, boundaries are okay. And it's okay to have them....and you really learn to not feel guilty about it. (Ingrid, mother of one; group A)

The most common core mothering beliefs that emerged from this analysis are described below.

6.6.1 Common "core mothering" beliefs

First of all, beliefs about bonding and attachment emerged as one of the common "core mothering beliefs" held by many of the mothers in this study. This theme was particularly salient in the narratives of mothers for whom the adjusting task of "connecting with the baby" took longer to accomplish. Importantly, mothers who talked about being more "realistic" or "flexible" in their beliefs about the innateness or immediacy of this process described having more positive adjusting experiences in this regard. As Suzanne and Violet both articulated in this context, for example:

> I think it helped that I intellectually knew it was going to take a while. Or it can take a while. And not everybody feels that bond at the start. I think I would have been totally like more depressed. I would have felt much more inadequate. Like there was something *really* wrong with me—more. I mean, I did feel a little bit like that through all the experience…[because] like I said, I think there's that expectation that you *do* feel like that from the start, like the second you lay eyes on your child you have this overwhelming sense of love and all that stuff. (Suzanne, mother of one; group B)

> I didn't tell people about it. So I obviously didn't feel it was something I should shout from the rooftops or something, right? But I don't think I beat myself up about it or anything. I mean, I know enough to know, like - pretty normal probably. And probably if you ask 50 women, 20 of them would say that, right? They would be, I would think, because I think it's just so overwhelming. That you—and there isn't much that you get back initially. Like there isn't, "I love you, mommy" or stuff like this, right? There isn't things that little babies can do that would build that connection. (Violet, mother of one; group B)

By contrast, mothers who held the belief or expectations that this adjusting task really should be innate and instantaneous noted how the violation of this belief inspired intense feelings of guilt. Chris, for example, stated the following:

> it's just such an emotional issue for me because I just feel wracked with guilt, because of things that I, you know, I didn't feel towards my daughter…..I just feel so bad about it. (postpartum experience after second child; group D).

For these mothers, a fundamental belief about themselves as mothers was undermined—that "good mothers" love their babies instantly, easily and instinctually. Notably, mothers who had internalized this core mothering belief were often not first-time mothers. As such, they articulated this core mothering belief in terms of an expectation that they would recreate a previous experience *that was* instantaneous and "magical" (Heather) or "like Christmas" (Mary). As Heather remarked in this context:

> I was expecting to have my son all over again. And I know that's wrong...but it was so magical the first time I thought it was going to happen again and then I got little [daughter]. (Heather, postpartum experience after second child; group D)

In this respect, the reality of these mothers' experiences as *not* being the same the second time—coupled with the strength of a cultural myth that presents mother-baby intimacy *as* instant and instinctual—created a particular contextual lens which exacerbated mothers' internalization of this expectation, and amplified their consequent feelings of guilt.

Another "core mothering belief" identified by a number of the mothers in this study had to do with the importance of breastfeeding. In this respect, being successful with breastfeeding was pivotal to their adjusting experience, and to the (re)construction identities as (good) mothers. As Fran commented, for example, "I wanted to commit myself to...be a good parent. To me breastfeeding was part of that." Excerpts from Natasha and Suzanne further illustrate how integrally breastfeeding featured as a "core mothering belief" for the mothers in this study:

> I had decided I was going to do the breastfeeding no matter what. So, yeah, I was very stubborn about that. I don't care how much it hurts or anything....for me, I felt like *I have to* do this naturally. *I have to*. And I don't know, I just—in my head I thought I'll wait for six or eight weeks but I knew even if that time came and went, I'd probably give it another two weeks. And another two weeks. And I would keep doing it. I just

> thought, I have to....I had to do it. No question. (Suzanne, mother of one; group B)
>
> it got to that point where I could not imagine *not* being successful with [breastfeeding] And, I just thought, I can't even go there with it, because it truly, I think, would have totally spiraled me into a serious probably state of depression....it just seemed to me that it would have been a really strong sense of failure, and failure as a mom and so I just, I couldn't feel this. I thought there's got to be a way to get around it....I think it could be a very serious situation if somebody feels that [strongly about breastfeeding, like I did] and then if they have to give it up, or just feel too overwhelmed to really keep going with it. That could end up being a serious—probably a very serious—post-partum issue. (Natasha, postpartum experience after first child; group A)

Most of the mothers who participated in this study identified breastfeeding as a "core mothering belief." In other words, there were few who did not identify strongly with the idea that breastfeeding was foundational to what good mothers do, to what good mothering was all about, and to what they needed to do in order to properly take care of their babies. As such, whether this belief was upheld or violated was a major theme in their adjusting stories.

Specifically, mothers who described situations where they were able to establish a breastfeeding relationship they were comfortable with often described this as helping to facilitate their adjusting efforts and abilities. These mothers often described feeling "proud" (Alice, for example) for persevering if they had experienced difficulties getting breastfeeding established, and described how their ability to protect this core belief was "empowering" (Jill) to their sense of self as a mother. Excerpts from my interviews with Alice and Jill are provided below:

> breastfeeding didn't get started well...except I was really determined. And we went to a breastfeeding specialist and [the baby] he was two weeks old by then, and he was failing to thrive. And the doctor...she understood my desire to feed him....So together we had supplements and breastfeeding and eventually the supplements went away and the breastfeeding went on

> for a year and it was really good. But I had yeast and I had mastitis. I had every possible—the doctor said there were six things she treated and I had five of them. So I guess that was very empowering....because I knew lots of people would have decided it wasn't worth it. And it was one of my first experiences....where I had a strong conviction about what was right and what I wanted to do. And I really backed it up with action. I hadn't had a lot of experiences like that in my life. And so despite all the problems it was very empowering. (Jill, postpartum experience after first child; group A)

> I have, I guess, a lot of strong beliefs that I didn't—oh, I kind of knew I had—but I didn't really realize how they impact me on how to raise a kid and what I believe is best for raising kids....feeling like, what happens if I *have* to give my baby formula? Well, I don't believe in that...Breast feeding is a big belief for me, yeah. Huge....I'm so glad that we worked through everything. If he refused the breast I would—that would be horrible. (Alice, mother of one; group A)

By contrast, mothers who held breastfeeding as a "core mothering belief" and were *not* able to establish a comfortable or satisfactory breastfeeding practice talked about how this negatively impacted their adjusting experience. Kiera, who was unsuccessful in her attempts to establish breastfeeding with her first child, commented for example, that the experience made her feel "like a failure....it was difficult" (Kiera, postpartum experience after first child; group B).

This was also Beth's experience. Beth struggled immensely with breastfeeding after the birth of her first child. As with most of the mothers who participated in this study, Beth held breastfeeding as a "core mothering belief." In addition, Beth also held as a core expectation that, for her, breastfeeding and mothering would come "naturally." As such, she described that her difficulties with breastfeeding came as "a shock" and noted the following about how the violation of this core mothering belief impacted her:

> I had several problems with breast feeding....She wouldn't latch on at all.....She really wouldn't. She wouldn't breastfeed, so eventually I just gave up and bottle fed. But I struggled for three months I think....I felt so horrible about myself that I couldn't do this for my child. I don't know.

> Even though I was doing everything I could, I mean, *everything*. I just could not. It just wouldn't happen for us, you know? It was so, I don't know. You feel like less of a person, less of a mother, less of a woman even, you know, that you can't do this for your child....It feels like they reject you. I think that's where really [the emotional difficulty] sort of came from, you know, I was, yeah, I was very sad about it. (Beth, postpartum experience after first child; group C)

The third "core mothering belief" that emerged from this analysis—and that played a key role in mothers' interpretations of their own adjusting experience—revolved around the theme of "being there" for their child(ren). This theme was expressed by the mothers in this study as their own interpretation and belief about how much "doing" and "being there" was "enough." As Alice expressed in this context:

> for me it's just never knowing like what's enough?...and you know, not knowing if you're doing a good job. If you're doing it right....if it's enough. If you're doing enough for your baby. (Alice, mother of one; group A)

Importantly, the wider ideological construction of contemporary "good mothering" communicates the idea that there is no such thing as "too much" when it comes to mothers giving attention to, doing things for, and most centrally, spending time with, their child(ren) (Hays 1996; Swigart 1991; Thurer 1995). This is a powerful discursive construction, which Holly pointed out as follows:

> there's all that media stuff out there now that it's like quality time, you have to spend a lot of time with your kid, and I'm a proponent of that. Like I really think that you need to spend a lot of time with your kids. So it's kind of like a controversial thing. I want to be here with him. And yet I have to be at work right now, too. (Holly, mother of one; group B)

Ironically, however, this discursive ideal is not well supported in existing research (Palacio-Quintin 2000; Anderson 1989; Wessels et al. 1996; Bibby 2001). As Genevie & Margolies (1987: 382) note, for example, there is "little evidence to support the notion that working per se is detrimental to either mother or child."

Nevertheless, many mothers expressed a deep internalization of this broader ideological tenet, articulating it as a personal "core mothering belief." To this end, mothers' internalization of this broader belief was often described as playing a key role in their adjusting experiences. Again, mother who identified themselves as having a "core belief" about the importance of "being there completely"—and who experienced threats to that belief (perhaps because of a desire or need to return to work, for example)—described how the violation of this belief was integral to their own understanding of their adjusting difficulties. As Beth and Jill articulated in this context:

> I don't like to leave the kids. I can't stand to leave them. I feel guilty. I feel guilty that I'm…not spending enough time with them or not quality time, or I don't know. I know how important it is to have time, you know, they're in their learning—they're in their formative years, you know, and if I spend as much time as I can with them then I'll make them good people. You know? Like I want them to be good people. Good, you know, of good morals and values. I guess if I'm not with them *all the time*, but when it comes to shaping their character that I won't be there for them….and I feel judged. Definitely so. (Beth, mother of two; groups C and B)

> I know in order to be a good parent I need to have a house that's not chaotic. But if I'm working on the chaos of the house I'm not with the kids and I feel guilty. (Jill, mother of three; groups A, D and D)

By contrast, mothers who described having less investment in the idea of "being there completely" often described this as being a helpful resource for their adjusting efforts, particularly for the tasks of integrating work with mothering/making decisions about work, and rebuilding day-to-day life. Ingrid, for instance, told the following story in this context:

> I'm going off to Greece for a month….and there was part of me that was torn [about deciding to go], but there was another part of me that said, well, there's no question. Like this is a great [career] opportunity….So part of me felt really guilty because [my mother-in-law] was kind of pointing out to me, "well, you ought to feel guilty." And I went to my

> mom the next day and I said, "I don't know. What do you think I should do?" And my mom said, "*I* went away for three weeks when *you* were little." Which I know for a fact I don't remember. So it obviously wasn't that traumatic. And it kind of put things in perspective. And I think that trying to put things in perspective is important. (Ingrid, mother of one; group A)

Also, as described in more detail above, mothers' internalization of this broader belief structure was also described as affecting their sense of entitlement to "getting enough help" with childcare and to take time for themselves to attend to their own self care needs. Kathy and Fran made the following comments in this context:

> there's some societies where...the mom goes away for 30 days with the baby and she's just with her baby and she is cared for...but in our society moms are supposed to do it all on their own—you have your baby, jump out of bed and go. (Kathy, postpartum experience after second child; group D)

> when I went to school when [baby] was nine months...I would drop her off, go to school, come right home, and go get her, you know. I *never ever* took any time to do anything besides what I absolutely had to do....because I felt really guilty about leaving her....There was a mental obstacle in my way thinking that I had to be home with the kid all the time or something. (Fran, mother of one; group C)

In short, mothers' adjusting experiences took place against the backdrop of culturally dominant constructions of good mothering (see also Miller 1995). It was in this vein that mothers identified the importance of having "realistic" or flexible" core beliefs and expectations. The main reason they identified having realistic or flexible core beliefs as being important for their abilities to adjust was because it helped ensure that the gap between expectations and reality would not be too great—and, most centrally, that the beliefs and expectations they held most closely to their own "picture of self" (Mercer 1995) were preserved or reinforced through their experienced realities. With the exception of the "core mothering belief" that mother-baby bonding is instantaneous and

instinctual, mothers from lower socio-economic positions were generally more likely to than mothers from more middle and upper middle class positions to describe having realistic or flexible "core mothering beliefs."

6.6.2 "Core mothering beliefs" and the role of ideology

As noted, the various "core mothering beliefs" that the mothers in this study described have their primary grounding in a broader ideology about contemporary mothers and mothering (Dally 1982; Bernardez 2003; Bassin et al. 1994; Pope et al. 1990; Richardon 1993). Sharon Hays (1996) calls this broader belief system "the ideology of intensive mothering" and argues that today's dominant parenting philosophy is based on the following beliefs: that parenting should be done all-but-exclusively by individual mothers (i.e., with little or no help from others); that mothers should be self sacrificing; that "good mothering" practices are those which are emotionally and labour intensive, as well as financially expensive; that good mothers rely on the advice and knowledge of experts; and that mothering "comes naturally" to women. She states the following:

> [the ideology of intensive mothering] tells us that children are innocent and priceless, that their rearing should be carried out primarily by individual mothers and that it should be centered on children's needs, with methods that are informed by experts, labor-intensive, and costly (Hays 1996:21).

