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Self-reported Stress and Posttraumatic Growth Following the Transition to Motherhood:
Investigating the Role of Social Support and Self-efficacy.

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Date of Submission: 24 October 2012

This thesis is presented in fulfilment of the requirements for the degree of a
Professional Doctorate in Psychology (Clinical)

USE OF THESIS

The Use of Thesis statement is not included in this version of the thesis.

STATEMENT OF CONFIDENTIALITY

Ethics clearance from the Edith Cowan University Human Research Ethics Committee was granted in June 2006. The confidentiality and privacy of the participants were protected at all times, including in all correspondence between myself, research supervisors and other colleagues. Participants' were assigned numbers and any names and/or other identifying information were removed following the collection of data. All raw data included in the thesis (i.e. verbatim quotes) were scrutinised for information that could identify the participant.

Abstract

The onset of parenthood signifies a transition point in a person's life, which requires adaptation to a variety of changes and is often considered a time of great stress and great joy. Posttraumatic growth (PTG) or positive psychological outcomes can be experienced as a result of an individual's struggles with highly stressful or challenging life events, such as the birth of a child. The current research explores the relationship between PTG and the transition to motherhood. Two studies investigated women's retrospective perceptions of PTG regarding their first experience of parenthood. Study One employed a quantitative methodology to examine the extent to which participants' perceived social support, self-efficacy, and level of perceived stress surrounding the birth of their first child, predicted PTG. A sample of 83 participants completed the Post Traumatic Growth Inventory; the Multidimensional Scale of Perceived Social Support; the Mastery - Self-Efficacy Scale; and the Impact of Events Scale-Revised. Data were analysed using a standard multiple regression analysis to determine which variable/s significantly and independently predicted the level of PTG. Results indicated that perceived social support was the only variable to achieve significance ($F(3,78) = 3.333$; $p < 0.05$). To gain a holistic perception of how and why social support played such a vital role in predicting PTG, a second study was conducted. Study Two followed-up with a qualitative exploration of ten women's perceptions of social support across the transition to motherhood, in order to illicit greater understanding of its relationship to PTG. Thematic content analysis of transcripts revealed four main themes: reassurance, help seeking, self-efficacy, and changes in the self. Additionally the role of the women's expectations and recommendations for others is discussed. This research has therapeutic implications for therapists who may be able to utilise these findings to encourage and enhance positive outcomes, coping, and adaptation in individuals experiencing a crisis

and/or stressful life transitions. Additionally this research adds to the evidence supporting the use of the PTGI as a general measure of growth, thereby allowing it to be applied to incidents and experiences outside of those traditionally defined as traumatic.

DECLARATION

I certify that this thesis does not, to the best of my knowledge and belief:

- i. Incorporate without acknowledgement any material previously submitted for a degree or diploma in any institution of higher education;
- ii. Contain any material previously published or written by another person except where due reference is made in the text; or
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Finally, I must recognise and express my gratitude to all the women who participated in my thesis studies, especially those women who willingly opened up to me about the struggles and joys they encountered as they became mothers. The honesty and courage of these women was admirable and humbling. When I eventually make the

transition to motherhood myself, I am sure I will reflect on these experiences and insights.

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Self-reported Stress and Posttraumatic Growth Following the Transition to
Motherhood: Investigating the Role of Social Support and Self-efficacy.

Introduction

Becoming a parent is often said to be one of the most life changing experiences and encompasses both stress and joy. Particularly for women, there is a higher risk for negative psychological effects and disorders around this period; much of which has been vigorously studied. However, little scientific research has been conducted into the positive outcomes from the transition to motherhood. The concept of Posttraumatic growth (PTG) has been an emerging area of study in the field of psychology generating interest, excitement, and hope for those who have experienced trauma and for the clinicians who work with traumatised populations. Generally researchers have applied the concept of PTG to traumatic incidents only, however there are now calls for it to be applied to events outside of those historically considered to be traumatic (e.g. the transition to motherhood). It is hoped that this might elucidate how the general process of human growth unfolds. Additionally it is anticipated that greater understanding of PTG and the factors which facilitate or predict it, can then be generalised and applied to interventions with the aim of not only treating those in psychological distress; but also enhancing positive adaption to the variety of human experiences across the lifespan. The purpose of the current paper was twofold: Study One quantitatively investigated factors that predicted PTG across the transition to motherhood; based on the results obtained, Study Two followed-up with a qualitative exploration into the relationship between social support and PTG across the transition to motherhood.

The following section provides a review of the literature pertaining to the transition to motherhood. Research regarding women's adjustments across pregnancy and birth are presented, along with findings on social support and self-efficacy for new

mothers and their children across this period. This is followed by a section which documents the general impact and outcomes of trauma, a theoretical orientation for understanding how trauma and central events affect people, and a review of the literature pertaining to PTG. A review of what little research has been published on PTG specifically across the transition to motherhood is discussed, along with the rationale for the current research.

Next the Methodology section explains the selection of a mixed method research design and documentation of rigour. Research questions and the methodological intricacies of Study One are outlined, followed by the presentation of the quantitative results and discussion of the findings. Social support was found to be the only significant predictor of PTG across the transition to motherhood. Following this section, a brief review of research methods previously employed in the literature pertaining to the transition to motherhood, a description of theoretical phenomenology, and qualitative rigour is presented; leading to the methodological details of Study Two. Subsequently, the method section for Study Two documents the process of qualitative exploration into how and why social support related to PTG across the transition to motherhood. A combined results-discussion of Study Two findings is then provided with the aid of participant quotes which highlight each of the four over-arching themes: reassurance, help-seeking, self-efficacy, and changes in the self. Participants' expectations and recommendations regarding the transition to motherhood are also presented. To conclude the research, an overall summary of the findings from both Study One and Two, the inherent limitations of the current investigations, implications, and future directions are provided, before the reference list and Appendices culminate the paper.

The Transition to Motherhood

The onset of parenthood signifies a transition point in a person's life which requires adaptation to a variety of changes including new routines, responsibilities, challenges, and a new lifestyle (Bost, Cox, Burchinal, & Payne, 2002). Parenthood is also associated with substantial reorganisation of the new parents' lives in terms of social and occupational participation, restructuring of priorities and values, along with changes in psychological well-being and self-identity (Knoester & Eggebeen, 2006). Becoming a parent can be a source of joy and happiness, as well as a time of great strain and difficulty (Bondas & Eriksson, 2001). This life altering event has been described as being either a disorganising incident or a developmental opportunity (Osofosky & Osofosky, 1984); a time for regression or an opportunity to grow (Antonucci & Mikus, 1988). It is possible that the transition to parenthood encompasses all of these descriptions as an individual gradually adapts to the new role of being a parent. Transition points in general, are associated with increased levels of stress and pressure, which can render a person vulnerable to negative psychological outcomes such as depression and anxiety (Bost et al., 2002; Campbell, Cohn, Meyers, Ross, & Flanagan, 1992; Millward, 2006). The transition to parenthood in particular, has the potential to have negative effects on individuals' mental health and marital satisfaction (Colpin, De Munter, Nys, & Vandermeulebroecke, 2000; Luo, 2006), which in turn can impact the quality of parenting provided to children (Bost et al., 2002).

Campbell, Cohn, Meyers, Ross, and Flanagan (1992) reported that first time parents, in particular, have an increased risk for anxiety and depression during their adjustment to parenthood. However women especially appear to experience higher levels of stress, more psychological symptoms, and lower marital satisfaction compared to men, after the birth of a child (Bost et al., 2002; Luo, 2006). Ford, Ayers, and

Bradley (2010) suggested that during births which might be considered 'normal' some women may perceive a loss of control or dignity and unsympathetic attitudes of the people around them may contribute to feelings of traumatisation. Additionally, Ford et al. (2010) reported that at three weeks postpartum over 30% of women rated childbirth as traumatic. This led the researchers to contend that some symptoms of posttraumatic stress may be experienced as a normal part of the recovery process. Research indicates that compared to the pregnancy period, women in the early post-natal months have a higher rate of admissions to psychiatric institutions (Kendell, Rennie, Clarke, & Dean, 1981). The Diagnostic and Statistical Manual for Mental Disorders IV-TR (DSM-IV-TR, American Psychiatric Association, 2000) states that up to 70% of women experience the "baby blues" during the ten day postpartum period, however the symptoms are considered to be transient and reportedly do not impair mothers' functioning. Baby blues are primarily a result of the multitude of neuroendocrine alterations in a new mother's body combined with the required adaptation to a new psychosocial context (DSM-IV-TR, American Psychiatric Association, 2000). Thus baby blues are a common and normal occurrence during the process of adjustment to motherhood.

More persistent symptoms however may equate to a diagnosis of a Postpartum Major Depressive Episode (DSM-IV-TR, 2000), also known as Postnatal Depression (PND). The average prevalence rate of PND is thought to be approximately 13% (Mallikarjun & Oyebode, 2005). The development of PND can potentially lead to long-term detrimental effects on the mother, her children, and the entire family (Mallikarjun & Oyebode, 2005). Additionally, once a woman has experienced PND, the risk of reoccurrence in subsequent pregnancies and births rises between 30-and-50% (DSM-IV-TR, 2000). Risk factors for PND are: depression or anxiety during pregnancy,

experiencing stressful life events during the pregnancy or postpartum period, low levels of social support, previous personal or familial history of depression, anxiety, or other psychiatric disorders, low self-esteem, marital status, poor marital adjustment, unplanned/unwanted pregnancy, abuse of the mother, “baby blues”, low socio-economic status, infant temperament, genetic predisposition, biological and physiological factors experienced during the postpartum period (e.g. sleep deprivation, fatigue), cultural/societal expectations, and low levels of self-efficacy (Dennis, Janssen, & Singer, 2004; Honey, Morgan, & Bennett, 2003; Mallikarjun & Oyebode, 2005; DSM-IV-TR, 2000; Albright, 1993).

However, not all new mothers develop PND, and researchers are beginning to examine the differences between these women and those that do develop PND (Albright, 1993; Bost et al., 2002; Page, 2004; Luo, 2006). Marital congruence (Luo, 2006), close families, healthy diets, religion, and limited use of cigarettes and alcohol (Page, 2004) have all been associated with beneficial adjustment to parenthood. Additionally, one of the most consistent findings in the literature is that mothers who perceive higher levels of social support report less postpartum stress, less feelings of depression, and better adjustment to parenthood (Albright, 1993; Bost et al., 2002; Hung, Tompkins, & Dienemann, 2005; Luo, 2006; Page, 2004). The importance and positive influence of social support systems has long been recognised (Cassel, 1974), and is thought to assist people to cope with crises and life transitions such as the birth of a child (Bost et al., 2002; Hurdle, 2001). Social support networks may help create healthier and more realistic expectations of parenthood, provide guidance, and a source of support for parents when they require some time away from the role of caregiver or even require looking after themselves (e.g. during illnesses). Social support networks

appear to be particularly important to women; as they tend to seek them out more than men (Hurdle, 2001).

Social support refers to any exchange of resources, whereby an individual's social network provides various types and magnitudes of assistance ranging from emotional, financial, physical, and/or practical resources (Collins, Dunkel-Schetter, Lobel, & Scrimshaw, 1993; Bost et al., 2002; Laireiter & Baumann, 1992). Whilst the term social network refers to the structural properties of the social ecosystem and the relational patterns, associations, and interconnections of members, independent of the functional supports they provide (Bott, 1971; Milardo, 1988; Wellman & Berkowitz, 1988). Structural factors of social networks include the frequency of contact with network members, network size and composition (Bost et al., 2002). Network membership, size, and composition are vital factors to consider when seeking to elucidate how and why the social ecologies people are embedded within influence well-being, particularly around the transition parenthood.

Research into the composition of support networks during the transition to parenthood reveal that they are comprised of a variety of different relationships. Research literature consistently finds that close family members, in particular husbands and women's own mothers tend to be the primary sources of support following the birth of a child (Crnic, Greenberg, Ragozin, Robinson, & Basham, 1983; Hopkins, Marcus, & Campbell, 1984; Levitt, Weber, & Clark, 1986; Tinsley & Parke, 1984). Husbands are repeatedly cited as being associated with better maternal adaptation (Cox, Cohen, Lewis, & Henderson, 1989; Goldstein, Diener, & Mangelsdorf, 1996), and women also tend to report that their friendships are a crucial source of support around this time (Goldstein & Genero, 1995; Crnic & Greenberg, 1990; Richardson, Barbour, & Baubenzer, 1995). Friendships appear to have particular salience for women during the

transition to parenthood; more so than men (Bost et al., 2002). Although research also suggests that support provided by community contacts is important, therefore social support from outside the familial or immediate friendship networks should be included in research investigating the transition to parenthood (Crockenber, 1981; Crnic et al., 1983).

Bost et al. (2002) examined the patterns and changes in couples' social networks (family and friends) during the transition to parenthood and its relationship to parental adjustment and depression. The study tracked 137 couples and collected data pertaining to network composition, and measures of depression and adjustment at four time periods; prior to the birth of their first child, 3-, 12-, and 24-months post-birth. Results showed there was considerable stability and continuity in individual differences of parental networks across the transition. Parents who reported larger network sizes and supports prior to the birth of their first child, were more likely to report having larger and more supportive networks 24-months post birth. That is, although specific network members were dropped and added to an individual's network, on the whole network size tended to remain fairly constant on an intrapersonal level. This finding is consistent with previous research by Belsky and Rovine (1984) and Lamer, (1990). Similarly, parents in the Bost et al. (2002) study who reported higher levels of depression and adjustment prenatally were also more likely to report higher levels at 24-months. The researchers offered an explanation of these findings based on Object Relations theory, in which individuals develop enduring internal working models of relationships, expectations of support availability and acceptance by network members, and the use of coping skills which influence how one adapts and behaves interpersonally during transitions and other stressful incidents in life.

In their detailed analysis, Bost et al. (2002) revealed dynamic changes in social system structures for both husbands and wives that appeared to be related to the parents' levels of adjustment and depression. Although the number of network members showed some decrease after the birth of the child, contact with family members in the couples' networks increased in frequency. These results augment previous research by Belsky & Rovine (1984) and McCannell (1987) that demonstrate changes in the frequency of contact with network members during the transition to parenthood. Individuals in the Bost et al. (2002) study who reported larger family network sizes also reported higher adjustment levels; however a negative relationship was revealed between frequency of contact with family members and adjustment. The authors suggested that less well adjusted parents may feel the need to seek more familial contact as they make the transition into parenthood. In line with this explanation is research which indicates it is the *perception* which is most crucial, individuals who report higher perceptions of support availability do not always display help-seeking behaviours or access the support (Barrera, 1981; Wethington & Kessler, 1986). Thus social support networks may only be activated and more frequently utilised when the individual is considered to be, or considers themselves as struggling to cope on their own; while those who perceive themselves or are observed by network members as managing sufficiently do not elicit extra support. It is also important to consider the suitability of the support provided by network members, for instance an enmeshed and undermining style of support is likely to reduce feelings of adjustment and contribute to learned helplessness and excessive dependence on others. Hence the need for in-depth idiosyncratic investigations of perceptions, usage, and functions of social support accessed and provided to individuals experiencing the transition to parenthood.

In addition, the Bost et al. (2002) study also revealed the amount of perceived give-and-take in social networks was consistently related to parental depression levels, however not necessarily to adjustment. Higher levels of reciprocity were indicative of greater psychosocial well-being, thus reciprocity as a form of social support appears to serve as a buffer against postpartum depression. It seems social support may have a cushioning effect on the emotional stressors that accompany the onset of parenthood. The finding that social support serves as a buffer against stressful life events in general, and is associated with better psychological functioning, physical health, and social adjustment is well documented in the literature (Cohen & Wills, 1985; Crnic & Greenberg, 1990; Koeske & Koeske, 1991; Kaplan & Toshima, 1990; Sarason, Sarason, & Gurung, 1997). However, Bost et al.'s (2002) study also exposed an interesting discrepancy between the ratings of reciprocity reported by new parents. Wives tended to report a rapid decline in the perceived level of give-and-take in their spousal relationship, compared to husbands who seemed to perceive a gradual increase in reciprocity with their wives over time. It is important to note that a general decrease in spousal satisfaction over the 24-month period was also reported. The overall decline in marital satisfaction across the transition to parenthood is well researched and documented in the literature (Belsky & Rovine, 1990; Belsky, Spanier, & Rovine, 1983; Belsky, Lang, & Rovine, 1985). It is possible that the greater dissatisfaction in reciprocity reported by wives may be due to the transition to parenthood generally resulting in more substantial changes to women's lives in terms of their employment status, household duties, parental roles, and their bodies. Further research is needed to extrapolate the differential perceptions of reciprocity between men and women, particularly in light of its impact on depression and general well-being in the postpartum period.

In explanation of the impacts, research consistently reveals that mothers continue to do the majority of traditionally feminine domestic tasks. Knoester and Eggebeen (2006) reported that although the amount of household chores and child-raising performed by men has increased in recent decades, women are still responsible for the bulk of care giving to children and the majority of household labour. Consequently the arrival of a couple's first child is likely to correspond to a vast change in a woman's domestic routines, with a comparatively small change for her male partner. More recently, Lachance-Grzela and Bouchard (2010) conducted a review of the literature pertaining to the division of household labour, published between 2000 and 2009, and reported the finding that women continue to perform the vast majority domestic tasks. Similarly, Gjerdingen and Chaloner (1994) reported that women assume primary responsibility for the majority of household errands such as cleaning, grocery shopping, cooking, washing clothes and dishes, household repairs, car maintenance, and garbage removal. Gjerdingen and Chaloner's (1994) study examined differences between women who had caesarean sections versus vaginal deliveries, and also those that returned to work compared to those that were stay-at-home mothers. Women who had caesareans and who returned to work perceived their husbands as participating more in traditionally feminine household chores. Importantly, women's satisfaction with their husbands' domestic contributions was significantly related to their own mental health, delivery type (caesarean), job status, family income, and to their husbands' occupation, expressions of caring, and participation in child care. However Gjerdingen and Chaloner (1994) stated that overall their findings suggested there were diminishing levels of emotional and practical support for women from their husbands following the birth of their first child; a time when their need for support is perhaps the greatest.

Gjerdingen and Chaloner's (1994) findings of perceived psychosocial benefits in women who returned to work following the birth of their first child, highlight the importance of investigating how employment is impacted during the transition to parenthood. Knoester and Eggebeen (2006) noted that with the transition to parenthood, men tend to demonstrate increased attachment to the labour force and increase the number of hours spent in paid labour, thereby enabling fathers to provide greater financial support for their families. The transition to parenthood for women involves at least a temporary break from the workforce, whether it be taking annual leave, maternity leave, or ceasing work altogether. During the pregnancy and prior to the birth, the majority of women are likely to be employed and may require time off work in order to attend doctor appointments, tests, and scans etc. or even to cope with morning sickness. Flexible, supportive, and understanding work environments would obviously be advantageous during the transition to parenthood and may form a component of the new parent's support network. Many women view working during their pregnancy as an overall positive experience (Pattison & Goss, 1996).

Thompson, Murphy, O'Hara, and Wallymahmed (1997) examined the levels of stress, daily hassles, and positive uplifts reported by employed and non-employed women of primigravida status (first pregnancy/birth). The study found no significant differences between employed and non-employed women in both the reported frequency and severity of hassles, or in the frequency and intensity of uplifts during their pregnancies. However during the early stages of pregnancy, both groups of women reported more severe hassles and more intense uplifts. By the latter stages of pregnancy, both employed and non-employed women cited more frequent hassles but with less severity, while the experience of uplifts during the second and third trimesters were described as less intense also. The authors suggested that the more severe hassles

reported earlier in the pregnancies may have related to the novel nature of the women's experience of being pregnant, in addition to the finite time they have to adapt to the new state. Towards the end of the pregnancy, the increase in reported hassles may be attributable to women's physical discomfort caused by physiological changes, altered body image and level of acceptance of the changes, as well as the multitude of emotions they experience with the impending delivery and post-birth adaptation. Furthermore, by the latter stages of pregnancy women may have developed greater ability to accept and manage hassles and consequently view them as less severe; particularly as the progression of the pregnancy is largely out of the woman's control.

