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The role of maternal self-care in new motherhood

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Abstract

Objective: to examine the following: (1) women's perceptions regarding the role of maternal self-care, (2) specific applications of self-care in new motherhood and (3) barriers to practising effective self-care.

Design: three focus groups were conducted in order to study women's perspectives regarding the key components of new motherhood.

Setting: recruitment took place in Allegheny County, surrounding Pittsburgh. The focus groups were held at the University of Pittsburgh's Medical School.

Participants: thirty-one adult women who had given birth in the year prior to enrollment participated in the study.

Methods: the focus group conversations were recorded and transcribed for purposes of qualitative analysis. Conversation related to maternal self-care, which was identified as a component of new motherhood, was grouped into one of three categories: (1) women's valuations of self-care, (2) effective applications of self-care and (3) barriers to good self-care practice.

Findings: two ideologies regarding the role of self-care emerged. In one conception of effective mothering, self-care was of primary importance. On the contrary, some women associated a sometimes extreme form of self-sacrifice with new motherhood. Effective applications of self-care included taking time to exercise, allowing the infant's father to care for the child for a period of time and going out to restaurants. Barriers to good self-care practice were time, other limited resources such as money and social support and difficulty accepting help and setting boundaries.

Key conclusions: additional focus groups should be conducted with the purpose of studying maternal self-care exclusively. This work is an important first step in identifying ways to help new mothers better care for themselves.

Keywords

Self-care; Postpartum; Maternal functioning

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Author disclosure statement

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Introduction

New motherhood is laden with challenges and represents a transition period for women. During this time of change, women must learn to integrate the responsibilities related to infant care into their existing set of responsibilities (Mercer, 1985). This represents a delicate balancing act due to the multiple roles (employee, family member, friend, mother and wife) (O'Hara et al., 1992) a woman often possesses. Rubin (1967a, 1967b) has described maternal role attainment (MRA) as a complex process which is learned, reciprocal and interactive. Building on this work, Mercer (2004) describes the process of becoming a mother (BAM) as dynamic and constantly evolving rather than a state that is attained. Postpartum fatigue (Runquist, 2007), which can persist well into the second year after childbirth (Parks et al., 1999), compounds the complexity of this already formidable process.

A lack of clear expectations related to the maternal role (Burr et al., 1979) represents an additional challenge for new mothers. Although social norms and a woman's culture provide some information regarding the expectations of new motherhood, there is no specific set of rules or guidelines (Mercer, 1981). Therefore, a woman must determine over time and through trial and error, what works best for her and her child. The demanding nature of this process can both stress the mother (Beck, 1996) and exceed her expectations (Logsdon et al., 2006). A discourse analysis by Weaver and Usher (1997) revealed that mothers' overwhelming love for their infants motivated them to persevere despite the apparent stressors.

In addition to the considerable learning curve associated with new motherhood, a woman must also grapple with the significance of her added responsibilities. A child's first interactional experiences are with his or her mother, and these interactions have the power to shape the child in a multitude of ways. In fact, Bowlby's (1951) pivotal work on attachment suggested that the absence of a close and sustained bond with a mother (or mother figure) would have irreversible mental health consequences on the child. Fowles and Horowitz (2006) concur, describing infant development as particularly sensitive to the quality of mother-child interaction in the first postpartum year. For these reasons, mothers make a tremendous contribution to society (Logsdon et al., 2006) as well as the family unit.

Although some responsibilities related to infant care such as feeding, diapering and bathing are common to all mothers, women's social circumstances may differ substantially. As the diversity of the United States increases, so too does the understanding that women's experiences of motherhood are anything but uniform (Koniak-Griffin et al., 2006). The childbearing population is culturally diverse and comprised of single, married and adolescent mothers. Each of these subgroups is embedded in a different social support structure. However, despite apparent disparities in circumstance, mothers are usually the primary caregivers of infants regardless of marital or employment status (Logsdon et al., 2006). In order to flourish in this role of primary caregiver, a woman must develop a set of skills specific to mothering and the integration of mothering into her life. The operationalisation of this skill set can be referred to as *maternal functioning*. Barkin et al. (2010a) describe a woman who (1) has adequate social support (social support), *and is able to* (2) take care of her own physical and mental needs (self-care and psychological well-

being), (3) take care of her infant (infant care), (4) attach to her infant (mother–child interaction), (5) juggle her various responsibilities (management) *and* (6) adapt over time (adjustment) as a *high-functioning* mother. The seven functional domains (social support, self-care, psychological well-being, infant care, mother–child interaction, management and adjustment) referred to in this characterisation of a capable mother were derived from three new mother focus groups ($n = 31$) which were held with the intention of studying postpartum functioning.