Part and parcel of this broader ideology of intensive mothers is also the belief that "mothers are always said to have "wants," unlike infants and children, who have "needs" (Lerner 1998: 77; see also Rubenstein 1998; Swigart 1991).

The various core mothering beliefs central to many of the mothers in this study—the importance of breastfeeding, the idea of "being there completely" the expectation that

connecting to one's baby occurs naturally and instantaneously for example—all fit comfortably within this broader understanding of "good mothering." Ideology, in this context, played a central role in mothers' experiences of postpartum adjustment.

Broader ideologies and discourses about mothering thus permeate and mediate mothers' experiences of mothering, and influence how those experiences are understood and evaluated (Rich 1986; Nakano Glenn et al. 1994). They shape "not only what can be said, not only what is heard, but also what can be understood" (Pope et al. 1990: 445; see also Rossiter 1988). As such, they serve as the lenses that filter and, to varying degrees, distort understanding and experience. As Nakano Glenn and colleagues (1994: 10) note in this context, "ideology is a powerful tool for keeping people in their place."

Ideologies are belief systems by which certain groups make sense of, and think about, the world. They do not persist because they are necessarily based in unquestioned "truths" or scientific "facts," but because they uphold a particular social order. In this context, many of the tenets of intensive mothering—tenets that many mothers in this study held as core beliefs about who and what they needed to be as mothers—are not concrete "facts."

As Eagan (1985: 93), points out, for example, this is particularly the case with the belief that the rearing of children should be carried out primarily by individual mothers:

> the fact is that no one has demonstrated any actual benefit to a baby of having only one caretaker. Babies do need consistency; they need some limited, stable, familiar group of people to care for them.

In keeping with this, the very idea that mothers should be the sole caretakers of their children is a recent development and construction (Dally 1982; Swigart 1991; Badinter 1980). As Eagan (1985: 50) also states in this context, for example,

> until recently servants carried a large measure of the responsibility we now lay on mothers, at least for the upper and middle classes. All but the nearly destitute had at least *some* help in the home (emphasis original).

As well, the importance placed on breastfeeding as indicative of good mothering and as necessary for baby's health is another belief that has been heavily critiqued (e.g., Law 2000; Knaak 2006), as has the more general idea that mothers themselves are the main influence on how their children "turn out" (Furedi 2002). Further, while many mothers feel torn and worry about "being there completely" for their children, it is rarely mentioned that, in general, mothers today spend more time with their children than did mothers of the 1920s and of the 1960s, despite massive increases in their labor force activity (Crittenden 2001; Bryant & Zick 1996; Furedi 2002).

Thus, the tenets of the ideology of intensive mothering are not necessarily "true" or "right" scientifically. Yet, the ideology of intensive mothering persists. It does so because it promotes a certain set of shared cultural values. According to Hays, it upholds and promotes values that specifically contradict the values imbedded by contemporary capitalist structures. She states:

> ...in a society where over half of mothers with young children are now working outside the home, one might wonder why our culture pressures women to dedicate so much time of themselves to child rearing. And in a society where the logic of self-interested gain seems to guide behavior in so many spheres of life, one might further wonder why a logic of unselfish nurturing guides the behavior of mothers....in no previous period is the distinction between what is appropriate in relation to mothering and what is appropriate in the outside world at greater odds (Hays 1996: x; 69).

Hays argues that the tenets of mothering ideology—which rely heavily on the values of unselfishness and self-sacrifice—are so powerful in today's world because they represent one of the primary counter-discourses to capitalist structures and values—which rely on the values of self-interest and self-gain. This tension, she suggests, reflects

a larger cultural ambivalence about the values we deem important, and wish to live by, as a society:

> these contradictions mark a fundamental cultural ambivalence about a society based solely on the pursuit of self-interested gain. Motherhood, in this sense, is one central field upon which a much larger struggle is waged (Hays 1996: 172).

Contemporary mothering ideology thus promotes a set of cultural beliefs about mothering and motherhood that are highly idealistic, largely unattainable, and also scientifically questionable (Mausart 1999; Mauthner 1998; Beck 2002; Furedi 2002). And as illuminated in this analysis, for those mothers who embrace various tenets of intensive mothering ideology—and for whom they become *core beliefs* about who and how they should be as mothers—the effects can be severe if those expectations do not materialize:

> in the collision of reality with mythology it is the mythology that tends to prevail, as the language and the conventions of the story shape....the ideology of mothering can be so powerful that the failure of lived experience to validate often produces either intensified efforts to achieve it, or a destructive cycle of self- and/or mother-blame (Pope et al. 1990: 442).

As this analysis also revealed, however, not all mothers are invested in intensive mothering ideology to the same degree. Perhaps unsurprisingly, the mothers in this study who actively critiqued and challenged various tenets of intensive mothering ideology felt that *not* having these idealistic "core beliefs" about motherhood and about themselves a mothers helped them in their adjusting efforts, and protected their emotional wellbeing. As Ingrid poignantly commented in this context:

> I think truly...this notion of there's only one good way to parent, there's only one right way to do things, I think is pretty dangerous, and I think it *lends* to people beating themselves up. And that's a pretty negative thing. (Ingrid, mother of one; group A)

Ideology, then, is a powerful force shaping mothers' personal beliefs, practices, and expectations. It provides a general "framework of understanding," which is resisted and embraced to varying degrees by different individuals. As Rossiter (1988: 214) states in this context, "people are not determined by [ideologies] just because they are there; people have ways of investing in ideology—in weak ways or strong ways, in conflicting or wholly committed ways." She further argues that the degree to which mothers are invested in the tenets of intensive mothering ideology is influenced by the various competing discourses, ideologies, knowledges and experiences that are available to individual mothers. It is through this general understanding of broader mothering ideology that the role played by "core mothering beliefs" in mothers' adjustment experiences and emotional wellbeing can best be understood.

6.7 Summary

The focus of this chapter has been to articulate the main reasons that the mothers in this study gave in explanation of why they experienced an easier or more difficult time accomplishing the various tasks of adjustment, and of reaching that point of "feeling adjusted." In this context, the six themes described in this chapter—prioritizing self care, having low situational stress, having enough help, feeling understood, "feeling ready" for the baby, and having realistic "core" beliefs and expectations—emerged as the main resources of the adjustment process. These resources were described by the mothers as the main things that facilitated their abilities to accomplish the work of adjusting.

Importantly, however, many mothers struggled to gain these resources. These mothers described how their resource deficiencies hindered their abilities to adjust, and made their adjusting work much more difficult to accomplish. One of the most dominant

themes in the narratives of these mothers was how various internalized beliefs—such as feeling "unentitled" to prioritize self care, and "unentitled" to ask for and expect help, for example—negatively impacted their abilities to access these resources.

In this way, the mothers' explanations of their adjusting experiences highlighted how these adjustment resources are overlapping and interconnecting with one another. Basically, mothers' ability for self care was the most direct or immediate link to their assessment of "how able" they felt about accomplishing the work of adjusting. However, not all mothers engaged in self care adequately. And there were a number of reasons for this, such as the demands on their time and energy (i.e., their degree of situational stress), by the amount of help they had, and also by their own (culturally-derived) beliefs about entitlement to self care.

The resource of "feeling ready" also interconnects with other resources. For one, physical readiness in many ways operates as a dimension of self care. Further, mothers' emotional readiness was influenced most heavily by the degree of situational stress they were experiencing prior to the birth of their babies. As well, the mothers described how their appraisals of their situational stress—and the manageability of that stress—was influenced by the amount of help and support they had. Poor self care, in this context, also exacerbated mothers' experience of feeling overwhelmed.

The quality of mothers' emotional and material support also had a direct influence on their ability to adjust. Support, in this context, provided mothers with information and resources, "help" and assistance, as well as sources of emotional understanding and connection. Support, most directly, provided a crucial mediating function for the mothers in this study: it mitigated mothers' sense of situational stress, and enhanced their abilities

to engage in adequate self care, during pregnancy as well as in the postpartum. Further, mothers' very abilities to solicit and mobilize their various supports needs were influenced by their broader beliefs about entitlement to support—about how much and what kinds of help were appropriate, and about what kinds of feelings were considered normal and acceptable (and therefore appropriate to talk about with others).

Finally, mothers' core beliefs and expectations about themselves as mothers, and about what motherhood "should be like" had a direct influence on their adjustment experiences. Of particular importance was the extent to which their core beliefs were upheld or violated through their experiences. Mothers' core beliefs, however, also influenced their adjustment experiences because they influenced the extent to which they prioritized, accessed, and felt entitled to various forms of emotional and material support, and to be able to prioritize self care. In general, mothers described how having core beliefs that on some level *went against* the ideals embedded in contemporary mothering discourses—was a major resource in facilitating their abilities to adjust.

Chapter 7:
A Model of Postpartum Adjustment—the Goal, the Tasks, and the Resources of Adjustment

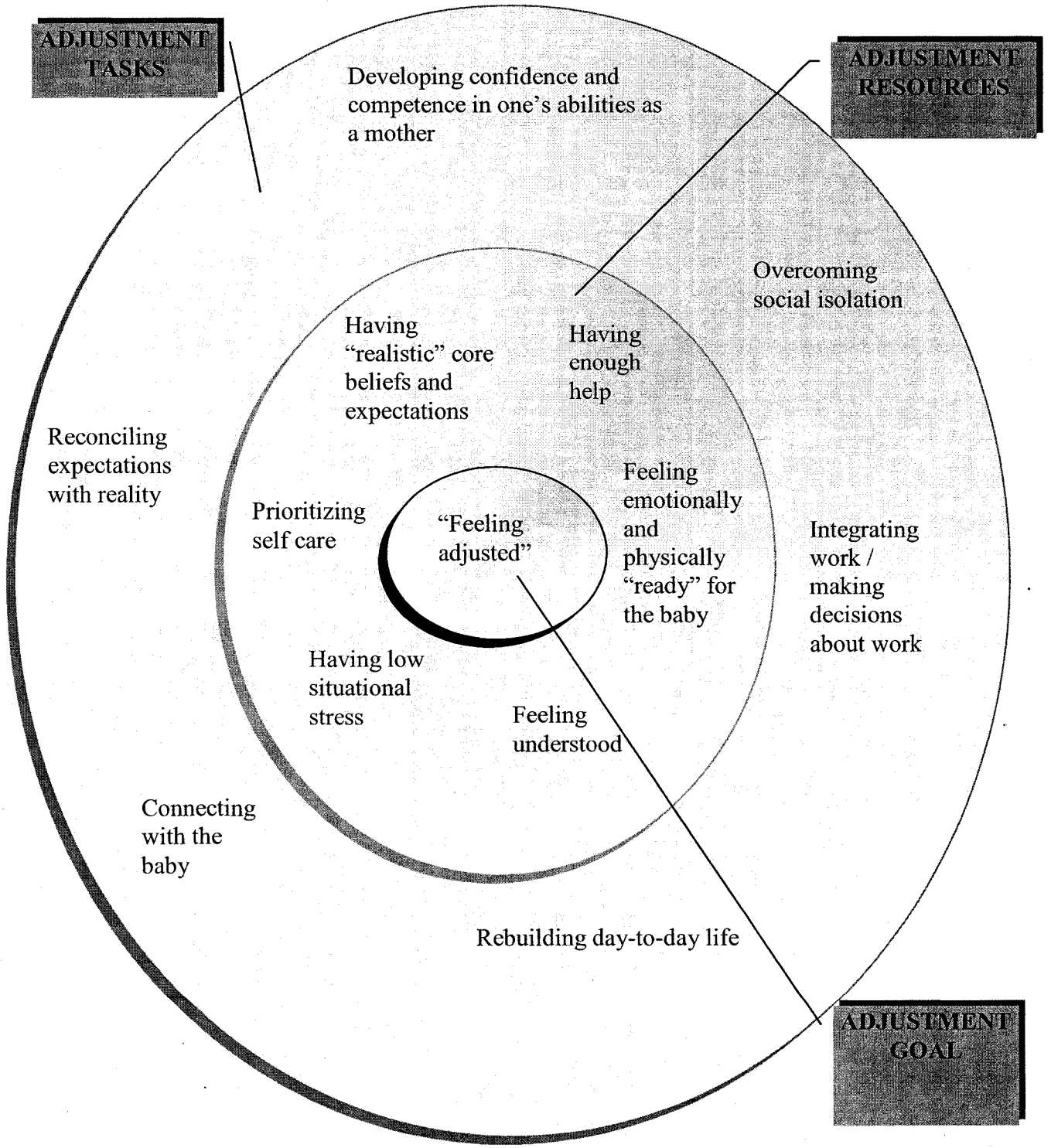
Mothers' narratives of their varying postpartum experiences can be understood in the context of a more general model of the process of postpartum adjusting. This model of postpartum adjustment encompasses the various themes described in Chapters 4, 5 and 6. While these chapters outlined the key dimensions of this process—the goal of the postpartum adjustment process (as described in Chapter 4), the key tasks of the adjustment process (as described in Chapter 5), and key resources of the postpartum adjustment process (as described in Chapter 6)—this chapter presents a model of the process as a whole.

