“It’s Hard Being a Mama”: Validation of the Maternal Distress Concept in Becoming a Mother

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ABSTRACT

New mothers actively adapt to new demands and challenges in the mothering role but some may find this adjustment difficult and distressing, depending on their perceptions and resources. Previous research on maternal distress is primarily concentrated on needs of mothers with depression but nonpathological approaches of viewing difficulties in early parenting should be explored. A secondary analysis of a descriptive, qualitative study was completed on new, low-income mothers in early parenthood to determine how maternal distress influences mothers’ transition to becoming a mother and to validate the use of the Maternal Distress Concept in the clinical setting. Findings reveal new mothers experience maternal distress on various levels: stress, adaptation, functioning, and connecting. Implications for practice and education are discussed.

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Becoming a mother is a dynamic, evolving process that is influenced by the mother’s social, cultural, environmental, and personal experiences (Mercer, 2004; Nelson, 2003). New mothers actively adapt to new demands and challenges in the mothering role; however, this transition may be considered difficult and distressing for some mothers, depending on their perceptions and resources (Mercer, 1995, 2004; Rogan, Schmied, Barclay, Everitt, & Willie, 1997). Health-care providers (HCPs) have used the term “depression” to describe any type of distress new mothers may experience but since the diagnosis of postpartum depression occurs in 11% of the U.S. population (Centers for Disease Control [CDC], 2016), HCPs must consider alternate approaches to viewing “distress” after childbirth, including the social context of early parenting and the dramatic lifestyle changes that confront new mothers (Barclay & Lloyd, 1996; Emmanuel & St John, 2010).

There are many challenges within motherhood and many new mothers feel overwhelmed, unprepared, not sure of their identity as a mother, drained, exhausted, and isolated, and so they draw heavily on their resources and personal strength to “work it out” and transition to the mother role (Barclay, Everitt, Rogan, Schmied, & Wyllie, 1997; Mercer, 2004; Rogan et al., 1997). In addition, new mothers may not admit that they are having problems adjusting

to the maternal role because becoming a mother is socially perceived as a happy event. New mothers may feel guilty about having negative thoughts about becoming a mother and may not seek help for their concerns (Barclay et al., 1997; Nicolson, 1999). To date, researchers have explored mothers' distress in the perinatal and early parenting time from a primarily biomedical and psychiatric model (Emmanuel & St John, 2010), appearing in the literature as "maternal distress," "emotional distress," "depression, "anxiety," "stress," "psychological distress," and "perinatal distress," but have not adequately and consistently defined "maternal distress" in their research studies. Concepts that are unclear and ambiguous benefit from concept analysis, a component of theory development (McEwen & Wills, 2014; Walker & Avant, 2011). Using Roger's evolutionary approach, Emmanuel and St John (2010) conducted a concept analysis of "maternal distress" and defined maternal distress as the woman's response to the transition to motherhood in which the mother responds to stress, adapting, function, and control, and connecting on a continuum. Concept development is a prerequisite to theory building (Walker & Avant, 2011). Since the Maternal Distress Concept is in the early stages of development, more research needs to be conducted to develop this concept.

Mothers who experience more maternal distress in becoming a mother may perceive less satisfaction and efficacy in the maternal role, which affects the quality of maternal–child interactions (Kingston, Tough & Whitfield, 2012) and maternal facilitation of the infant's cognitive growth (Singer et al., 2003). Further, low-income mothers may experience a stressful transition to motherhood due to inadequate resources and environmental stressors (Suplee, Garber, & Borucki, 2014). More research needs to be conducted on how maternal distress affects mother's perceptions of the maternal role so health-care professionals can develop interventions that meet the emotional needs of new mothers. In addition, developing the Maternal Distress Concept brings a shift in perspective of viewing the concept from a pathologic disease or psychiatric approach (Arditti, Grzywacz, & Gallimore, 2013; Barclay & Lloyd, 1996; Emmanuel & St John, 2010) to an alternate view. Therefore, as defined in the Maternal Distress Concept (Emmanuel & St John, 2010), the purpose of this study is to analyze the mother's perceptions of maternal distress among low-income, first-time mothers in early parenthood and to verify the utility of the Maternal Distress Concept.

LITERATURE REVIEW

The Maternal Distress Concept (Emmanuel & St John, 2010) served as the framework for this study and offers a different perspective on the emotional health of contemporary mothers as they transition to the maternal role. In addition, the Maternal Distress Concept offers a framework for health-care professionals to use when evaluating mothers' adaptation and needs when becoming a mother. Further, the Maternal Distress Concept expands the work of other researchers (Barclay et al., 1997; Barclay & Lloyd, 1996; Nicolson, 1999; Rogan et al., 1997) who studied the emotional well-being of new mothers. These researchers asserted that maternal distress in early parenting may not be due to "depression," but rather to the mother's current social context and dramatic lifestyle changes that occur with becoming a new mother. The Maternal Distress Concept was based on Rogan et al.'s (1997) theory on *Becoming a Mother* in which these researchers conducted a grounded analysis of 55 first-time mothers' experiences during 2 to 26 weeks postpartum. Categories that developed from maternal data included mothers being isolated and alone, being unprepared and not ready, experiencing loss, realizing something new and being overwhelmed, being mentally and physically drained, and working it out by developing new skills and confidence. Currently, family researchers are taking a more holistic, nonbiomedical approach in evaluating the maternal distress of new mothers, asserting that postnatal adjustment difficulties must be destigmatized so that women can acknowledge their perceptions and moods without feeling like a failure as a mother (Arditti, Grzywacz, & Gallimore, 2013; Bilszta, Ericksen, Buist, & Milgrom, 2010; DiPietro, Goldshore, Kivlighan, Pater, & Costigan, 2015; Emmanuel & St John, 2010; Silva & Carneiro, 2014). However, since the concept of maternal distress is not consistently and clearly defined in early parenthood, Emmanuel and St John (2010) conducted a concept analysis of maternal distress to obtain clarification and understanding on how to define and interpret

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maternal distress for future research, practice, and policy development.

The focus of the Maternal Distress Concept is to describe a woman's response to the transition to motherhood and adds to the knowledge on maternal distress by refining the concept so researchers and health-care professionals can use the theory to differentiate between normal stress responses of mothers in early parenthood with those who have mental health problems (Emmanuel & St John, 2010). Upon completion of an extensive literature search on maternal distress, the following four attributes of stress—adapting, functioning, control, and connecting, representing mothers' responses to motherhood—were identified (Emmanuel & St John, 2010). All responses to maternal distress are designated on a continuum. See Table 1 for more description on these four attributes. For a mother to experience maternal distress, she must first become a mother and experience role and body changes, along with challenges to relationships and social context. The consequences of maternal distress include alterations in mental health, maternal role development, quality of life, ability to function, quality of relationships, and social engagement. Whether the mother perceives the maternal distress as high or low depends on contributing factors such as maternal and infant characteristics, reproductive factors, health and functioning, and relationships and social context (Emmanuel & St John, 2010). Becoming a mother is a fluid and continuous process in which the mother experiences a dynamic transformation and develops a new identity. However, even with this transformative experience, mothers report some level of distress in the transition to motherhood (Keating-Lefler & Wilson, 2004; Martell, 2001; Mercer, 2004).