The maternal self-care domain is the focus of this paper and is broadly defined by Barkin et al. (2010a,b) as the mother's ability (and willingness) to take care of herself both physically and emotionally. Proper nourishment, taking time out for one's self when necessary, attention to hygiene and physical appearance, adequate sleep, willingness to delegate and the ability to set boundaries are practical applications of self-care in motherhood. This skill was chosen as the subject of study for several reasons. Firstly, the importance of self-care in new motherhood was a prevalent theme in the focus group study, yet many women reported having difficulty practising self-care. Secondly, whereas there are many well-validated instruments that tap constructs such as maternal competence (Gibaud-Wallston and Wanders-man, 1978), maternal identity (Walker et al., 1986), infant care (Froman and Owen, 1989), feelings towards one's infant (Leifer, 1977), maternal gratification (Russell, 1974; Mercer, 1985) and social function (O'Hara et al., 1992), self-care is underemphasised in or omitted from most frequently used maternal health measures (Barkin et al., 2010a). The Inventory of Functional Status After Childbirth (IFSAC) (Fawcett et al., 1988), however, does measure performance related to self-care in the context of new motherhood, as well as performance related to infant care, occupational activities, household activities and social and community activities. The IFSAC definition of self-care differs somewhat from the characterisation by Barkin et al. (2010a). Self-care is measured by nine items on the IFSAC which are focused on physical aspects of new motherhood. For example, women are asked to report the frequency at which they are taking walks, laying down, sleeping and engaging in sexual intercourse after childbirth (Fawcett et al., 1988). The IFSAC does not attempt to gauge the emotional aspects of maternal self-care.

Despite its focused approach to assessment of self-care, studies that have used the IFSAC to assess maternal functional status have resulted in findings which support evidence from the new mother focus group study (Barkin et al., 2010a, 2010b) regarding women's difficulty in consistently practising maternal self-care. Functional status was measured by the IFSAC at three weeks, six weeks, three months and six months post partum in a study of 97 women who had delivered healthy full-term infants (Tulman et al., 1990). This study revealed that at six months post partum, over 80% of the women had not yet fully resumed usual self-care activities. Less impressive were the 6%, 20% and 30% of women who had not fully resumed desired or usual levels of infant care, household activities and social and community activities, respectively. In a study of two hundred Australian mothers (who delivered healthy singleton infants), 40% had not yet assumed their desired level of infant care, fewer than 20% reported full resumption of usual household and social activities and none reported full resumption of usual activities in the area of self-care at six weeks post partum (McVeigh, 1998). A study by Posmontier (2008) revealed that the presence of postpartum depression predicted lower personal (self-care), household and social functioning, but no difference was

found in infant care after adjusting for infant gender, number of nighttime infant awakenings and income. Several other studies report that women can manage to provide good physical infant care regardless of the presence of depressive symptomatology (Tammentie et al., 2004, Hall, 2006; McLearn et al., 2006). Women suffering from depression in the post partum, however, are most likely not practising adequate self-care.

The new mother focus groups that served as the basis for the Barkin et al. (2010a) definition of maternal functioning provided an opportunity to study the functional domain of maternal self-care in greater detail. Three focus groups resulted in six hours of detailed and candid conversation. Women's valuations of self-care, practical applications of self-care in new motherhood and barriers to effective self-care are explored in this paper (Fig. 1).

Methods

Recruitment

The methods associated with this study including recruitment procedures, a description of the study population, focus group procedures and the qualitative data analysis technique have been previously reported (Barkin et al., 2010a, 2010b). Approval for this study was issued by the University of Pittsburgh's Institutional Review Board. Recruitment occurred in February and March of 2008 and was facilitated via flyers that were posted in schools, health clinics, daycare facilities and university hospitals throughout Allegheny County, surrounding Pittsburgh. Eligibility criteria included the following: (1) having given birth within the year prior and (2) being 18 years of age or older. Of the 33 women who enrolled, 31 completed the study and received compensation in the form of a \$50 gift card. The two women who did not complete the study had unexpected issues with child care. Of the 31 completers, 11 women participated in the first group, and 10 attended the second and third groups. In total, the study represented a one-time, two-hour commitment for each woman.