7.1 A Model of the Process of Postpartum Adjustment

The model of the process of postpartum adjustment is highlighted in Figure 7.1 below. This model highlights a number of important connections about mothers' experiences of postpartum adjusting. First of all, the model emphasizes that mothers' adjusting efforts are focused on the attainment of a particular goal, that of "feeling adjusted." Feeling adjusted, for the mothers in this study, was perhaps articulated most succinctly by Jill, who described the accomplishment of this process as feeling "fully myself and fully a mom and somehow mesh them."

Figure 7.1

A Model of the Process of Postpartum Adjustment



Mercer (1986, 1995) has labeled the goal of postpartum adjusting the achievement of an "integrated maternal identity," which she summarizes as follows:

> [once] she has integrated the [maternal] role into her self system with a congruence of self and other roles; she is secure in her identity as a mother, is emotionally committed to her infant, and feels a sense of harmony...and competence in the role" (Mercer, 1995:14).

This same achievement was described by the mothers in this study as the goal of their adjusting experience—of "feeling adjusted"

As further emphasized in Figure 7.1, the achievement of an integrated maternal identity—or, in the language of the mothers in this study, "feeling adjusted"—occurred through the accomplishment of a variety of adjusting tasks. These tasks emerged as the major components of the postpartum adjustment process. They were the main things the mothers in this study needed to accomplish in order to "feel adjusted." The postpartum adjusting process thus requires the accomplishment of the following major tasks: connecting with the baby, developing competence and confidence in one's abilities as a mother, rebuilding day-to-day life, overcoming social isolation, integrating paid work/making decision about paid work, and reconciling expectations and reality.

Lastly, Figure 7.1 highlights the role of the various resources described in the previous chapter. These resources—prioritizing self care, having low situational stress, having enough help, feeling understood, feeling physically and emotionally "ready" for the baby, and having realistic or flexible "core beliefs"—were those things that facilitated mothers' abilities to adjust. In other words, these were the things that helped the mothers accomplish the major tasks of the adjustment process and, consequently, to reach the point of "feeling adjusted."

Key to the objectives of this study—which was to explore and better understand the variability of mothers' postpartum experiences—this model also provides greater clarification about how mothers' adjusting experiences vary. Most specifically, it illuminates why—according to the perspectives of mothers themselves—mothers experienced an easier or more difficult time accomplishing this process of postpartum adjustment. Basically, mothers who described greater difficulties in accomplishing the tasks of adjusting attributed their difficulties largely to deficits in their adjusting resources. Also importantly, as these mothers found themselves increasingly able to access these various resources, they also described feeling "more able" to accomplish their adjustment work.

Mothers' varying experiences of "how much difficulty" they had in accomplishing the work of adjusting, then, can be understood through the specific relationship between mothers' postpartum adjusting tasks (which can be perceived, assessed and experienced as being either bigger or smaller in magnitude) and their postpartum adjusting resources (which can be perceived, assessed and experienced as being more or less adequate). Mothers' varying experiences of how long it took them to "feel adjusted," and how salient various aspects of the adjusting process were for them can also be understood as being a function of the relative congruence or incongruence between the perceived magnitude of their adjusting tasks, and the perceived adequacy of their adjusting resources.

Arguably, the particular value of the model of postpartum adjustment that emerged from these mothers' narratives is that it accounts for a *diversity* of adjustment experiences. And as discussed in Chapter 2, accounting for such diversity is something

that has been identified as a gap in the existing literature. Currently, much of the literature on mothers' postpartum experiences falls into one of two main camps. One camp is the examination of mothers' experiences with, or risks for, postpartum depression or "adjustive failure." The other camp examines the experiences and processes of "becoming a mother." The focus in this literature is usually on the "normal" or "typical" experience of *first-time* motherhood.

This research, then, which aimed to capture a *range* of postpartum experiences—from first-time mothers as well as from multiparas mothers, *and* from a range of vantage points of emotional wellbeing from mostly happy to clinically depressed—offers a more comprehensive or "inclusive" analytical framework for understanding mothers' postpartum experiences. The model presented here provides the possibility of *bridging* these two separate bodies of literature. It does so by showing how mothers' varying postpartum experiences—and their explanations and understandings of those varying experiences—coalesce into a model of postpartum adjustment that emphasizes both the commonality of the process, as well as its variability. In other words, the model of postpartum adjustment presented here unites our understanding of what this process is and what is involved in its accomplishment (currently the domain of the "becoming a mother" literature) with our understanding of the various factors that help or hinder mothers' abilities to accomplish this process (currently the domain of the postpartum depression literature).

7.2 Returning to the Literature on PPD

The literature reviewed in Chapter 2 focused heavily on the specific phenomenon of postpartum depression. It was hoped that the research design implemented here—

exploring a diversity of postpartum emotional wellbeing states—might also provide insight into postpartum depression. There are a number of connections that can be made from this analysis back to the existing PPD literature that will be briefly pointed out here.

First of all, as noted above, the mothers' narratives of their experiences—and the specific connection they made between their emotional wellbeing and their experience of adjusting—suggests that the analysis presented in this dissertation intersects well with interpretations of postpartum depression as an "adjustment disorder" (Whiffen 1992; Juist & Janson 2001; Romito 1990). Further, mothers' descriptions of their emotional wellbeing as going hand-in-hand with their interpretations of how much difficulty they had adjusting add support to the "continuum" model of postpartum adjusting, whereby PPD is theorized to exist "at the extreme end of a continuum of postpartum adjustment experiences" (Christler & Johnston-Robledo 2002: 187; see also Lee 1997).

Secondly, mothers' own interpretations of why they had an easier or more difficult time adjusting provide support to existing literature on the various "risk factors" for PPD highlighted in the psychosocial and the cultural-feminist literatures. However, as illuminated through this analysis, these "risk factors"—such as lack of material and emotional support, stressful life events, or an incongruity between expectations and reality, for example—can also be thought of as "resources" of adjusting. It is notable, I would argue, that *all* of the mothers' narratives—from mostly and mainly happy to clinically depressed—relied on the six types of resources described in Chapter 6 as being central to their adjusting experiences. These resources, as described above, were prioritizing self care, having low or manageable situational stress, having enough help, feeling understood, feeling physically and emotionally ready for the baby, and having

realistic "core" expectations and beliefs. Thus, in as much as these six themes were described by the mothers as "hinges" around which their adjusting work was helped along or hindered, this analysis highlights even further the integral role of these resources in the process of adjusting itself.

Calling these concepts "resources" instead of "risk factors" is little more than a semantic shift. However, I would argue that it is a useful shift in our conceptualization of these variables. Specifically, highlighting them as "resources" better emphasizes their active and integral role in actually *facilitating* mothers' abilities to adjust. Thus, it is not only that an absence of these resources presents a "risk," it is also that the presence of these resources helps mothers accomplish the work of adjusting.

Thirdly, this analysis extends current understandings of this phenomenon by highlighting the centrality of *self care* in mothers' own assessment of their emotional wellbeing. This factor was a dominant theme in virtually all of the mothers' narratives, and emerged as the most direct and immediate link to their adjustment experience/emotional health. However, the theme of prioritizing self care—as well as more specific variables such as sleep deprivation, fatigue, and lack of respite, for example—*have not* been a part of dominant models of PPD and postpartum emotional distress (Kendall-Tackett 2005; Mercer 1995; Sebastian 1998) or of postpartum adjustment more generally (Lentz and Killien 1991), despite being acknowledged in health literature as having important consequences for physiological and psychological wellbeing (e.g., see Olson 2007). As Kendall-Tackett (2005: 28) argues in this context, for example:

> sleep deprivation wreaks havoc on one's emotional state. Perhaps because it is so common, its influence on a mothers' mental health is often overlooked.

This analysis thus suggests that prioritizing self care—the ability for mothers to get adequate sleep, rest, nutrition, exercise, and, equally as important, respite—is a major resource of adjusting. But as this analysis also illuminates, contemporary mothering discourses tend to work *against* the prioritization of self care. In this context, access to this adjusting resource often required, for the mothers in this study, something of a radical resistance to, or rejection of, dominant cultural norms. As such, the findings from this analysis suggest that greater theoretical and empirical attention needs to be given to understanding how *self care* functions as an integral resource for this process, as well as how mothers' abilities to adequately prioritize and engage in self care are mediated by broader mothering discourses.

Fourth, because this research emphasized the point of view of mothers themselves, it highlighted mothers' own understandings of what these resources mean to them and how they influence their adjusting experiences. As such, mothers' descriptions and articulations of these various adjusting resources add greater conceptual depth to how these variables should be understood and interpreted (whether as "resources" or as "risk factors"). This is a useful elaboration, as it has been oft-noted that a greater understanding is needed of how such things as social support (discussed by the mothers in this study as "having enough help" and "feeling understood"), stressful life events (described by the mothers in this study as "having low or manageable situational stress"), poor marital relations (described by the mothers in this study as an issue of negative support), and psychological orientations (described by the mothers in this study as "having realistic or

flexible core beliefs and expectations) are subjectively defined by mothers themselves. In this way, this analysis provides greater qualitative depth and conceptually elaborates on the *meaning* of these variables.

Lastly, this analysis provides greater understanding about how the various "adjusting resources" identified by the mothers in this study interacted with each other, and worked together to influence their adjusting experience. Importantly, the connections the mothers made in this regard point to important opportunities to integrate cultural-feminist understandings of PPD—which emphasize the role of oppressive cultural discourses—with the psychosocial literature.

For example, this analysis highlights how broader cultural beliefs are internalized by mothers to greater or lesser degrees, and that the internalization of these beliefs play a key role in mothers' abilities to access and mobilize various adjusting resources, such as prioritizing self care and "getting enough help"—both of which also influence the manageability of mothers' situational stress. Specifically, the internalization of various tenets of intensive mothering influence mothers' perceptions and prioritizations of their own entitlement to support and self care, and their own understandings of what "good" mothers feel and experience.

Notably, the use of a psychosocial framework has been argued to be the most promising way to approach such an integration of models. As Chrisler & Johnston-Robledo (2002: 191) state: "the stress and coping model is consistent with both feminist and bio-psychosocial approaches, and it may prove to be the most useful way to understand women's experiences and to advise them on how to solve the problems that are the basis of their negative affect." As much as "the mother is embedded in the

microsystem of the family, which is embedded in the mesosystem of the community and institutional structures…which is embedded in the macrosystem of ideology and belief systems" (Mercer 1995: 16), mothers' adjusting experiences *are* organized and influenced by the particular ways various individual, social and cultural factors interconnect with one another. Hence, an integration of the contributions of various models *should be* a theoretical goal.

Lastly, Barclay et al. (1997: 727) have cogently argued that that what has been missing in the current literature "is a framework that draws together women's experiences of early motherhood, conceptualizes the magnitude of the change required and provides strategies to help women negotiate this experience." Arguably the model of postpartum adjustment presented here—in articulating the goal of the adjustment process, the major tasks of the process, and the main resources that facilitate mothers' abilities to accomplish those tasks—represents the beginnings of such a framework.

Chapter 8:
Implications for Policy and Programming

There are a number of policy and programming implications that arose out of this analysis. Specifically, the mothers in this study articulated a number of ideas and suggestions about changes that could be made to existing resources, or about additional kinds of resources they would find helpful to them as they undertake their adjusting work.

The first suggestion made by mothers involves making changes to current postnatal public health programming, specifically to "The New Moms Network" in Edmonton. "The New Moms Network" is the general postnatal program offered through Capital Health to new mothers. Currently, "The New Moms Network" offers six weekly group sessions at local community health centers. This program is available to all mothers in Edmonton's Capital Health Region with babies between the ages of six weeks to six months of age (Capital Health 2007).[16] In general, the mothers in this study found this to be a useful program in that it provided valuable information on the "how tos" of baby care, and provided opportunities for them to overcome feelings of social isolation and to "get out." However, this analysis also revealed that there are many ways this program could be improved in order for it to function more effectively as a form of support, and therefore as a facilitator for mothers' adjustment efforts.