Conversely the employed and non-employed women in Thompson et al.'s (1997) study did differ significantly on the types of daily hassles they reported, with the non-employed women rating more inner concerns and financial uncertainties. The authors proposed a rationale for this finding may relate to the scale items for this component seeming to tap into the women's feelings of isolation as questions included 'not seeing enough people', 'friends or relatives too far away', 'too much time on my hands', and 'being lonely'. Thus again the perception of available social supports and networks, be it family, friends, and work colleagues, appear to play a vital role in the psychosocial coping women report during the transition to parenthood. As both groups of women neared the latter stages of their pregnancies, the hassles they reported related increasingly to inner concerns (compared to those from the first trimester). The increase in inner concerns for the employed women may have been due to their growing mindfulness of the isolation away from a valuable support system at their work. Thus, as the parallels increased between employed and non-employed women's lives, so too did their subsequent concerns.

Employed pregnant women however, demonstrated less concerns regarding their financial responsibilities compared to the non-employed women, and this may result in better psychological health. As the Thompson et al. (1997) study did not differentiate between the numbers of hours women in the employed group worked; this meant that both part- and full-time employed women were grouped together which may have altered the outcomes somewhat. Full-time employed women may experience more stress and hassles than part-time employed women who are likely to have more time to balance the demands of both work and pregnancy. Furthermore, all women in the study were in (marriage like) relationships. Pregnant single women are more likely to be disadvantaged in that not having a partner would equate to greater individual financial responsibility and they may also lack someone who can provide close emotional and practical support (although it should be acknowledged that a person other than a partner may be able to provide this support). None-the-less, Thompson et al.'s study provides evidence to suggest that whilst working during pregnancy may not alter the level of hassles or uplifts women report, it does appear to modify the type of hassles reported.

Adjustments to identity across the transition to motherhood

A variety of physical, relational, mental and emotional changes occur during the pregnancy and post-pregnancy period which inevitably precipitate adjustments to one's identity and self-concept. Thus the transition to motherhood can be said to qualify as an event that becomes central to one's identity, prompting a woman to re-organise her view of the world, her 'self', and her life story (Boals, Steward, & Schuettler, 2010; Boals & Schuettler, 2011). A study by Milward, (2006) reported that overall women subjectively struggle to maintain their rights, needs, and concerns as mothers while simultaneously sustaining their identity as valued and functional members of the work organization. In Milward's study women described feelings of gradual invisibility as a valued employee

and tended to experience dilemmas about returning to work following the birth of a child, which could only be resolved by altering expectations. Smith (1999) reported that women tend to assume less public positions during pregnancy, with the more personal world of family replacing the public world of work and wider social context. According to Smith (1999) although the internal and external worlds are connected in a complex and multi-faceted way, a shift in the woman's focus typically occurs with increasing value placed on the immediate family environment.

Smith's (1999) article attempts to document the progression of change women experience across the transition to parenthood, from early, middle, and late pregnancy, through to the post-birth phase. His study utilised qualitative idiographic case-studies of four British women undergoing the transition to motherhood. The justification for the small sample size was that it enabled Smith to gather in-depth information across successive transition points from participants who were comparable on a range of factors. Inclusion criteria included: first pregnancy; joined the study within their first trimester; no history of miscarriage or termination; not an unwanted pregnancy; and all women were in long-term heterosexual relationships. Participants completed repertory grids and were interviewed at three-, six-, nine-months pregnant, and again five-months post-birth, the women were also asked to keep a once-weekly diary across the entire period of the study. (In recognition of the large degree of time and effort required of participants, each was paid a small reward of £25). Smith contended that this reasonably homogenous sample enabled the formulation of a theoretical model of how aspects of a women's sense of identity are transformed during the transition to motherhood. Employing an interpretative phenomenological analysis of the data obtained, Smith devised a processual model of the transition. A brief summary of the main focuses and tasks during each stage are summarized:

Early Pregnancy: Adjustment and Uncertainty

According to Smith (1999), women in the early pregnancy phase are adjusting to their new pregnant state. It appears to be a time of great uncertainty and ambiguity, with the novel situation and subtle physical changes often leaving the woman feeling bewildered, anxious, and excited. The women in Smith's study described their desires for physical changes possibly as further confirmation of their pregnancy, which in turn might facilitate the woman's adjustment to her new status. Early pregnancy involves a large amount of self-reflection and questioning as part of the adjustment, particularly due to the lack of definitive physical signs of pregnancy.

Middle Pregnancy: Changing Self-perception and Psychological Preparation for Mothering

During the second trimester, women in Smith's (1999) study noted withdrawing from the more public work aspects of their lives, in favour of closer involvement with their family and local community spheres and support networks. Smith hypothesised that this process may facilitate psychological preparation for motherhood, and the woman's changing identity. Around this point, it appears women's priorities begin to shift from more public domains which they described as irritating and less important; towards significant others such as partners and immediate family members who tended to occupy their thoughts with increasing frequency. Smith postulates that the importance of social support for women during this transition relates to their psychologically informative nature. The women's identities or roles appear malleable, and they utilise interpersonal contact with significant others as experimentation and preparation for their developing mothering skills. The women in the study demonstrated that as social contact with significant others increased, so too did the women's perceptions of psychological similarity to them. The women in the study also seemed to

perceive themselves as calmer, more agreeable, and content to allow others to handle certain things (i.e. work related matters) in order for them to focus on what they identified as important. The drawing closer in family and other support networks during middle pregnancy seems to be associated with the evolution of a more relaxed and cohesive self conception. Additionally closer family connections allow for practice of the women's new emerging maternal identity.

Late Pregnancy: Attention Returns Outwards and Increased Ambivalence

The impending birth seems to create excitement and trepidation in pregnant women (Smith, 1999). The inward focus typical of middle pregnancy appears to diminish and attention returns to external factors, with the act of birth seeming to be the central mechanism for this change. The process of pregnancy is nearing completion and practicalities of labour and post-birth adaptation require greater attention, hence increased external focus. A mixture of apprehension and impatience occupies the woman's mind. Some of the physical discomfort associated with the third trimester may lead women to yearn for the end of their pregnancy, however concerns about what to expect and whether they will be able to cope both during the birth and afterwards in the their new role as mother leave women with a sense of vacillation (Smith, 1999).

Post-birth: Transformation of the Woman's Priorities and Life Plans

Following the significant and life altering event that is child birth, women tend to re-evaluate their options in life. The process of psychological development that occurs in the woman during pregnancy prompts her to review her general plans, assumptions, and more generally her existence. Smith (1999) theorised that the changes the woman experienced, such as the turning away from public spheres to more a private, local, and familial context instigates a transformation of her life projects and a desire to achieve a greater balance and holistic approach to life; particularly one that is more

conducive to the needs and interests of her family, relationships, and work. It would seem that the new mother becomes consciously aware of the pressures her previous working life demanded, and she then seeks to reorganise, redesign, and re-evaluate her priorities. The very existence of her child and its new life symbolises and becomes the impetus for her to adapt, create, and alter her own existence.

The women in Smith's (1999) study noted that following the birth of their child, they viewed themselves as more tolerant and less competitive. The majority of their attention and time was directed towards their child; bonding, nurturing, and pre-empting the baby's needs. This other-focus (on the baby as opposed to their previous natural self-focus) appeared to develop a greater understanding and empathy for others in general, along with appreciation for the difficulties others experience when attempting to cope with new and challenging situations. The more relaxed and empathic stance women's lives underwent, seemed to generalise and inform their larger scale life plans.

Many of the women in Smith's (1999) study noted a shift in their work interests, whether this meant maternity leave, reduced hours/part-time employment, or a completely new occupation and location altogether. It seems that the processes and changes involved in pregnancy and the post-birth adaption influence women to channel and re-direct their skills and resources in different ways or directions; towards a more holistic lifestyle. However Smith did note a side-effect of this process in his participants; it seems the women experienced a reduction in their confidence related to their work identity and what they could offer an organisation in the context of a competitive public world of work. The loss of a productive work identity appeared to be a detrimental side-effect. Consistent with the finding reported earlier by Milward (2006) that women experience a subjective struggle between maintaining adequate mothering capacities whilst preserving a productive, competent, and dedicated employee identity.

The reorganisation of a woman's priorities following the transition to motherhood necessitates alterations in the many facets of her identity and functioning. The new mother's closer involvement in the family world can act as an important support and marker for identity (Smith, 1999).

Emergence of a new mother identity

The transition to parenthood necessitates the emergence of a new mother identity for women. During the course of pregnancy women's attention and focus shifts from an individual external focus, towards an internal and familial focus, before externalizing once more following the birth of the child (Smith, 1999). At this point, the mother and baby are involved in what can be described as a semi-symbiotic state where the new mother is often highly attuned to the needs, desires, and comfort of her infant. In order for this to unfold, the woman's own natural self-focus that was characteristic of her life prior to her becoming a mother is placed after the child's, and possibly even after her partner/husband's. The assumptions of her previous identity formations and functioning are no longer adequate, or valued to the same extent and therefore require reorganisation. For example, Smith (1999) noted an increase in self-doubt and decrease in new mothers' perceptions of themselves as productive employees, and Milward (2006) described women's subjective struggle when attempting to continue operating according to their pre-motherhood work identity in the context of the new mother identity.

The loss of or lack of fit between a woman's pre-pregnancy identity and her new mother identity could potentially leave her feeling lost in terms of her self-concept, self-integration, and her abilities to meet the demands of her responsibilities and roles (mother, wife/partner, co-parent, homemaker, employee, friend, daughter, sister, aunty, cousin, neighbour, individual etc.). Smith (1999) proposed that interpersonal contact

with a woman's support network can inform the way an individual perceives themselves. The study found that as pregnancy progressed, the women seemed to report greater similarities in the descriptions they gave about themselves and their significant others. Smith concluded that a woman's development and discovery of her changing role and new identity as a mother was facilitated by her relational connections with others. Thus it would seem that identity is not only based on our own experience of ourselves and the responsibilities we have, it is also highly dependent on our interactions with, and the way in which others perceive us. Smith (1999) described pregnancy as a time of psychological preparation for the new mothering identity as it provides an opportunity for the woman to invoke and practice aspects of her future mother self during interactions with others. It is a time of image-making and testing, and the ability to visualise oneself as a mother has been linked to good adaptation post-birth (Shereshefsky & Yarrow, 1973).

Social Support outcomes for the child

Good support networks are not only associated with better coping and adaptation for mothers, but also seem to enhance the physical, emotional, and cognitive well-being of children. Dipietro, Millet, Costigan, Gurewitsch, and Caulfield (2003) found that higher levels of social support were associated with increased levels of prenatal attachment to the developing infant. Greater prenatal attachment is likely to lead to stronger and more healthy post-birth attachment between mother and infant and could potentially reduce the incidents of failure to thrive due to emotional neglect. Evidence from Collins et al. (1993) suggests women who receive more social support have better labour progress and babies with higher Apgar scores. (The Apgar is a composite rating of a newborn infant's physical condition across five criteria: heart rate, respiration, muscle tone, reflex irritability, and skin colour. The rating scale for each criterion is

zero-to-two with an optimal score of ten. Higher Apgar scores are associated with reduced infant mortality and other types of distress; Collins et al., 1993). Similarly, Barrera and Balls (1983) found that for young mothers, social support and social network size influenced the health of their newborn child as well as whether birth complications occurred. Therefore it seems the context of mothers' social support and networks can have an important bearing on the child's wellbeing, with large networks of social support being more conducive for optimal birth and development.

An interesting study conducted by Huizink, Robles de Medina, Mulder, Visser, and Buitelaar in 2003, examined whether psychological and endocrinological measures of stress during human pregnancy would predict developmental outcome of infants at three- and eight-months of age. The rationale for this study was based on previous animal research which had shown prenatal maternal stress may be related to cognitive impairments in offspring. The study obtained mothers' self-reports of perceived daily hassles and pregnancy-specific anxieties, along with levels of salivary cortisol (a natural hormone released during stress). Participants were 170 nulliparous women and data was collected at early, mid, and late pregnancy, healthy infants born at term were followed up after birth. The significant findings revealed that: high levels of pregnancy-specific anxiety in mid-pregnancy predicted lower mental and motor developmental scores in infants at eight-months; high amounts of daily hassles in early pregnancy were associated with lower mental developmental scores at eight-months; and early morning levels of cortisol in late pregnancy were negatively related to both mental and motor development at three-months, and motor development at eight-months. On average, the results revealed a decline of eight points on the mental and motor development scale. The authors concluded that stress during pregnancy appears to be a contributing factor for delay in motor and mental development in infants, and thus could be a risk factor for

later developmental problems. It was unclear from this research whether these delays are transient, persistent, or progressive (Huizink et al., 2003). This adds further weight to the importance of understanding and reducing pregnancy-specific hassles and anxieties, not only for the well-being of mothers, but also for the health and development of infants.

Maternal social support appears to facilitate optimal mother-child attachments and better quality parenting during childhood. Burchinal, Follmer, and Bryant (1996) reported that African American mothers who had larger support networks were more responsive and less directive in their interactions with their toddlers, than mothers with smaller social networks. The beneficial effects that social support provides for parenting have been demonstrated for infants (Crockenber, 1981), pre-school children (Jennings, Stagg, & Conner, 1991), and throughout childhood from age two to 12 (Szykula, Mas, Turner, & Crowley, 1991). Conversely, depressed mothers have been observed to respond less consistently to their infants' signals and cues and are less likely to display positive emotions when interacting with their infants (Cohn, Campbell, Matias, & Hopkins, 1990). Meanwhile well-adjusted mothers tend to exhibit warmer interactions with their babies (Mangelsdorf, Gunnar, Kestenbaum, Land, & Andreas, 1990). Hence, the impact of social support, or the lack of it, can have enduring effects.

Based on findings such as these, the importance of social support and reducing stress as women transition into motherhood gains vital importance. Social support can function as a medicinal buffer, a respite, and plays a sustaining role in emotional health and well-being that safeguards women against the effects of stress, traumatic change, and maladaptive outcomes for themselves, their child, families, and wider society (Lazarus, Kanner, & Folkman, 1980). By examining the types of social support and the processes involved in producing the positive effects, researchers and practitioners can

build and develop strategies, programs, and support systems to facilitate women through the transition to motherhood. Additionally researchers and practitioners may be able to identify those women who are at risk of poor adjustment and provide interventions aimed at improving their adaptation. Hence there is a need for ongoing and in-depth studies which investigate the transition to motherhood and the factors which facilitate positive adaptation.

Self-efficacy

Another aspect which is reported to positively influence adaptation across the transition to motherhood is self-efficacy. In 1977 Albert Bandura described the concept of self-efficacy, defining it as the belief that one can successfully perform necessary behaviours required to produce a certain outcome. According to Bandura's theory, self-efficacy expectations are derived from four principal sources of information: performance accomplishments, vicarious experience, verbal persuasion, and physiological states. He posited that expectations regarding self-efficacy or personal mastery affect both the initiation and persistence of coping behaviours (Bandura, 1977). If a situation or task is perceived to exceed the individual's current skill set or coping mechanisms and is viewed as fearful or threatening, the person will most likely avoid the task. Conversely, situations or activities that are considered to be within the capabilities of the person are more likely to be attempted with perseverance, eventually resulting in mastery of the activity. This process expands on and even creates corrective experiences which reinforce the individual's attempts at new challenges and are then integrated into the person's sense of self-efficacy (Bandura, 1977). Thus an individual's expectations of self-efficacy will influence how much effort is expended, on which activities, and the duration of persistence despite difficulties and negative/stressful/or threatening circumstances. Successful attempts increase the sense of mastery and self-

efficacy meanwhile failures reduce self-efficacy (Bandura, 1977). Self-efficacy tends to generalise to additional events and activities as confidence in one's capabilities grows.

Generalised self-efficacy beliefs have been demonstrated to have a powerful effect on psychological well-being during times of adaptation and change (Harwood, McLean, Durkin, 2007). Across the transition to motherhood, a variety of challenges must be faced including sleep deprivation, mastery of infant care giving skills, altered self-identity, routines, and finances etc., consequently the expansion of self-efficacy is an important factor in successful adaptation for new parents. In applying the concept of self-efficacy to parenting, de Montigny and Lacharite (2004) conducted a review of the parenting literature and devised the following definition of parenting efficacy, "beliefs or judgements a parent holds of their capabilities to organize and execute a set of tasks related to parenting a child" (p. 387). The development of a sense of parental efficacy after the birth of a child, especially one's first child, is considered to be a fundamental step in the development of a family unit. Maternal efficacy beliefs have been found to mediate the effects of depression, social support, and infant temperament on parenting behaviours (Teti & Gelfand 1991; Cutrona & Troutman, 1986). It seems mothers who possess high parental efficacy beliefs experience less psychological distress than do those with low efficacy beliefs (Halpern & McLean, 1997), and are more likely to perform adequate parenting practices (Teti & Gelfand, 1991). High efficacy beliefs may also function as a psychological resource buffering the effects of environmental stressors compared to low efficacy beliefs which may constitute a vulnerability (Harwood, et al., 2007; Maciejewski, Priegeron, & Mazure, 2000).

The next section presents a review of the literature in the field of trauma and the psychological impacts, outcomes, and the importance of event centrality. Existing

research into PTG across the transition to motherhood is critiqued, followed by the rationale for the current research.

The Impact of Trauma:

An 'assumptive world' theory – understanding how trauma impacts the way humans function

In 1975, C. M. Parks coined the term '*assumptive world*' as a means of explaining the unique view of reality that an individual possesses. An assumptive world refers to an organised schema or set of foundational assumptions about the world and oneself which are sturdily adhered to and operate as a means for recognising, planning, and acting. Parks (1975) believed people's assumptive worlds were spawned and consolidated by experiences over many years, and were therefore accepted as fact and rarely questioned let alone altered. They then form a cognitive framework that anchors and orientates the individual, providing meaning and purpose to their life (Beder, 2004-2005). Perception, behaviour, and identity are thought to be influenced by the foundational assumptions which allow people to experience the world and the self as predictable, controllable, and safe (Rini, Manne, DuHamel, Austin, Ostroff et al., 2004; Pals & McAdams, 2004).

Building on the work of Parks (1975), Janoff-Bulman (1992) proposed three core foundational assumptions that form our worldview: Firstly, the world is benevolent; second, the world is meaningful; and the third foundational assumption is that the self is worthy. According to Janoff-Bulman, the benevolent assumption refers to the belief in a safe world where others have good intentions and things usually have positive outcomes. The assumption that the world is meaningful relates to the belief that things generally make sense and that events are determined by cause and effect in a predictable manner. The final assumption, that the self is worthy pertains to the idea that

we perceive ourselves as likable, moral, and capable or efficacious individuals. Janoff-Bulman (1992) summarised by saying an individual's assumptive world leads them to believe they are a good person living in a benign world in which events generally make sense. Needless to say, the basic beliefs of an individual's assumptive world are linked to their psychological and physical health as well as adjustment (Taylor & Brown, 1988; Rini et al., 2004).

Kaufmann, (2002) described the process in which trauma may challenge or even shatter the foundational assumptions of an individual's world. When an unexpected unprovoked and/or chance incident occurs, the coherence safety and security with which the world was previously viewed may be abruptly destroyed (Kaufmann, 2002; Fleming & Robinson, 2001; Beder, 2004-2005). Loss of the assumptive world equates to loss of predictable surroundings and a secure sense of self that may overwhelm the person leaving them without a framework by which the self can orientate and function (Pal & McAdams, 2004). This generally results in a panic state as the self is in danger (Kaufman, 2002). According to Pal and McAdam (p 66, 2004), an event is considered traumatic if it "is intense enough to challenge deeply and even destroys central schemas, goals, and assumptions that give life meaning and purpose—features of identity that we see as rooted in how people narrate their life stories." If the traumatic event is unable to be denied or defeated it leaves the individual with two options, either try to maintain the shattered old assumptions or to integrate the event and adaptively create a new assumptive worldview (Kaufman, 2002). Zoellner and Maercker (2006) suggest that the ability to accept situations that cannot be altered is crucial for adaptation to uncontrollable or unchangeable events. Thus reappraising the crisis or event in a positive light, such as an opportunity for developmental change, is thought to be one path to the emergence of Posttraumatic Growth (Schaefer & Moos, 1998; Pal &

McAdams, 2004; Zoellner & Maercker, 2006). The growth or development of new skills and abilities following confrontation with a traumatic or stressful event can result in increased self-efficacy (Bandura, 1977).