Participants

In order to capture the characteristics of the study population and depression status, participants were asked to respond to a brief demographic survey and to complete the Center for Epidemiologic Studies Depression Scale (CES-D) (Radloff, 1977). The CES-D is a 20-item self-report screening tool for depression. The total score on the CES-D ranges from 0 to 60, with higher scores indicating greater levels of depressive symptomatology. The CES-D has well-established psychometric properties (Radloff, 1977) and is useful in settings where screening (rather than diagnosis) is the primary intention. A score of 16 is common for indicating case status (Vazquez and Blanco, 2006). Both the CES-D and demographic survey were completed anonymously at the outset of each discussion. This information was collected for the purpose of describing the focus group population as a whole. In brief, survey results indicated that most participants were married (80.7%), White (80.6%), non-Hispanic (96.8%) and living with at least one other adult (93.5%). The participants were 30.9 years old on average and the mean infant age was 6.6 months ($SD = 3.6$). Women's responses regarding employment status revealed that 40% of women were working part-time, 36.7% were working full-time and 23.3% were stay-at-home mothers. Almost half of the women (46.7%) had a post-graduate education, 41.9% had a total yearly household

income between \$70,001-\$100,000 (£44,479–£63,541), 58.1% were primiparous, 54.8% were utilising daycare and 26.7% had scored 16 on the CES-D.

Discussion topics

The focus groups were led by a discussion facilitator who asked a set of six prepared questions over the course of two hours. At the outset of each discussion, the facilitator explained that quotations from the discussion may be selected for publication. Participants were also assured that no potentially identifying information would be included with published quotations. Our intention was to create an environment where women felt comfortable being candid when describing their postpartum experience. Because focus groups are only semi-structured, the participants also influenced the direction and depth of the conversation. In order to ensure that each of the prescribed research questions was addressed, the facilitator gently redirected the conversation when necessary. The participants were asked to describe the following: (1) what responsibilities are associated with new motherhood, (2) the changes that have occurred in their lives since giving birth, (3) their feelings about the changes that have occurred, (4) what a 'good mom' looks like, (5) the circumstances surrounding their high functioning periods and (6) the circumstances surrounding their low functioning periods. In cases where participants did not understand a discussion question, the facilitator rephrased the question.

Analysis

The focus group conversations were recorded, transcribed and then returned in the form of text files. The text files from the three focus groups were subsequently combined into one large file which served as the basis for the ensuing qualitative analysis. The combined file contained over six hours (156 pages) of text data. Focus group number (one, two or three) was not included in the analysis file as the intention was to analyze the data in aggregate. Removal of the focus group number also served to further ensure the anonymity of the study participants. A coding method, taught as part of a focus group training course at the University of Pittsburgh, was employed to analyze the data. The course methodology was based on the instructor's experience facilitating and analyzing focus groups and the methodology of Krueger (1997) and Morgan (1998). More specifically, text was grouped together based on content and emotive tone. The research team had the advantage of observing each of the focus group discussions. Therefore, the analyst had additional insight regarding the tone/context of the conversation. The seven grouping categories were maternal self-care, social support, psychological well-being (of the mother), infant care, mother-child interaction, management and adjustment; these categories also constitute the domains of maternal functioning (Barkin et al., 2010b).

In order to critically examine the role of self-care, conversation related to this domain of maternal functioning was extracted from the text files and examined for persistent themes. This resulted in the further grouping of text into one of the three following categories: (1) women's valuations of the role of self-care in new motherhood, (2) applications of self-care and (3) barriers to practising effective self-care (Fig 1).

Findings

Discussion related to self-care was rich and abundant. Because it was not possible to present all discussion related to each of the three self-care subcategories, representative quotations were chosen to illustrate each of the concepts.

Women's valuations of self-care in new motherhood

Over the course of the discussions, women expressed judgments regarding the significance of self-care in motherhood. Two potentially conflicting themes emerged.

Self-care is of primary importance

Many of the women expressed the importance of self-care. These women felt that effective mothering was contingent upon their own physical and emotional health state and exhibited an awareness of women's tendency to neglect self-care. 'When you're in the middle of it, it's so hard to see. And I think that's the most important thing for a mom is just to take care of herself.' (Barkin et al., 2010b).

One mother described her struggle to balance infant care and self-care: 'Because I really didn't pay attention to myself. Like my main focus was on him. Making sure he was eating every hour. And as far as me, when a counselor came in and she was like, 'Well, are you eating breakfast?' 'Are you eating lunch?' And you really have to stop and look back and think like okay, yes, I need to take care of myself as well as the baby'. But you don't really think about that until someone brings it to your attention.'

There was also substantial discussion of maternal self-care in relation to breast feeding. For a portion of the women, breast feeding was physically and mentally uncomfortable. The women described guilty feelings associated with deciding to artificially milk-feed their child. Despite the guilt, some of the mothers made the ultimate determination to transition to formula feeding. This was recognised as an act of self-care. 'For you to not be healthy and not be able to physically and mentally be there 100 percent for your kid, give up the breast milk. Everybody's lived on formula for hundreds of years. There's no reason why they can't do it now.' Selflessness is synonymous with motherhood.