Various levels of maternal distress are normally experienced by mothers in pregnancy, after birth, and during early parenthood (Arditti et al., 2013; Emmanuel & St John, 2010). In addition, there are many factors that affect the mother's perception of maternal distress in the postpartum period including the infant's crying and temperament (Kim, Capistrano, & Congleton, 2016; Loutzenhiser, McAuslan, & Sharpe, 2015; Pilkington, Whelan, & Milne, 2016; Russell & Lincoln, 2016; Staehelin, Kurth, Schindler, Schmid, & Zemp Stutz, 2013); health, recovery needs, and quality of life (Declercq, Sakala, Corry, Applebaum, & Herrlich, 2014; Emmanuel & Sun, 2013; McGovern et al., 2006; Suplee et al., 2014; Runquist, 2007); maternal attitudes (Castle, Slade, Carranco-Wadlow, & Rogers, 2008; Sockol, Epperson, & Barber, 2014); social support and partner support (Emmanuel, St John, & Sun, 2012; Fenwick et al., 2013; Glazier, Elgar, Goel, & Holzapfel, 2004; McClain, Villarreal, & Padilla, 2015; Nam, Wikoff, & Sherraden, 2015; Razurel, Kaiser, Sellenet, & Epiney, 2013; Stapleton et al., 2012); depression, anxiety, and stress (Clout & Brown, 2015; McFarlane, Burrell, Duggan, & Tandon, 2017; Sockol & Battle, 2015; Sockol et al., 2014); and mothers with prior mental health problems (Seimyr, Welles-Nystrom, & Nissen, 2013) or postpartum posttraumatic stress (Iles & Pote, 2015; Simpson & Catling, 2016). Further, the presence of maternal distress can compromise maternal–infant interactions (Beebe et al., 2008; Coburn, Crnic, & Ross, 2015; Kingston et al., 2012; Singer et al., 2003). Overall, it is important to evaluate the mother's response to motherhood from a contextual, societal, cultural, and transitional perspective (Arditti et al., 2013; Emmanuel & St John, 2010; Mercer, 2004) and to adequately prepare and support new mothers so they can confidently provide nurturance and care to their infants (Copeland & Harbaugh, 2017).

Due to the abrupt physiological and psychological changes that women experience in becoming a mother, first-time mothers are at higher risk of experiencing depression, anxiety, and insomnia in the postpartum period (Murphey, Carter, Price, Champion, & Nicols, 2016). However, Coates, deVisser, and Ayer (2015) conducted a qualitative study of 17 new mothers with infants less than 1 year and found that mothers identified other types of emotional distress that was not recognized or supported by the health-care system. In addition, mothers stated that seeking support for other mental health problems should be normalized, and health-care professionals, in general, should provide support to women who are or are not diagnosed with depression or other postnatal symptoms of distress. Further, low-income mothers have fewer resources and more stressors that contribute to maternal distress such as living situations and finances and are indifferent to their own self-care (Suplee et al., 2014). Moreover, low-income mothers report higher stress levels, exposure to violence, and feelings of intense isolation and loneliness

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TABLE 1

Low and High Continuum Responses of the Four Attributes in the MD Concept and Implications for Prenatal Educators and Perinatal Nurses

Attribute	Description of Low and High MD Responses	Implications
Stress	Low MD results in stress responses such as worry, concern, and mild anxiety. High MD results in anxiety and depression responses such as being unhappy, low mood, and highly anxious.	Encourage the mother to talk with HCPs about her concerns during pregnancy and in early parenthood. Use mindfulness-based interventions to decrease stress and increase coping.
Adapting	Low MD results in adaption to the maternal role by developing new identity and behaviors as a mother to her baby, including maternal–infant attachment behaviors, and incorporating baby into family systems. High MD results in poor maternal role development and difficulty adjusting to the maternal role, including poor maternal–infant attachment behaviors.	Provide infant care-taking information in postnatal period. Assess mother's infant care-taking skills. Use peer-counseling and peer-support groups to provide pre/posteducation. Involve father and families in teaching sessions.
Function and control	Low MD results in functional behaviors such as coping, in control, mastery, using information and resources, energy, and caring for self and infant. High MD results in dysfunctional behaviors and processes such as not coping, out of control, inability to seek and use information and resources, fatigue, and inability to care for self and infant, including poor recovery from childbirth.	Assess maternal confidence. Assess mother's resources. Instruct the mother on infant skills so she can cope with infant crying and feeding. Instruct the mother on how to interpret infant cues and behavior to increase maternal control. Instruct mother and family on techniques to seek out maternal self-care moments.
Connecting	Low MD results in being connected and having relationships with the infant, partner, relatives and friends, and seeking support within the community and society. High MD results in being disconnected and feeling alone, disharmony in relationships, and inability to seek support.	Involve the father and family in all prenatal/postnatal education. Offer classes with peer mentoring and support. Refer to community programs such as *Centering Pregnancy* or a home-visiting program.

HCP = health-care providers; MD = maternal distress.
Source: *Adapted from Emmanuel and St John (2010).*

(Bloom, Glass, Curry, Hernandez, & Houck, 2013) and are at higher risk of having inconsistent social support which contributes to lower self-esteem and more loneliness (Hudson et al., 2016). Also, personal psychological resources of single, low-income mothers, such as self-esteem and sense of control significantly influence maternal role development (Copeland & Harbaugh, 2010). Finally, low-income mothers are at higher risk for developing chronic diseases and engaging in unhealthy health promotion activities compared to higher income mothers which affects their health status after birth (Bombard et al., 2012). Given the social and contextual factors in which low-income mothers care for their infants, more research is needed on the maternal distress of low-income mothers.

METHODS

Design

This qualitative study was a secondary analysis of a mixed-method, cross-sectional, study on maternal competence, self-esteem, and sense of mastery among first-time, low-income mothers; the study was reviewed and approved by an academic review board. In this qualitative study, researchers explored perceptions of maternal distress of mothers using Emmanuel and St John's (2010) Maternal Distress Concept.

Sample and Setting

A convenience sample of 21 low-income mothers, of which 5 were married and 16 were single, was recruited from a Women, Infants, and Children (WIC) clinic that is located in a suburban area in southeast Louisiana. WIC clinics serve low-income families who are nutritionally at risk and provide a federal supplemental nutrition program to address these needs. First-time mothers were eligible to participate if they were 18 years of age, birthed a full-term infant aged 6 weeks and 6 months with no post-birth complications, and were able to read and write in English.

The mothers in this sample fit the profile found in WIC populations (U.S. Department of Agriculture, 2015). Mothers were primarily younger, less ethnically diverse, primarily Caucasian, and less educated. The mean age of the mothers was 21 (standard deviation [*SD*] = 2.88) and the majority of mothers were Caucasian (95%). Most mothers reported their marital status as single (76%) and income was verified at being below the poverty line as indicated by enrollment in a WIC program. Differences existed in educational levels with over 50% of the mothers reporting completion or some completion of high school (57%) while over 43% of mothers reported completion or some completion of postsecondary training or education. In regard to birth and infant characteristics, most mothers experienced vaginal deliveries (52%) and elected to bottle feed (81%). In addition, most of the infants' ages ranged between 2 and 4 months after birth (81%) and most mothers reported previous experience with taking care of children (95%). See Table 2 for information on demographics, birth mode, and infant age.

TABLE 2

Information on Demographics, Birth Mode, and Infant Characteristics

Variable	*f*	%
Age		
18	3	14.3
19	2	9.5
20	2	9.5
21	4	19.0
22	3	14.3
23	3	14.3
24	1	4.8
25	1	4.8
27	1	4.8
29	1	4.8
Race		
African American	1	4.8
White	20	95.2
Marital status		
Single	16	76.2
Married	5	23.8
Educational level		
High school	9	42.9
High school-incomplete	3	14.3
Technical school	1	4.8
College-complete	2	9.5
College-incomplete	6	28.6
Type of birth		
Vaginal	11	52.4
Cesarean	10	47.6
Type of infant feeding		
Bottle	17	81.0
Breast	4	19.0
Age of baby in months at interview		
1	1	4.8
2	5	23.8
3	6	28.6
4	6	28.6
5	2	9.5
6	1	4.8

Procedure

Eligible mothers were recruited from a WIC nutrition class. The investigator provided a brief overview of the study before the class started and asked interested mothers to stay after the class to complete four tools and a private interview. All participating mothers were consented before completing study materials. All interviews were audio-taped and ranged from 15 to 30 minutes. Participating mothers were given a $10 Walmart gift care to compensate for their time.