Outcomes of Trauma

Initially, academic literature tended to focus on the negative consequences and pathological outcomes of intensely stressful or traumatic experiences (Morris, Shakespear-Finch, Rieck, & Newbery, 2005; Davis, Nolen-Hoeksema, & Larson, 1998; Cadell et al., 2003). Post-Traumatic Stress Disorder (PTSD) was included in the 1980 third edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association). PTSD involves the development and continuation of characteristic symptoms including intrusive thoughts or memories, disorganised and/or agitated behaviour following the exposure to an extreme and traumatic stressor. Individuals with PTSD may persistently re-experience the event, attempt to avoid stimuli associated with the trauma, experience numbing, and hyper-vigilant arousal. The precipitating event can be either a direct or indirect danger relating to actual or threatened death, serious injury, or another threat to the physical integrity of oneself or another person (DSM-IV-TR, 2000). There is also substantial evidence to indicate co-morbid depressive symptoms with PTSD (Cadell et al., 2003; Freedman, Brandes, Peri & Shalev, 1999).

For a time, the absence of these symptoms and any psychological distress following a traumatic event was considered to indicate healthy adjustment (Morris et al., 2003; Snape, 1997; McIntosh, Silver, & Wortman, 1993; Aldwin, Levenson, & Spiro, 1994; Taylor, Lichtman & Wood, 1984). However, Hagedaars and van Minnen (2010) suggest that the inability to feel emotions (including negative ones) might be related to an inability to experience growth from trauma. As Fournier (2002) posited the

traditional focus on negative outcomes of trauma and basic symptom relief, failed to capture or understand the underlying growth and adaptation process that can occur post-trauma. Some victims of trauma report experiencing positive changes as a result of traumatic events and negative emotional experiences. Morris et al. (2005) asserted that understanding the positive life changes are just as, if not more, pertinent to an individual recovering from a traumatic experience, as they may elucidate factors involved in healthy adjustment.

Archaic literature, philosophical and religious texts from a variety of cultures attest to the notion that traumatic or extremely stressful events can result in positive changes (Prati & Pietrantonio, 2009; Taylor, 1983). Interestingly, Cadell, Regehr and Hemsworth (2003) reported that the Chinese symbol for crisis is a combination of the characters for danger and opportunity, which seems to symbolise the relationship between risk and the potential for growth. By struggling with stressors or crises, an individual is often required to alter their functioning in order to adapt to a challenging situation, ideally resulting in transformational coping; the development of beneficial changes within the person (Aldwin, 1994; Tedeschi & Calhoun, 1995). Heatherton and Nichols (1994) have even gone as far as suggesting trauma may be a necessary precursor for the growth and change of an individual.

During the last few decades there has been a drive to incorporate a positive psychology paradigm in adjustment (Davis & McKearney, 2003). Additionally, psychological interventions and treatments should not only aim to heal the damage caused by trauma, but also has the important task of identifying and enhancing the strengths and virtues of clients so they may reach their full potential (Seligman, 1998). This led to a shift in emphasis away from the medical model's tendency to focus only on the pathogenic legacy of traumatic experiences (Stuhlmiller & Dunning, 2000),

thereby allowing a dual focus of both positive and negative symptoms arising from trauma and the process of adjustment (Folkman & Moskowitz, 2000; Cadell et al., 2003; Pal & McAdams, 2004; Morris et al., 2005). Ongoing research is required to clarify and illuminate the relationship between positive and negative adaptations and to measure the extent and effect trauma can have on individuals (Morris et al., 2005).

Posttraumatic Growth

Contemporary research in the fields of trauma and stress have identified the area of *Posttraumatic Growth* (PTG), also known as “positive psychological changes,” “perceived benefits,” “stress-related growth,” “thriving,” and “positive re-interpretation” (Hoyle, 2000). PTG refers to an individual’s experience of significant positive change that occurs as a result of their struggles with a highly challenging life crisis or traumatic event (Tedeschi & Calhoun, 2004; Calhoun, Cann, Tedeschi, & McMillan, 2000; Durkin & Joseph, 2009). PTG involves a number of specific positive changes in the self, interpersonal relationships, and philosophy of life that occur in response to intensely negative experiences; such as life-threatening illnesses, war, detainment in concentration camps, being a refugee, accidents and disasters etc. (Morris et al., 2005; Linley & Joseph, 2004).

Tedeschi and Calhoun (1996) performed a principal components analysis on reports of positive outcomes after trauma and discovered five areas in which PTG manifests:

- (1) increased appreciation for life;
- (2) more meaningful interpersonal relationships;
- (3) an increased sense of personal strength;
- (4) changed priorities; and
- (5) a richer existential and spiritual life.

This led to the development of a five-factor scale called the Post-traumatic Growth Inventory (PTGI; see Method section for further details). PTG does not negate the existence or the absence of negative effects of traumatic experiences, instead it considers pain and growth as being inextricably linked in the process of recovery (Saakvitne, Tennen & Affleck, 1998, Park, 1999; Pal & McAdams, 2004; Morris et al., 2005; Prati & Pietrantonio, 2009). Boals and Schuettler (2011) reported results which suggest the PTGI taps into more than general coping; their findings indicated that it also incorporates a variety of complex mechanisms such as cognitive processing and emotional reactions, in addition to coping. Previous research concerning posttraumatic growth has claimed a score of 42 on the Posttraumatic Growth Inventory is indicative of growth (Polatinsky & Esprey, 2000). Aldwin et al. (1994) discovered that American war veterans who perceived more positive benefits from their military experience were less likely to experience high levels of PTSD than those that did not perceive benefits. It has been suggested that PTG is both a process and an outcome in which an individual struggles in the aftermath of an event and which ideally results in personal growth (Tedeschi & Calhoun, 1995; Anderson & Lopez-Baez, 2008). Helegson, Reynolds, and Tomich (2006) found that PTG was significantly related to measures of positive well-being, and postulated that perceptions of positive change could be viewed as an indication of positive mental health in trauma survivors. It is hoped that research into PTG may aid in the discovery of paths that lead to the “light at the end of the tunnel” after trauma (Almedom, 2005).

During the process of PTG, individuals often perceive themselves as having transformed and may even appear to thrive following the traumatic experience (Cadell et al., 2003). Thriving suggests not merely returning to their pre-event state, but also potentially evolving beyond it to achieve enhanced levels of functioning (Morris et al.,

2005; Tedeschi, Park, & Calhoun, 1998; Ickovics & Park, 1998). Durkin and Joseph (p 232, 2009) found that PTG was related to psychological well-being and deem it to be “a developmental process of self-motivated engagement rather than a restorative process of emotion regulation and symptom management.” Although the pathway to PTG may be painful, those who have experienced it often describe it as an invaluable process that afforded them greater value in their life, closer interpersonal relationships, appreciation and insight into important life lessons, perceptions of greater self-efficacy, coping, and resilience (Affleck, Tennen, & Rowe, 1991; Davis & Nolen-Hoekseman, 2001; Schaefer & Moos, 1998; Tedeschi & Calhoun, 1995; Bandura, 1977). In particular, the ‘victim’ mentality often associated with traumatic events can be redefined away from simply having endured and survived, towards the development and acquisition of positive skills and competencies that can be applied to future encounters with problems.

Moos and Schaefer (1986) investigated stress-related growth via personal accounts of adaption and discovered that finding meaning or understanding of a traumatic event was of significance to participants. This was followed by Burt and Katz’s (1987) study which investigated the impact and recovery of 113 rape victims (all female) between one-and-14 years after the event. Surprisingly, less than 15% of the women perceived themselves as having changed for the worst, whereas more than half of the participants reported experiencing changes in a positive direction as a by-product of coping with the traumatic event. Similarly, Calhoun and Tedeschi (1990) conducted interviews with bereaved adults to investigate benefits arising from their experience. The majority of participants reported experiencing increased appreciation of available social support, felt more independent, accepting of their mortality, improved self-efficacy and strength, increased religious commitment, and felt more capable of expressing their emotions. Research has found that as spirituality, social support, and

stressors increase, the level of PTG also increases (Cadell et al., 2003; Morris, Shakespeare-Finch, Rieck, & Newbery, 2005). In recent years, PTG has gained increasing attention of researchers who have begun to systematically study it (Affleck & Tennen, 1996; Calhoun & Tedeschi, 1996).

Despite researchers agreeing that PTG is multi-dimensional, there are inconsistent findings regarding the number of factors involved (Magwaza, 1999; Morris et al., 2005; Anderson & Lopez-Baez, 2008; Cohen, Cimboric, Armeli, & Hettler, 1998; Prati & Pietrantonio, 2009; Joseph, Linley, & Harris, 2005; Sheikh & Marotta, 2005). A study by Cohen et al. (1998) supported the five factor model of PTG originally proposed by Tedeschi and Calhoun (1996). However Anderson and Lopez-Baez (2008) reported that a variety of factor structures have been found in samples using the PTGI and results have generally been unsuccessful in finding the five-factor structure of Tedeschi and Calhoun (1996). Other researchers have found one-factor (Joseph et al., 2005), two-factor (Sheikh & Marotta, 2005), three-factor (Powell, Rosner, Butollo, Tedeschi, & Calhoun, 2003), and four-factor models of PTG (Ho, Chan, & Ho, 2004). Possible reasons for the disparate findings could be due to differences in the traumatic events or cultural influences in the experience of PTG; the three-factor model involved Sarajevo refugees from the war in Bosnia, and the four-factor model came from a study of Chinese cancer survivors. Further validation for cultural differences in PTG comes from two Australian studies Morris et al. (2005) and Shakespeare-Finch, Smith, Gow, Embleton, and Baird, (2003). Both Australian samples reported low levels of spiritual growth in PTG, contrasting the findings of American samples which tend to report high levels of spiritual change (Morris et al., 2003; Tedeschi & Calhoun, 1998).

Although interest in PTG has increased, there are a number of conflicting findings in the research literature that require further investigation (Cadell et al., 2003;

Anderson & Lopez-Baez, 2008; Prati & Pietrantonio, 2009). In a meta-analytic review of PTG Prati and Pietrantonio (2009) investigated moderator variables and found that religious coping was more beneficial for older people and for women. Prati and Pietrantonio (2009) also noted the potential for different traumatic or stressful events to cause diverse PTG profiles. There is controversy in the literature regarding whether or not PTG increases over time. For instance, despite Moos and Schaefer's (1986) conclusion that finding meaning and understanding in a traumatic event was indicative of growth, Linley and Joseph (2011) suggest it might be slightly more complex. They discovered that "the *presence* of meaning was associated with greater positive change and less negative change, but the *search* for meaning was associated with greater negative change." (Linley & Joseph, p 150, 2011. Italics added). It was considered that while searching for meaning might be crucial for the development of PTG, the essential cognitive processing required might have an intrinsic negative quality. The authors call for idiographic longitudinal studies to understand how people construe meaning and to track whether the search for meaning predicts its presence over time and thus shifting from negative to positive changes. Some authors are even beginning to hypothesise that PTSD and PTG might have a curvilinear relationship, suggesting that some levels may be adaptive while others could indicate avoidance of the real trauma consequences (Hagenaars & van Minnen, 2010; Kleim & Ehlers, 2009; Zoellner & Maercker, 2006).

According to Joseph and Linley (2005), PTG is a process that develops with the passage of time and the gradual cognitive accommodation to the post-trauma environment and re-organised foundational assumptions. Support for this view comes from Cohen et al. (1998) and Polatinsky and Esprey (2000). However Morris et al. (2005) failed to find a significant relationship between time since trauma and PTG, despite the theory that PTG takes time to occur. Stanton, Bower, and Low (2006)

reported that previous research is unclear as to whether time since trauma is related to the amount of growth. McMillen, Zuravin, and Rideout (1995) proposed that for some stressors growth may be evident almost immediately after the crisis, whereas PTG from other events (e.g. child abuse) may not be apparent until years after the event. Adding to this possible explanation of divergent findings Stanton, et. al., (2006) suggested the time elapsed may be relevant for people who continue to endure challenging circumstances (e.g. chronic or terminal illnesses), conversely circumstances in which the trauma or crises is able to be consigned to the past could account for the different results.

The influence of prior trauma on subsequent traumatic experiences was examined by Rini et al. (2004). This study explored whether prior trauma was a risk factor for poor adjustment to subsequent stressors. It was hypothesised that mothers of children undergoing a bone marrow transplant (BMT) and who had a history of trauma in their lives would be more likely to approach the medical procedure with more negative basic beliefs, than those without a trauma history. This prediction was derived from studies in which trauma had been shown to alter the physiological response to subsequent stressors due to the re-activation of previous symptoms associated with trauma (van der Kolk, 1994; Yehuda, 2001). The Rini et al. (2004) study found that mothers with more lifetime traumas reported more negative self-worth beliefs at the time of the BMT, analyses confirmed that this was due to traumatic events experienced in their childhood rather than adulthood. This finding was also consistent with Janoff-Bulman's (1992) in which childhood trauma appeared to cause greater damage than adult traumas. Implications of mothers' self-worth beliefs were that those with more positive self-worth cognitions demonstrated superior mental functioning both at the time of BMT and one year later, including participating in social activities, emotional influences on their roles, perceptions of vitality, and general mental health.

However an intriguing finding in the Rini et al. (2004) research was that mothers with a history of trauma tended to achieve more positive change in self-worth beliefs *after* the BMT. The authors proposed that having to cope with prior trauma may have enabled these women to develop coping skills that afforded them greater resilience in self-views. Additionally, the ability to alter and adapt their perceptions of control seem to be related to positive coping, as demonstrated by the finding that when future outcomes were uncertain it appeared more adaptive for mothers to accept an external locus of control over treatment outcomes. Rini et al. (2004) explained this finding by linking it to secondary control strategies, whereby they accommodate the objective loss of control by changing their beliefs about the environment (e.g. such as believing in fate or chance). However the adaptive nature of this strategy appears temporary, since once the trauma has past, returning to an internal locus of control is associated with better functioning.

It is possible that prior experience with trauma may develop and allow for more flexibility in control and self-beliefs, whereas an individual who has remained relatively unchallenged by traumatic events in the past may struggle to do this. Rini et al. (2004) suggested the important point may be the extent to which prior traumas are perceived as having been successfully resolved. None-the-less, it is evident that there is substantial individual variation in how people react to stress and trauma. Prati and Pietrantoni (2009) have suggested future research should investigate and distinguish between the various ways and types of social support (such as belonging, self-esteem, and tangible support) that may influence PTG and adjustment. Morris et al. (2005) discovered higher growth in interpersonal relationships closer to the traumatic experience. Hence the need for in-depth investigations into the precise role that social support plays in assisting people to successfully resolve and grow from traumatic experiences.

Posttraumatic Growth is not limited to only traumatic experiences

The PTGI developed by Tedeschi and Calhoun (1996) is considered to be a general measure of growth and there are increasing calls for it to be applied to typically stressful events and transition points in life; areas and events outside of those traditionally considered to be traumatic (Anderson & Lopez-Baez, 2008; Prati and Pietrantonio, 2009). The idea that positive change and growth can occur without the presence of trauma per se, was espoused long ago by Rogers (1961), Maslow (1968), Bandura (1977), and Ryff (1989). Stress is an inevitable aspect of everyday life, and tends to exacerbate the intensity of our emotional reactions to events as well as impacting our use of coping mechanisms and resources. Balk, (1999) considered stress a crucial element for the optimal development of personality and robust psychological functioning. Balk, (1999) supposed PTG can result from almost any type of challenge to one's assumptive world (not just exclusively to trauma). PTG is often associated with critical events such as loss, however loss can refer to the loss of a relationship, possessions, a job, or even one's identity or role (Balk, 1999). Tedeschi and Calhoun (2004) have called for researchers to apply their PTGI to non-trauma related experiences in order to test its empirical validity for measuring growth in general.

Beder (2004-2005) posited that any profound life disruptions caused by a stressful event may lead people to experience a violation in their assumptive world. According to Calhoun and Tedeschi (1999), for PTG to occur an event must be perceived as causing considerable psychological upset and disruption to the person's assumptions about the world, how it operates, and how they fit into the world. Ideally the PTGI allows researchers to measure the responses people have to a wide range of events throughout the average lifespan. Thereby enabling a greater understanding into the core elements of personal growth, development, and adjustment (Tedeschi &

Calhoun, 2004); it is thought that the five factors espoused in the authors' 1996 PTGI tap into a collection of areas relevant to the general human growth process.

Under the hypothesis that PTG captures a variety of growth related processes and experiences, researchers have commenced applying the PTGI as a general measure of growth; beyond the traditionally defined traumatic applications it was originally designed for (Anderson, Lopez-Baez, 2008; Cordova, Cunningham, Carlson & Andrykowski, 2001). Anderson and Lopez-Baez (2008) stated that the relationship between commonly experienced stressors and PTG is not yet clear and therefore call for studies to explore how stress initiates the growth processes, and under what circumstances adaption is achieved. Although it is believed PTG occurs when encountering experiences which challenge or break one's foundational assumptions, Tedeschi and Calhoun (2004) also suggested that extraordinarily positive experiences could potentially serve a similar function. Furthermore, the authors speculated that successive experiences of normal development may also lead to gradual growth over time.

Event Centrality

One of the recent directions in PTG literature which is showing a great deal of promise is the importance of event centrality (Boals et. al., 2010; Boals & Schuettler, 2011). Event centrality refers to the extent to which an individual's core beliefs (or foundational assumptions) are challenged by an event; an event is said to become central to identity when it acts as an organising principle for the person's sense of self and view of the world (Boals et. al., 2010). Central events are often considered as defining moments which may designate the start or end of a phase in life, providing meaning and contributing to one's identity, self-efficacy, and the narrative of one's life (Conway & PleydellPearce, 2000; Singer, 1995; McAdams, Josselson, & Lieblich,

2006; Boal & Schuettler, 2011). Central events may also impact a person's behaviour and goals (Sutin & Robins, 2008). Hence it is not surprising that event centrality is being associated with the concept of PTG which involves positive changes in the self, interpersonal relationships, priorities, and life and philosophies generally in response to intensely negative experiences.

Berntsen and Rubin (2006) have developed the Centrality of Events Scale (CES) which assesses the degree to which an individual construes a stressful or traumatic event as a primary reference for their identity. It taps into three memory functions and measures the extent to which a memory becomes: (1) a reference point for everyday inferences; (2) a turning point in one's life story; and (3) a component of personal identity. Boal et. al., (2010) attempted to clarify PTG findings by utilising the CES and discovered that the relationships between PTG and other variables became stronger when they limited adverse events to those that were perceived as central to identity. Their explanation was that if an event is not perceived to be life-changing (i.e. low CES score), then the event was considered to be less severe (less intrusive and avoidant thoughts) and surmised it was less likely to culminate in PTG. In a subsequent study, Boal and Schuettler (2011) then explored the influence of event centrality further, finding it had an association both with PTSD symptoms and PTG. Event centrality predicted PTG scores even after controlling for depression, coping styles and cognitive processing of the event, PTSD symptoms, and DSM-IV PTSD criterion A1 and A2 status of the event; (A1: experienced, witnessed, or confronted an event involving actual or threatened death, serious injury, or threat to physical integrity of self or others; A2: experienced a response such as fear, helplessness, or horror). Boal and Schuettler (2011) concluded that the perception of an event as central to one's identity could become a double-edged sword, enabling debilitation and/or growth outcomes.