Several participants associated selflessness with good parenting. At times, the conversation conveyed potentially unhealthy degrees of selflessness. Some women reported neglecting their own hygiene or refusing to allow a trustworthy family member or a friend to care of their child while they rested or took time out for themselves.

'*Facilitator*: Since giving birth, what areas of your life would you say have changed the most?' '*Respondent*: You don't have a life.'

Several women described a shift in priorities since becoming a mother. 'You can't be self-centred anymore—the whole act of becoming sort of selfless is definitely associated with being a new mom.'

Applications of self-care in new motherhood

Throughout the focus groups, women relayed situations in which they were able to apply some form of self-care. Some women delegated infant care tasks to their partners to alleviate strain. 'I think that is healthier. Because when I get really angry with him (husband) is when I feel like I've been putting in more than my share and it really—it's like a cancer in the relationship. I think it is so much more healthy to just be like 'see ya'.'

Several participants took time to engage in stress reducing activities when approaching burn out. 'That really helped whenever I'm having a really bad day and he (husband) gets home, he'll take her for an hour or so and I'll go downstairs and I'll do some exercise and then I'm okay to deal with her again.' Women also described taking long showers, applying cosmetics, dining out, socialising with peers and going on dates with their partners as ways of taking care of themselves.

Barriers to practising effective self-care

Time.—Many of the women reported no longer having time in their daily lives to engage in the activities that they enjoyed before giving birth. 'The recreation pursuits definitely went to the wayside. I used to swim. I used to run. And I haven't done it in two years. And it's just like I never thought it would be—like you said, you'd be able to carve the time out somewhere.'

Limited resources.—One woman described the struggle of managing on a small budget. 'I'll spend all my money on my kids, but when it comes to me, I'm just like I'm okay. I could have one pair of shoes for like six months. As long as my kids are okay, I'm okay. And I mean I like nice stuff, but my kids need what they need.'

As a new resident of the area, one mother explains the difficulty in finding someone to watch her child, in the case that she wanted to go out for an evening with her husband. 'And even if you did have the money, being a transplant or kind of new or not having—I don't know any of the teenagers in my neighborhood. Probably wouldn't leave my child with most of them.'

Difficulty accepting help and setting boundaries.—A number of the women identified their own behavior as a barrier to adequate self-care. In this study population, several of the women reported having partners, friends or family members who were willing to help with child care. However, several of these same women also reported 'not trusting' their husband/partner to take care of their child even though he had proven capable in the past. One woman explained that although in reality her husband was fit to care for their child, he didn't 'do things her way.' In several instances, being unwilling to accept help affected women's ability to take time out for themselves. 'I've been away from her a grand total of about 10 hours since she's been born and she's six months—in about an hour I'm going to start getting anxious. So it's one of those things that I do need the help (with the infant) but I just don't know how to actually be that comfortable to accept it.'

Women also described circumstances where they had difficulty placing a high priority on their own needs and setting boundaries. 'It finally occurred to me, he (husband) never asks me if he can take a shower. So I finally just started like, 'I'm taking a shower now'. And he

knows that he has to watch the infant. I think we do it to ourselves in some ways—It's a guilt complex.'

Discussion

This study is a qualitative analysis examining the role of self-care in new motherhood. Women's perceptions of the importance of self-care were initially examined, followed by an exploration of practical applications of self-care and barriers to good self-care practice. Although it has been identified as an important component of new motherhood (Fawcett et al., 1988; Barkin et al., 2010a, 2010b), there is evidence that women have difficulty practising good self-care with regularity. Both studies that have used the IFSAC to measure maternal functional status (Tulman et al., 1990; McVeigh, 1998) and the new mother focus group findings reported here suggest that maternal self-care is often neglected in the postpartum period. Additionally, the role of self-care is not emphasised in many popular self-report questionnaires aimed at assessment of maternal wellness.

Two ideologies regarding the significance of self-care became apparent over the course of the three focus group discussions. Many of the participants articulated the importance of a mother taking care of her own emotional and physical needs. They explained that an unhealthy mother would ultimately be a less effective mother. However, this philosophy was, at times, in contrast with the belief that selflessness is synonymous with good parenting. In some cases, women were practising extreme versions of selflessness. Many women reported having difficulty finding a balance between providing good infant care and tending to their own physical and emotional health.