Interview Questions

The investigators used Ruchala and Halstead's (1994) semi-structured interview guide (*n* = 8 questions) to assess the postpartum experience of mothers in early parenthood. The semi-structured guide was developed based on Bandura's (1977) Social Cognitive Theory and examples of these questions include, "What has it been like for you since you brought the baby home from the hospital?" "How do you feel in general? Physically? Emotionally? About being a mother?" and "What has been the easiest and hardest thing about taking care of your baby?" The primary investigator added the following self-efficacy question to the guide: "What advice would you give to new mothers taking care of their infants?" The final semi-structured guide consists of nine questions. The primary investigator completed all interviews and used probing questions to explore the mothers' experiences.

Data Analysis

Descriptive statistics were used to assess demographic characteristics and directed content analysis (Hsieh & Shannon, 2005) was used to analyze interview data. The goal of directed content analysis is to validate or extend a theoretical framework or theory, and provide more description to an incomplete or new concept (Hsieh & Shannon, 2005; McEwen & Wills, 2014). Using Hsieh and Shannon's guidelines, directed content analysis was initiated by hand-coding the data from the mothers' interview responses with the definitions of the four attributes (stress, adapting, function and control, and connecting) from Emmanuel and St John's (2010) Maternal Distress Concept. Categories were developed for each attribute with interview data and trustworthiness of data and category selection verified by the coinvestigator. The categories that were developed under the stress attribute include (a) emotional concerns, (b) pregnancy, and (c) managing life and relationships. Categories developed under the adapting attribute include (a) maternal role adaptation, (b) maternal expectations, and (c) taking care of infant. Categories developed under the functioning and control attribute include (a) recovery and health concerns and (b) taking care of self. Categories developed under the connecting attribute include (a) social support and (b) relationships. Supportive data describes these categories in the Results section.

RESULTS

Stress Attribute

Emotional Concerns. Mothers reported a variety of emotions when describing their experience with the infant while at home and used certain describers such as "stressful," "scary," "overwhelmed," "crazy," and "difficult" to describe this experience. One mother said "it was scary home alone on first day but exciting to wake up and see her" (mother #1). However, another mother said she "gets upset sometimes over little things and am still nervous" (mother #2) while another mother reported the following issue demonstrating low mood: "I know when I first came home the postpartum hit me a little but it wasn't anything horrible" (mother #12). One mother was stressed due to social and environmental changes in her life: "I'm a little stressed because we're trying to buy a house and getting married in July [and] my fiancé and me are living with my mom, which can be frustrating" (mother #14). Another mother was stressed due to a feeding issue and explained, "The first 3 days I felt crazy. I didn't know what she wanted. I was breastfeeding at first and didn't know if she was getting enough and she was crying" (mother #3). Another mother stated she had bad dreams "that something was going to happen to him, like I burp him and he spit up or choke, or, I was going to wake up and he was not breathing—just scary new-mother stuff" (mother #5).

Pregnancy. Even though the interviews were completed during the postpartum period, several mothers addressed their emotional state during pregnancy. One mother stated that she was scared during pregnancy and another mother stated she was very emotional during pregnancy. One woman stated, "Emotionally, yeah. I'm like, when I was pregnant it was bad, but I never got over that" (mother #18). Overall, no mothers reported they were diagnosed with depression in pregnancy or postpartum but one mother stated that "through my pregnancy, I was actually kind of depressed a lot and scared, but my views and feelings have changed so much" [meaning in the postpartum period] (mother #16). For some mothers, pregnancy was a time of emotional turmoil that still resonated with them in the early postpartum period.

Managing Life and Relationships. The majority of mothers expressed concerns over how pregnancy will affect their lives and family relationships. For example, one younger mother stated:

> *I was very scared. I was still in high school and I waited until after graduation to tell my parents that I was three months pregnant. I was really stressed at the beginning and was scared that her dad [the baby's dad] wasn't going to stick around. We'd only been together for a year. But he surprised me because he works every day and he supports her. (mother #14)*

Another mother stated "I guess the hardest thing is trying to manage everything, doing a bunch of things, as well as taking care of her [the baby]. Cause I'm still in school. I'm just trying to manage my time and stuff now" (mother #20). In addition, one mother verbalized frustration with incorporating the baby into her family business work schedule. She states, "So, I'm with the baby 24/7 and I bring the baby to work but can't get any work done" (mother #9). Becoming a mother involves transition and change

and as one mother summed up, mothers think about how the baby will change their lives. She states:

> *When I was pregnant I thought oh my God, my life is over. I'm never going to be able to do anything. I'm not going to be able to finish school. But that's all changed. I figured out that everything is accomplishable. (mother #20)*

Adapting Attribute

Maternal Role Adaptation. Some mothers reported difficulty adjusting to the maternal role and described the adjustment as "hard." When questioned about what it was like to be a mother, one mother stated, "[it was] hard sometimes. Don't think I could have another one right now and I don't think I want to have more kids. It's hard being a mama" (mother #4). Other mothers described the process of becoming a mother as "difficult but rewarding" and another mother described becoming a mother as "rough" due to experiencing childbirth pain. One mother summed up the factors involved in becoming a mother:

> *The first couple, three months or two, it was pretty hard. You know, just getting used to it and learning everything to do. Everybody keeps telling me 'It's gonna get easier. It's gonna get easier,' and it has. It's gotten so much easier. You know exactly what to do now. You have a routine and like, you know, you're just completely into the role of mother now. Everything comes so natural now. It's been wonderful for me. It's stressful, of course, but good. (mother #16)*

Maternal Expectations. Mothers reported different expectations related to what life would be like as a mother; one mother stated she did not think about becoming a mother until she was home with the baby. She states, "I did not think about it while pregnant. Pretended that the pregnancy was going away. It did not click with me [and] it did not become real until I brought the baby home" (mother #15). In addition, the same mother said she thought she would not become a mother: "I didn't think I would [become a mother]. I was scared I wouldn't be a good mother" (mother #15). Another woman stated that since becoming a mother, she feels like a role model for others. "I'm a role model now and have to watch for the mistakes I make. Somebody's looking up to me now" (mother #18). Other mothers reported expectations about infant care and expected type of birth as exemplified by the following statement: "I didn't want a cesarean. I wanted the natural, I want to feel everything so I could have that experience" (mother #17). When asking mothers if their feelings had changed about being a mother between pregnancy to after birth, mothers expressed more uncertainty in pregnancy than after birth. As one mother stated, "not really [meaning her feelings did not change after the birth]. I didn't know what to expect. I was just scared and nervous but everything workout and she's [the baby] is good" (mother #11). Another mother said, "When you're pregnant, you don't know how things are gonna go. You're nervous about the delivery and it was my first thought, but she [the baby] everything turned out so perfectly" (mother #12). In general, many women did not know what to expect in becoming a mother as exemplified by this statement: "Not having gone through it before, you don't know what it's like. You don't know what to expect, you know. So when it does come, you're like what do I do? How am I going to survive? But, it's not as hard as I thought it would be" (mother #4).

Becoming a mother is often a nonlinear path and mothers will experience various degrees of maternal distress involving changing social circumstances, adaption to the maternal role, recovery from birth, and maintaining and/or reintegration of partners, family, and social networks.