Notably, many mothers felt that "The New Moms Network" did not focus enough on the emotional aspects of mothers' adjustment experiences, and often did not provide a "safe" enough environment for them to really connect emotionally with other mothers. As Suzanne remarked about her experience, for example:

[16] This program is offered for a fee of $30. However, reductions in this charge are provided to some mothers (Capital Health 2007).

> I find that it's not a very open forum. Like people talk about—like maybe difficulties with baby stuff, like being fussy or colicky or I don't know. Spitting up or something. You know? But they don't talk much about emotional stuff...And it really hasn't been encouraged...I hope there's an evaluation or feedback form. I think that group would be—I think it's good, but it could really be so much better. To be able to talk more about the emotional stuff. (Suzanne, mother of one; group B)

In this respect, many mothers spoke about how their interactions in this program remained on a somewhat superficial level. As Gabrielle and Raeanne commented, for example:

> ahh, the new mom's group in public health. Yeah, there's a few things I've learned, certainly. I think you always learn something new. But I haven't really found it a great venue for making friendships. I was kind of hoping, though. That was part of the reason I went, you know.... (Gabrielle, postpartum experience after second child; group B)

Arguably, then, "The New Moms Network" is not currently fulfilling its potential as a form of emotional and informational support for mothers, and as such, helping to facilitate the process of postpartum adjustment. In its current form, "The New Moms Network" represents a manifestation of what Susan Mausart (1999) calls the "mask of motherhood"—a more general conspiracy of silence about the highly varied and ambivalent realities of mothers' experiences and feelings. She states thus:

> there are many masks of motherhood, but the one of silence is the most treacherous one of all....The "mask of motherhood" keeps women from speaking clearly what they know and from hearing truths too threatening to face (Mausart 1999: xx; 7).

In this same context, many mothers expressed concerns about the extent to which they felt comfortable "reaching out" and/or drawing on institutional programs and services more generally, particularly those offered through their local public health centre and as a part of the Health Beginnings Program. For instance, the mothers in this study felt that the home visit they received shortly after their return from the hospital was

extremely valuable. As Ingrid mentioned, for example, "I really appreciated somebody coming in and saying, "No, she looks fine. Okay, let's see you breastfeed. No, you're doing it right. Everything seems okay" (Ingrid, mother of one; group A). However, many mothers commented on how they wished these visits provided more opportunities to discuss emotional concerns, and to explore how they were coping with the immediacy of their new realities. As Suzanne remarked, for example:

> I thought maybe that when they have the public health nurse come out to see the new moms, I thought maybe they would do a little bit more of that [talking about emotional things]. Sure, she asked how I was feeling, but again, there is so much more than just the physical and the breastfeeding going on when you have a baby. (Suzanne, mother of one; group B)

Similarly, Tammy and Bettina made the following comments about more general interactions with the nursing staff at their local community health centres:

> the interactions I've had have generally been very good, but they're more focused on the child, not necessarily the mother. And again, I just feel like you're expected to be supermom, so that's what I portray when I go into those places, you know. I'm not lying, but I'm trying very hard to be doing things right and so that I appear this way, that I shouldn't be unhappy or depressed or this is all just normal and I just need some sleep, or my husband's away so it'll get better when he's back. (Tammy, mother of one; group B)

> some of the health care nurses are really pushy, is the word, um, and they kind of scare some people off....and with my cousin, too. She had a baby two weeks before me, her second one, and she doesn't like contacting them. I can't remember the specific instance, but yeah, and some of the other moms, like just like when they first come and they first come for the Healthy Beginnings...they're really pushing the breastfeeding and even myself when I was doing my checkup with one of the nurses, and there was a mom there, and she was just crying and she was cracking and bleeding when she was breastfeeding, and her husband came home with cans of formula. And the nurse went through the fence with that, like, she was going to be formula feeding. I don't blame her. She was really trying and she was bawling and she got a three year old son that she's got to take care of, too. But this nurse was mad because she was going to give up breastfeeding, rather than supporting her through that and stuff. Yeah.

> Some of the moms have kind of talked about that. (Bettina, mother of one; group A)

Thus, a more concentrated focus on breaking though this "mask" would be a valuable improvement to the "New Moms Network" and in facilitating mothers' interactions with the professionals working with the Healthy Beginnings Program and at the community health centres more generally.

As well, the mothers in this study identified a strong need and desire to understanding what was "normal," not only in terms of baby care, but in terms of the *range and variability* of adjustment experiences more generally. In this context, many mothers felt that there were certain realities, feelings, thoughts, concerns, and experiences that they could not share or express openly with the community health nurses or in the "New Moms Network." The mothers felt that these forums were often not "open" enough for them to explore and share the variability, difficulty, or uncertainty of their own experiences. They felt, in short, that there was a certain standard and expectation of "normal"—a standard of "normal" derived from intensive mothering ideology. In this respect, many mothers felt that the services and programs offered through the Healthy Beginnings and the community health centre promoted rather than challenged the mythical and idealistic standards of intensive mothering.

In this context, mothers expressed a desire and a need for forums—especially already-existing programs and services—to explore, learn and express the "real realities" of adjusting to a new baby, and to discuss and understand what really is "normal" in terms of the experiences of postpartum adjustment. As such, a general reshaping of these various support services and programs to focus on the process of adjustment more generally, and to provide information on, and opportunities for mothers to explore the

variability of each others' adjustment experiences—in terms of magnitude, difficulty saliency, and duration, for example—would enable these services to function more effectively as forms of support to new mothers.

This implication for change also extends to the arena of pre-natal programming, particularly with respect to the need to adequately prepare mothers for the experience of birth, and in helping mothers to become emotionally and physically ready. In this respect, many mothers felt that the content of what was covered in their prenatal program did not sufficiently cover the range of likely birth situations, as well as other information about baby care and "what to expect" in the early weeks and months. As Holly and Suzanne remarked, for example:

> we went to the prenatal class. And I think the biggest problem they have at prenatal class, they have this—they kind of promote—at least mine did, anyway, that doctors and hospitals push all the drugs and stuff. You don't really need them and you can go through without them, and they give you all these different positions and stuff to try, and I found that when I actually felt, when I actually felt the pain...no, I wasn't prepared. I wasn't prepared for how it would feel. (Holly, mother of one; group B)

> we had a prenatal class. You know, they did their thing about labor and what labor's going to be like, and...I didn't feel prepared for the possibility of a C-section through that prenatal class. I did not. I think they mentioned it. But there was no information about a C-section in the prenatal class at all. They didn't talk about what that was. So what I knew of it was just through like the books that I had read....they didn't talk about anything in the prenatal class and yeah, I felt kind of like it was a waste of time to go. You know, because I mean they just talked about the phases of labor and vaginal birth and all that, so they never talked about baby care at all. It was something I really wanted. Because like I said, I don't think I'd ever really changed a diaper in my life. (Suzanne, mother of one; group B)

In this context again, then, mothers' stories revealed a desire for more comprehensive information and openness about the range of possible experiences. This kind of comprehensive knowledge and openness, they felt, was integral to their ability to "feel

ready," and to ensure that their experienced realities would not be too incongruent with their expectations.

As well, the findings from this study suggest that alternative formats for the delivery of support programming could prove beneficial to mothers. Alternatives such as delivering the "New Moms Network" over the internet, or connecting mothers to existing internet or telephone resources would help the many mothers who found the logistics of attending their local "New Moms Network" in person overly difficulty or cumbersome. Ingrid, for example, spoke of her experience in this context as follows:

> No. No, I never took part in that mom-and-tot program they have through Capital Health. I mean, I kind of wish I would have. But it really just seemed like one more thing to put on my plate....Yeah. It just seemed like one more obligation that if I could get out of it, maybe I would...because new moms are already so busy and so tired. But I don't know, I guess having someone there to talk to. Even being *encouraged* to talk was so important. And uh I know for me, like even being able to make those relationships on the internet. Like even if new moms were given, here's a list of internet resources. You don't have to leave the house. You know, she's taking a nap and here's a bunch of people you know, who are talking about this or that subject or whatever kind of problem that you're dealing with. That would be handy to have. (Ingrid, mother of one; group A)

Another implication for policy and programming stems from the finding that mothers' postpartum adjusting work often extends far beyond the first few months after birth. In this context, many mothers described how standard postnatal services, such as the EPDS screening (currently offered at approximately six-weeks postpartum) and home visitation from a public health nurse (which currently occurs within 48 hours of release from hospital), should also be available at later points after the baby's birth. As Tammy remarked, for example:

> I think that if there was more of a follow-up after you've immediately given birth, and then sort of a consistent meeting opportunity throughout the year. Because I think, as I said, the impression I got was that you're

> going to get depressed within the first week; two weeks; and I don't see why you couldn't get depressed three months later or six months later or nine months later, you know. (Tammy, mother of one; group A)

It was also in this context that many mothers described a desire for more continuity in their postnatal care—specifically in their interactions with public health nursing staff. These mothers commented on how the ability to establish a relationship and to "get to know" a nurse or other health professional would have enabled these interactions to provide more effective support. Tammy and Indri, for example, stated the following in this context:

> there's just no consistency. So you drift in and out of the system at different times as different things arise. It's not like you're going to be seeing any one person often enough that if it's something you don't recognize off the bat or don't know how to explain or verbalize or ask for something, you're not going to get it. You don't really see it and nobody else is seeing it, either, so you're just muddling along. And I'm really glad that we have the pediatrician and the nurses that I've had for the last year. (Tammy, mother of one; group B)

> having a post care nurse would be a big help...something like that is good because, like there are midwives that specialize in the prenatal stuff and then there's the actual birth, but then they also deal with the postnatal. And if there is consistency of care from prenatal to birth to postnatal, there's someone there that you've gotten to know, that you feel comfortable with, that you can talk to, and you know they're expert, theoretically, you know, like they've dealt with many of these things and I think that would help. (Indri, postpartum experience after third child; group C)

It was in this context that Raeanne, a mother who delivered her baby at a birthing centre with the assistance of midwives, described the continuity of her relationships with her midwives as a valuable source of support. She stated that because she had gotten to know them so well, she felt relaxed and comfortable in accessing them as a source of emotional and informational support:

> my best part of post-partum, I think, was like going...and being with the midwives and talking with them and—its just relaxed, right, so you don't

> have to feel like you're not the perfect mom or something. You can just be yourself. (Raeanne, mother of one; group A)

Another recommendation coming out of this analysis arises from the fact that many mothers found it difficult to locate particular forms of information, support or other resources. In this context, some mothers indicated how having access to a pamphlet or list of available services and programs would have been helpful to them in their adjustment efforts. As Tammy and Fiona both remarked, for example:

> I think that unless you're really going to sit down and go after the help you're—otherwise you're not going to find it. I think a lot of what Edmonton has to offer is hidden treasures. I think a lot of the resources and supports are definitely hidden treasures. And I don't think it should be like that. I think that every new mom should know everything that's out there and have the opportunity to take advantage of it....I personally think on a piece of paper this big on front and back you could incorporate everything that a new mom of any background would possibly need. I think it's really that simple. And I just don't know why somebody hasn't sat down and done it. (Fiona, mother of one; group C)

> one of the few things that I would really like to have had from the beginning, and not necessarily have to go out of my way to go find, was that there should have been a pamphlet or a list of sites or a number of phone numbers that are just groups of mothers at the same kind of age that have dedicated times where they get together. That you could draw on as a resource. But also to have a nurse or some kind of medical person there as well, so that it is not just the blind leading the blind. If there are some experts there that you could also talk to if you needed to or some people with some experience beyond just the all the mothers talking about the same thing. (Tammy, mother of one; group B)

Another important implication for policy pertains to the important role mothers' abilities for self-care—including the ability for respite—played in their emotional wellbeing. In this context, many mothers expressed a need for more programs and/or services that allowed mothers a way to engage in self care and to "get a break." As Ingrid remarked, for example:

> I think more support in terms of things like daycares and even like, sounds silly, but respite care or something like that, like just uh some way for moms to have that private time. (Ingrid, mother of one; group A)

As well, Fran made the following comment in this context:

> I feel what's been a big challenge for me has been the fact that you know, when you're in grad school, a big part of your graduate experience is sharing with other students. Sitting around and having beer and chatting, sharing, that to me is such an important part of grad school, you know…I felt like I never had that chance to take advantage of that…and so like, I felt like I'd missed out on a lot…because of that informal part of academia. And feeling that I have a commitment at home I need to get to….So I think that if there was something available like a drop-in kind of nursery, play area, you know, for kids, like for pre-schoolers…or somewhere that you could kind of drop them off for a couple hours and go do that. Go listen to a lecture. Go have a beer with somebody. I totally would have taken advantage of something like that. Yeah, in a minute….yeah, I think a place to drop off for an hour, like, it would be phenomenal. (Fran, mother of one; group C)

The final major implication pertains to the potential role policies and programs play in reinforcing and/or challenging broader beliefs about "good mothering." As emphasized above, mothers' abilities to adequately engage in their own self-care—including the ability for respite—emerged as a major resource for adjusting. However, for many mothers, engaging in self care meant failing to subscribe to the tenets of "good mothering"—particularly if it meant relying on (especially paid) others for assistance in this regard. In this context, self care emerged primarily as an issue of entitlement.