Both of the Boal studies (Boal & Schuettler, 2011; Boal et al., 2010) recommend that future investigations into PTG would benefit from limiting catalyst events to those that are subjectively considered to challenge the individual's core beliefs and force re-examination of the self identity. Thus an event such as childbirth and the transition to motherhood could reasonably be construed as a central event as it implicitly results in substantial alterations to a woman's life, disruption to her regular routines, and the inclusion of a mother identity in the self.

Posttraumatic Growth and the transition to motherhood

There have been few published studies in the area of PTG pertaining specifically to the transition to motherhood. In 2009 Sawyer and Ayers investigated PTG in women following childbirth. Their study employed a quantitative cross-sectional method to explore associations between PTG, social support, and control during birth and symptoms of PTSD. The sample comprised 219 United Kingdom women aged between 18 and 42 who were fluent in English and had given birth to either their first or a subsequent child within the preceding 36 months. Participants completed an online questionnaire consisting of the PTGI; the Posttraumatic Stress Diagnostic Scale (PDS) adapted to measure symptoms in relation to child birth; the Coping Response Inventory (CRI) which includes sub-scales that assess approach responses (logical analysis, positive re-appraisal, seeking support, and taking problem solving action) along with sub-scales reflective of avoidant coping (cognitive avoidance, acceptance or resignation, seeking alternative rewards, and emotional discharge); and finally the Support and Control during Birth Questionnaire (SCBQ) which measures internal control (reactions to pain, emotions, and behaviour), external control (over procedures, decisions, and information), and support during birth (from health care professionals). (See Sawyer and Ayers, 2009 for scale references and additional details).

Sawyer and Ayers (2009) found moderate levels of PTG in 50.2% of their participants and reported that the average level of PTG in their sample was comparable to those experienced after traumatic accidents and assaults. Findings revealed positive correlations between scores on the PTGI and approach coping responses and the avoidant strategy of seeking alternative rewards. However PTGI scores were found to be uncorrelated with support and control during birth, other avoidant coping strategies post birth, and PTSD symptoms. That Sawyer and Ayers study failed to find a positive correlation between PTG scores and support is somewhat surprising given the strong association between these two variables in the literature (e.g. Cadell et al., 2003; Morris et al., 2005). Sawyer and Ayers' (2009) finding is perhaps due to the particular scale used to measure perceptions of support the SCBQ (Ford et al., 2010) which measures the degree of perceived support from health care professionals during the birth event only. Meanwhile, other socially supportive provisions provided by partners, family, or friends were likely captured within the approach coping items such as seeking support, which did achieve a significant correlation.

Sawyer and Ayers (2009) also found that the main predictor of growth after birth was age, with younger women reporting more PTG. The authors speculated this finding may be due to older women tending to be in a life phase where developmental change is less apparent, or that other life events could be hindering growth for them. However, another possible explanation could be that older women were more likely to be reporting on successive birth experiences rather than their initial transition to motherhood, which might decrease the amount of perceived growth. The application of PTG across the transition to motherhood is a novel and promising area emerging from the field of trauma/stress related growth and necessitates further investigations to

elucidate the factors that contribute to it, in addition to gaining greater insight into how this process unfolds.

A subsequent study conducted by Sawyer, Ayers, Young, Bradley, and Smith (2012) investigated PTG via a prospective longitudinal design across childbirth. A sample of 125 United Kingdom women, fluent in English, and aged between 18 and 42 completed self-report questionnaires during their third trimester and again at eight weeks postpartum. The majority of women were pregnant with their first or second child (43.2% and 40.8% respectively), and over half the women gave birth via normal vaginal delivery (55.2%). Scales included: the Self-Reporting Questionnaire-20 (SRQ-20) to measure general distress during pregnancy and after the birth; specific posttraumatic stress symptoms were assessed via the Impact of Event Scale – Revised (IES-R); Childbirth related PTSD symptoms at Time Two were measured on an adapted version of the PTSD Symptom Scale – Self Report (PSS-SR); perceived social support was measured on the Multidimensional Scale of Perceived Social Support (MSPSS); and PTG was assessed via the PTGI.

The results of the Sawyer et al. (2012) study revealed 47.9% of the women reported a degree of PTG after childbirth, although the levels were lower than those reported in Sawyer and Ayers (2009) study. Sawyer et al.'s (2012) regression analyses for age, delivery type (vaginal/assisted/planned or emergency caesarean), posttraumatic stress symptoms during pregnancy and general distress postpartum significantly predicted 32% of the variance in PTG after childbirth. Caesarean delivery and posttraumatic stress symptoms in pregnancy were the strongest predictors of PTG. Younger participants were again found to report experiencing higher levels of PTG. Whilst a positive correlation was found between general post-natal distress and PTG, pre-natal general distress was not associated with PTG. Additionally, contrary to

expectations social support both pre- and post-natal were not significantly associated with PTG. Sawyer et al. postulated that this finding could be due to different types of support having differential impacts on the women's PTG and recommend future research investigate different types of support and their relationship to growth. However the Sawyer et al. (2012) findings must be interpreted with some caution as the authors discovered a significant difference between responders and non-responders; with the latter group recording higher levels of general psychological distress at the pre-natal collection phase before being lost from the sample at the post-natal phase.

Summary and Rationale for the current investigation

Becoming a parent for the first time is generally considered to be one of the most joyous events in life; however it is also a time of intense stress that requires a multitude of adaptations (Bondas & Eriksson, 2001; Bost et. al., 2002; Knoester & Eggebeen, 2006). In particular, women's lives are the most affected by the transition to parenthood, experiencing changes in all domains; physically, emotionally, occupational, and often financially (Bost et. al., 2002; Luo, 2006; Colpin et. al., 2000). The post-natal period is associated with increased psychiatric diagnoses such as PND, and increased hospital admissions (Kendell et. al., 1981; Mallikarjun & Oyebode, 2005). With the recognition that not all new mothers experience PND, researchers have begun to investigate the factors associated with positive adaption to motherhood. A review of the existing literature indicates healthy life styles, religion, close families and supportive relationships are associated with more beneficial adjustment to motherhood (Luo, 2006; Page, 2004; Albright, 1993; Bost et al., 2002; Hung et. al., 2005; Crockenber, 1981; Crnic et. al., 1983; Hopkins, et. al., 1984; Levitt et. al., 1986; Tinsley & Parke, 1984; Cox et. al., 1989; Goldstein & Genero, 1995; Goldstein et. al., 1996; Richardson et. al., 1995). A number of adjustments in women's identities, self-concepts, maternal efficacy,

and priorities also seem to occur across the transition to motherhood (Milward, 2006; Smith, 1999; Shereshefsky & Yarrow, 1973; Teti & Gelfand 1991). Mothers who have high parental efficacy beliefs reportedly experience less psychological distress than those with low efficacy beliefs (Halpern & McLean, 1997).

Social support appears to be especially salient and is believed to serve a cushioning affect or buffer against stressful life events; it is frequently associated with better psychological functioning, physical health, and social adjustment in general (Cohen & Wills, 1985; Crnic & Greenberg, 1990; Koeske & Koeske, 1991; Kaplan & Toshima, 1990; Sarason, et. al., 1997). High levels of perceived social support for mothers also appear to have beneficial effects for their children (Dipietro et. al., 2003; Collins et al., 1993; Barrera & Balls, 1983; Huizink et al., 2003; Burchinal et al., 1996; Crockenber, 1981, Jennings et al., 1991; Szykula et al., 1991; Lazarus et al., 1980). The Sawyer and Ayers' (2009) finding that social support was uncorrelated with PTG is perhaps due to the SCBQ scale which measures perceived support from health care professionals at the birth event only. Thus it seems the relationship between social support and PTG is not yet clear and more research which aims to provide clarity to this relationship is required. Maternal efficacy beliefs have also been reported to mediate the effects of social support, depression, and infant temperament (Teti & Gelfand 1991; Cutrona & Troutman, 1986). Additionally high efficacy convictions have also been described as a psychological buffer against environmental stressors (Harwood, et al., 2007; Maciejewski, Priegeron, & Mazure, 2000). Despite the vast array of findings it remains unclear as to how and why social support and self-efficacy are associated with such beneficial adjustments to motherhood, and whether one or a combination of the two factors will predict more successful maternal adaptation; further research into the psychological impacts and processes are warranted.

As the transition to motherhood necessitates immense changes in a woman's life, it is likely that her foundational assumptions (Parks, 1975) about the world and herself undergo a number of radical changes. Alterations in the meaning, purpose, focus, self-efficacy, and control of her life are likely to occur (Beder, 2004-2005; Rini et al., 2004; Bandura, 1977), and thus the transition to motherhood acts as a central event for her 'self' identity (Boal et. al., 2010; Boal & Schuettler, 2011). Research suggests individual's assumptive worlds are linked to their psychological health and adjustment (Taylor & Brown, 1988; Rini et al., 2004), and when experiencing trauma or highly stressful periods in life the basic beliefs one holds may be shattered (Kaufmann, 2002). This led to the conception of PTG (also known as stress-related growth) whereby one's struggles with highly challenging crises or traumas may improve functioning and result in changes in the self, efficacy, interpersonal relationships, and life philosophies (Tedeschi & Calhoun, 1996; Tedeschi & Calhoun, 2004; Calhoun et al., 2000). With the development of Tedeschi and Calhoun's (1996) PTGI researchers have commenced applying this to an array of traumatic and stressful events to ascertain whether growth occurs.

Studies such as the two reported in the current research, which seek to understand how the process of PTG unfolds, are likely to provide insights into how mental health professionals and support systems might best be able to facilitate favourable adaptations across the transition to motherhood and minimise PND. Building on the positive psychology zeitgeist of the modern era (Seligman & Csikszentmihalyi, 2000), the current paper aims to enhance psychological knowledge and theoretical understanding surrounding both the recovery and ability to thrive following confrontation with traumatic, stressful, and/or transitory phases and experiences. By drawing together the findings and unanswered questions of the literature reviewed thus

far, the current paper seeks to make an innovative and valuable contribution to the field of PTG. Research such as this also has important therapeutic implications for clinical psychologists, social workers, and other mental health practitioners who may be able to utilise these findings to encourage and enhance positive outcomes, coping, and adaptation in individuals who have experienced trauma, crises, and/or stressful life transitions. If we are able to facilitate the process of PTG in our clients and aid in the revision of their assumptive worlds; we may be able to shift some people away from experiencing themselves as traumatically damaged victims, and instead help them construct a 'self' that is empowered, strengthened, and more resilient.

In view of Sawyer and Ayers (2009) quantitative investigation into PTG after childbirth which was derived from a sample of women in the United Kingdom, the current research sought to explore the experience of PTG across the transition to motherhood in an Australian sample. As identified in the literature, there may be certain cultural variations in the experience of PTG and its associated factors (Morris et al., 2005; Shakespeare-Finch, et al., 2003). It appears Sawyer and Ayers (2009) are the first published researchers to apply PTG to childbirth, and thus further investigation of their contention that growth is experienced after childbirth is warranted. Study One of the current research measured perceived PTG as an outcome via Tedeschi and Calhoun's (1996) PTGI. Based on the conflicting findings that high levels of perceived social support, greater self-efficacy, and elevated levels of stress are associated with better scores on the PTGI, the current research aimed to determine which factor/factors best predicted the degree of PTG across the transition to motherhood. The predictor variables were measured on the following scales: perceived levels of social support via the Multidimensional Scale of Perceived Social Support (Zimet, Dahlem, Zimet, & Farley, 1988); perceived self-efficacy via the Mastery Self-Efficacy Scale (Pearlin &

Schooler, 1978; Pearlin, Menaghan, Lieberman, & Mullan, 1981); and the perceived degree of stress and/or trauma related to participants' first birth experience via the Impact of Events Scale-Revised (Weiss & Marmar, 1997). Study One of the current paper expands upon Sawyer and Ayers' (2009) work by using different measures to investigate which factor/s best predicted the amount of PTG reported by women across the transition to motherhood. Additionally, the current research differed in that it narrowed the definition of the pivotal event from *any* childbirth, to participants' *initial experience of motherhood* only. The sole variable of perceived social support was found to be the only significant predictor of the PTGI score in the Australian sample.

As suggested by Prati and Pietrantonio (2009), and Aspinwall and Tedeschi (2010), future research should investigate and distinguish between the various ways and types of social support (such as belonging, self-esteem, and tangible support) that may influence and lead to PTG and adjustment. As commented by Urquhart (2011), to date much of the research into PTG has utilised quantitative methods, which place constraints on participants' descriptions of PTG and may not unearth the essence of their experience. The current research sought to qualitatively investigate the relationship of perceived social support to PTG across the transition to motherhood in order to illicit a rich, holistic, and comprehensive understanding of growth and adjustment to motherhood. Therefore Study Two explored women's discourses regarding their experience of PTG as it pertained to the birth of their first child along with their perceptions about the social support they did, or did not perceive around their transition to motherhood. Additionally the study investigated their perceptions, expectations, and recommendations regarding the transition. Findings of the current research are discussed later in an effort to capture the totality of the women's experience.

The following section details the methodology and justification of the research design for Study One and Two of the current research.

Methodology

This section outlines the methodology of the current study. First the use of a mixed methods design is discussed and then a more detailed presentation of the quantitative (Study One) and qualitative components (Study Two) is presented.

Mixed Method Design

A mixed method design was selected for the current study as this enables the strengths of both quantitative and qualitative methods to be applied to the study of Posttraumatic growth (PTG) across the transition to motherhood; thereby revealing potentially different facets of the PTG experience and permitting in-depth understanding of the transition process. While quantitative methods provide specific information derived from a large sample of the population of interest, they do not allow for ascertaining a comprehensive understanding of complex processes and phenomena (Patton, 2002; Urquhart, 2011), such as PTG. The use of qualitative methods does enable a detailed exploration and understanding of such an experience (Patton, 2002; Smith, 1995). Pal and McAdams (2004) declare that quantitative approaches (such as those that use the PTGI) would be well complemented by the addition of qualitative methods (such as growth themed narrative accounts). Additionally, Aspinwall and Tedeschi, (2010) challenged researchers to utilise both quantitative and qualitative methodologies to enable measurement and unprejudiced exploration of PTG and its process. The combination of quantitative and qualitative approaches in the current study will capitalise on the strengths, and mitigate the associated disadvantages of the respective approaches and will also strengthen the rigour of the current investigation.

Rigour

Research rigour refers to the application of strict and meticulous standards when conducting investigations. The rigour of quantitative methods can be authenticated via

measures of validity, reliability, and objectivity. (For example a coefficient of reliability such as Cronbach's alpha can be obtained via statistical analysis which provides a quantifiable measure). However qualitative methodologies, by their very nature do not permit as straight forward assessment of rigour. Thus it is necessary to dictate the process of rigour utilised in a qualitative investigation which can then assist consumer confidence in the conclusions drawn from the research. It has been suggested that the trustworthiness of qualitative findings can be determined according to credibility, transferability, confirmability, and dependability (Lincoln & Guba, 1985). Further explanation of rigour will be undertaken in each respective study presented below.

Current Study Design and Research Questions

The overall aim of the current research was to examine PTG across the transition to motherhood. An initial quantitative investigation sought to determine which factor/s best predicted PTG. This was followed up with a qualitative exploration that endeavoured to unearth the processes of PTG as it pertains to the transition to motherhood as well as greater understanding into the overall process of adaption following the birth of a woman's first child. In order to achieve this, two studies were specifically designed.

Study One

Research Design

This study utilised a quantitative cross-sectional methodology to gather data via self-report scales. The independent variables (IVs) were participants' ratings of perceived social support, self efficacy, the impact of the event (birth of their first child), and perceived degree of distress experienced during their adjustment to parenthood. The dependent variable (DV) was the participants' ratings of PTG. The specific question that was addressed by Study One is:

- (1) Do perceived social support, self-efficacy, the impact of the event, and/or the perceived degree of distress experienced across the transition predict the amount of PTG reported?

Participants

The population that the sample was drawn from were female adults (women aged 18 years and over), who had given birth. Participants were asked to complete survey items with the birth of their first child in mind (anyone who had subsequently given birth was directed to focus on the birth of their first child only) and to base their answer on a three month time frame beginning at the birth. A sample of eighty-three women were surveyed and participants were recruited on a voluntary basis from Edith Cowan University campus (between classes) and via the snowball method of sampling. Snowball sampling is a process in which participants who have already partaken in a study are asked to identify and recruit other potential participants from the same population of interest (Urquhart, 2011; Patton, 2002). Descriptive statistics (see Table 1) revealed that the average age range of women at the time of sampling was 31-40 years old, and the average time elapsed since the birth of their first child was between 5-10 years. The women were also asked to provide a rating of the severity of distress they perceived experiencing around the birth, the mean rating was 'a little distressing' however was only marginally short of reaching the 'moderately distressing' category.

Table 1.
Descriptive Statistics for Study One Sample

| | N | Minimum | Maximum | Mean | Std. Deviation |
|---------------------------------------|----|---------|---------|-------|----------------|
| Participant Age Group | 84 | 2 | 5 | 3.54 | 1.04 |
| Time Lapsed Since Birth | 84 | 1 | 4 | 3.31 | 1.06 |
| Severity of Perceived Distress Rating | 84 | 0 | 5 | 1.96 | 1.19 |
| Perceived Social Support | 82 | | | 68.39 | 11.61 |
| Self-Efficacy | 82 | | | 27.24 | 4.50 |
| Impact of Event | 82 | | | 8.12 | 10.26 |
| PTGI | 82 | | | 68.49 | 20.90 |

*See Appendix C for coding information.

Materials

Participants received a questionnaire pack containing an information letter (Appendix A) that outlined details of the study, including who to contact if the participant became distressed as a result of participation, instructions on how to complete the surveys, and a reply postage-paid envelope addressed to Edith Cowan University. The questionnaire pack included a consent letter (Appendix B), and demographic information sheet (Appendix C) asking participants to identify their age category, their self-reported rating of the level of distress they experienced around the birth of their first child, and the time elapsed since the birth. Additionally, the questionnaire pack (Appendix D) included the following scales: the Post Traumatic Growth Inventory (PTGI); the Multidimensional Scale of Perceived Social Support (MSPSS); the Mastery Self-Efficacy Scale (MSES); and the Impact of Events Scale-Revised (IES-R).

The first scale used is the PTGI (Tedeschi & Calhoun, 1996) which is a 21-item self-report scale that includes items that measure the degree of reported positive changes following a major life crisis or trauma (in this study, participants' birth of their first

child). The participants rate responses to items on a 6-point Likert scale from 0 “not at all” to 5 “very great degree.” For example, they indicate a degree of change in “Having compassion for others,” and “Appreciating each day.” The PTGI has been found to have good internal reliability (.90) and test-retest reliability (.71) following a two-month retest (Tedeschi & Calhoun, 1996). These findings were supported in a recent study and the PTGI was found to be a good measure of the five domains of PTG (Morris et al., 2005).

The second self-report scale is the MSPSS (Zimet, et al., 1988) which is used to measure perceived adequacy of support by dividing perceived social support into three distinct constructs encompassing family, friends, and significant others. The MSPSS consists of 12-items that are scored on a 7-point Likert scale ranging from 1 “very strongly disagree” to 7 “very strongly agree.” For example participants indicate their agreement with statements such as “I get the emotional help and support I need from my family,” “My friends really try to help me,” and “There is a special person in my life who cares about my feelings.” The MSPSS was found to have good internal reliability with co-efficient alphas for the subscales and scale as a whole ranging from .85 to .91. Test-retest reliability ranged from .72 to .85 (Zimet et al., 1988).

The third scale is the MSES is part of a larger study detailing which factors contribute to personal stress (Pearlin & Schooler, 1978; Pearlin, et al., 1981). The object of this self-report scale is to ascertain whether individuals regard ‘one’s life’s chances as being under ones’ own control’. The MSES comprises seven items and utilises a 5-point Likert scale ranging from 1 “strongly agree” to 5 “strongly disagree”. Examples of items include “I have little control over the things that happen to me,” and “What happens to me in the future mostly depends on me.” Total scores for this scale can range from seven (low) to 35 (high). The data used to develop this scale was gathered from 2

300 people aged 8-65 years. The reported Cronbach's alpha reliability score is .69 (Pearlin & Schooler, 1978).