Taking Care of Infant. Most mothers expressed common concerns with taking care of their infants, specifically related to responding to infant crying, feeding, and infant jaundice. One mother stated that her "baby was jaundiced and we had to take her to visit the doctor every other day. It was hard getting into a routine" (mother #4). In regard to bottle feeding, another mother stated she was worried about her baby "spitting up at first but changed formulas" (mother #11) and another mother stated that she "was breastfeeding at first but didn't know if she [the baby] was getting enough" (mother #3). For most mothers, the infant's crying was a major concern since it affected the amount of sleep the mother was able to get. Some mothers did not know how to respond to the infants' crying. One mother summed up the problem with the following statement:

I've always been the kind of person that has to have my sleep. So you know, to have to get up in the middle of the night in the middle of a dead sleep, and to train myself to get up, it's hard . . . You know, she's not a fussy child but there were two or three occasions where she cried and cried and cried and I don't know what's wrong. (mother #4)

Other mothers believed that their previous experience with taking care of children would help them in the mother role. One mother stated her previous experience taking care of children made it easy to take care of her baby but the hardest thing was that "I would get tired because there are so many things to do with the baby, like feeding" (mother #10). Another mother said her "sleepless nights wore her out" (mother #3), but stated that she could not get mad at the baby since it was not the baby's fault. When asked to provide advice to other mothers about taking care of the infant, one mother advised, "Don't overwhelm yourself. If he is crying and you can't figure it out, step back and take a moment to think about the situation. Give the example of a colicky baby, you will figure it out. Hold him and love him" (mother #9). Mothers demonstrated attachment to their babies by acknowledging that being a mother was stressful, but to be patient, and hold and love their babies.

Taking Care of Self. For mothers, the most difficult barrier was to take care of their own needs while taking care of the infant. One mother stated:

I don't have time to myself. The baby seems to know when I am eating or taking a shower. He [the baby] doesn't want his dad. Just me. . . . I can't really think about myself because I need to make sure he's got everything he needs. (mother #9)

Further, the same mother stated that the hardest thing about taking care of her infant is "him wanting so much of my attention." Another mother stated that she did not "have time to take care of myself" (mother #5). One mother stated it was hard being a mother when her significant other did not help her take care of the baby. This mother stated:

At first it was hard because my boyfriend was scared of her and I didn't have a lot of help. I had to do it all on my own. Kind of tore us apart a little bit because I didn't know, really, if he just didn't want to take care of her or if he was scared but it got better over time and he helps now. (mother #6)

Mothers needed support from family and friends to help her take care of herself. As one mother advised new mothers, "just go off and let other people take of her [the baby]" (mother #20).

Functioning and Control Attribute

Recovery and Health Concerns. Some mothers reported postchildbirth health problems in the postpartum period. For example, one mother stated "I still hurt a lot because I had a cesarean section and my scar is sore" (mother #15). Another mother said, "I have a lot of health problems and have headaches every day . . . [also] have bad allergies and congested and itching" (mother #1). One mother reported that she had hemorrhoid surgery 2 days after birth. Further, mothers reported experiencing a lot of fatigue due to altered sleep patterns as result of taking care of the baby. A mother stated, "I feel very exhausted but not enough that I can't take care of him [the baby] or myself. I am still tired" (mother #5). Another mother said, "I haven't slept a whole lot for the last week, my baby is teething, and I have to work too and don't get enough rest" (mother #6). In regard to health promotion, several mothers expressed a desire to lose weight and "get back in shape." One mother said, "I feel good. Just wish I could get this weight off" (mother #14).

Connecting Attribute

Social Support and Relationships. Overall, mothers received different types of social support from her family and friends, including emotional, informational, physical, and appraisal types of support. However, one mother felt disconnected and alone and experienced disharmony in the relationship. She states, "My family's not here so it's hard, you know. I don't have anyone here to kind of enjoy it with, you know" (mother #19). Another mother stated:

My mother was not a good parent and I didn't want to end up like her but when I got pregnant, my whole attitude towards children changed. I straightened up my act and straightened my boyfriend too. We

Health-care providers must inform new mothers that it is "normal" to have some level of distress when becoming a mother so the mother will be more apt to disclose her feelings and receive help and resources from her social support and professional networks.

decided that is what God intended for us and what we are going to do. I'm glad now that I had her [the baby] now cause I'd probably don't know where I'd be right now. She's wonderful. (mother #6)

Another mother talked about how the baby's dad helps out with the baby but he works all day and describes an up and down relationship with her mother who helps with the baby:

My mom, she drives me up a wall but she's my rock. She really is. I mean me and my mom have a close relationship and I think that's why we tie into it sometimes. But I could do it without her, but it would be difficult. (mother #14)

DISCUSSION

New mothers' perceptions of maternal distress in early parenthood varied on a continuum and were influenced by a variety of factors. Mothers reported concerns related to stressful events, adapting to the maternal role, recovering from childbirth and taking care of self, and connecting with social support networks. Overall, most mothers reported some level of maternal distress, but the group as a whole expressed lower levels of maternal distress. Even these lower levels of distress required mothers to adapt to the mother role, as demonstrated by their interview responses. Becoming a mother is often a nonlinear path and mothers will experience various degrees of maternal distress involving changing social circumstances, adaption to the maternal role, recovery from birth, and maintaining and/or reintegration of partner, family, and social networks (Emmanuel & St John, 2010; Mercer, 2004). No mothers in the interviews stated that they were diagnosed with a mood disorder in pregnancy or in early parenthood, but this reality cannot be validated since a question on mood disorders was not asked in the original study. However, the findings in this study revealed that most mothers reported some type of concern related to becoming and adjusting to the mother role. Further, the findings reveal a new perspective on maternal distress that is not related to psychiatric diagnoses, but rather "normal" feelings and adjustments to becoming a mother that affect mothers' emotional well-being.

In this study, mothers' perceptions of stress related to their emotional concerns with being a new mother, managing change in their social and environmental events, and verbalizing distress in pregnancy were noted. These feelings are supported by other researchers that assert that mothering elicits changes in emotional well-being associated with the transition to the maternal role (Mercer, 1995, 2004; Nelson, 2003). Although maternal attitudes in pregnancy can be related to severe mood disorders, such as depression and anxiety, in the postpartum period (Sockol et al., 2014), it is important to assess the total experience of becoming of a mother, rather than only mood disturbances (DiPietro et al., 2015; Matthey, 2011). It is important for HCPs to encourage mothers to talk about their pregnancy and birth stories in the postpartum period so mothers can obtain a better understanding of their fears, concerns, unclear understandings about pregnancy and birth events, and feelings of inadequacies or disappointments (Callister, 2004). Further, the concept of maternal distress should not be strictly assessed as a medical problem, but rather as a normal response to becoming a mother (Arditti et al., 2013). It is expected that mothers will experience various levels of maternal distress in becoming a mother due to a variety of factors (Emmanuel & St John, 2010; Matthey, 2011).

Many mothers talked about the importance of having social support and one mother advised new mothers "to always have someone you can lean on for advice because it makes it [being a mother] easier" (mother #2).