The implication for policy and programming, then, is to increase awareness and understanding about the extent to which existing programs and services knowingly or unknowingly reinforce and/or challenge mothers' beliefs in this regard. Similar questions need also be asked of other popular "core mothering beliefs," such as the connection between breastfeeding and "good mothering," for instance, as well as the assumption that the experience of bonding should be instantaneous and instinctual.

As Mannheim (1936) points out, ideology does not only exist in the realm of ideas and thoughts, but manifests concretely in institutions and other material forms. As such, efforts towards increased awareness, reflection, examination, and ongoing vigilance about the extent to which pre- and postnatal programs and services implicitly and explicitly challenge, reinforce and otherwise intersect with broader mothering ideologies remains an important avenue for potential improvements.

Conclusion

The analysis presented in this dissertation has been derived directly from the stories, opinions, and voices of mothers themselves. Importantly, however, it is important to emphasize that it still is, nevertheless, an interpretive product. While I have made every effort to remain "close to the data," the very goal of grounded theory *is* to construct theoretical understandings of basic processes and experiences—to "climb up analytical levels and raise the theoretical import of your ideas, while…keep(ing) a taut rope tied to your data on solid ground" (Charmaz 2006: 1).

It is in this context that Charmaz (2006) argues that processes of abstraction—whether they proceed according to qualitative *or* quantitative modes of inquiry—are always interpretive exercises. As such, this analysis "offers an interpretive portrayal of the studied world, not an exact picture of it" (Charmaz 2006: 10). Thus, my role and subjectivity as a researcher must be understood as part of the analytical process itself.

This acknowledgement of subjectivity is not a unique limitation of this study. Rather, it reflects my position on the construction of knowledge more generally, that researchers themselves are always part and parcel of the analytical process—they influence how and in what ways data are identified, gathered, interpreted and presented. As Charmaz (2006: 2006:10) argues in this context:

> neither data nor theories are discovered. Rather we are part of the world we study and the data we collect. We *construct* our grounded theories through our past and present involvements and interactions with people, perspectives, and research practices.

The quality of this analysis, and the extent to which it "fits" and "works" as a framework for understanding mothers' varying postpartum experiences, can best be determined through an assessment of rigour. Without question, rigour was of central

importance in this study, and my priority throughout the analytical process was that all my theoretical renderings and interpretations remained solidly grounded in the data (Glaser & Strauss 1967; Strauss & Corbin 1992; Charmaz 2001, 2006; Morse 2001; Schreiber 2001). As described in Chapter 3, for example, the analytical process emphasized "in vivo" coding, meaning that the analytical categories generated through this analysis relied heavily on terms and phrasing commonly employed by the mothers themselves.

As also described in Chapter 3, the sampling process was theoretically focused, and aimed to capture a diverse range of postpartum experiences. I did not stop interviewing until theoretical saturation had been reached. Memo-writing was another technique used to ensure the rigour of the analysis. Memos were ongoing throughout the research process, and were used as a key tool to ensure that the emerging theory was both "fitting" and "working." Memo-writing tracked the evolution of the theoretical interpretation, thereby providing a "roadmap" of the analytical process—how the analysis generated out of, and also connected back to, the mothers' own narratives and perspectives.

Further, according to Glaser & Strauss (1967) the quality of a grounded theory study is also determined by the extent to which the resulting theory is relevant and modifiable. As Glaser (1978:5) importantly argues, "though basic social processes remain in general, their variation and relevance is ever changing in our world." Many of the mothers who participated in this study spoke directly of the relevance of this research project. Specifically, many mothers felt that there was insufficient information available about the process and experience of postpartum adjustment, and about what other

mothers experienced, emotionally, in the weeks and months after giving birth. Many mothers also noted that their decision to participate in this research was based, in part, on a desire to enhance knowledge and understanding about what mothers experience after they have a baby.

As Glaser (1978:5) further argues, "the theory can never be more correct than its ability to work the data–thus as the latter reveals itself in research the former must constantly be modified." As such, in as much as this analysis both "fits" and "works" as a theoretical understanding of mothers' varying postpartum experiences, it is hoped—and expected—that future research enables further expansions and refinements of the model presented here.

One particular area where I hope future research will be able to expand and/or refine that which is presented here is in relation to the "process" piece of this theoretical model, the currently least-fully developed component of the model. While this analysis certainly does explicate the "process" element of adjustment—its main stages, and the main factors that signaled mothers' transition from one stage to another (see Chapter 4), for example—the data from this study were richer, thicker and more "complete" for the other aspects of the postpartum adjustment model; namely, the goal of adjusting, as well as the main tasks and resources of the process.

The main implication of the study's limitation in this regard is not towards the quality of the study as a whole (i.e. the integrated theoretical model), or the completeness of any of the model's other main components. As Strauss (1987: 34) reminds us, the quality of a grounded theory's analysis lies in its explication of a core category:

> the goal of grounded theory is to generate a theory that accounts for a pattern of behavior which is relevant and problematic for those involved.

> The generation of theory occurs around a core category. Since a core category accounts for most of the variation in a pattern of behavior, its different kinds of appearances under different conditions, the core category has several important functions for generating theory. It is relevant and its works.

In this context, the details of stages and phases of adjusting are but one dimension of the core category of adjusting. As such, the main implication of the study's limitation in this regard is that it points to opportunities for future research which specifically emphasize and elaborate on this "process piece" of the model.

The other limitation to note about his study's findings is in regards to the homogeneity of the research sample along the dimension of ethnicity. As noted in Chapter 3, only one of the mothers who participated in this study was not of Euro-Canadian descent. As such, it is important that interpretive caution be used when considering the "fit" of this model among mothers from non Euro-Canadian backgrounds and communities. As such, this is another area where future research is needed to contribute to the refinement/modification/elaboration of the model of the process of postpartum adjustment described in this dissertation.

This dissertation ends on a final note of consideration for future investigations into an issue this analysis was only tangentially able to address. This is an exploration and consideration of the question of "normal" as it pertains to mothers' postpartum adjustment experiences and their emotional wellbeing.

The first consideration for future research is to generate a better understanding of the extent to which the variations in mothers' adjustment experiences captured in this analysis occur among mothers in the population more generally. Without question, many mothers in this study felt unsure about whether or not their experience could be

considered "normal," *precisely because they did not know the extent to which other mothers might also share similar experiences and emotions*. In this context, the mothers in this study voiced a genuine need and desire to know what other mothers experience in the postpartum, and about the full range of what might be considered "commonly occurring" experience. As Natasha remarked, for example:

> and to me, whenever I start feeling at that extreme, I don't know, it almost seems by instinct I just try to seek out more information. I feel, okay, I've got to understand, where am I at with this? You know. Am I at the extreme end and if I am, then I need to seek, you know, professional help with this. Or where am I at with this? What's going on? And stuff like that, too, because like I can't be the only one feeling like this, and if I am, then I need to deal with it. (Natasha, postpartum experience after second child; group B)

And while this analysis does explicate the inherent variability of the postpartum adjustment process and mothers' adjustment experiences, it does not do so in terms of proportions or distributions. Thus, while it provides crucial knowledge about the range of experience that might be considered "commonly occurring," it cannot articulate the specifics of the extent to which any particular variation or adjustment experience might occur. It captured, for example, the variation in mothers' experiences in the adjustment task of developing a connection with one's baby. However, it did not capture the average amount of time it takes mothers to accomplish this task, nor did it capture the proportion of mothers for whom this process takes until four weeks, eight weeks, twelve weeks, or sixteen weeks after birth for example.

In many ways, our very understandings and definitions of "normal" are based on the extent to which certain experiences and phenomena occur in the population. As such, it is not only important to know *what* different mothers experience, but also *how many* mothers experience particular expressions and variations of this process of postpartum

adjustment. Quantitatively capturing mothers' varying adjustment experiences is thus one way in which this question can be investigated. This question is thus about better capturing, analyzing, and theorizing the distribution of occurrence of different postpartum experiences.

The second major area of investigation is an exploration of the question of "normal" specifically as an issue of health and wellbeing. As described in Chapter 2, for example, the very definition of postpartum depression ("what is postpartum depression?") remains contested. And as Durkheim (1964[1895]) teaches, the process of defining and deciding what is "normal" and what is not (what is considered postpartum depression, for example) is a social undertaking. Busfield states the following in this context:

> social processes shape the very concepts of mental health and disorder, thereby setting the boundaries of what constitutes mental disorder and the categories that are used to distinguish one disorder from another (Busfield 2000: 544).

It occurs through activities such as categorization, conceptualization, argumentation, and, of course, observation (Brown 1990; Busfield 2000). As Canguilhem (1991: 228) argues in this context:

> strictly speaking...there is no biological science of the normal. There is a science of biological situations and conditions *called* "normal" (emphasis original).

Specifically understanding the various ways that *mothers themselves* contribute—intentionally and unintentionally through their help-seeking and other behaviours, for example—to how PPD is defined, conceptualized, and distinguished from other adjustment experiences thus remains an important area of inquiry. This kind of inquiry remains fundamentally important to improving our understanding of mothers' adjustment experiences because, as Rosenberg (1992: xvii) aptly points out, "in many ways, disease

does not exist as a social phenomenon until we agree that it does, by perceiving, naming, and responding to it." As such, it is imperative that future research seeks to better understand "the process of disease definition, and…the consequences of such definitions in the lives of individuals, in the making and discussion of public policy, and in the structuring of medical care" (Rosenberg 1992: xvi).

References

American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition Text Revision. 2000.Washington, D.C.: American Psychiatric Association.

Anderson. B.E. 1989. "Effects on public day care: A longitudinal study," *Child Development*. Vol 60: 857-866.

Arizmendi, T.G. and D.D. Affonzo. 1987. "Stressful events related to pregnancy and postpartum," *Annual Review of Nursing Research* 9: 103-120.

Arnup, Katherine. 1994. *Education for Motherhood: Advice for Mothers in Twentieth-Century Canada.* Toronto: University of Toronto Press.
Babbie, Earl. 2..5. *The Basics of Social Research*, 3rd Edition. Toronto: Thompson Wadsworth.

Ball, Jean. 1994. *Reactions to Motherhood: The role of Postnatal Care*. Cheshire, England: Books for Midwives Press.

Barclay, L.M., L. Everitt, F. Rogan, V. Schmeid, and A. Wyllie. 1997. "Becoming a mother—an analysis of women's early experience of early motherhood," *Journal of Advanced Nursing*. 25: 719-728.

Barclay, L. M. and B. Lloyd.1996. "The misery of motherhood: alternative approaches to maternal distress," *Midwifery* 12: 136-139.

Barrett, Nina. 1990. *I Wish Someone Had Told Me*. New Work: Simon & Schuster.

Bassin, Donna. Margaret Honey and Meryle Mahrer Kaplan (Eds.). 1994. *Representations of Motherhood*. New Haven & London: Yale University Press.

Beck, Cheryl Tatano. 2004. "Birth trauma: In the eye of the beholder," *Nursing Research*. 53(1): 28-35.

_____. 2002. "Postpartum Depression: A Metasynthesis," *Qualitative Health Research* 12 (4): 453-472.

Beck-Irland, Nancy. 1986. *"Help! I'm a Mother."* Washington, DC: Review & Herald Publishing.

Benedek, T. 1970. "The family as a psychologic field," Pp. 109-136 in E.J. Anthony & T. Benedek (Eds.), *Parenthood: Its Psychology and Psychopathology*. Boston: Little Brown.

Berggren-Clive, K. 1998. "Out of the darkness and into the light: Women's experiences with depression of childbirth," *Canadian Journal of Community Mental Health* 17: 103-

120.

Bergum, Valerie. 1997. *A Child on her Mind: The Experience of Becoming a Mother.* Westport, Connecticut: Bergin & Garvey Publishers.

_____. 1989. *Woman to Mother: A Transformation.* Massachusetts: Bergin & Garvey Publishers.

Bernardez, Teresa. 2003. "The 'good-enough' environment for 'good-enough' mothering," pp. 299-317 in Dale Mendell and Patsi Turrini (Eds.), *The Inner World of the Mother.* Madison, Connecticut: Psychosocial Press.

Bernazzani, O, Saucier J, David H, Borgeat F. 1997. "Psychosocial predictors of depressive symptomatology level in postpartum women," *Journal of Affective Disorders* 46:39-49.

Berthiaume, Marc, David Helene, Saucier Jean-Francois, Borgeat, Francois. 1996. "Correlates of gender role orientation during pregnancy and the postpartum," *Sex Roles* 35 (11/12): 781-800.