The final scale was the IES-R (Weiss & Marmar, 1997) which measures subjects' distress to any specific life event. It is a 22-item self-report measure that is scored on a 4-point Likert scale and measures three factors; avoidance, intrusions, and hyper-arousal. Participants are asked to relate the scale to a specific event (in this case the birth of the participants' first child) and rate each item on the scale. For example "I was aware that I still had a lot of feelings about it but I didn't deal with them." Items are rated from 0 "not at all" to 4 "extremely." The Cronbach's alpha reliability was reported at .89 to .94 and test-retest reliability was found to be .89 to .94. The IES-R is scored by summing the means of the three subscales.

Procedure

Participants were offered a questionnaire pack on Edith Cowan University Campus between classes, or for those recruited via the snowball method, questionnaire packs were provided to participants at a location convenient to them. Packs contained instructions for participants about their participation and how to complete the four scales. Once completed, the participants returned the questionnaires in the postage-paid University addressed envelopes provided.

Results and Discussion of Study One

Prior to the analysis, initial data screening was conducted to ensure its suitability for statistical examination. Any questionnaires which were missing a response on an item were removed from the data set resulting in $n = 82$. No major deviations in normality were discovered when examining scatter plots. Initial reliability testing for the scales were conducted and the respective Cronbach's alpha scores were robust: PTGI = .948; IES-R = .928; MSPSS = .919; and although the MSES = .714 (Connelly, 2011). The sample size ($n = 83$) was sufficiently large enough to conduct a Standard Multiple Regression (Tabachnick & Fidell, 2001). (Although the sample was not large enough to conduct further examinations into the PTGI subscales).

The first analysis to be carried out was the Pearson's Product Moment Correlations, which determined the degree of relationship between PTG scores and the ratings of perceived social support, self-efficacy, the impact of the event, and perceived degree of distress experienced during the participants' adjustment to motherhood. The correlations presented in Table 2 demonstrated that the variables were not highly correlated with each other (see Table 2). Both self-efficacy and social support were significantly correlated with the scores on the PTGI ($r = 0.241, p < 0.05$) and ($r = 0.243, p < 0.05$) respectively. While IES-R was not significant with PTGI, IES-R did reach a significant negative correlation with social support ($r = 0.250, p < 0.05$). The mean rating for perceived degree of distress experienced during the adjustment to motherhood was 1.96 (standard deviation 1.19), coding values were as follows 1 = a little distressing, 2 = moderately distressing). The frequency distribution was bimodal with categories 1 and 2 being endorsed by 26 participants.

Table 2.
Variable Correlations

| | PTGI | IES-R | MSES | MSPSS |
|-------|------|-------|-------|--------|
| PTGI | - | .040 | .241* | .243* |
| IES-R | | - | -.056 | -.250* |
| MSES | | | - | .124 |
| MSPSS | | | | - |

* Correlation is significant at the 0.05 level (2-tailed).

** Correlation is significant at the 0.01 level (2-tailed).

A Standard Multiple Regression analysis was then conducted to ascertain which independent variable/s best predicted the PTGI score following the transition to motherhood (See Table 3). Independent variables were the Impact of Event - Revised (IES-R), Mastery Self-Efficacy Scale (MSES), and perceived social support (MSPSS) while the dependent variable was the PTG scores (PTGI). The four assumptions of regression were met (variables were normally distributed, linear relationship between independent and dependent variables, predictor variables not excessively correlated, and homoscedasticity variance was within the acceptable range).

Table 3.
Predictors for Posttraumatic Growth (PTGI) following the transition to motherhood

| Predictors | Beta | B | R ² | Adjust. R | t | Sig. |
|------------------------|------|------|----------------|-----------|-------|------|
| IES-R | .114 | .233 | | | 1.040 | .301 |
| MSES | .215 | .998 | | | 1.995 | .050 |
| MSPSS | .238 | .429 | | | 2.148 | .035 |
| [f(3,78)=3.333, p<.05] | | | .114 | .080 | | |

N = 83 *, p<.05

The model accounted for 8% the variance in PTGI scores, although this was a relatively small figure the analysis of variance was significant (F(3,78)= 3.333; $p < 0.05$). Further examination of the coefficients revealed that perceived social support was the only independent factor to reach significance ($t(78)=2.148$; $p < 0.05$). Although of note is the self-efficacy factor which was on the cusp of significance ($t(78)=1.995$; $p =$

0.05). Inspections of residual scatter plots were determined to be adequately sufficient so as not to warrant further analyses (normality, linearity, homoscedasticity were all at acceptable levels). Default values for multicollinearity are built into the SPSS computer program and thus it will not admit variables that are a problem in this area (Coakes, 2005).

Summary and discussion of Study One findings

Becoming a parent can be a source of joy and happiness, as well as a time of great strain and difficulty (Bondas & Eriksson, 2001). This life altering event has been described as being either a disorganising incident or a developmental opportunity (Osofosky & Osofosky, 1984); a time for regression or a chance to grow (Antonucci & Mikus, 1988). Previous research suggests women appear to experience higher levels of stress, more psychological symptoms, and are at higher risk of being diagnosed with psychiatric conditions following the birth of a child (Kendell et al., 1981; Campbell et al., 1992; Bost et al., 2002; Luo, 2006). Despite the possibility for negative outcomes, statistical analysis of the data from Study One revealed that women report experiencing PTG across the transition to parenthood. PTG refers to an individual's experience of significant positive change that occurs as a result of their struggles with a highly challenging life crisis or traumatic event (Tedeschi & Calhoun, 1996; 2004; Calhoun, Cann, Tedeschi, & McMillan, 2000). According to Tedeschi and Calhoun (1996) there are five areas in which PTG manifests: (1) increased appreciation for life; (2) more meaningful interpersonal relationships; (3) an increased sense of personal strength; (4) changed priorities; and (5) a richer existential and spiritual life.

In line with the suggestion of Almedom, (2005) Study One sought to investigate possible paths that lead to PTG, specifically it examined which factor/s best predicted the amount of PTG reported across the transition to motherhood. Quantitative measures

of participants' perceived social support, self-efficacy, and level of perceived stress surrounding the birth of participants' first child were entered into a Standard Multiple Regression equation. The outcome revealed that perceived social support significantly and solely predicted the amount of PTG reported. Participants who identified having greater levels of social support around the transition to motherhood, reported experiencing higher levels of PTG. The results of this study corroborate the findings of previous research which has found that mothers who perceive higher levels of social support are associated with less postpartum stress, less feelings of depression, and more beneficial adjustment to parenthood (Albright, 1993; Bost et al., 2002; Hung et al., 2005; Luo, 2006; Page, 2004; Hurdle, 2001; Goldstein et al., 1996; Goldstein & Genero, 1995; Crnic & Greenberg, 1990; Richardson, Barbour, & Baubenzler, 1995; Cassel, 1974; Crnic et al., 1983; Cox et al., 1989; Hopkins et al., 1984; Levitt et al., 1986; Tinsley & Parke, 1984). However the significance of social support is contrary to Sawyer et al. (2012) and Sawyer and Ayres (2009).

Lazarus, et al. (1980) espoused the belief that social support can function as a medicinal buffer or respite and assists by sustaining emotional health and well-being; safeguarding an individual against the effects of stress, traumatic change, and maladaptive outcomes. However Anderson and Lopez-Baez (2008) stated that the relationship between commonly experienced stressors and PTG is not yet clear and therefore call for studies to explore how stress initiates the growth processes, and under what circumstances adaption is achieved. Thus although Study One confirmed that greater perceptions of social support are equated with higher levels of PTG, certain questions remain unanswered. For instance: How does this process of growth across the transition to motherhood unfold? What is it about social support that seems to facilitate PTG? And what types of social support are beneficial compared to those that are not?

By examining the types of social support and the processes involved in producing the positive effects, we can build on these and develop strategies, programs, and support systems to facilitate women through the transition to motherhood. Additionally, developing a greater understanding into the core elements of personal growth, development, and adjustment may reveal a collection of areas relevant to the general human growth process. Consequently, Study Two employed a qualitative approach to explore women's experiences and perceptions regarding the social support they experienced during the transition to motherhood, in order to illicit greater understanding of its relationship to PTG. Furthermore, Study Two sought to explore the overall process of transitioning to motherhood.

Study Two

Based on the results of Study One, a subsequent qualitative investigation was carried out to ascertain a holistic understanding about the process of adjustment across the transition to motherhood. Additionally it investigated how and why the significant predictor variable of social support (from Study One) facilitated PTG across the transition to motherhood (Study Two). In particular, Study Two utilised semi-structured interviews to investigate the social support the women perceived during the experience; the types of network members; how they distinguished between social support that was beneficial versus unsupportive and why; along with their view on how it might have been improved. This study also sought to identify the perceived stresses and whether social support interacted with participants' stress. Additionally, Study Two inquired about any PTG outcomes the women experienced as a result of the transition to motherhood, and attempted to elucidate in which areas of their lives and in what way it altered them (if at all). Finally, the participants were asked to comment on whether they perceived any links between the amounts of support they felt and any positive outcomes they experienced across the transition to motherhood.

Research methods previously employed in the area of transitioning to Motherhood

A large portion of the research investigating the transition to motherhood has tended to focus on the potential negatives and clinically diagnostic psychiatric outcomes (e.g. PND, anxiety, and maladaptive adjustment etc.). As Smith (1999, p281) puts it: "Often the pathological has been stressed, at the expense of the 'normal'." This tendency however, neglects the range of possible experiences of women during the transition to motherhood. Whilst we now have a fair amount of insight into the factors which are associated with detrimental outcomes, less is known about the positive features connected to favourable adjustment to motherhood. For example we have

literature stating that factors such as social support are beneficial during the transition to motherhood (Albright, 1993; Bost et al., 2002; Hung et al., 2005; Luo, 2006; Page, 2004; Hurdle, 2001; Goldstein et al., 1996; Goldstein & Genero, 1995; Crnic & Greenberg, 1990; Richardson, Barbour, & Baubenzer, 1995; Cassel, 1974; Crnic et al., 1983; Cox et al., 1989; Hopkins et al., 1984; Levitt et al., 1986; Tinsley & Parke, 1984) however, little is known about how, why, and what types of social support best facilitate women's adjustment. The field calls for new research to extend the theorising around the transition to motherhood (Cadell et al., 2003; Smith, 1999), and in particular to focus on the different supportive provisions provided by women's support networks (Bost et al., 2002). Additionally, future research needs to examine context-specific social support, because distinct modes of support are needed at different points during the transition to motherhood, and one would suspect the types of support required may also differ depending on the individual and their unique psychosocial situation (Vaux, 1988).

Smith's (1999) study utilised an idiographic and qualitative approach to investigate the transition across pregnancy and early post-natal adjustment in women, (a research methodology he has also used successfully in the past; Smith, 1995). Semi-structured interviews (such as those employed during the two Smith studies and also in Study Two of the current research) are an ideal way to illicit a particular individual's account of reality. The investigation is less concerned with an *objective reality*, and instead seeks to understand individual women's experiences of reality. Thus the task relates to facilitating each woman to provide her *own* story during data collection. Although the account of concern is not the investigators, analysis does require the researcher to interpretatively engage with the interview transcripts to uncover the overarching themes and commonalities derived from the sample. This is an emergent

process and is primarily concerned with discovering and recording an experience rather than testing preconceived hypotheses, it moves from examining individual cases towards a tentative grounded theory pertaining to the transition (Smith, 1999).

Qualitative interviews provide rich narratives, and the analysis of these involves searching for patterns and common themes amongst the differing accounts, all the while constantly modifying and evolving the hypotheses that emerge from the data;

integrating and refining them to incorporate new pieces of information (Smith, 1999).

The outcome of the process aims to identify significant constructs from the participants' narratives of their experience.

Another benefit of this methodology is that it is 'woman-centred.'

'Woman-centred' refers to a perspective which takes women's accounts as *central* and does *not* consider women to be at the 'mercy of their hormones' or in any other way intrinsically pathological. It relies on the assumption that whatever individuals report about their experience should be taken *as their interpretation of reality*. (Nicolson, 1986, p 146, italics in original).

Too often people's, and in particular women's experiences of normal and natural events are over pathologised. Therefore the current studies did not specifically select women who had complications or medically defined 'traumatic' births, nor did it seek to include only those considered to have 'normal' or 'easy' and uncomplicated births and post-natal adjustments.

Study Two allowed women to self-select to participate in the study and utilised a snowball sampling methodology, it sought to explore any commonalities that arose from the different experiences of women in the sample. Consequently this could either be viewed as a limitation or strength depending on the reader's preference. None-the-less, the findings from the current research are likely to have implications for psychologists, and other health providers who may be able to utilise these findings to

encourage and enhance positive outcomes, coping, and adaptation in individuals experiencing a crisis and/or stressful life transition, such as the onset of motherhood.

Phenomenology

As Study Two sought to elucidate the dynamics between social support and PTG across the transition to motherhood, the theoretical approach of phenomenology was considered appropriate. Phenomenology seeks to discover the essential properties and structures of subjective experience via the study of reflections about a particular phenomenon (Urquhart, 2011; Willis, 2007; Patton, 2002; Moustakas, 1994). This process of interpretive inquiry dates back to the 20th century, originating from the work of Edmund Husser (1859 – 1938) within the philosophy discipline. Central to phenomenology is the concept of *intentionality* which relates to the intended target of one's conscious experience and the meanings assigned to it (Urquhart, 2011). The essence of experience pertaining to the phenomenon is explored and reduced to its base components in order to better understand it. However the ultimate purpose is not the reductions, instead it aims to understand in what way the different components interact to form the overall lived experience; akin to a gestalt where the sum is greater than its parts. Thus qualitative data such as interviews are conducted with participants who are encouraged to openly discuss and reflect upon the phenomenon in question with the intention of developing an authentic, comprehensive, and detail rich understanding of the experience in its entirety.

Rigour

The credibility of qualitative findings refers to the sense of plausibility and/or probability of the obtained results. It relies upon triangulation: data is considered to be triangulated when it employs the same method to amass data from a range of sources, while methodological triangulation involves obtaining data via multiple methodologies

(Patton, 2002; Urquhart, 2011). The triangulation will either verify findings, or in the case of divergent findings might indicate further complexities within the phenomenon of interest. The present studies provide methodological triangulation by means of a mixed method design. Additionally data triangulation was achieved via the collection of ten semi-structured interviews with women who had undergone the transition to motherhood. The sample size of Study Two was considered to be sufficient once saturation of thematic data was achieved, this was apparent by the tenth interview. Saturation of data refers to the point at which similar themes are mentioned by most participants, with little or no new themes emerging (Morse, 1994).

Transferability rigour is evidenced by providing meticulous descriptions of the research process. Lincoln and Guba (1985) suggest that the inclusion of elements such as context and the specific process of analysis enable research consumers to determine whether the findings are reasonably valid and therefore analogous to the wider population. Hence the necessity of stipulating sample recruitment techniques, compilation of information, and analysis of the data. Interpretative rigour is another aspect contributing to the trustworthiness of qualitative research. Within this component, the focus centres on the perceived accuracy of identified results and whether they appear to appropriately reflect the participants' views or opinions. In order to achieve this, it is essential for the researcher to signify the process undertaken when interpreting findings from the collated data. With the inclusion of extensive extracts from interview transcripts, the research consumer is able to view the original passage of discourse and the ensuing theme identified by the researcher. This bare all approach also enables the consumer to ascertain their own impressions from the rich idiographic raw data, whilst also providing them an opportunity to closely engage with the phenomenon under investigation.

Lincoln and Guba (1985) also recommend the use of an audit trail, whereby the researcher documents the tasks and procedures carried out across the course of the qualitative study and analysis. A fastidious account of the entire process is recorded, including raw data (transcripts), the processes and phases involved in analysing the data, methods of data reduction and synthesis, and process notes etc. The utilisation of an audit trail ensures the process and outcome is both dependable and able to be confirmed; adding further weight to the trustworthiness of the qualitative investigation (the audit trail for the present research is detailed later in the paper). Patton (2002) and Urquhart (2011) describe the significance of approaching phenomenological research with an Epoche, which is a conscientious attempt on the researcher's part to be aware of any possible personal biases and to then place them aside during data analysis. This is done to reduce the researcher's preconceptions that pertain to the area of study, and instead allow them to immerse with, and understand the participants' lived experience of the phenomenon. In the present study, this was perhaps facilitated by the fact that the researcher has not yet transitioned into motherhood and thus is quite naive to the whole process.

Study Two Method

Participants

A sample of 10 women who volunteered from Study One were interviewed, that is women aged 18 and over who have given birth at least once. Recruitment of participants started with a convenience sample (women known to the researcher) and then via snowballing (initial participants were asked to pass the researcher's contact details and an Interviewee Information Sheet Appendix E on to other potential women). All potential participants were informed that their participation was voluntary and confidential. Women who agreed to participate in the study were then contacted by the

researcher to arrange a time and location for the interview convenient to the participant, all participants signed a Consent Form prior to their interview commencing (See Appendix E, F, and G).

Materials

Participants were provided with an additional Interviewee Information Sheet (Appendix E) and were given the opportunity to ask any questions prior to the interview recording beginning. Those that consented to participating were then asked to sign a Consent Form (Appendix F). Each interview was based on the questions listed in the Interview Schedule (Appendix G). As suggested by Smith (1995) the interview schedule was created prior to interviews to ensure the links between social support and PTG were covered, it also allowed for the identification of any difficulties with the questions and possible ways of managing them. This enabled the researcher to immerse herself within each participant's account during the course of interviews and to probe any interesting areas brought up by the participant. (For further details see Smith's, 1995 chapter on Semi-structured Interviewing for a detailed description of how to construct an Interview Schedule).

Procedure

The recruitment of participants began by obtaining written consent for their participation in the interviews and arranging a time for the interview to be conducted. The interviewer commenced with a brief introduction of herself and an explanation of the study's purpose and procedure in order to build rapport and orientate participants to the study. Interviewees were given time to read the Interviewee Information Sheet and an opportunity to have any questions they had answered by the interviewer. The interviewer then requested to start recording the interview (the digital audio-recording device was borrowed from Edith Cowan University). The interview questions sought

information about women's experiences of social support during the transition to motherhood; (including the people involved in their support networks, the positive and negative aspects of the support, and how they feel the support could have been improved). The interviewer probed answers for additional information where necessary. If the interviewer felt a participant had become too distressed during the course of the interview, the participant was offered a break and/or to terminate the interview. None of the participants chose to terminate their interview, although most women took short breaks to tend to their child's needs during the interviews. All participants were reminded of the help lines on the Interviewee Information Sheet at the end of interviews in case they desired or required further follow-up with any of the content raised during their interview. At the conclusion of all interviews, participants were thanked for their time and reassured as to the confidentiality of their responses.

Analysis

Following the completion of all interviews, the recordings were transcribed by the researcher. To ensure participants' confidentiality, all recordings were given a pseudonym and stored in a password protected electronic file on the researcher's computer; following transcription the digital voice recordings were erased. (Verbatim transcripts of the interviews will be securely stored by the university for a period of seven years following the completion of this project). Transcripts were then examined with an interpretive phenomenological analysis orientation according to Smith's (1995) form of thematic analysis. This involved the transcripts being read and re-read in a cyclical manner by the researcher in order to identify common themes and sub-themes in the participants' experiences. (Urquhart, 2011; Hinchliff and Gott, 2004; Ranson, Siler, Peters, and Maurer, 2005 have also employed thematic analyses to analyse interview data).