In regard to adapting to the maternal role, mothers reported difficulty adjusting to the maternal role, incongruence of expectations related to being a mother and childbirth, and concerns with taking care of the infant related to infant feeding and crying. Each can negatively affect the mother's fatigue level and sleep patterns. The process of becoming a mother and adapting to the reality of being a new mother can be difficult. Despite preparatory efforts of new mothers in the perinatal period, mothers are usually overwhelmed and unprepared for the mother role (Choi, Henshaw, Baker, & Tree, 2005; Mercer, 2004; Nelson, 2003). Further, it is common for all mothers, depressed or nondepressed, to experience negative thoughts after childbirth due to physical, emotional, and social changes involved in the transition process of becoming a mother. Therefore, it is very important for health-care providers to adequately assess and evaluate the mothers' negative thoughts and appraisals so interventions and resources can be developed to meet mothers' emotional and educational needs (Hall & Papageorgiou, 2005; Hall & Wittkowski, 2006). Finally, DiPietro et al. (2015) investigated the positive and negative

events after birth and developed an instrument to evaluate the lifts and hassles of early mothering among 136 mothers. Study results revealed that mothers with 6-month old infants rated their maternal experience as more positive than negative and that mothers' appraisal of their pregnancy significantly predicted their appraisal of early motherhood. Other researchers found that mothers did not identify with the concept of postnatal depression and that the health-care system did not recognize symptoms of postnatal distress other than postnatal depression (Coates et al., 2015). It is important for health-care professionals to offer postnatal care that addresses mothers' emotional needs (Fenwick et al., 2013) and their unrealistic expectations of motherhood that have been socially constructed by their social norms and environment (Choi et al., 2005).

In regard to functioning and control, mothers reported functioning and health concerns related to childbirth, such as recovering from cesarean surgery, dealing with hemorrhoid surgery, coping with sleep deficits, and difficulty initiating health promotion activities. Mothers' level of functioning after childbirth and postpartum health problems has been explored in the literature (Barkin, Wisner, Bromberger, Beach, & Wisniewski, 2010; Clout & Brown, 2015; McVeigh, 2000; Walker & Wilging, 2000; Webb et al., 2008) and fatigue has been reported as a major factor in maternal daily functioning (Giallo, Seymour, Cooklin, Loutzenhiser, & McAuslan, 2015; Loutzenhiser et al., 2015). Further, Declercq et al. (2014) analysis of the *Listening to Mothers III* national survey on experiences of 2,400 childbearing women in pregnancy and postpartum revealed that within the first 2 months after birth, the most commonly cited health problems were from mothers who experienced cesarean surgeries. Of these mothers, 58% reported pain at their incisional site and 41% of mothers who had vaginal deliveries reported pain in their perineum as a major problem. Mothers with cesareans reported more difficulty with completing their routine activities due to pain at the cesarean scar. Although physical problems in the postpartum period are considered transient and comparatively minor, these physical problems can affect the mothers' functional status and lead to poor emotional health (Webb et al., 2008). Moreover, it is important for health providers to support low-income mothers with their health promotion activities (Walker & Wilging, 2000) and use effective health promotion interventions that help them focus on stress management strategies and involvement of family members (Sterling, Fowles, Kim, Latimer, & Walker, 2011).

In regard to connecting, mothers reported concerns related to social support and relationship issues, specifically with dealing with conflict between family members over the type of social support received, feeling disconnected and alone from family members, and disharmony in relationships with partners and parents. When women become mothers, they engage in cognitive restructuring that allows them to adjust to the changes in relationships with their partners, family, and friends and provide nurturing and physical care to their infants (Mercer, 2004). The mother's level of social support positively affects her transition to the maternal role and improves maternal mental health (Campbell-Grossman et al., 2016; Chavis, 2016; Mercer, 2004) but there may be a disconnect between the type of social support mothers receive versus what they expect to receive from family and health-care professionals (Razurel, Brunchon-Schweitzer, Dupanloup, Irion, & Epiney, 2009). Further, low-income mothers are at more risk for having less social support in becoming a mother (Hudson et al., 2016). In a qualitative study on the needs, concerns, and social support of single, low-income mothers, Keating-Lefler, Hudson, Campbell-Grossman, and Fleck (2004) found that low-income mothers in early postpartum felt isolated, had an array of emotions, and received both positive and negative support with a need for informational, appraisal, emotional, and tangible support. Single, low-income mothers who report lower social support and have a poor relationship with their partners and are at higher risk of decreased emotional well-being (McLeish & Redshaw, 2017); however, Castle et al. (2008) found that first-time mothers who reported higher emotional expression, meaning individuals can effectively signal their needs, reported significantly higher social support. Formal and informal networks are considered primary sources of social support for first-time mothers and the woman's partner and mother are very important in the mother's informal network (Leahy-Warren, 2007; Sampson, Villarreal, & Padilla, 2015). In this study, some mothers had conflicts with their partners and mothers and felt very isolated due to geographical disconnects from their families.

The limitations of this study include use of a homogenous sample, secondary analysis of previous data, and cross-sectional design. The sample was

predominately White and the majority of mothers were single but this sample described the usual race of a WIC population in which 58.7% are White, as reported in the *WIC Participant and Program Characteristics Final Report* (U. S. Department of Agriculture, 2014). Also, secondary analysis of previous data was used and richer results may have been obtained if all interview questions were directed at obtaining information on maternal distress. Finally, the initial study data were collected using a cross-sectional design with no opportunity for follow-up questions.

Implications for Practice

There are several implications for how to reduce maternal distress for new mothers in becoming a mother. First, health-care professionals (HCPs), such as prenatal educators and perinatal nurses, need to conduct earlier assessments of women in late pregnancy and early postpartum to determine their risk needs. When mothers require more resources, HCPs should communicate with other professionals, such as social workers, and follow up with family practitioners to ensure mothers receive the care and resources that they need to reduce maternal distress (Emmanuel, Creedy, St John, & Brown, 2011). In addition, since it is important for mothers to feel comfortable in expressing their concerns and problems in the perinatal period, HCPs who regularly have contact with this population should have the opportunity to develop and manage this population, especially in the area of strengthening communication with mothers (Bilszta et al., 2010).

Prenatal educators and perinatal nurses have a unique opportunity to influence the mother's transition in becoming a mother. It is important that prenatal educators provide information specific to both the prenatal and postnatal periods since many parents may be more prepared for childbirth than actually learning how to take care of their infants afterwards at home (Entsieh & Hallstrom, 2016). Introducing postnatal information in early parenthood may facilitate transitions of new parents to the parenting role. In addition, prenatal education classes should be expanded to include health promotion topics since research has shown the benefit of prenatal classes in promoting healthy behaviors in women (Hanson, VandeVusse, Roberts, & Forristal, 2009). Other suggestions for improving prenatal education classes include (a) structuring classes for a participatory experience, (b) involving fathers and other family members in classes, (c) using adult learning principles to enhance meaningfulness of content to parents, (d) focusing on the individual or parents as the consumer to facilitate acquisition of learning needs, (e) providing realistic information and challenges about early parenthood, and (f) offering other services, such as support groups and counseling, to complement prenatal education classes (Entsieh & Hallstrom, 2016; Hanson et al., 2009).

In order to provide responsive nursing care to mothers, perinatal nurses need to assess more than the routine and include assessment of maternal confidence level and cultural background (Mantha, Davies, Moyer, & Crowe, 2008). Perinatal nurses need to be knowledgeable of infant cues so they can instruct parents on infant states, cues, and behaviors to enhance parent–infant interactions (White, Simon, & Bryan, 2002). Further, perinatal nurses need to develop intervention curricula to support parents' coping skills, especially with caregiver responses to the infant's crying (Russell & Lincoln, 2016), and to develop mindfulness-based interventions for mothers in early parenthood to decrease stress and improve emotional well-being (Frazier & Stathas, 2015; Perez-Blasco, Viguer, & Rodrigo, 2013).

Home-visiting programs for high-risk populations have proven to be effective in supporting mothers (Ferguson & Vanderpool, 2013; Gardner & Deatrick, 2005; Miller, 2015), especially with peer supports and understanding of the mothers' age and any cultural and linguistic differences, social and environmental circumstances, and the mothers' needs (Leger & Letourneau, 2015). Recently, cognitive behavioral therapy has been used in mother groups, through home-visiting programs, to reduce maternal distress (McFarlane et al., 2017). Also, the *Centering Pregnancy* program, using a relationship-centered approach, has been successful in providing group prenatal care to women and families that has enhanced relationships between HCPs, encouraged active care participation among pregnant women, and facilitated peer support in group settings (Massey, Rising, & Ickovics, 2006). Finally, because women experience a variety of emotions after birth, it is important for clinicians, program developers, and researchers to use a multidimensional measure when assessing maternal distress (Fontein-Kuipers et al., 2015).