Bibby, Reginald. 2001. "Canada's teens: A national reading of family life," *Transition Magazine.* 31(3), Ottawa: Vanier Institute of the Family.

Blumer, H. 1969. *Symbolic Interactionism: Perspective and Method.* Berkeley, CA: University of California Press.

Bramadat, I.J. and M. Driedger. 1993. "Satisfaction with childbirth: theories and methods of assessment," *Birth* 20: 20-29.

Brown, G. and Harris T. 1978. *Social Origins of Depression.* London: Tavistock.

Brown, Phil. 1990. "The name game: toward a sociology of diagnosis," *The Journal of Mind and Behavior* 11: 385-406.

Brown, Stephanie, Judith Lumley, Rhonda Small, and Jill Astbury. 1994. *Missing Voices: The Experience of Motherhood. Melbourne.* Oxford University Press.

Bryant, W.K., and C.D Zick. 1996. "Are we investing less in the next generation? Historical trends in time spent caring for children," *Journal of Family and Economic Issues,* 17, no. 3/4: 365-91.

Busfield, Joan. 2000. "Introduction: Rethinking the sociology of mental health," *Sociology of health and illness* 22 (5): 543-558.

Canguilhem, Georges. 1991. *The Normal and the Pathological.* NY: Zone Books.

Capital Health. 2007. "New Moms Network." Accessed at www.captalhealth.ca/ProgramsAndServices/BrowseServicesbyAlpha/Content.htm, March 19, 2007.

Caplan, G. 1964. *Principles of Preventive Psychiatry*. London: Tavistock.

Chan, Sally Wai-Chi, Valerie Levy, Tony K.H. Chung, and Dominic Lee. 2002. "A qualitative study of the experiences of a group of Hong Kong Chinese women diagnosed with postnatal depression," *Journal of Advanced Nursing,* 39(6): 571-579.

Charmaz, Kathy. 2006. *Constructing Grounded Theory*. Thousand Oaks, CA: Sage.

_____. 2001. "Grounded theory," Pp. 335-352 in Robert Emerson (Ed.) *Contemporary Field Research: Perspectives and Formulations*, 2nd Edition. Prospect Heights, Illinois: Waveland Press.

Chrisler, Joan C. and Ingrid Johnston-Robledo. 2002. "Raging Hormones? Feminist Perspectives on Premenstrual Syndrome and Postpartum Depression," Pp. 194-197 In *Rethinking Mental Health and Disorder.* Edited by Mary and Laura S. Brown Ballou. London: Guilford Press.

Cohen, Sheldon, William J. Doyle, David P. Skoner, Bruce S. Rabin and Jack M, Gwaltney. 1997. "Social ties and susceptibility to the common cold," *JAMA* 227: 1940-44.

Cooper, Peter and Lynne Murray. 1998. "Clinical review: Postnatal depression," *BMJ* 316 20 Jun: 1884-1886.

_____. 1995 "The course and recurrence of postnatal depression," *British Journal of Psychiatry* 166: 191-195.

Cooper, P., Murray L, Hooper, R, and A. West. 1996. "The development and validation of a predictive index for postpartum depression," *Psychological Medicine* 26:627-34 (1996).

Cotter, D. et al. 2001. "Reduced glial cell density and neuronal size in the anterior cingulated cortex in major depressive disorder," *Archives of General Psychiatry* 58: 545-53.

Cox, John L. 1996. "Perinatal mental disorder--a cultural approach," *International Review of Psychiatry* 8 (1): 9-15.

Cox, J.L. Holden, J.M., and R. Sagovsky. 1987. "Detection of Postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale," *British Journal of Psychiatry* 150: 782-786.

Crittenden, Ann. 2001. *The Price of Motherhood: Why the Most Important Job in the World is Still the Least Valued.* New York: Henry Holt and Company.

Cutrona, C.E. & B.R. Troutman. 1986. "Social support, infant temperament, and parenting self-efficacy: A mediational model of postpartum depression," *Child Development* 57: 1507-1518.

Dally, Ann. 1982. *Inventing Motherhood: The Consequences of an Ideal.* London: Burnett Books.

Dalton, K and W. M. Holton. 2002. *Depression after Childbirth: How to Recognize, treat, and prevent postnatal depression.* New York: Oxford University Press.

DeGrandpre, Richard. 2000. *Ritalin Nation.* New York and London: W.W. Norton & Company.

Dennis, C. L. and J. Kavanagh. 2003. "Psychosocial interventions for preventing postpartum depression [protocol]," *The Cochrane Library* 1.

Dix, Carol. 1985. *The New Mother Syndrome.* NY: Doubleday.

Douglas, Ann. 2001. *The Mother of All Baby Books.* Toronto: MacMillan Canada.

Durkheim, Emile. (1964[1895]). *Rules of Sociological Method.* New York: Free Press

Eagan, Andrea Borcoff. 1985. *The Newborn Mother: Stages of her Growth.* Boston: Little Brown & Company.

Eckenrode, John (Ed.). 1991. *The Social Context of Coping.* New York: Plenum Press.

Edmonton Board of Health. 1994. "Postpartum Parent Support Program (PPSP) Evaluation Report Phase Two." Edmonton, AB: Edmonton Board of Health.

Eisenberg, Arlene, Murkoff, Heidi and Sandee Hathaway. 1996. *What to Expect the First Year.* New York: Workman Publishing.

Evans Jonathan, Heron Jon, Francomb Helen, Oke Sarah, and Jean Golding. 2001. "Cohort study of depressed mood during pregnancy and after childbirth," *BMJ* 323, 4 August: 257-260).

Eyer, Diane. 1996. *Motherguilt: How our Culture Blames Mothers for What's Wrong with Society.* NY: Times Books.

_____. 1992. *Mother-Infant Bonding: A Scientific Fiction.* New Haven & London: Yale University Press.

Fernandez, Ricardo. 1992. "Recent clinical management experience," Pp. 78-89 in Hamilton, James Alexander, Harbinger Patricia Neel (Eds.) *Postpartum Depression: A Picture Puzzle.* Philadelphia: University of Pennsylvania Press.

Fremont, Allen, and Chloe Bird. 1999. "Integrating sociological and biological models: an editorial," *Journal of Health and Social Behavior* 40(June): 126-129.

Fried, M.N. and M.H Fried. 1980. *Transitions: Four Rituals in Eight Cultures.* New York: Norton.

Furedi, Frank. 2002. *Paranoid Parenting: Why Ignoring the Experts may be Best for your Child.* Chicago: Chicago Review Press.

Genevie, L and E. Margolies. 1987. *The Motherhood Report: How Women Feel About Becoming Mothers.* New York: MacMillan.

Georgiopoulos Anna M. Bryan, Tonya L., Wollan Peter, and Barbara Yawn. 2001. "Routine Screening for Postpartum Depression," *The Journal of Family Practice* 50 (2): 117-122.

Glaser, Barney. 1978. *Theoretical Sensitivity.* Mill Valley, CA: The Sociology Press.

Glaser, Barney and Anselm L. Strauss. 1967. *The Discovery of Grounded Theory.* Chicago: Aldine Publishing Company.

Gordon. R.E., Kapostinis, E., and K.K. Gordon. 1965. "Factors in postpartum emotional adjustment," *Obstetrics and Gynecology.* 25(2). 158-166.

Grant, Julia. 1998. *Raising Baby by the Book: The Education of American Mothers.* New Haven & London: Yale University Press.

Green, J. M. 1998. "Post-natal depression or perinatal dysphoria? Findings from a longitudinal community-based study using the Edinburgh Postnatal Depression Scale," *Journal of Infant and Reproductive Psychology* 16 (1).

_____. 1997. "Positive experiences of early motherhood: Predictive variables from a longitudinal study," *Journal of Reproductive & Infant Psychology* 15(2):141-158.

_____. 1990. "Who is unhappy after childbirth?: Antenatal and intrapartum correlates from a prospective study," *Journal of Reproductive and Infant Psychology* 8: 175-183.

Gregoire, A.J.P, Kumar, R., Everitt, B., Henderson, A.F., and J.W.W. Studd. 1996. "Transdermal oestrogen for treatment of severe postnatal depression," *Lancet* 347: 930-933.

Harris, B. 1994. "Biological and hormonal aspects of postpartum depressed mood," *British Journal of Psychiatry* 164: 288-292 (1194).

Harris, B., L. Lovett, R.G. Newcombe, et al. 1994. "Maternity blues and major endocrine changes," *BMJ*, 308: 949-953.

Hamilton, James. 1992. "The issue of unique qualities," Pp. 15-31 in Hamilton, James Alexander, Harbinger Patricia Neel (eds.) *Postpartum Depression: A Picture Puzzle.* Philadelphia: University of Pennsylvania Press .

Hamilton, James Alexander, and Patricia Neel Harbinger (Eds.). 1992. *Postpartum Depression: A Picture Puzzle.* Philadelphia: University of Pennsylvania Press.

Harberger, P.N., Berchold, N.G. and J.I. Honikman. 1992. "Cries for help," Pp. 41-60 in Hamilton, James Alexander, Harbinger Patricia Neel (eds.) *Postpartum Depression: A Picture Puzzle.* Philadelphia: University of Pennsylvania Press.

Harkness, Sara. 1987. "The cultural mediation of postpartum depression," *Medical Anthropology Quarterly* 1: 194-209.

Harrison, Margaret J., Anne Neufeld, and Kaysi Kushner. 1995. "Women in transition: Access and barriers to social support," *Journal of Advanced Nursing*, 21(5): 858-864.

Hays, Sharon. 1996. *The Cultural Contradictions of Motherhood.* New Haven and London: Yale University Press.

Hendrick, Victoria, and Lori Altshuler. 1999. "Biological determinants of postpartum depression," Pp. 65-82 in Miller, L. J. (Ed.) *Postpartum Mood Disorders.* Washington DC: American Psychiatric Press.

Herz, Elizabeth. 1992. "Prediction, recognition, and prevention," Pp. 65-77 in Hamilton, James Alexander, Harbinger Patricia Neel (eds.). 1992. *Postpartum Depression: A Picture Puzzle.* Philadelphia: University of Pennsylvania Press.

Hickman, Robert. 1992."Husband support: A neglected aspect of postpartum depression," Pp. 305-312 in Hamilton, James Alexander, Harbinger Patricia Neel (eds.) *Postpartum Depression: A Picture Puzzle.* Philadelphia: University of Pennsylvania Press.

Hopkins, Joyce, Marcus Marsha, and Susan B Campbell. 1984. "Postpartum depression: A critical review," *Psychological Bulletin* 95(3): 498-515.

Humenick, S.S. and L.A. Bugen. 1981. "Mastery: the key to childbirth satisfaction? A study," *Birth and the Family Journal* 8(2): 84-90.

Jelabi, C. 1993. "A feminist perspective on post-natal depression," *Health Visitor* 66 (2): 59-60.

Keicolt-Glaser, Janice K, Phillip Marucha, William Malarkey, Ana Mercado and Ronald Glaser. 1995. "Slowing of wound healing by psychological stress," *Lancet* 346: 1194-96.

Kendall-Tackett, K. 2005. The Hidden Feelings of Motherhood: Coping with Mothering Stress, Depression and Burnout, 2nd Edition. Amarillo, Tx: Pharmasoft Publishing.

Kendler, Kenneth, Chalerles Gardner, and Carol Prescott. 2002. "Toward a comprehensive model for major depression in women," *American Journal of Psychiatry*, 159 (July): 1133-1145.

Kitzinger, Sheila. 1990. *The Crying Baby*. New York: Penguin Books.

Kramer, Peter D. 2005. *Against Depression*. New York: Penguin Books.

Kruckman, Dean. 1992. "Rituals and support: An anthropological view of postpartum depression," Pp. 137-148 in Hamilton, James Alexander, Harbinger Patricia Neel (eds.) *Postpartum Depression: A Picture Puzzle.* Philadelphia: University of Pennsylvania Press.

Kruckman, Laurance and Susan Smith. 2003. "An Introduction to Postpartum Illness," located at www.postpartum.net. Accessed September 18, 2003.

Kurtz-Landy, Christine and Wendy Sword. 2006. "Experiences of socio-economically disadvantaged postpartum women," Paper presented at the International Institute for Qualitative Methodology's *Qualitative Health Research* Conference. April 2-5. Edmonton, AB.

Kushner, Kaysi Eastlick. 2005. "Embodied context: Social institutional influences on employed mothers' health decision-making," *Health Care for Women International*, 26:69-86.

Latour, Bruno. 1987. *Science in Action.* Cambridge, Mass: Harvard University Press.

Lazarus, Richard. 1999. *Stress and Emotion: A New Synthesis*. New York: Springer Publishing Company.