During the initial reading any and all themes were documented from each transcript in line with the idiographic approach suggested by Smith (1995). Following this the researcher attempted to collate similar subject matter into over-arching themes and sub-themes. The transcripts were then re-read and each relevant passage was assembled under the appropriate theme heading to develop generalised findings from the qualitative data (Smith, 1995). Upon the completion of this, each section with its associated quotes was read in order to verify it belonged within that sector. The next phase involved reducing data by the researcher once more reading the grouped data and attempting to create a prioritised list of the most pertinent quotes within each section (See Smith's 1995 chapter on Semi-structured Interviewing in *Rethinking Methods in Psychology* for a more detailed description and explanation of qualitative data analysis). All analyses to this point were conducted by the one researcher. The themes were then checked by the researcher's supervisor as a form of member checking (Lincoln & Guba, 1985) and to aid in further reduction of the number of quotes within themes. All the while the researcher kept process notes and an audit trail regarding her thought processes and ideas for analysing and drafting the results of Study Two.

The entire thematic data set was then entered into the results section to be integrated and synthesised with prose pertaining to the interpreted meaning and relevance under each theme. As suggested by Smith (1995) discussion and explanation of the findings were interspersed with verbatim extracts from the transcripts to exemplify the themes and sub-themes.

Results, Interpretations, and Discussion of Study Two

Thematic Content Analysis of social support across the transition to motherhood revealed the following four major themes: reassurance, help seeking, self-efficacy, and changes in the women’s identity and priorities. A number of expectations and recommendations were also provided by the participants. (See Table 4 for a complete list of the themes and sub-themes derived from the qualitative data). Although Study Two loosely focused on social support, many of the participants’ quotes directly supported the five areas of change typically reported in PTG (Tedeschi and Calhoun, 1996), including: (1) increased appreciation for life; (2) more meaningful interpersonal relationships; (3) an increased sense of personal strength; (4) changed priorities; and (5) a richer existential and spiritual life. In order to capture the richness of the experiences the women underwent, each theme and sub-theme will be discussed in detail with the aid of quotes from the transcripts.

Table 4
Social Support Themes and Sub-themes across the transition to motherhood

| Themes | Sub Themes |
|--------------|---|
| Reassurance | Intervention in worry cycle Confidence building Emotional processing Experiential learning process and normalisation Mothers’ groups concurrent experiences Trouble making new networks Avoiding being a panicky parent Constant changes fear and mastery Negatives Aloneness Proximity of supports |
| Help Seeking | Difficulty identifying help Perceived inability to use support networks Practical support Need for social contact and comparison Direct vs indirect knowledge delivery |

| | |
|-----------------------------------|--|
| | Information resources Self-initiated knowledge seeking |
| Self-efficacy | External confidence Internal confidence Expectations/good-enough mother Perceived need for control vs flexibility Sense of achievement Shock |
| Changes in the Self | Identity (tolerance, perspective, relaxed) Fluctuating moods as adapting Shifts in independence-dependence Perceived loss of self vs increased complexity Physical body self-concept Increased responsibility and other-focus Increased appreciation of relationships Altered sense of love Changed priorities |
| Expectations | To be the 'perfect' mother 'Stepford Wife' Comparing self to perceptions of other mothers Expecting mothering to come naturally Expectations of catering to baby's every need Expecting to have everything under control Expectations of co-parent/other members of support network |
| Recommendations to other new mums | Build and sustain social support networks Avoid trying to be 'perfect' Try to set up routines, but allow flexibility Maintain self-care as a priority Expect money stress and changes to budget Get information from reading books and courses |

Reassurance

With the transition to motherhood all participants commented on their perceptions of embarking on an unknown experience in which they frequently grappled with both the unexpected and their own self-expectations. This experience seemed to leave most women feeling quite anxious about whether things were progressing

‘normally.’ Not surprisingly the women sought reassurance from a number of social support networks, including partners, family, friends, medical professionals (doctors, nurses, mid-wives etc), government parenting clinics, mothers’ groups, and telephone help lines to name a few. The assortment of people that comprised the women’s networks in the sample is consistent with those reported in the support network literature (Crnic et al., 1983; Hopkins et al., 1984; Levitt et al., Tinsley & Parke, 1984, Cox et al., 1989; Goldstein et al., 1996; Goldstein & Genero 1995; Crnic & Greenberg, 1990; Richardson et al., 1995; Bost et al., 2002; Crockenber, 1981).

Existing evidence suggests social support can act as a buffer against stressful life events (like the transition to parenting), and is frequently associated with better psychological functioning, physical health, and social adjustment (Cohen & Wills, 1985; Crnic & Greenberg, 1990; Koeske & Koeske, 1991; Kaplan & Toshima, 1990; Sarason et al., 1997). Additionally, the beneficial effects that social support provides for parenting have been demonstrated for infants (Crockenber, 1981), pre-school children (Jennings, Stagg, & Conner, 1991), and throughout childhood from age two to 12 (Szykula, Mas, Turner, & Crowley, 1991). The value placed on support networks seems to link in with the second factor in Tedeschi and Calhoun’s (1996) PTG model in which interpersonal relationships are perceived as more meaningful following a traumatic or stressful event. When trying to understand the impact that the support networks’ reassurance had on mothers in the current study, a number of participants’ quotes seemed to elucidate the process. The following quote illustrates how the reassurance seemed to prevent the mother from becoming extremely stressed and agitated over things by intervening in the anxiety cycle.

(P3) “It was just having someone to listen to me; people who took me seriously. People who were able to give the reassurance and a bit of practical advice. I’m a person who worries... So it was very nice to be able to have people come along and go ‘you

don't have to worry, that is fine.' And there were times I needed that and that would then break me out of the worry cycle and I would never get worked up about it because I had someone who was able to intervene... it would help me get it back in perspective. That definitely helped prevent the stress turning into, you know real stress as opposed to just little stress."

Additionally, the reassurances appeared to calm new mothers' nerves, soothe concerns regarding their capabilities as a parent, inspire confidence, and self-efficacy in their new role. This finding appears to tie in with the third factor of PTG in which participants' felt an increased sense of personal strength (Tedeschi & Calhoun, 1996).

(P1) "[Social support] just seemed to instill in me calmness and a belief that yes everything will be alright. So I was able to, when I was really worried and stressing out about whether I could fulfill my role as a parent, and be a mother, it just seemed to give me that little bit of hope that yes, I was going to be ok and do the job properly."

(P8) "At the time all I wanted was a kiss and cuddle and a 'there, there, everything's alright, you're doing a great job, you're a marvelous mother; you still look fantastic, even though you don't brush your hair and you're in your pajamas all day, and the house is great.' My husband was really good; he said you know you don't have to do all this stuff. But unfortunately you're your own worst enemy sometimes. It did take a while for me to finally realize and now I couldn't give a stuff."

The next quotes seem to describe the way in which having someone to talk to and reassure the mother provided a space for her to process and work through her emotional reactions during the transition. This could be interpreted as further evidence for the second PTG factor in which interpersonal relationships are considered more meaningful (Tedeschi & Calhoun, 1996).

(P5) "Talking to a mid-wife at the chemist just helped make sense of things early on. I suppose it just made sense of what was normal and kind of providing a bit of reassurance... It was an opportunity to vent or make sense of what was happening, so at least then you could learn from it. In relation to the social networks, I think I probably drew more upon them to help make sense of it."

(P4) "I guess because I was able to talk about it to someone at some stage, I was able to shed some of the hopelessness and the depression, and the feeling that everything was on top of it. You

could kind of come out of it and see a light at the end of the tunnel, or you know talking about it you'd just sort of go oh well you know it doesn't seem that big-a-deal after all. Or it's not insurmountable anymore. So having someone there to listen or if I was really stuck; you know what do you do here? Or what have you done in the past? Being able to ask that question and hear, you know even if you didn't agree with it, at least other options. It kind of opened your eyes to a new awareness and you kind of go, oh well even if I don't do that maybe I could look in this source that they mentioned."

It also appears that many of the mothers coped and learnt via experience, or a trial and error process. When the new mothers came across a problem or felt they were struggling to adjust they would trial alternative approaches, much of the time this advice and reassurance came from another mother (either one that had previously raised children or one that was concurrently raising a child). Not only did it provide new information, but the advice seemed to normalise the trial and error process for transitioning mums. It is likely that the experiential learning process during the post-birth adaption phase may help women form new foundational assumptions, striving to learn how to predict, control, and find security in their new life as parents (Rini et al., 2004). Across time, the trial and error process lead to mastery and a greater sense of parenting efficacy (de Montigny & Lacharite, 2004; Bandura, 1977) As explained by Beder (2004-2005), people's assumptive worlds are generated and solidified by a multitude of experiences, thus it seems the transition to parenthood requires some adjustments in their pre-existing assumptions in order to re-orientate the individual according to their new circumstances and perceived purpose.

(P4) "My mum kept calling up and saying 'oh keep going, try this' you know just very resourceful and suggesting different things to try, and just keeping me very positive and you know reassuring; building my confidence that I can do it. 'It does happen, it is ok' you know that sort of thing was very, very informative. Whereas my mother-in-law was, I think she was just aware about how much pressure new mums are under and she was reassuring that it's not the end of the world if you do need to go onto baby formula."

One of the most talked about sources of reassurance came from mothers' groups, in which the mothers detailed the importance of being supported by other women who were going through the transition at the same time. This is perhaps an integral component of coping with the transition to motherhood and again places increased meaning and value on interpersonal relationships (Third PTG factor, Tedeschi & Calhoun, 1996). Such a finding further validates those of Hurdle (2001) and Bost et al., (2002) in which it was found that women readily recognised the importance of social support networks and tended to seek them out more than men, networks were also found to be especially salient during the transition to parenthood.

(P4) "You always have that phase where you're wondering if you're doing the right thing, and you know you look at your baby and you're wondering if they're doing or achieving the milestones and if they're getting enough food and things like that. So at these group meetings which occurred once a week, we were able to talk about oh you know my baby is doing this, what's your's doing? Oh ok so it's the same, it must be about the right thing... They were more accessible and friendly and approachable than having to organise a medical check up... because it was more of a friendship thing, so it was satisfying information, reassurance, and you know developing a friendship and giving you more feedback that way. You were more equal sharing information between each other, rather than an authority figure, such as a doctor or a nurse saying this is what should be happening."

(P6) "Once I did find that mothers' group I definitely felt better about things. I found that to be really helpful and really reassuring; I was definitely less stressed once I knew that was there, you know other people experiencing similar things. It wasn't just that I was really crap at it. It's a very hard thing. We were all at the same stage, learning everything at the same time."

A few new mums also described their concerns and difficulties around developing new friendships. The drastic changes in their routine from pre-birth (often in working environments) to post-birth (with the majority of time spent home alone with the baby) limited their social interactions. This validates the view espoused by Knoester and Eggebeen (2006) that the extreme reorganisation of new parents' lives can have far-

reaching implications for their social and occupational participation. Unfortunately, this also resulted in reduced usage of adult-to-adult conversation and intellectual skills, along with less knowledge of the current affairs in their communities or wider cultural contexts.

(P6) “When I first had my daughter it was like I was just in this little cocoon where I was just focused completely on me and on her and just on babies and nappies. That’s another impediment to actually going out and meeting people, because all you can talk about is babies and how much sleep you’re not getting.”

(P4) “You tend to be more confident and expressive when talking about problems with a friend you’ve had for years, whereas with someone new, like the mothers’ group was at first, it just feels like such a risk opening up to them and instilling too much information and scaring people off cause they’re going ‘wow, these people are you know a bit intense or something.’ You just want to ease people in and divulge little bits, a little bit at a time. So with the mothers’ group that was certainly a problem, like if it was related to the baby that was ok, but I felt a bit limited in that respect, they were mostly talking about mothering problems or baby related problems, or you know the good things about that. It centred around that a great deal in the early days almost solely.”

Many of the new mums spoke of their concerns about people thinking they were a ‘panicky-parent’ or that they were stupid for seeking help. At times these worries influenced who and how often they would search for reassurance from their support networks. It is possible that concerns such as these periodically limited their access/usage of networks, consequently preventing them from freely engaging with the second PTG factor: more meaningful interpersonal relationships (Tedeschi & Calhoun, 1996).

(P7) “My cousin had twins and she said anytime I wanted to call her I could. So I’d call and ask ‘What do I do now? Do I feed them first or bath them first, what do you do?’ She just said ‘Do it whichever way feels best for you, and comfortable for them.’ So it’s just the things that you’ve got no idea about. It helps to have someone to go to and someone to give you that reassurance... she’d known me my whole life so if I sounded stupid it didn’t matter.”

(P9) “I thought there was something wrong with my son so I took him to the hospital, but they seemed to just think it was a parenting issue and sent me away with a pamphlet. But my mother-in-law who was staying with us at the time, has had seven children and she also thought something was wrong. I figured she knew babies so it made me feel more confident and I took him back to the hospital and it turned out there was a problem.”

Additionally, the frequent and at times sudden changes in rhythms of new babies meant that just as the new mother began to feel confident and competent, she would again be thrust back into the unknown. One of Janoff-Bulman’s (1992) core foundational assumptions of an individual’s worldview was that the self is worthy, likable, moral, and capable. The constant changes and attempts to master motherhood are likely to lead new mothers to question their capabilities as a parent and thus lead to uncertainties about the perceived success of their adaptation to the new role (de Montigny and Lacharite, 2004). It may also lead to doubts or insecurities regarding the third PTG factor; although once mothering skills and routines are mastered it may produce the increased sense of personal strength and abilities typically reported in PTG (Tedeschi & Calhoun, 1996). The next few quotes highlight the fear experienced by new mums, which can at times be followed by a sense of mastery.

(P3) “One day I called another mother friend going ‘the baby is just sleeping and sleeping, he never sleeps that long,’ you know, ‘have I done something wrong?’ She said ‘No that’s perfectly normal for him to suddenly sleep for like two hours.’ I was like ‘oh ok, sorry to have interrupted your Tupperware Party.’”

(P4) “I guess the reassurance kind of renewed my hope, or sense of confidence in myself. Or even if you didn’t feel confident right away, it gave you something to think about, new avenues to look down, and inevitably something would work or the baby would go out of that phase or whatever the problem was. It would suddenly not be such a big deal anymore, and you’d go ‘Yeah! I’ve coped through that, and you know I can do this, I can do that; I can do anything almost!’”

In a few instances, some of the mothers discussed negative or unhelpful aspects of the social support they received. Often the detrimental impact seemed to be related to the perceived lack of reassurance, criticisms, and horror stories from others which seemed to leave the new mums with reduced confidence. If the new mum was also required to complete tasks to accommodate for network members visiting, it increased pressure. Additionally, rushing in and/or assuming too soon that the mother could not cope with the baby also seemed to result in a negative experience. Negative social support experiences have been strongly linked to increased risk of PND (Dennis et al., 2004; Honey et al., 2003; Mallikarjun & Oyebo, 2005; DSM-IV-TR, 2000; Albright, 1993). It is possible that negative social support experiences may deprive people of the more meaningful interpersonal relationships and increases in parenting efficacy and personal strength associated with PTG (factors two and three of Tedeschi & Calhoun's model, 1996).

(P9) "My father-in-law was just being so full on, picking up our son as soon as he made a noise and always saying 'here give him to me.' I think that made me more stressed cause I was like, you're acting like I'm not capable of looking after my child!"

(P6) I didn't have a lot of confidence in the first four weeks after having my daughter because I was suddenly- I knew I wouldn't know what to expect, but I really didn't know how it was going to go. And then because things weren't working the way I thought they would, I didn't have any confidence and then going to a centre for help and you know having the nurses criticise you for not being able to do something properly, it was quite demoralising."

Many of the new mothers described pervasive feelings of aloneness in the early parts of their transition. This feeling seemed to make the mothers crave adult interactions, whether in person or over the telephone. These expressions of isolation are particularly concerning since low levels of social support have been linked to increased risk of PND (Albright, 1993; Bost et al., 2002; Hung et al., 2005; Luo, 2006; Page,

2004). It seems the innate desire for interpersonal connection seen in humans may be due to the role they can play in recovery, adjustment, confidence, and resilience following traumatic events and/or stressful life transitions.

(P8) “You feel as though you’re the only one who’s ever had a baby and it sounds ridiculous but it’s true. You know you think, there are a lot of people feeling this, but you don’t think about it at the time; you realise that later.”

(P1) I just felt like there was something wrong, and it wasn’t until I read the Nursing Mothers’ Magazine and realised I had post-natal depression... after I read that I was ok. I thought ‘hey other mothers’ feel like this; I’m ok.’ That helped a lot. Just for those times when you feel a little bit out on a limb and you just want someone to talk to or have a cup of tea with.”

A few of the new mothers specified that face-to-face contact with support networks was more beneficial for them.

(P4) “It felt more fulfilling to see someone face to face. I guess you get all the physiological cues, you know the frowns and the nods and understanding that you just can’t really get over the phone. So I guess you’re more likely to open up because you know if you start crying over the phone to your mum, she’s just going to get really stressed and be upset for you and worry more over you. You know you don’t really want to do that as much as if you were to go next door and have a cry and they can put their arms around you and offer that kind of soothing and support.”

Help Seeking

Many of the women described feeling initially uncertain and hesitant when it came to identifying what type of help would benefit them across the transition to motherhood. Furthermore, they often reported feeling lost or unconfident in trying to search for avenues which would provide the desired resources or information the women were seeking.

(P1) “I probably didn’t know where to source more help, or the sort of help that I knew would help me with breast feeding and the new things that were happening with my baby. I don’t think I really asked a lot of questions, I just... don’t know, I was very inexperienced... I don’t think I really realised that the support services were there and to what extent they would be

able to help me. Just a lack of knowledge on my part I guess.”
(P10) “You don’t know what you’re looking for, I mean babies have all sorts of sounds they make when they’ve got wind or when they’re tired and that. And at first you just don’t know these things, let alone where’d you’d go to find out about them!”

A few of the mothers seemed to discuss a number of reasons why they felt unable to utilise their support networks for help at different times. Frequently reported concerns included feeling they could not trust others to adequately care for their babies, their own separation issues, self-expectations about having/wanting to do it all on their own, anxieties related to the perceived burdening of their support networks, and negative experiences when seeking help in the past. Due to the crucial role social support plays in positive adjustment to motherhood and PTG, the perceived inability to access networks is disconcerting.

(P4) “I tried to do it on my own... I was trying to be very strong and cope, and do it all by myself without relying too heavily on my husband. I felt hindered by that I guess, because I didn’t want to put too much pressure on him, in case he melted down and couldn’t cope with anything. He was already probably close to breaking point... So I couldn’t really share or moan about that too much. I kind of felt like I was doing it by myself... There was this community nurse that seemed like a tyrant! I didn’t ask many questions or get much helpful feedback during those particular meetings. I also noticed that the other mothers in the group seemed to feel the same way; we just weren’t as relaxed or game to ask questions. This nurse was so abrupt and her answers seemed inconsistent so you ended up feeling confused.”

(P9) “Sometimes I felt overwhelmed by my family’s support and too much help then made me feel like I wasn’t a capable parent. It made me feel really, really stressed and under pressure.”

Aside from obtaining reassurance from their support networks regarding their transition into the mother role, the women also sought practical help and information. When it came to dealing with the stress of having a new baby and handling the physical care and day-to-day responsibilities, the majority of mothers attempted to utilise their networks. Tasks ranged from watching the baby while the mother slept or tended to her

own needs, through to the delegation of household chores. Whilst many of the mothers continued to grapple with high self-expectations to be able to manage everything on their own, it seemed those that relied more on their support networks for practical help, tended to report less stress and adjustment difficulties in their new role. This further validates the importance of meaningful support networks to facilitate PTG (factor two, Tedeschi & Calhoun, 1996).

(P8) “I thought that I could do it all myself and initially rebuffed a lot of people and said ‘no, no, it’s alright.’ Cause the house was a mess and I didn’t want people coming over and seeing my house. But I was very lucky that I had a mid-wife who said to me ‘don’t do it all yourself; you’re not superwoman you know, get help!’ After trying to do it all by myself for two or three weeks, I suddenly realised that there is no way you can do it all on your own! [Laughing] You’ll go nuts! The mid-wife said ‘look if you have people come round, you say to them you’re doing the washing up, you’re going to put clothes on the line, do you want a job ok you’re folding clothes...’ and that’s what I did and it was great. I warned everyone if you want to come and visit you’ll get a job and they did.”