The process of becoming a mother is usually perceived as a happy event, one that requires many changes and adaptations to successfully attain the maternal role; however, as this study and

others (Barclay et al., 1997; Barclay & Lloyd, 1996; Emmanuel & St John, 2010; Fenwick et al., 2013) indicate, many mothers may find this process quite distressful, depending on the adequacy of resources and support. In the perinatal period, it is important to view emotional distress as more than a psychiatric diagnoses of depression, anxiety, or another psychiatric disorder, but to recognize that new mothers experience dramatic lifestyle changes and adaptations when becoming a mother that include incorporating an infant into her family and social system. Further, HCPs must inform new mothers that it is "normal" to have some level of distress when becoming a mother so the mother will be more apt to disclose her feelings and receive help and resources from her social support and professional networks. For HCPs, the Maternal Distress Concept analysis is very useful for assessing mothers' distress levels in the domains of stress, adapting, functioning and control, and connecting as she transitions to becoming a mother. The results of this study confirm the work of Emmanuel and St John by providing an alternate view of maternal distress and serve as a building block to a descriptive theory.

REFERENCES

Arditti, J. A., Grzywacz, J. G., & Gallimore, S. W. (2013). A demedicalized view of maternal distress: Conceptualization and instrument development. *Psychological Services, 10*(4), 386–394. doi:10.1037/a0029954

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review, 84*, 191–215. doi:10.1037/0033-295X.84.2.191

Barclay, L., Everitt, L., Rogan, F., Schmied, V., & Wyllie, A. (1997). Becoming a mother-An analysis of women's experience of early motherhood. *Journal of Advanced Nursing, 25*(4), 719–728. doi:10.1046/j.1365-2648.1997.t01-1-1997025719.x

Barclay, L. M., & Lloyd, B. (1996). The misery of motherhood: Alternative approaches to maternal distress. *Midwifery, 12*, 136–139. doi:10.1016/S0266-6138(96)90057-1

Barkin, J. L., Wisner, K. L., Bromberger, J. T., Beach, S. R., & Wisniewski, S. R. (2010). Assessment of functioning in new mothers. *Journal of Women's Health, 19*(8), 1493–1499. doi:10.1089/jwh.2009.1864

Beebe, B., Badalamenti, A., Jaffe, J., Feldstein, S., Marquette, L., Helbraun, E., . . . Ellman, L. (2008). Distressed mothers and their infants use a less efficient timing mechanism in creating expectancies of each other's looking patterns. *Journal of Psycholinguistic Research, 37*(5), 293–307. doi:10.1007/s10936-008-9078-y

Bilszta, J., Ericksen, J., Buist, A., & Milgrom, J. (2010). A qualitative study of health professionals involved in the care and treatment of women with postnatal emotional distress. *International Journal of Mental Health Promotion, 12*(3), 5–13. doi:10.1080/14623730.2010.9721814

Bloom, T., Glass, N., Curry, M. A., Hernandez, R., & Houck, G. (2013). Maternal stress exposures, reactions, and priorities for stress reduction among low-income urban women. *Journal of Midwifery & Women's Health, 58*(2), 167–174. doi:10.1111/j.1542-2011.2012.00197.x

Bombard, J., Dietz, P., Galavotti, C., England, L., Tong, V., Hayes, D., & Morrow, B. (2012). Chronic diseases and related risk factors among low-income mothers. *Maternal Child Health Journal, 16*, 60–71. doi:10.1007/s10995-010-0717-1

Callister, L. C. (2004). Making meaning: Women's birth narratives. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 33*(4), 508–518. doi:10.1177/0884217504266898

Campbell-Grossman, C., Hudson, D. B., Kupzyk, K. A., Brown, S. E., Hanna, K. M., & Yates, B. C. (2016). Low-income, African American, adolescent mothers' depressive symptoms, perceived stress, and social support. *Journal of Child and Family Studies, 25*, 2306–2314. doi:10.1007/s10826-016-0386-9

Castle, H., Slade, P., Carranco-Wadlow, M. M., & Rogers, M. (2008). Attitudes to emotional expression, social support and postnatal adjustment in new parents. *Journal of Reproductive and Infant Psychology, 26*(3), 180–194. doi:10.1080/02646830701691319

Centers for Disease Control. (2017). *Trends in postpartum depressive symptoms – 27 states, 2004, 2008, and 2012*. Retrieved from https://www.cdc.gov/mmwr/volumes/66/wr/mm6606a1.htm?s_cid=mm6606a1_w

Chavis, L. (2016). Mothering and anxiety: Social support and competence as mitigating factors for first-time mothers. *Social Work in Health, 55*(6), 461–480. doi:10.1080/00981389.2016.1170749

Choi, P., Henshaw, C., Baker, S., & Tree, J. (2005). Supermum, superwife, supereverything: Performing femininity in the transition to motherhood. *Journal of Reproductive and Infant Psychology, 23*(2), 167–180. doi:10.1080/02646830500129487

Clout, D., & Brown, R. (2015). Sociodemographic, pregnancy, obstetric, and postnatal predictors of postpartum stress, anxiety and depression in new mothers. *Journal of Affective Disorders, 188*, 60–67. doi:10.1016/j.jad.2015.08.054

Coates, R., de Visser, R., & Ayers, S. (2015). Not identifying with postnatal depression: A qualitative study of women's postnatal symptoms of distress and need for support. *Psychosomatic Obstetrics & Gynecology, 36*(3), 114–121. doi:10.3109/0167482X.2015.1059418

Coburn, S. S., Crnic, K. A., & Ross, E. K. (2015). Mother-infant dyadic state behavior: Dynamic systems in the context of risk. *Infant and Child Development, 24*, 274–297. doi:10.1002/icd.1913

Copeland, D. B., & Harbaugh, B. L. (2010). Psychosocial differences related to parenting infants among single and married mothers. *Issues in Comprehensive Pediatric Nursing, 33*(3), 129–148. doi:10.3109/01460862.2010.498330

Copeland, D. B., & Harbaugh, B. L. (2017). Early maternal-efficacy and competence in first-time, low-income

mothers. *Comprehensive Child and Adolescent Nursing, 40*(1), 6–28. doi:10.1080/24694193.2016.1200695

Declercq, E. R., Sakala, C., Corry, M. P., Applebaum, S., & Herrlich, A. (2014). Major survey findings of listening to mothers III: Pregnancy and birth. *Listening to Mothers, 23*(1), 9–16. doi:10.1891/1058-1243.23.1.9

DiPietro, J. A., Goldshore, M. A., Kivlighan, K. T., Pater, H. A., & Costigan, K. A. (2015). The ups and downs of early mothering. *Journal of Psychosomatic Obstetrics & Gynecology, 36*(3), 94–102. doi:10.3109/0167482X.2015.1034269

Emmanuel, E., & St. John, W. (2010). Maternal distress: A concept analysis. *Journal of Advanced Nursing, 66*(9), 2104–2115. doi:10.1111/j.1365-2648.2010.05371.x

Emmanuel, E., St. John, W., & Sun, J. (2012). Relationship between social support and quality of life in childbearing women during the perinatal period. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 41*, e62–e70. doi:10.1111/j.1552-6909.2012.01400.x