Also littered throughout the discussions were examples of effective self-care. Coupled with these applications was an acute awareness on the mother's part regarding her own health state. For example, one woman explained that when she is feeling overwrought, she gives the infant to her husband and takes time to do something that she enjoys. Women who reported taking time out for themselves often reported returning to the child in a more relaxed state. It is also important to note that certain aspects of self-care are specific to each woman. One mother explained that taking long showers made her feel better whereas another woman felt good when she took the time to apply cosmetics each morning. For some, it was important to find the time to go out to a restaurant once a week. In a focus group study of low-income, adolescent mothers, self-care strategies included talking to social support providers, praying and going to church, writing one's feelings down, playing with the infant and sleeping (Logsdon et al., 2009).

Time, limited resources and difficulty in accepting help and setting boundaries emerged throughout the discussions as barriers to practising self-care in the post partum. Nearly 77% of the women were working part-time or full-time, and almost 42% had more than one child. In many cases, the demands of work and family life left little time for the women to engage in restorative activities. Some women reported having given up exercise and socialising due to a lack of time. It is possible that infant age plays a role in women's self-care (or lack thereof) activities. For example, a primipara with an 11 month old may have more time to practise self-care than a woman with a newborn and an older child. There was also a

contingent of single mothers (19.3%) in the study population. Although most women reported living with at least one other adult (93.5%), it is possible that many non-married women have less readily-available child care than their married counterparts. Each of these factors influenced the amount of time the women had available to devote to their own needs. Limited resources, in general, were a barrier to self-care practice. Although almost 42% of the participants reported a total household income of \$70,000 or more, there was a contingent of lower income women present. These women often chose to spend their money on their child/children which frequently meant depriving themselves. Difficulty accepting help and setting boundaries emerged as another barrier to good self-care practice. This obstacle was more closely related to the mother's ability or willingness to self-regulate, than external circumstances. Several women acknowledged (within themselves) an unwillingness to delegate child care tasks. This unwillingness was often in relation to the child's father and frequently persisted even when the father had proven capable in the past. Even in situations where they felt overwhelmed and exhausted, women were often hesitant to delegate tasks related to child care.

In general, the study population was comprised of married, educated and articulate women, which resulted in rich discussion regarding the significance of maternal self-care in the larger scope of motherhood. The women also provided a high level of self-disclosure in their discussion. An advantage to using focus groups rather than individual interviews is that the presence of a peer group (and therefore group dynamics) often encourages the expression of ideas (Morgan, 1998). The participants communicated directly with each other as well as the facilitator and at the conclusion of the groups, several women asked 'can we do this again?' This level of compliance and enthusiasm allowed for a substantial exploration of the challenges related to new motherhood. A limitation of the study was that it was largely comprised of married, white females (80.7% Married; 80.6% White; 16.2% Black; 3.2% Asian). Although the parenting experiences of lower income, single mothers and racial minorities were discussed, they were not represented to the same extent. Several of the applications of self-care alluded to in this study are dependent, to varying degrees, on the availability of time and other resources, such as help with child care and disposable income. Whereas these were also cited as barriers to self-care practice in this study population, these barriers would be more pervasive in a less fortunate sample of women. For example, a single mother juggling several jobs in order to pay her rent likely would not often have the luxury of taking an hour to exercise or shop for clothing. Therefore, in a sample with different socio-economic characteristics, it is likely that applications of self-care would also differ. Perhaps the specific applications of self-care would more closely resemble those revealed in the Logsdon et al. (2009) study, which can be done at low cost (talking to social support providers, praying and going to church, writing one's feelings down, playing with the infant and sleeping). Mother's age and education level had a positive effect on data quality in this study. It is unlikely that a less mature and less articulate group of mothers would convey their experiences with such clarity.

Conclusions and future directions

Time, limited resources and difficulty accepting help and setting boundaries were identified as obstacles to the practice of self-care. Additional focus groups, dedicated exclusively to the

study of maternal self-care, should be conducted. The relationship between efficacy of specific self-care strategies and culture/socioeconomic status should be examined. The reasons behind women's struggle to accept help and set boundaries should be explored in detail. As stated by McVeigh (2000), 'such knowledge may assist practitioners develop situation specific client centered interventions that aim to prevent distress and dysfunction post partum.' The development of a behavioral intervention aimed at improved self-care practice among new mothers is the long-term goal of this research. Interventions should be tailored to the mother's individual circumstances and preferences. Self-care strategies that are both attractive and feasible for the individual woman will be more effective. Additionally, the availability of such an intervention will enable health-care providers to make better recommendations to women who are struggling to care for themselves and their infant concurrently.

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Fig. 1.
Self-care focus—domains of maternal functioning (Barkin et al., 2010a).