(P5) “In those early months, if I’d had more support as in other relatives around, I think some of those initial stresses may have been alleviated. But I think if I’d had even less support, I would have been a lot more emotionally unstable.”

After the initial few weeks, many of the mothers explained that once their partners had returned to their regular work patterns, and other visitors slowly declined in frequency their needs for social contact increased. By this stage mothers were beginning to feel more capable in terms of feeding and caring for their babies, however their focus began to shift towards checking the child was on par with developmental milestones and being able to discuss their challenges and successes with like-minded individuals. This appears to relate to factors two and three of Tedeschi and Calhoun’s (1996) model of PTG; meaningful interpersonal relationships, and increased sense of personal strength and abilities. Much of this information was provided by mothers’ groups with a comparable range of similarly aged children.

(P5) “Once everybody went back home and my husband went back to work, I started to wonder who I could then draw on who would be going through the same sorts of things. Fortunately through the Community Health Centre, they had a new parents group and I started it from there. It was 4 x 1.5 hour programs, with the idea that after it finished you would then network on your own initiative and keep meeting up; and we still do... The mothers’ group is non-judgemental and if you say you’re having a bad day then that’s ok. If you’re having a good day or if you’ve had a good experience or a bad one, then you can just share that with the group and they’ll either provide their suggestions as to what’s worked or just emotional support outside of the family. It was an excellent experience really.”

It also appeared that the preferred method of knowledge delivery differed depending on the type of knowledge sought and the point along the transition. For instances prior to the birth and during the actual birth process, mothers’ tended to describe a desire for more directive and factual types of support and information (e.g. how big the baby would be, what pain management techniques are available, what the mother’s body is physically doing prior to and during the birth etc). Whereas after the birth, particularly once the baby was home, mothers’ seemed to prefer more suggestive, indirect, experience based information (e.g. the mother’s personal coping and adjustment, soothing/settling/sleep strategies for the baby etc).

(P3) “I could tell them [support networks] about the things that were going wrong and they would give sensible advice. But they both sort of, if they disagreed with what I was doing, they wouldn’t come in and tell me – they didn’t boss me around. It was more like, well if you’re struggling with this you could try this, or I tried this, or you did that when you were a kid. So that was good, they were really open and suggestive with things.”

(P9) “My mother-in-law was good because she was providing advice; the difference between her and my father-in-law was that she would ask me if I wanted help, whereas he would just take the baby.”

Most mothers’ spoke of a *red book* they received from the hospital at the time of their baby’s birth. This book apparently contained a variety of factual information about

new born babies and multiple contact details for professional assistance and support.

This was a vital resource for mothers following the birth of their child and was frequently referred back to when the mother required information.

(P2) “The red book was given to me at the birth and it actually proved to be a very useful book, because at the time of the birth I sort of looked through it and then forgot about it. And then a friend told me about a phone number from it and I went and looked it up again. Then a bit later another mother from my group brought up the red book again, she said it talked about which foods to introduce and when; it was a nice guide. Since then I’ve actually looked at the book a fair bit.”

(P5) “I know the government provides packs to new parents. But it just seemed to be really disjointed, they give you a video, they give you some reading material, but there’s only so much you can read and make sense of, cause at that point is when you really want human interaction to help have that two-way communication to get answers. Rather than trying to read a book or read the frequently asked questions, and that sort of thing.”

The degree of self-initiated knowledge seeking varied between mothers, some appeared to be more passive in the process while others were extremely active and eager to discover as much as they could about the birth and care giving strategies. It is possible that the women differed in their levels of internal versus external loci of control, with the former tending to self-initiate knowledge seeking. As the mothers’ self-perceived levels of personal strength were not quantitatively measured in the current study, it is not possible to comment on whether an internal locus of control is associated with higher levels of perceived personal strength and thus a higher propensity for self-initiated knowledge seeking; although this is suspected to be the case.

(P1) “It never occurred to me to read books and find out some information for myself. So I suppose whatever the support staff told me and anything they volunteered, I sort of gleaned that information and tried it. I don’t think I really asked for a lot of advice. I only started reading more about what is to be expected for babies, as my daughter developed.”

(P5) “I really did just want someone to tell me... again is was someone telling me what to do; to go here, to go there, and then putting me in contact with those networks to help then reduce the stresses... I know I could have been a bit more pro-active, but at that time it was the last thing that was on my mind! I didn’t want to have to do a whole lot of research because it felt like I didn’t have the time to sit at the internet and search around and discount other websites that weren’t useful or you know, sit there and then write down phone numbers and then call people. I really wanted a directory and to just be guided and told, go here, do that; because I had enough decisions that I had to make about like when do I feed, when does she sleep, am I doing the right thing. That was consuming my brain. With the sleep deprivation as well! There was definitely that need to be directed as opposed to self-research.”

(P8) “I wasn’t going into this with my eyes closed, put it that way. Once I found out I was pregnant, I started reading! I did a lot of research beforehand and took a lot of advice from a lot of people who’d had children already.

Self-efficacy

Self-efficacy is the belief in one’s self regarding the necessary skills and abilities to successfully perform behaviours (Bandura, 1977) and appeared to be an important process in women’s adaption to motherhood. The women’s levels of self-efficacy varied greatly over time and between individuals. A number of factors were identified as impacting their beliefs including external and internal components. The external elements that seemed to build new mother’s self-efficacy were often derived from members of the support network who were perceived as encouraged her confidence and persistence. Again there seemed to be a link between helpful and meaningful support networks and mothers’ perceptions of personal strength and confidence; the second and third factors of Tedeschi and Calhoun’s (1996) model of PTG.

(P1) “I mostly trusted in, before I left hospital another woman in there who had just had her fourth baby said to me ‘Don’t worry, everything will be ok, just relax. Have faith in your own abilities as a mother. Follow your instincts, no one knows your baby like you do, so you do what you think is right and what works for you.’ That was a big help to me, I found it a great boost to my confidence. And as long as I could say she

said it'll be ok everything's alright, I could cope and I felt a lot better about dealing with most of the new issues in my life, with a bit more confidence."

(P3) "It was nice to have people go 'yes I've been there when your baby is screaming for like an hour and a half and there's seemingly nothing wrong and they're just screaming. You're not being a bad mum; that's just life.' It gave me more confidence that I was doing the right thing, because they were saying 'yes you're doing well, he looks great.' So yeah, the positive... um... feedback from them really built up my confidence."

(P4) "Mum kept calling up and saying oh keep going... to try and keep me very positive and reassured, it built my confidence that I can do it. She offered a lot of support over the phone and you know built me up morally with reassurance"

Another aspect of self-efficacy seemed to be intrinsic to some mothers' personalities, like an internal sense of confidence. It is possible that some of the women in the current study exhibited high levels of perceived personal strength prior to the transition to motherhood, which may have placed them in a better position for adapting to their new role and the prospect of increased levels of PTG. As reported in the Bost et al. (2002) study, individuals with larger support networks tended to report elevated levels of adjustment however the authors also discovered a negative correlation between the frequency of contact with the support networks and adjustment. Similarly, research conducted by Barrera (1981) and Wethington and Kessler (1986) indicated it was the *perception* of available social support which was most important, and that individuals with high perceptions of support did not necessarily need to access the support.

(P4) "I'm probably more resilient than I thought! A lot stronger than I thought. I can do a lot more on my own than I probably thought initially. I thought I was a strong person anyway, but this you know, proved oh yeah I can do it! I'm certainly more confident... like um, a growing sense of self-reliance. I was more confident in my self-reliance, more confident in my capabilities of looking after myself and a newborn baby, so even if I didn't do it really well, I can do it to survive until I can function better and then improve you know step by step as everything sort of comes together and you get more sleep and stuff like that... More personal strength, and confidence in what I can cope with."

(P9) “In terms of how I think I coped with the birth and stuff, I think that was more intrinsic if that’s the right word. It wasn’t necessarily any of the external factors or the social support; it was just what I had inside.”

Many of the women reported initially struggling with idealised expectations about mothering which often left them with feelings of inferiority. However with experience, most developed some understanding of the concept of a ‘good-enough mother’ and this seemed to reduce the pressure and build self-confidence.

(P5) “Coming to that realisation that you can’t be all and you can’t be perfect; having to re-adjust your own perceptions and expectations. I suppose it created an internal conflict and internal stresses when I was trying to be the perfect mother.”

(P8) “My own thoughts were the most negative thing, like when you think I’m not doing a good enough job...Breaking down those unrealistic self-expectations was crucial.”

It seemed that some of the women’s self-confidence was influenced by their perceptions of how much control they felt they had. Many of the women in the sample spoke in detail about how they felt they had more control and organization in their lives prior to the birth of their child (e.g. at work and over their schedules). This was viewed as a set of developed skills which allowed them to function more effectively; and was possibly evidence of their assumptive world prior to parenthood. However, once they became mothers those who tried to maintain high levels of control seemed to experience more stress and pressure. The majority of mothers explained that once they were able to relinquish a degree of perceived need for control, they tended to relax and enjoy their time with their child more. Greater flexibility and the ability to go with the flow seemed to be new skills that arose from their experience and were also likely to facilitate the emergence of a new assumptive world that incorporated their role as a parent. This seems to be where PTG factors like perceived personal strengths/abilities and changes

in the women's priorities were being discussed (Tedeschi & Calhoun, 1996, factors three and four).

(P5) "Particularly with our mothers' group, a lot of the ladies are professional women as well. So I talked to them a little about um... I suppose coming to terms with juggling work and – the transition from working to being a full-time mum. Normally you'd have control at work, or a certain amount of control and knowing what you're doing at work, to having a baby and thinking I know absolutely nothing with what I'm doing! [Laughing]. Knowing that there are control issues that you have to let go of... particularly when you've been in whatever field of work it is, and that you're probably very competent in what you're doing, and then suddenly you're feeling like you don't have control anymore and sometimes that inability to multi-task is normal. Whereas pre-baby you would have been able to do that. It can be frustrating, but you can work through it."

(P8) "I think new mothers today, especially when they're in their 30's after they have had a career... I think when women have had a certain amount of responsibility and they're pushed to go and get a career and they're pushed to have a job, and they're pushed to be independent, and then all of a sudden you're stuck at home with a baby... and you can't tell anybody what to do... all your routines are out the window, you don't talk to any adults, and it's really shocking."

The mothers who attempted to maintain high levels of control and rely more on themselves tended to turn down offers of help or deny themselves the opportunity to ask for support. Unfortunately, these periods were also often described as quite stressful and negative, and may have limited the PTG processes.

(P4) "Mum kept offering to come down and help out and I think probably I should have accepted the offer, but I was really aware that she wouldn't be earning money in the mean time and for them money was tight. So I tried to tough it out by myself... I guess my husband was just spreading himself too thin [with work and study commitments] and I didn't want to put any more pressure on him that way."

(P6) "I've always been financially independent and then to go into a situation, even though we'd been married for ages before we had kids, I was still financially independent... Then I had a child and suddenly I felt like I was getting pocket money even though that's not at all how my husband intended it, but that's how it felt to me. Suddenly it's not YOUR money even though it is OUR money. It's your partner out there

earning it, and you've never had that feeling before where you've not been the one earning as well."

Another important element of self-confidence and efficacy came from the sense of achievement the women experienced. This ranged from the achievement they experienced as a result of being fertile and bringing a child into the world, through to the achievement of their child's developmental milestones and growth. The women's dialog seemed to be moving towards existential themes and a greater appreciation for life, which links in with Tedeschi and Calhoun's first and fifth areas of PTG; increased appreciation for life, and richer existential and spiritual aspects of living.

(P3) "I wanted to have kids and of course I was definitely going to have them. So obviously having a kid was a real achievement in itself, yeah. I am much happier now that I've got the munchkin that I wanted for so long."

(P4) "It was like just see if she lives through today or tonight. You know getting her off the CPAP breathing machine was an achievement." [Premature baby].

(P5) "The general growth and development of our daughter was although at times frustrating, it also felt like a real achievement. There are those simple rewards that provide you with a warm feeling, sort of internal rewards."

In terms of self-efficacy and coping, a few mothers reported experiencing a profound sense of shock following the birth of their first child. Despite having approximately nine months to prepare themselves, it seems the final act of birth remains the defining transition point. For some mothers' it elicited fundamental thought processes for surviving moment to moment. The realization of being ultimately responsible for another person's life and the irreversible momentum of the event coupled with the birthing process (natural or cesar) seem to form the traumatic pinnacle of the transition into motherhood. (Obviously factors such as premature births or emergency procedures during the birthing process may exacerbate the degree of trauma experienced).

(P4) "I think I kind of just went numb and I didn't want to

think about anything else other than yep, we'll just deal with this day by day, or even hour by hour and just hope for the best. I guess I thought maybe I shouldn't get too attached, like being really brutally honest I thought well she's seven weeks early...I thought there's nothing I can do to stop the labour, it's going to have to happen. And then she was out and you have your first cuddle and you kind of look at her and go, oh it's my baby... I just felt numb thinking well if she dies, I don't want to be too attached. You know I don't want to be too devastated and I would have been still, but I don't know I guess I embraced that numbness and didn't think too much maybe. Maybe that kind of helped me afterwards with not having any support networks- or the ones that were there weren't quite as accessible. I just kind of embraced the numbness and you know, just don't think about it, just deal with it, just do it, just don't think..."

Researcher: "It sounds like the transition to motherhood, albeit especially because you had a premature child, it pushed you into a functioning mode of survival; life or death and just day to day dealing with what's right there in front of you?"
 (P4 response) "Yeah. I certainly didn't dwell on any issues. Yeah I think that's probably part of what the numbness was, it was dealing with the here and now; don't think too far ahead. If you think about it too much it just overwhelms you. So yeah it was definitely a survival tactic."

Changes in the self

The women described noticing changes in their identity following the transition to motherhood. This finding seems to link in with Tedeschi and Calhoun's (1996) third and fourth areas of PTG in which people tend to perceive an increased sense of personal strength or assets, and changes in their priorities. Research indicates that the basic beliefs of an individual's assumptive world are linked to their physical and psychological health as well as adjustment (Taylor & Brown, 1988; Rini et al., 2004). Pal and McAdams (2004) commented that PTG is a process whereby one constructs a narrative understanding of how the self was positively altered by a 'traumatic' event; this is then incorporated into the overall sense of self and becomes an identity defining life story. Examination of the transcript narratives regarding each woman's understanding of the impact to her self-identity as a result of the transition to

motherhood was quite profound. The types of changes in the self that were reported by participants in the current research illuminated integral components in the process of PTG and adaptation across the transition to motherhood. The majority of mothers described increases in their tolerance levels and ability to put stressors and incidents into perspective. In line with previous findings from Smith (1999), women well into the transition to parenthood perceived themselves as calmer, more agreeable, tolerant, and content to allow others to handle things so they could focus on what they considered important; leading to the development of a less competitive, more relaxed, and cohesive self conception.

(P1) “I think the stresses that I went through have improved me, I have a higher tolerance level for other people who have problems... I think I learnt that I could probably cope with a lot more, well I learned to cope with a lot more things than I had ever done before; learnt to have a higher level of patience. Also you sort of understand that everybody copes in their own way and there’s more than one way of coping with a problem to get to the positive end. There’s more than one way of bringing up a child.”

With their new found patience and perspective, the women also perceived themselves as being more relaxed, post-transition.

(P3) “I am a fairly organized person so that was pretty stressful for me to learn that I can just relax and go with the flow and it’s not the end of the world; it won’t shatter. So of the things that I’ve learnt out of being a mum, that’s probably one of the main ones, to learn to come to terms with it. You don’t come to terms with it over night [laughs]. I’m still learning it and I guess I’ll be learning it for the next 30 years! But yeah, you do just have to go with the flow and make it up as you go along. I am getting less stressed about the fact that I can’t organize it... So I save my emotional energy for something else. Becoming more flexible definitely has been a positive outcome... I always used to get very stressed at work when things went wrong and I couldn’t control them. I’m hoping that will be one of the things I’ll be able to be a bit more philosophical about in the future. You know, if I can cope with my baby re-arranging my life, then hopefully I’ll be able to cope with a manger re-arranging three hours.”

(P9) “Yeah definitely flexibility, and yeah I think I’ve become a lot more relaxed since I’ve had kids... before I’d put all this pressure on myself to get done what I’d planned to get done. Whereas after it, if I didn’t get it done then it was just like, oh well it doesn’t matter; it’s not going to be the end of the world.

The participants also spoke of fluctuations in their moods during the transition to motherhood; particularly in the earlier stages. Whilst some of the reported moods were likely attributable to hormonal changes during the final stages of pregnancy and the initial weeks post-birth (DSM-IV-TR, 2000), some of the alterations in their moods appeared to relate more to the actual transition and acquisition of their new roles as mothers. As documented by Knoester and Eggebeen (2006), it is not uncommon to see changes in the psychological well-being and identities of new parents. Research has also shown the transition to parenthood can have potentially negative effects on individuals’ mental health and marital satisfaction (Colpin et al., 2000; Luo, 2006; Campbell et al., 1992). Kaufmann (2002) equated the loss of one’s assumptive world with the loss of predictable surroundings and a secure sense of self, potentially leaving the person without a framework to orientate the self or function. Due to the perceived loss of coherence, safety, and security provided by the old assumptive world, it may result in mood instability and leave the self in a state of panic and danger (Kaufmann, 2002; Felming & Robinson, 2001; Beder, 2004-2005).

(P1) “You don’t realise the tiredness that you’re going to experience when you’ve had a baby. And you don’t realize how it affects your temperament and how you handle the baby. It’s just a deathly tiredness deep inside you that you never can experience until you’ve been through it... I seem to remember feeling happy that I was home, you know, that was the way my life just changed. I enjoyed being a mother even though I didn’t realise that I was still a bit... Oh its weird [laughs] I was sad, but I was happy... but the happiness was not as full blown as it probably could have been.”

(P9) “I think it’s made me more grounded and it’s made me more, I think for a while there I felt like I didn’t have a place where I belonged or like the kind of place I could call home. I think having this family now and I guess I do have a sense

of purpose and a sense of belonging; and I think that's why I don't have the travel bug anymore... there's no where I want to go now, cause this is where I want to be."

Another dramatic change in the women's identities corresponded with changes in the women's sense of financial independence and the loss or shifts in their occupations and careers. Since many of the women in the sample were in their 30's most had worked in and established professional careers and/or held jobs with moderate-to-high levels of responsibility for themselves and other staff. The literature suggests many women view working during their pregnancy as an overall positive experience (Pattison & Goss, 1996). However following the transition to parenthood women generally seem to struggle to maintain their rights, needs, and concerns as mothers whilst also sustaining their identity as valued functional members of their work environment (Milward, 2006). Following the birth of their babies and the necessity of taking at least some time off, the women in the current study had to adjust to changes in these areas. Knoester and Eggebeen (2006) highlighted associations between the changes in social and occupational participation of new parents and variations in their psychological well-being. Similarly Gjerdingen and Chaloner (1994) reported perceived psychosocial benefits in women who returned to work following the birth of their first child. Whilst it seems there might be some benefit for women returning to work, at this stage it is unclear as to whether the benefits relate to part- or full-time work and how it can be successfully integrated with the responsibilities of parenting.

(P6) "Financial independence was a huge thing! I didn't think about that, but that was a BIG shock to me. Not that my husband's ever made a big deal about it, but it's really important. I can't explain this to him when I go off on one of my rants about why I like going back to work, but just having that knowledge that you are, if anything ever happens, you're able to support yourself...After I had our baby, I felt like I was getting 'pocket money', even though that's not at all how he intended it, but that's how it felt to me."

(P3) "I had a few hazy bits early on in the pregnancy, which

was sort of more just the stress of realising oh I'm not going to have a job anymore! I'm in my late 30's and I've had a career for 15 years and I'm now going to go and be a full-time mum. I mean I love being a full-time mum, but it was like all of a sudden a huge part of my life was disappearing."