Emmanuel, E. N., Creedy, D. K., St. John, W., & Brown, C. (2011). Maternal role development: The impact of maternal distress and social support following childbirth. *Midwifery, 27*(2), 265–272. doi:10.1016/j.midw.2009.07.003

Emmanuel, E. N., & Sun, J. (2013). Health related quality of life across the perinatal period among Australian women. *Journal of Clinical Nursing, 23*, 1611–1619. doi:10.1111/jocn.12265

Entsieh, A. A., & Hallstrom, I. K. (2016). First-tine parents' prenatal needs for early parenthood preparation-A systematic review and meta-synthesis of qualitative literature. *Midwifery, 39*, 1–11. doi:10.1016/j.midw.2016.04.006

Fenwick, J., Gamble, J., Creedy, D., Barclay, L., Buist, A., & Rysing, E. L. (2013). Women's perceptions of emotional support following childbirth: A qualitative investigation. *Midwifery, 29*, 217–224. doi:10.1016/j.midw.2011.12.008

Ferguson, J. M., & Vanderpool, R. C. (2013). Impact of a Kentucky maternal, infant, and early childhood home-visitation program on parental risk factors. *Journal of Child and Family Studies, 22*(4), 551–558. doi:10.1007/s10826-012-9610-4

Fontein-Kuipers, Y., Ausems, M., Budé, L., Van Limbeek, E., De Vries, R., & Nieuwenhuijze, M. (2015). Factors influencing maternal distress among Dutch women with a health pregnancy. *Women and Birth: Journal of the Australian College of Midwives, 28*(3), e36–43. doi:10.1016/j.wombi.2015.02.002

Frazier, C., & Stahas, S. A. (2015). Mindfulness: Being present in the moment. *International Journal of Childbirth Education, 30*(2), 77–84.

Gardner, M. R., & Deatrick, J. A. (2005). Understanding interventions and outcomes in mothers of infants. *Issues in Comprehensive Pediatric Nursing, 29*, 25–44. doi:10.1080/01460860500523756

Giallo, R., Seymour, M., Cooklin, A., Loutzenhiser, L., & McAuslan, P. (2015). Factors associated with the course of maternal fatigue across the early postpartum period. *Journal of Reproductive & Infant Psychology, 33*(5), 528–544. doi:10.1080/02646838.2015.1021769

Glazier, R. H., Elgar, F. J., Goel, V., & Holzapfel, S. (2004). Stress, social support, and emotional distress in a community sample of pregnant women. *Journal of Psychosomatic Obstetrics and Gynecology, 25*, 247–255. doi:10.1080/01674820400024406

Hall, P. L., & Papageorgiou, C. (2005). Negative thoughts after childbirth: Development and preliminary validation of a self-report scale. *Depression and Anxiety, 22*, 121–129. doi:10.1002/da.20119

Hall, P. L., & Wittkowski, A. (2006). An exploration of negative thoughts as a normal phenomenon after childbirth. *Journal of Midwifery & Women's Health, 51*(5), 321–330. doi:10.1016/j.jmwh.2006.03.007

Hanson, L., VandeVusse, L., Roberts, J., & Forristal, A. (2009). A critical appraisal of guidelines for antenatal care: Components of care and priorities in prenatal education. *Journal of Midwifery & Women's Health, 54*(6), 458–468. doi:10.1016/j.jmwh.2009.08.002

Hsieh, H. F., & Shannon, A. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15*, 1277–1288. doi:10.1177/1049732305276687

Hudson, D. B., Campbell-Grossman, C., Kupzyk, K. A., Brown, S. E., Yates, B. C., & Hanna, K. M. (2016). Social support and psychological well-being among low-income, adolescent, African American, first-time mothers. *Clinical Nurse Specialist, 30*(3), 150–158. doi:10.1097/NUR.0000000000000202

Iles, J., & Pote, H. (2015). Postnatal posttraumatic stress: A grounded theory model of first-time mothers' experiences. *Journal of Reproductive & Infant Psychology, 33*(3), 238–255. doi:10.1080/02646838.2015.1030732

Keating-Lefler, R., Hudson, D. B., Campbell-Grossman, C., & Fleck, M. O. (2004). Needs concerns, and social support of single, low-income mothers. *Issues in Mental Health Nursing, 25*(4), 381–401. doi:10.1080/01612840490432916

Keating-Lefler, R., & Wilson, M. E. (2004). The experience of becoming a mother for single, unpartnered, Medicaid-eligible, first-time mothers. *Journal of Nursing Scholarship, 36*(1), 23–29. doi:10.1111/j.1547-5069.2004.04007.x

Kim, P., Capistrano, C., & Congleton, C. (2016). Socioeconomic disadvantages and neural sensitivity to infant cry: Role of maternal distress. *Social Cognitive and Affective Neuroscience, 11*, 1597–1607. doi:10.1093/scan/nsw063

Kingston, D., Tough, S., & Whitfield, H. (2012). Prenatal and postpartum maternal psychological distress and infant development: A systematic review. *Child Psychiatry Human Development, 43*, 683–714. doi:10.1007/s10578-012-0291-4

Leahy-Warren, P. (2007). Social support for first-time mothers: An Irish study. *MCN: The American Journal of Maternal Child Nursing, 32*(6), 368–374. doi:10.1097/01.NMC.0000298133.39785.a2

Leger, J., & Letourneau, N. (2015). New mothers and postpartum depression: A narrative review of peer support intervention studies. *Health & Social Care in the Community, 23*(4), 337–348. doi:10.1111/hsc.12125

Loutzenhiser, L., McAuslan, P., & Sharpe, D. P. (2015). The trajectory of maternal and paternal fatigue and factors associated with fatigue across the transitions to parenthood. *Clinical Psychologist, 19*, 15–27. doi:10.1111/cp.12048

Mantha, S., Davies, B., Moyer, A., & Crowe, K. (2008). Providing responsive nursing care to new mothers with high and low confidence. *MCN: The American Journal of Maternal Child Nursing, 33*(5), 307–314. doi:10.1097/01.NMC.0000334899.14592.32

Martell, L. K. (2001). Heading toward the new normal: A contemporary postpartum experience. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 30*(5), 496–506. doi:10.1111/j.1552-6909.2001.tb01569.x

Massey, Z., Rising, S. S., & Ickovics, J. (2006). Centering pregnancy group prenatal care: Promoting relationship-centered care. *Journal of Obstetric, Gynecologic, and Neonatal Care, 35*, 286–294. doi:10.1111/j.1552-6909.2006.00040.x

Matthey, S. (2011). Assessing the experience of motherhood: The being a mother scale. *Journal of Affective Disorders, 128*, 142–152. doi:10.1016/j.jad.2010.06.032

McClain, S., Villarreal, Y., & Padilla, Y. (2015). Association between support and maternal stress at one year postpartum: Does type matter? *Social Work Research, 39*(1), 49–59. doi:10.1093/swr/svu031

McEwen, M., & Wills, E. M. (2014). *Theoretical basis for nursing* (4th ed.) Philadelphia, PA: Lippincott Williams & Wilkins.

McFarlane, E., Burrell, L., Duggan, A., & Tandon, D. (2017). Outcomes of a randomized trial of a cognitive behavioral enhancement to address maternal distress in home visited mothers. *Maternal Child Health, 21*, 475–484. doi:10.1007/s10995-016-2125-7

McGovern, P., Dowd, B., Gjerdingen, D., Gross, C. R., Kenny, S., Ulestad, L., . . . Lundberg, U. (2006). Postpartum health of employed mothers 5 weeks after childbirth. *Annuals of Family Medicine, 4*(2), 159–167. doi:10.1370/afm.519

McLeish, J., & Redshaw, M. (2017). Mothers' accounts of the impact on emotional wellbeing of organized peer support in pregnancy and early parenthood: A qualitative study. *BMS Pregnancy & Childbirth, 17*, 1–14. doi:10.1186/s12884-017-1220-0

McVeigh, C. A. (2000). Investigating the relationship between satisfaction with social support and functional status after childbirth. *MCN: The American Journal of Maternal Child Nursing, 25*(1), 25–30. doi:10.1097/00005721-200001000-00006

Mercer, R. T. (1995). *Becoming a mother: Research on maternal identity from Rubin to the present*. New York, NY: Springer.