_____. 1991. *Emotion and Adaptation*. New York: Oxford University Press.

_____. 1976. *Patterns of Adjustment*. New York: McGraw-Hill book Company.

_____. 1969. *Patterns of Adjustment and Human Effectiveness*. NY: McGraw Hill.

Lee, C. 1997. "Social context, depression, and the transition to motherhood," *British Journal of Health Psychology* 2: 93-108.

Lentz, Martha and Marcia Killien. 1991. "Are you sleeping? Sleep patterns during postpartum hospitalization," *Journal of Perinatal and Neonatal Nursing*, 4(4): 30-38.

Lerner, Harriet. 1998. *The Mother Dance: How Children Change Your Life*. NY: Harper Collins.

Lewis, Cynthia Copeland. 1989. *Mothers' First Year: A Coping Guide for Recent and Prospective Mothers.* Whitehall, Virginia: Betterway Publications.

Lewis, S. E. 1995. "A search for meaning: Making sense of depression," *Journal of Mental Health* 4: 369-382.

Link, Bruce G. and Jo Phelan. 1995. "Social conditions as fundamental causes of disease," *Journal of Health and Social Behavior* Vol 35, Extra Issue: 80-94.

Madsen, Lynn. 1994. *Rebounding from Childbirth: Toward Emotional Recovery.* Westport, CT: Bergin & Garvey.

Mannheim, Karl. [1936] 1968. *Ideology and Utopia: An Introduction to the Sociology of Knowledge*. Translated by Louis Wirth and Edward Shils. New York: Harcourt, Brace & World.

Mausart, Susan. 1999. *The Mask of Motherhood.* NY: The New Press.

Mauthner, N.S. 1999. "*Feeling low and feeling really bad about feeling low: Women's experiences of motherhood and postpartum depression,*" Canadian Psychology 40: 143-161.

_____. 1998. "It's a woman's cry for help: A relational perspective on postnatal depression," *Feminism & Psychology* 8: 325-355.

Mayan, Maria. 2001. *An Introduction to Qualitative Methods*. Edmonton, Alberta: International Institute for Qualitative Methodology, University of Alberta.

McIntosh, J. 1993. "Postpartum depression: women's help-seeking behaviour and perceptions of cause," *Journal of Advanced Nursing* 18: 178-184.

McMahon, Martha. 1995. *Engendering Motherhood: Identity and Self-transformation in Women's Lives*. NY: The Guilford Press.

Meertens, Vivian, Peer Scheepers, and Bet Tax. 2003. "Depressive symptoms in the Netherlands 1975-1996: A theoretical framework and an empirical analysis of socio-demographic characteristics, gender differences and changes over time," *Sociology of Health & Illness*. 25(2): 208-231.

Mercer, R.T. 1995. *Becoming a Mother: Research on Maternal Identity from Rubin to the Present.* NY: Springer Publishing Company.

_____. 1986. *First-time Motherhood: Experiences from Teens to Forties*. NY: Springer Publishing.

_____. 1977. *Nursing Care for Parents at Risk.* Thorofare, NJ: C.B. Slack.

Miller, Laura J. 2002. "Postpartum Depression," *Journal of the American Medical Association JAMA* 287 (6): 762-765.

_____ (Ed.). 1999. *Postpartum Mood Disorders*. Washington, DC: American Psychiatric Press.

Miller, Tina. 1995. *Making Sense of Motherhood: A Narrative Approach*. Cambridge: Cambridge University Press.

Miller, W., C. Yahne, and J. Rhodes. 1990. *Adjustment: The Psychology of Change*. New Jersey: Prentice Hall.

Milliken, Jane P. and Rita Sara Schreiber. 2001. "Can you "do" grounded theory without symbolic interactionism?", pp. 177-189 in Sara Rita Schreiber and Phyllis Noerager Stern (Eds.) *Using Grounded Theory in Nursing,* New York: Springer Publishing Company.

Mirowsky, John and Ross Catherine E. 1989. *Social Causes of Psychological Distress.* New York: Aldine de Gruyer.

Morgan, M., S. Matthey, B. Barrett, and C. Richardons. 1997. "A group program for postnatally depressed women and their partners," *Journal of Advanced Nursing*, 18: 178-184.

Morse, Janice. 2001. "Situating grounded theory within qualitative inquiry", pp. 1-15 in Sara Rita Schreiber and Phyllis Noerager Stern (Eds.) *Using Grounded Theory in Nursing,* New York: Springer Publishing Company.

_____ (Ed.). 1992. *Qualitative Health Research*. Newbury Park, California: Sage.

_____ and Lyn Richards. 2002. *Read Me First: A User's Guide to Qualitative Research*. Thousand Oaks, CA: Sage.

Murphy, Elizabeth. 1999. "Infant feeding decisions and maternal deviance," *Sociology of Health & Illness* 21(2): 187-208.

Murray, D., Cox J.L., Chapman G. and Jones P. 1995. "Childbirth: life event of start of a long-term difficulty," *British Journal of Psychiatry* 166: 595-600.

Nahas, V., S. Hillege, and N. Amasheh. 1999. "Postpartum depression: The lived experiences of Middle Eastern migrant women in Australia," *Journal of Nurse-Midwifery* 44: 65-74.

Nakano Glenn, Evelyn, Chang, Grace, and Linda Rennie Forcey. 1994. *Mothering: Ideology, Experience, Agency*. NY and London: Routledge.

Nicholson, Paula. 1999. "Loss, happiness, and postpartum depression: the ultimate paradox," *Canadian Psychology* 40: 162-178.

_____. 1998. *Post-Natal Depression: Psychology, Science and the Transition to Motherhood.* London: Routledge.

Oakley, Ann. 1992. *Social Support and Motherhood.* Oxford & Cambridge: Blackwell.

____. 1980. *Woman Confined: Towards a Sociology of Childbirth.* Oxford: Martin Robertson.

_____. 1979. *Becoming a Mother.* New York: Schocken Books.

O'Hara, M.W. 1997."The nature of postpartum depressive disorders" Pp. 3-31 in Lynne Murray. and Peter Cooper (Eds) *Postpartum Depression and Child Development.* New York: Guilford.

O'Hara M.W., Schlechte, J.A, Lewis, D.A., and M.W. Varner. 1990. "Controlled prospective study of postpartum mood disorders: Comparison of childbearing and non-childbearing women," *Journal of Abnormal Psychology* 99: 13-15.

O'Hara, M. W. and A. M. Swain. 1996. "Rates and risk of postpartum depression: a meta-analysis," *International Review of Psychiatry* 8: 37-54.

Olson, Karin. 2007. "A new way of thinking about fatigue: A reconceptualization," *Oncology Nursing Forum* 34(1): 93-99).

Palacio-Quintin. 2000. "The impact of day care on child development," *Isuma*. Autumn: 17-22.

Parker, Rozsika. 1995. *Torn in Two: The Experience of Maternal Ambivalence.* London: Virago Press.

Paykel, E.S., Emms E.M., Fletcher J. and E.S. Rassaby. 1980. "Life events and social support in puerperal depression," *British Journal of Psychology*. 136: 339-346.

Pfost, K.S., Lum C.U., and M.J. Stevens. 1989. "Femininity and work plans protect women against postpartum dysphoria," *Sex Roles* 21: 423-43.

Pope, Deborah, Naomi Quinn, and Ellen Jordan. 1990. "Editorial: The Ideology of Mothering: disruption and reproduction of Patriarchy," *Signs* 15(3): 441-446.

Rajkowska, G. 2000. "Postmortem studies in mood disorders indicate altered numbers of neurons and glial cells," *Biological Psychiatry* 48: 766-77.

Rich, Adrienne. 1986. *Of Woman Born: Motherhood as Experience and Institution*. New York: W.W. Norton and Company Inc.

Richardson, Diane. 1993. *Women, Motherhood, and Childrearing*. NY: St. Martin's Press.

Robson, K.S. & H.A. Moss. 1970. "Patterns and determinants of maternal attachment," *Journal of Pediatrics*, 77: 976-985.

Rodrigues, Merlyn, Vikram Patel, Surinder Jaswal, and Nandita de Souza. 2003. "Listening to mothers: Qualitative studies on motherhood and depression from Goa, India," *Social Science & Medicine*. 57: 1797-1806.

Romito, Patrizia. 1990. "Postpartum depression and the experience of motherhood," *Acta Obstetricia et Gynocologa Scandinavica* 69 suppl: 154-155.

Rosenberg, Charles, E. 1992. "Framing disease: Illness, society and history," in Charles E. Rosenberg and Janet Golden (Eds.), *Framing Disease: Studies in Cultural History*. New Brunswick, NJ: Rutgers University Press.

Rossiter, Amy. 1998. *From Private to Public: A Feminist Exploration of Early Mothering*. Toronto: The Women's Press.

Rubenstein, Carin. 1998. *The Sacrificial Mother*. New York: Hyperion.

Rubin, R. 1967a. "Attainment of the maternal role: Part 1. Processes," *Nursing Research* 16: 247-245.

_____. 1967b. "Attainment of the maternal role: Part 2. Referrants," *Nursing Research* 16: 342-346.

_____. 1984. *Maternal Identity and the Maternal Experience*. New York: Springer Publishing Co.

Sebastian, Linda. 1998. *Overcoming Postpartum Depression & Anxiety*. Omaha, Nebraska: Addicus Books.

Schreiber, Rita Sara. 2001 "The "how to" of grounded theory: Avoiding the pitfalls", pp. 55-83 in Sara Rita Schreiber and Phyllis Noerager Stern (Eds.) *Using Grounded Theory in Nursing,* New York: Springer Publishing Company.

Sears, William & Martha Sears. 2003. The Baby Book: Everything you Need to Know about your Baby from Birth to Age Two. New York: Little Brown and Company.

Seel, Richard 1986, 'Birth Rite: a Possible Link Between Obstetric Practice and Postnatal Depression', *Health Visitor* 59(6):182-4.

Service Canada. 2007. "Employment Insurance (EI) and maternity, parental and sickness benefits," located at http://www.hrsdc.gc.ca/asp/gateway.asp?hr=en/ei/types/special.shtml#Maternity3. Accessed March 9, 2007.

Sheline, Y.I., et al. 1999. "Depression duration but not age predicts hippocampus volume loss in medically healthy women with recurrent major depression," *Journal of Neuroscience* 19: 5034-43

Spock, Benjamin and Steven Parker. 1998. *Dr. Spock's Baby and Child Care*, 7th Edition. New York: Pocket Books.

Stern, Daniel, and Nadia Bruschweiler-Stern. 1998. *The Birth of a Mother: How the Motherhood Experience Changes you Forever*. NY: BasicBooks.

Stern, G. and L. Kruckman. 1983. "Multi-disciplinary perspectives on postpartum depression: An anthropological critique," *Social Science and Medicine* 17: 1027-1041.

Strauss, Anselm. 1987. *Qualitative Analysis for Social Scientists*. New York: Cambridge University Press.

Strauss, Anslem and Juliet Corbin. 1998. *Basics of Qualitative Research*, 2nd Edition. Thousand Oaks, CA: Sage.

Swigart, Lane. 1991. *The Myth of the Bad Mother*. NY: Doubleday.

Taylor, Verta. 1996. *Rock-a-by Baby: Feminism, Self-Help and Postpartum Depression.* New York and London: Routledge.

____. 1995. "Self-labeling and women's mental health: postpartum illness and the reconstruction of motherhood," *Sociological Focus* 28 (1): 23-47.

Thoits, Peggy. 1985. "Self-labeling processes in mental illness: The role of emotional deviance," *American Journal of Sociology*. 91(2): 221-249.

Thurer, Shari L. 1995. *The Myths of Motherhood: How Culture Reinvents the Good Mother*. New York: Penguin Books.

Thurtle, V. 1995. "Post-natal depression: the relevance of sociological approaches,"

Journal of Advanced Nursing 22: 416-424.

Torgus, Judy & Gwen Gotsch. 2004. *The Womanly Art of Breastfeeding*. New York: Plume.

Wessels, H., M. Lamb, and C.P. Hwang. 1996. "Cause and causality in daycare research: An investigation of group differences in Swedish childcare," *European Journal of Psychology in Education*. 11(2): 231-245.

Whiffen, V. E. 1992. "Is postnatal depression a distinct diagnosis?," *Clinical Psychology Review* 12: 485-508.

_____. 1988. "Vulnerability to postpartum depression: A prospective multivariate study," *Journal of Abnormal Psychology* 97: 467-474.

Whitton, Anna and Louis Appleby. 1996. "Maternal thinking and the treatment of postpartum depression," *International Review of Psychiatry* 8 (1): 73-78.

Wile, Joanne and Maria Arechiga. 1999. "Sociocultural aspects of postpartum depression" Pp. 83-98 in Laura Miller (Ed.) *Postpartum Mood Disorders*. Washington and London: American Psychiatric Press.

Wilson, Janet. 1982. *Perspectives on Motherhood: A Phenomenological Study on Women's Transitions to Motherhood*. (Master's Thesis). Edmonton, AB: University of Alberta.

Zelkowitz, P. 1996. "Childbearing and women's mental health," *Transcultural Psychiatric Research Review* 33: 391-412.

Appendix A

Recruitment Posting

[U of A logo]

ATTENTION MOTHERS!!

DO YOU HAVE A CHILD BETWEEN THE AGES OF 9 MONTHS AND 5 YEARS?

I am a Ph.D. student from the University of Alberta, and I am interested in interviewing mothers about what they went through in the weeks and months after having a baby.

The aim of my study is to better understand the process of postpartum adjustment—the wide range of experiences, feelings and thoughts women deal with in the days and months after having a baby. This study recognizes that every woman is different and will experience this postpartum period in her own unique way, whether positively, negatively, happy, sad or somewhere in-between.

Taking part in the study would involve sitting down with me for a one-on-one (in-person) interview to talk about your postpartum experience, your pregnancy, the birth, your feelings about motherhood, and what your life as a mother has been like. The interview would last approximately two hours, and would be carried out at a time and place most convenient to you.

The interviews would be strictly confidential (private). No one other that me would have access to your responses. Eventually, this project will be written up as a Ph.D. thesis. However, individual mothers would remain anonymous so that they could not be identified in any way. It is hoped that the findings from this research project will contribute to providing better services for new mothers in the future.

If you are interested in learning more—or if you would like to participate--please:

- Complete the attached form, and mail it back using one of the attached self-addressed stamped envelopes; or

- **Phone me directly at 231-4955**. If I'm not near my phone, please leave a message with your contact information, and I will phone you back as soon as possible.

THANK YOU VERY MUCH FOR YOUR INTERST IN THIS STUDY!!

If you would like to learn more—or take part—in this research project, please fill in the information below and return this form in the attached self-addressed stamped envelope

Your Name: _____

Your Address: _____

_____

Phone Number(s): _____

_____

E-mail Address: _____

Appendix B

Interview Guide

Introductory Comments

First of all, I would like to extend my thanks to you for agreeing to take part in the study and for agreeing to be interviewed.

As mentioned in the information letter, I am undertaking this project for my Ph.D. in Sociology. The intention of the project is to better understand the process of postpartum adjustment—the different things women deal with after they have a baby. I am interested in the wide range of feelings, thoughts, experiences, and opinions that women have during pregnancy and after giving birth, and in the ways in which these might vary in different mothers. Before I continue, would you like to ask any questions about the research project?

As explained in the letter, any information you share with me will be kept confidential. No one other than me will have access to the tapes or transcriptions of the interview.

The interview is quite unstructured. It is really more of a discussion than a question-answer type interview. The areas I would like to ask you about include your pregnancy, the birth, your feelings about motherhood, the relationships in your life, your sources of support, your employment situation, and your postpartum experience.

If there are any questions in the interview that you do not understand or things you do not wish to talk about, please tell me and we'll move on. Also, if for any reason you would like to stop the interview, please say so. If we do not manage to finish the interview today, I am quite happy to come back another day, assuming that also works for you. *[Establish how much time the respondent has to carry out the interview]*

Before we begin the interview, I just want to let you know that I am also a mother. Now, what I have experienced as a mother may or may not be similar to the things you will tell me today. Why I tell you this is to reassure you that can feel safe to speak freely about your feelings and thoughts—I am here because I truly want to understand more about what postpartum adjustment is <u>really</u> like for all of us mothers.

Would you mind if I use a tape recorder to tape the interview? *[If yes, turn on tape recorder and begin interview; if no, get a pen and paper to jot notes, then begin interview]*

[Note: Interview questions are intended as a guide, not a verbatim script]

Introductory "warm-up" questions

Can I ask you why you felt you wanted to take part in this study?

Before we continue, why don't I get a bit of background information so I know how to frame the questions, and have a better understanding of the people in your life and their relationship to you.
[get info about marital status and details; family make-up—number of kids; who lives in the house; parents or other family in town; how close are these relationships? Is respondent working for pay? If so, get some employment details. If not, when did they stop working and what type of work were they doing? Age of respondent and age(s) of child(ren)]
[Be sure to establish how many children respondent has. If more than one, agree to first talk about child born most recently]

General question inviting participants to "tell their story" about their postpartum experience(s)

I'm interested in hearing your story about what you experienced after having a baby. I would like you to tell me a bit about what was going on in your life at that time, what you experienced, and how you remember feeling after your (most recent) baby was born. You can begin with at any point in time that feels comfortable—your pregnancy, the birth, six months after the baby was born, your childhood, the beginning of your relationship with the baby's father—wherever.

Probing questions to capture additional details and guide the overall interview

Tell me about your (most recent) pregnancy.
Possible probes: Was it planned or unplanned? Were these decisions about planning made jointly? How did you feel about the pregnancy? What about your husband? Others in your life? What was going on in your life then? What was your pregnancy like (physically and emotionally)? What were some of the feelings you were experiencing? Why do you think you were feeling that way?

Tell me about the birth experience.
Possible probes: What was the birth like? Was it what you expected? Better/worse? In what ways? How did you feel about the process of the birth? Was anyone there with you during the birth? How did you feel about having them there (did you find them supportive/helpful/not supportive etc.)? Were you surprised by the baby's sex? How did you feel about it being a boy/girl?

Tell me a bit about your experience with feeding the baby.
Possible probes: Did you start off breastfeeding or formula feeding? How did it go? How did you feel about this experience?

What was it like when you first returned home from the hospital with the baby?
Possible probes: How were you feeling? Did you have anyone helping you then? Who was around, how often and in what capacity? How did you feel about the support/lack of support you were getting? What was going on in your household at that time?

In the six months or so after your baby was born, how would you describe your emotional state?
Possible probes: What do you remember most clearly about how you felt in the six months or so after your baby was born? What was going on in your life? What were you doing (typical daily tasks/activities)? Recall vivid experiences/memories? Describe the different feelings you had and when they came about. Why do you think you felt this way? How does this compare with how you feel now? How does this compare with how you would describe your typical emotional state more generally?

Were you ever diagnosed with postpartum depression?
[*if yes, get details]*. Who diagnosed you? When were you diagnosed? How did the diagnosis come about? What was the treatment? Previous history of depression or PPD? What were your symptoms? When did you start feeling down/low/unhappy/depressed? When did you start to think that something was "wrong"? Had you ever experienced something like this before? Did you think you had PPD?

[if had PPD] **Tell me more about your experience having postpartum depression.**
Possible probes: Did you have anyone you felt you could talk to about how you felt or what you were going through (spouse/friend/relative/doctor etc)? Why or why not? How helpful were the different people in your life? In what ways were they helpful/supportive? In what ways did you feel let down? What were your days like when you had PPD (what did you do, how did you feel, what did you think about?) What were your sources of information? Did you hear of or join a support group?

[all] **Why do you think you felt the way you did during those months after having your baby?**
Possible probes, as applicable: What was going on in your life then and in what ways do you think those things (e.g., relationships/social support and getting help/employment/mothering activities/other life events) might be connected with how you were feeling? Lots of people say women's moods are connected to hormones—how does that relate with your experience? How do you think your emotional state during that six-month period or so would compare to someone with/without postpartum depression ? Do you think you should have been diagnosed with PPD/Do you think you had PPD? Why do you think you were protected from getting postpartum depression / why do you think you got PPD? What is your understanding of the reasons why some women get PPD? What is your understanding of how women generally feel/are supposed to feel after having a baby? How does this fit in with your own experience?

Tell me more about your relationship with your husband/partner/baby's father.

Possible probes: Did the relationship change before/after the birth of the baby? In what ways? How do you feel about him as a father (involvement in physical tasks/emotional involvement? Is his relationship to the baby/children what you expected it to be? Why or why not? How do you feel about that? Is he a confidant to you—do you feel you can tell him intimate things about how you are feeling? Why or why not? How do you feel about that? To what extent would you say he is a source of support for you? Tell me more about that.

Do you have any people in your life who you feel you can turn to for support?
Possible probes: Tell me more about this person/these people and your relationships with them. What kind of support do they provide? Can you tell me about a time when you called on him/her/them for help of some kind (to talk/listen/material support etc). What role did this person/these people in helping you adjust after having a baby? *[if no one]* Why do you feel you have no one to turn to? Tell me what you do to cope when things feel tough (feel down/too much to do/something bad has happened etc). Has this/have these relationship(s) changed since having a baby? In what ways?

Can you tell me a bit about what motherhood has been like for you?
Possible probes. Tell me about how you feel about being a mother. Has it been what you expected it to be? Why/why not? Is there anything you really resent/love about begin a mother? How satisfied are you with yourself as a mother? Do you find that you compare yourself to other mothers? Do you think that others (e.g., husband; own mother; friends) feel a certain way about you as a mother? Where did/do get your ideas and information about mothering/childrearing? Do you have an ideal in your mind about whom or what the "perfect" mother does and is? Do you compare yourself to that ideal and if so, how do you feel you "measure up"? Do you ever feel things towards your child(ren) or about motherhood that you think you shouldn't be feeling? Has motherhood changed the way to see yourself? In what ways?

Tell me more about all the different kinds of work you do and how you feel about it
Possible probes: Do you feel like you have enough time to get everything done you need to? How is the childcare work divided up in your household? How do you feel about that? What about the housework? Has this distribution of labour changed since you've had a child/children? What about time for yourself…do you feel you have enough of it? How important is personal time to you? Why/why not? How do you feel about leaving your job/continuing to work? How did you reach the decision about employment? What do you see as the ideal arrangement (for employment/childcare/housework/other work)? How close is your situation to that ideal?

<u>Concluding Questions and Debriefing</u>

Before we finish, I just want to make sure I'm clear on a few factual details that came out in our discussion. *[clarify any factual details re: life events—moving, death in family, accident, lost job, illness in family, friends, pets, etc--housing conditions, significant financial changes/stresses, other relevant demographic info not captured earlier, etc]*

Is there anything else that we haven't spoken about that you would like to mention?

How did you feel about taking part in this interview?

[Wrap up interview by thanking participant for her time. Leave information package of relevant support/counseling services, and remind her how she can contact me if she has any questions or has an afterthought she wishes to share. Also ask permission to contact her for a follow-up interview, if the need arises]

Appendix C

Participant Information Letter & Declaration of Informed Consent

Stephanie Knaak
Ph.D. Candidate
Department of Sociology
University of Alberta

May, 2004

This study is being conducted as part of a research project for my doctoral degree in Sociology. The aim of the project is to better understand the process of postpartum adjustment—the wide range of experiences, feelings and thoughts women deal with after they have a baby. This study recognizes that every woman is different and will experience this postpartum period in her own unique way, whether positively, negatively or somewhere in-between.

I will be conducting one-on-one (in-person) interviews with about 35 mothers in the Edmonton area who have given birth in the last five years. The interview will have quite a loose structure, and should last approximately two hours. It will be arranged at a time and place convenient to you. I will ask you to talk about your pregnancy, the birth, your feelings about motherhood, the relationships in your life, your sources of support, your employment situation, and your postpartum experience. There are no right answers, only you can tell me about what your experiences were like, what they meant to you, and what you feel is important for me to know in order to gain better insight.

All information will be held strictly confidential, except when professional codes of ethics or legislation require reporting (e.g., I would be required to report instances of abuse). No one other than me will have access to your responses, and interviews will be audio taped only with your permission. The information you provide will be kept for at least five years after the study is done. The information will be kept in a secure area (i.e., a locked filing cabinet). Your name or any identifying information will not be attached to the information you gave. Your name will also never be used in any presentations or publications of the study results.

While all interview data will be aggregated in the analysis, it is likely that portions of individual interviews will be extracted and quoted in the final thesis. Any extracts used for this purpose will ensure that your anonymity is fully protected. Also, the information gathered in this study may be looked at again in the future to help me answer other study questions. If so, the ethics board will first review the study to ensure that I use your interview information ethically.

Your participation in this study is completely voluntary. You have the option to stop the interview at any time. You are free to terminate the study, and/or refuse to answer any questions whenever you like without repercussions.

If you have any questions about the study, you may call either myself at 492-5234 or my Supervisor at 492-0479 at any time. I do hope you agree to participate in this study!

Declaration of Informed Consent:

I agree that I have read and understand the above information. I agree to participate in the study about mothers' postpartum experiences, conducted by Stephanie Knaak of the University of Alberta.

I understand that my participation in this study is voluntary, and that I may refuse to respond to any questions, stop the interview, and/or withdraw from the study at any time with no repercussions. I understand that the information given by me will be kept in strict confidence, and that my anonymity will be protected.

I also understand that the information I give in this study may be also be used by Stephanie Knaak in future studies to help answer other study questions.

_____ _____

Name (Please Print) Date

_____ _____

Phone Number E-mail (if applicable)

_____

Signature