Mercer, R. T. (2004). Becoming a mother versus maternal role attainment. *Journal of Nursing Scholarship, 36*(2), 226–232. doi:10.1111/j.1547-5069.2004.04042.x

Miller, T. R. (2015). Projected outcomes of nurse-family partnership home visitation during 1996-2013. *Prevention Science, 16*(6), 765–777. doi:10.1007/s11121-015-0572-9

Murphey, C., Carter, P., Price, L. R., Champion, J. D., & Nicols, F. (2017). Psychological distress in healthy low-risk first-time mothers during the postpartum period: An exploratory study. *Nursing Research & Practice,* 1–12. 2017 doi:10.1155/2017/8415083

Nam, Y., Wikoff, N., & Sherraden, M. (2015). Racial and ethnic differences in parenting stress: Evidence from a statewide sample of new mothers. *Journal of Child Family Studies, 24*, 278–288. doi:10.1007/s10826-013-9833-z

Nelson, A. M. (2003). Transition to motherhood. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 32*, 465–477.

Nicolson, P. (1999). Loss, happiness and postpartum depression: The ultimate paradox. *Canadian Psychology, 40*(2), 162–178. doi:10.1037/h0086834

Perez-Blasco, J., Viguer, P., & Rodrigo, N. F. (2013). Effects of a mindfulness-based intervention on psychological distress, well-being, and maternal self-efficacy in breastfeeding mothers: Results of a pilot study. *Archives in Women's Mental Health, 16*, 227–236. doi:10.1007/s00737-013-0337-z

Pilkington, P. D., Whelan, T. A., & Milne, L. C. (2016). Maternal crying and postpartum distress: The moderating role of partner support. *Journal of Reproductive & Infant Psychology, 34*(1), 64–76. doi:10.1080/02646838.2015.1067884

Razurel, C., Brunchon-Schweitzer, M., Dupanloup, A., Irion, O., & Epiney, M. (2009). Stressful events, social support and coping strategies of primiparous women during the postpartum period: A qualitative study. *Midwifery, 27*(2), 237–242. doi:10.1016/j.midw.2009.06.005

Razurel, C., Kaiser, B., Sellenet, C., & Epiney, M. (2013). Relation between perceived stress, social support, and coping strategies and maternal well-being: A review of the literature. *Women & Health, 53*, 74–99. doi:10.1080/03630242.2012.732681

Rogan, F., Schmied, V., Barclay, L., Everitt, L., & Willie, A. (1997). 'Becoming a mother'-developing a new theory of early motherhood. *Journal of Advanced Nursing, 25*(5), 877–885. doi:10.1046/j.1365-2648.1997.1997025877.x

Ruchala, P. L., & Halstead, L. (1994). Social support, knowledge of infant development, and maternal confidence among adolescent and adult mothers. *Maternal-Child Nursing Journal, 22*, 83–89.

Runquist, J. (2007). Persevering through postpartum fatigue. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 36*, 28–37. doi:10.1111/j.1552-6909.2006.00116.x

Russell, B. S., & Lincoln, C. R. (2016). Distress tolerance and emotion regulation: Promoting maternal well-being across the transition to parenthood. *Parenting Science, 16*, 22–35. doi:10.1080/15295192.2016.1116893

Sampson, M., Villarreal, Y., & Padilla, Y. (2015). Association between support and maternal stress at one year postpartum: Does type matter? *Social Work Research, 39*(1), 49–59. doi:10.1093/swr/svu031

Seimyr, L., Welles-Nystrom, B., & Nissen, E. (2013). A history of mental health problems may predict maternal distress in women postpartum. *Midwifery, 29*(2), 122–131. doi:10.1016/j.midw.2011.11.013

Silva, C. S., & Carneiro, M. (2014). Adaptation to parenthood: The birth of the first child. *Revista de Enfermagem Referencia, 4*(3), 17–27. doi:10.12707/RIII13143

Simpson, M., & Catling, C. (2016). Understanding psychological traumatic birth experiences: A literature review. *Women & Birth, 29*(3), 203–207. doi:10.1016/j.wombi.2015.10.009

Singer, L. T., Fulton, S., Davillier, M., Koshy, D., Salvator, A., & Baley, J. E. (2003). Effects of infant risk status and maternal psychological distress on maternal-infant interactions during the first year of life. *Developmental and Behavioral Pediatrics, 24*(4), 233–241. doi:10.1097/00004703-200308000-00003

Sockol, L. E., & Battle, C. L. (2015). Maternal attitudes, depression, and anxiety in pregnant and postpartum multiparous women. *Archives in Women's Mental Health, 18*, 585–593. doi:10.1007/s00737-015-0511-6

Sockol, L. E., Epperson, C. N., & Barber, J. P. (2014). The relationship between maternal attitudes and symptoms of depression and anxiety among pregnant and postpartum first-time mothers. *Archives in Women's Mental Health, 17*, 199–212. doi:10.1007/s00737-014-0424-9

Staehelin, K., Kurth, E., Schindler, C., Schmid, M., & Zemp Stutz, E. (2013). Predictors of early postpartum mental distress in mothers with midwifery home care—results from a nested case-control study. *Swiss Medical Weekly, 27*(143), 1–10. doi:10.4414/smw.2013.13862

Stapleton, L. R. T., Rini, C., Hobel, C. J., Westling, E., Glynn, L. M., & Sandman, C. A. (2012). Perceived partner support in pregnancy predicts lower maternal and infant distress. *Journal of Family Psychology, 26*(3), 453–463. doi:10.1037/a0028332

Sterling, B., Fowles, E., Kim, S., Latimer, L., & Walker, L. O. (2011). Ethic-specific perceptions of altered control among American women: Implications for health programs after pregnancy. *Health Care for Women International, 32*(1), 39–56. doi:10.1080/07399332.2010.529353

Suplee, P. D., Gardner, M. R., & Borucki, L. C. (2014). Low-income, urban minority women's perceptions of self and infant care during the postpartum period. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 43*, 803–812. doi:10.1111/1552-6909.12506

U. S. Department of Agriculture. (2015). *WIC participation and program characteristics 2014 (Summary)*. Retrieved from https://www.fns.usda.gov/wic/wic-participant-and-program-characteristics-2014

Walker, L. O., & Avant, K. C. (2011). *Strategies for theory construction on nursing* (5th ed.) Boston, MA: Prentice Hall.

Walker, L. O., & Wilging, S. (2000). Rediscovering the 'M' in 'MCH': Maternal health promotion after childbirth. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 29*(3), 229–236. doi:10.1111/j.1552-6909.2000.tb02044.x

Webb, D. A., Bloch, J. R., Coyne, J. C., Chung, E. K., Bennett, I. M., & Culhane, J. F. (2008). Postpartum physical symptoms in new mothers: Their relationship to functional limitations and emotional wellbeing. *Birth: Issues in Perinatal Care, 35*(3), 179–187. doi:10.1111/j.1523-536X.2008.00238.x

White, C., Simon, M., & Bryan, A. (2002). Using evidence to educate birthing center nursing staff about infant states, cues, and behaviors. *MCN: The American Journal of Maternal Child Nursing, 27*(5), 294–298. doi:10.1097/00005721-200209000-00011

DISCLOSURE

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