Although some women seemed to feel a loss of 'self' across the transition to motherhood, others appeared to only alter or integrate aspects of their new role into their existing identity. This finding parallels the dichotomous outcome opportunities that were described by Osofosky and Osofosky (1984) and Antonucci and Mikus (1988) in which the process of adjusting to parenthood could be either a disorganising period of deterioration or a developmental opportunity for growth. Kaufmann (2002) suggested that if a traumatic event is unable to be denied or defeated, it leaves the individual with two options: either to try and maintain the shattered old assumptions or to integrate the event and adaptively create a new assumptive worldview. It is possible that the women who tried to cling exclusively to the foundational assumptions of their pre-parenthood world were faced with incompatible demands; whereas those who were more flexible and willing to assimilate new aspects into the 'self' were eventually able to adapt and experience growth.

(P3) "It was a whole change of your identity. So having people around who knew me before and still saw me as ME, and treated me as me was good; but who also helped with the new stuff, I found that really helpful... I guess because [at my hobby group] you're mixing with other women who have been through it. Even though you're sitting there and you're talking about your kids, there is still that sense of you again. A lot of women in my group have done the same thing as me, they gave up work when their kids were little. I can now see them going back to work, and sort of see the progression ahead of me. So on days when I think all I am is a mum, I can go no I'm not and I can see I will get back into other things like work etc."

(P8) "I have a very good friend who doesn't do babies as she said [laugh]. She doesn't have children of her own, she has dogs. It was good to have somebody who wasn't a mum, to just sit there and have a talk about things that didn't concern babies at all... I wanted to maintain that connection to my pre-baby self

but also be able to add on the new mother side of me.”

Another aspect related to the mothers’ changing identities seemed to be associated with their physical body and the changes it underwent during pregnancy and birth. Most spoke of various attempts to re-gain their pre-pregnancy bodies, which appeared to be related to the women’s self concepts.

(P5) “People’s comments about how big I was getting towards the end of my pregnancy or in that early post-birth phase... you know you shouldn’t let it get to you, but you’re so sensitive to anything; it just sort of niggles at you. Especially cause your body has undergone so many changes by that point. Yeah that was a big deal for me also, coming to terms with not being a size ten anymore. That’s sort of what you focus on beforehand, before you have a baby it’s all about body image and you know that sort of stuff. But no more! [Laughs]... As for personal expectations, my husband and other family members were very good at the time to say well you can’t expect to have your pre-pregnancy body back and you can’t expect to do everything all at once. It was nice to hear them say that.”

Participants described an increased sense of responsibility following their transition to motherhood. In line with Tedeschi and Calhoun’s (1996) fourth PTG factor, the women’s priorities were altered as they entered motherhood, with greater emphasis placed on their responsibility to others. The participants often expressed their frustration that their husband’s/partner’s life underwent little or no change in comparison to their life. This could shed some light on previous findings in the literature which show women seem to experience higher levels of stress, more psychological symptoms, and lower marital satisfaction compared to men following the birth of a child (Bost et al., 2002; Luo, 2006). Additionally, prior evidence suggests there is a discrepancy in the perceptions about the amount of give-and-take in the spousal relationship of new parents, with wives reporting a decline and husband reporting an increase in reciprocity (Bost et al., 2002). It has also been shown that despite recent increases in men’s participation with household chores and child-raising,

women continue to be responsible for the majority of care giving and domestic labour (Knoester & Eggebeen, 2006).

(P1) “When I had the baby my husband’s life didn’t seem to change, but mine changed totally. I had someone who was wholly and solely dependent on me for everything. And yet he was still free to come and go and do things without having to consider someone like a baby first, before he did them. It’s just my life seemed to change so much and my husband’s didn’t, so I resented him because his life didn’t seem to have any restrictions put on it, but mine did because I had a baby... I think it was just adjusting to the new role in my life, I just never had any concept of what would be involved until I was actually in that role.”

The profound shift from self-focus to other (namely the baby’s needs) appeared to occur at a very deep level for the women in the current study. This mirrored the findings of Smith (1999) who found that new mothers seemed to report a greater understanding and empathy for others in general, as well as an increased appreciation for the difficulties others’ experience when attempting to cope with new and challenging situations. This may explain how the second PTG factor in Tedeschi and Calhoun’s (1996) model occurs; the increased empathy and appreciation of others’ experiences may be another reason for why interpersonal relationships are perceived as more meaningful. The current study’s findings also support the position put forward by Bost et al. (2002) that parenthood is a significant transition point which necessitates changes in terms of the types of responsibilities and the overall impact on one’s lifestyle, and consequently their priorities.

(P2) “Having a child has made a big impact on my life. You know instead of always thinking about myself, I guess it gives me a consciousness of thinking about my baby as well.”

(P6) “You can’t be selfish in what you’re doing because you’ve got a person who completely relies on you for everything, so you just have to suck it up and do it; deal with it. I think that’s probably something that was definitely a positive outcome. I think I’ve developed that ability to just get on with it because I know that I can deal with it, but there’s a little person who can’t deal with the situation. Rather than

moping around thinking ‘oh poor me’ I probably just get on with it a lot more than I used to.”

(P8) “It’s interesting to look at this little bundle, that’s half of you and half of your husband; so you’ve actually created another person and that gives you a whole new definition on life. To think that it’s not just you any more, you’re actually looking after somebody else as well. And that little person is going to look up at you as their role model and as their carer and the one they come to when they’re hurt, or sad, or upset, and it’s a huge responsibility. You really have to grow up very quickly.”

With the transition to motherhood, many of the women described an increased appreciation towards their relationships; (relating to more meaningful interpersonal relationships, the second PTG factor of Tedeschi & Calhoun’s model, 1996). In particular, the women seemed to reach a new level of understanding and gratitude for what their own mothers had gone through in order to raise them. The importance of a new mother’s mother and other support networks has long been recognised in the literature (Levitt et al., 1986). Smith (1999) also found that women undergoing the transition to motherhood seemed to shift their focus away from broader public matters, towards their immediate family. Naturally, this seemed to change some of their priorities (the fourth PTG factor, Tedeschi & Calhoun, 1996).

(P5) “I think as an adult, when you have those relationships with your parents, you actually forget that they have raised you along the way and molded you and provided you with those values. It’s not until then that you’re faced with imparting those values and caring for somebody who really can’t do anything for themselves that you probably, and I personally re-value the time and effort that your parents put into raising you.”

(P4) “I just kind of felt more open to sharing my inner feelings, whereas I might not have done that normally. Maybe it was the pregnancy hormones and you know the bonding hormones that get released. I certainly had teary and hormonal sessions, and I felt really connected with people that I didn’t normally feel connected to.”

(P8) “But talking about relationships, when you have children you tend to see everybody a lot more because they want to see the kids and you want your children to have a relationship with their grandparents, their uncles and aunts. Not only to

cement the family, but because you also know that if something happens to you and the kids are quite young, they're going to need somebody who knows them and loves them and is willing to take them on, and if they don't have a bond with their care givers... then that's not going to happen. So it's for a lot of reasons that you put time into the various family relationships."

The women also conveyed their experience of having an altered sense of love to that which they had previously felt. This supports Tedeschi and Calhoun's (1996) second and fifth PTG factors: more meaningful interpersonal relationships, and a richer existential and spiritual life.

(P1) "It's been a positive transition because you grow from each experience... I've learnt to love in different ways to what I had before; the love that grows; unconditional love. I didn't realise the extent of my unconditional love until I became a mother. It's like your child can do anything to you and you'll still love them no matter what. It's such a deep happiness. The love that you feel... it just changes you, your whole outlook on life. And to appreciate the little things, every little thing that the baby does, it just enriches your life; it's a deeper happiness."
 (P8) "Yeah it just changes the way you think, for the better for my husband and I anyway. It's made our lives incredibly richer. If anything, we're far more in love now than we were before and any time we get mummy and daddy time is far more enjoyable compared to before because it's stolen moments!"

The women also noticed changes in their priorities and overall life goals, which is suggestive of changes at a very deep and enduring level of their personalities (fourth factor of PTG, Tedeschi and Calhoun, 1996). This adds further weight to the previously reported findings from a variety of researchers that parenthood functions as a transition point in people's lives, seeming to serve as a pivotal central event that instigates changes in people's priorities, values, meaning, and purpose (Bost et al., 2002; Beder, 2004-2005; Knoester & Eggebeen, 2006). Smith (1999) discovered women in the post-birth phase tended to re-evaluate their options in life and review their general plans, assumptions, and existence. Additionally the women in Smith's study frequently transformed their life projects in order to achieve a better balance that would be more

conducive to the needs and interests of their families, relationships, and work. The women were also found to become more aware of the previous pressures that their working life demanded, which seemed to prompt them to reorganise and re-evaluate their priorities.

(P1) “You’re more selfish when you are just a couple living together without children. When you have a child, your priorities change completely. You know like dress shopping, or personal things, frivolous things don’t become as important anymore. Your whole centre of priority changes, you have this little baby that you just want so much for them. Yeah, it changes your whole lifestyle.”

(P4) “It increased my appreciation of life, I think because you’re sort of in awe going ‘wow this little person can now suck for a long time’ or ‘she can now lift her head’ so you know the milestones; the little things that you kind of take for granted are suddenly very clear for you and they’re major things for you and for a new person.”

(P5) “Yeah there certainly was a time, particularly early on that I think we both had to come to terms that we were slightly different people now that our daughter was here. The way that we interacted changed... So there certainly were some very challenging times to start with.”

(P6) “Things are very different now, compared to how they used to be. I don’t stay out late drinking, I come home instead; and on weekends we have family picnics now. So they might not necessarily be better or worse – it’s just a different life now; It definitely changed my priorities. I think I could always have had the potential to gain the skills that I have through becoming a parent, but I guess it just gave me the opportunity to develop those.”

Expectations

It was quite apparent that the women in the sample expected a variety of things throughout their transition to motherhood. There seemed to be subtle, yet important differences in their expectations depending on which part of the transition the women were describing. Most spoke of having extremely high self expectations during the early phases which progressively transformed towards attempting to reduce the pressure and expectations they placed on themselves. The foremost expectations in the women’s quotes were:

To be the perfect mother or 'Stepford Wife' (Levin, 1972) and catering to every need of the baby

The women's self-expectations were frequently about needing or wanting to live up to perceived cultural expectations. At times these expectations seemed to be unrealistically high and appeared to tie in with an idealised or 'perfect mother' image and the supposed ability to cater to their baby's every need.

(P5) "I suppose I had this 'Stepford Wife' picture in my mind before my daughter came, that I would be able to look after her during the day and then when she went to sleep I would prepare these beautiful meals and keep a nice house – and be the 'Stepford Wife' and perfect mother. I realised quite quickly that that was not going to be possible! [Laugh]. And in coming to that realisation that you can't be all and you can't be perfect; you have to re-adjust your own perceptions and expectations. I suppose it created an internal conflict and internal stresses..."

(P8) "The only negative thing was um, actually my own thoughts. When you think I'm not doing a good enough job, the house looks like a mess, I haven't done anything all day... My expectations of myself were definitely a challenge! I didn't have any outside stresses, it was really just myself."

Comparing self to perceptions of other mothers

Many of the women seemed to derive their expectations about motherhood based on a comparison to what they perceived other mothers to be. This was frequently said to leave the new mother feeling inadequate. However this tendency appeared to be particularly strong in the early phases of the transition to motherhood and as their adaption progressed many participants seemed to interpret it less as a negative comparison and more as a source of evidence and permission for variation.

(P1) "I just sort of felt that there was something missing. That there was... I don't know I just didn't feel like I thought I should. It's hard to describe [laugh]. I'd see other mums and think, why aren't I smiling and talking happy like that?"

(P8) "It was like you're a baby in the woods with your first baby. Because you think everyone is looking at you, and you think everybody is judging you on what your house looks like, or how you dress when you go out, or how your child behaves. Like oh my god her child is crying all the time, god she must

be a terrible mother. You're just trying to do your best, trying to do beyond your best. You're trying- or I was trying to do what I thought everybody thought I should be doing you know, which was silly but I didn't realise it at the time."

Expecting mothering to come naturally

Another stress associated with the transition to parenting was that many of the women reported expecting motherhood to come naturally. This may have resulted in a steep learning curve as they grappled with the trial and error process of experiential learning.

(P6) "Yeah it was like being thrown in the deep end. I think I just expected that it was natural so it would be easy, and it didn't work... it didn't work at all!"

Expecting to have everything under control

Similarly the majority of the women spoke about their expectation of wanting to have everything under control. Many of the women in the sample spoke of feeling a greater level of control in lives prior to parenthood and some desperately sought to recapture that sense of control, although it is likely that the alterations of their circumstances necessitated the development of a new type of control that allowed greater flexibility.

(P5) "It helped once I admitted I had control issues and realised that I just had to let go of them."

(P9) "Also probably the biggest thing is not to have too many expectations, like don't make plans and think that you're going to stick to them [laugh]. Like don't say I'm going to be out of the house by 10:00 AM because you'll just disappoint yourself."

Expectations of co-parent and other members of the extended support network

The women also commented on their expectations of their co-parent and extended family members, at times feeling they didn't measure up. This finding may relate to that of Bost et al.'s (2002) study which revealed a discrepancy between the

ratings of reciprocity reported by new parents; namely that wives rated it as declining following the transition to parenthood, whereas husbands tended to perceive it as increasing. Additionally this may also relate to Knoester and Eggebeen's (2006) finding that men tend to increase the number of hours spent in paid labour following the transition to parenthood. It is possible that the women's feelings about their partner's not measuring up could be due men's attempts to contribute to the family by increasing the family's income.

(P1) "It's tested our relationship, my husband and I together. There's been times when we've had a lot of stressful moments between us because I expect more of him, and he's had to learn to be a better father. But I've also felt like I've had to be the teacher and that he should know some of these things. So I suppose that's been very exasperating, that I've had to try and lift up his fathering skills to a higher level than he had expectations of it having to be. That's been very stressful on our relationship... you have higher expectations of your partner than you thought you had."

(P6) "It's such a different thing; I don't think you know what to expect until you're actually doing it. So I did expect more people to visit or give us some assistance, but yeah I didn't really get that from them."

Recommendations

When asked if they had any recommendations for women who were about to undergo the transition to motherhood, the women in the sample provided a wealth of information and suggestions.

Build and sustain social support networks

The most frequent recommendation was encouraging others to join and invest heavily in their support networks, particularly mothers' groups but also existing networks like family, friends, work colleagues, and neighbours. The women strongly advised asking for help and accepting help when it was offered, as many reported struggling with it themselves. There was also particular emphasis on nurturing the relationship to the baby's father and maintaining a strong connection as a couple.

Clearly, the women in the current sample highly valued their support networks and saw them as a vital component of their adjustment to motherhood.

(P3) “I would say get a mix of people in your life, of women who are going through it right now (like a mothers’ group), and women who have six year old children, and women who have 15 year old children, and grandmothers; preferably positive people. So that you’ve got ones close enough to go well this is the product you want to buy. Then you’ve got older ones who have seen their kids grow up, and all the way through to high school so they can go ‘believe me by the time they get to uni you won’t care!’ [Laugh]. That full range of people, if you can get into that in the early pregnancy or whatever, make those relationships.”

(P8) “Find out who you can call in the middle of the night and see if they’ll come. To be quite honest, you’ve really got to know who your friends are and your family are... You can’t just rely on your family because family will not be there all the time. You can’t just rely on your husband all the time either, because husbands eventually have to go back to work at some point.”

(P10) “You need to get a regular doctor all the way through your pregnancy and then you know you’ve got that support because they know you and they know your personality. I suppose that would help you more. But if you’re just seeing a nurse here and a nurse there etc, while yes they might have a file with all your information on it, you’re not getting that personal relationship; I found that really hard. You need to see the same person all the time just to have that support. Then you know that if you’ve got problems afterwards you can call them and talk to them and explain what has happened. I suppose you can develop that connection after the baby is born, but its better if it’s already in place. Although your GP is not always available, so that makes it hard.”

Avoid trying to be ‘perfect’

The majority of women in the sample spoke of the difficulties they faced particularly in relation to the extremely high standards or expectations they set for themselves according to an idealised form of mothering and housekeeping; somewhat like a ‘Stepford Wife’ (Levin, 1972). It seems as though it took quite some time for the women to devise more realistic, healthy, and achievable expectations. Hence participants provided strong recommendations for other transiting mothers to avoid trying to be a ‘perfect parent’ and instead encouraged trying one’s best and learning as

you go. For instance, the women cautioned other mothers to not feel bad if their house was not as clean as they would usually like.

(P1) “Although when you’re trying to cope with motherhood and all the tiredness and stress levels etc, I’d like to remind them that you’re supposed to enjoy this experience as well. Stop trying to be so perfect and do everything ‘right.’ You just do the best you can at the time with the knowledge and experience that you have.”

(P8) “When the baby sleeps, you sleep! Everybody says it, but you HAVE to do it. Don’t worry about the housework etc, just sleep. And never judge another mother! [Laugh] Always keep your mouth shut, never ever give another parent parenting advice unless they ask for it. Never ever, ever offer it to a stranger out of the blue! Its really rude, and it’s not called for. I haven’t done it and I haven’t had it happen to me personally, but I have seen it happen; it’s not pretty.”

Try to set up routines, but also allow for some flexibility

Many of the women suggested transiting mothers try to incorporate routines into their day; however they expressed the need to remain somewhat flexible. The mothers explained that not all routines suit everyone and in addition to that, the fast paced developmental changes meant that even suitable routines didn’t last very long.

(P5) “Sometimes routines don’t work, certainly try them but sometimes they don’t work, sometimes they do. Sometimes you just need to go with the flow I think, to help with that transition that you’re going through.”

Maintain self-care as a priority

A crucial piece of advice from many of the women was to ensure as a new mother you take care of yourself and your needs. Many women described putting their needs after their baby’s and sometimes even after their partner’s needs, which either drained their resources or even made them feel resentful. It seemed to take a little while for the women to prioritise their self-care following the transition to motherhood. There was strong encouragement for maintaining activities that supported the women’s identities, sanity, and connectedness.

(P8) “I’d recommend that first thing in the morning, the first thing you need to do is get out of bed, have a shower, and put something presentable on. Put something on that you’d walk down the street in. Once you start doing that you feel so much better. You must start putting yourself first and the baby second. It took a few weeks for me to be able to do it, to finally come to the conclusion that the child was not going to stop breathing as soon as you left the room. It also helps if you get/have a hobby, something you can do at home just for yourself.”

(P9) “I suggest just getting out of the house. Just make the effort to get out of the house [laugh], even if it does take you all day. Try and get out of the house and do something with your day.”

(P10) “Don’t work too late into your pregnancy; I think you need the time to mentally get used to the fact that you’re going to be at home.”

Expect money stress and changes in your household budget

The majority of participants stressed the impact of financial adjustments post-birth and recommended other new mothers try to prepare for some of this and/or expect certain feelings in response to a reduced household income and some form of financial dependence on a partner/family. Of the maternity leave packages available, most considered the time frames to be vastly insufficient.

(P8) “Seriously you will have no money. So I’d suggest start living on just one wage as soon as you find out you’re pregnant, put the other wage away in the bank and live on one wage because that is what you will be doing after you have the baby. If you’re lucky to get maternity leave great, but as soon as that finishes that’s it and you’re on one wage.”

Get information from reading books and courses

Many of the women in the sample spoke of reading many books on birth and parenting, some even reported feeling overwhelmed and confused by the amount of material out there. Although they cautioned that the information in a book does not compare to actual experiences across the transition.

(P8) “I suggest reading about the birth as well as the period just after it; get one of those for the first year books. Like ‘*Contented Little Baby*’ by Gina Ford, it was brilliant!”

(P10) “I recommend the anti-natal classes, I definitely think everyone should go to that before they have their first baby. But I’ve also read that you can go to breast feeding classes before you have your baby through the Breast Feeding Association. There are certain things women can learn before they have their baby and then it can be less stressful because they’ve got some kind of frame of reference to know what to look for.”

Summary of Study Two Findings

In summary, the qualitative investigation of Study Two revealed four overarching themes in participants’ discourses regarding social support across the transition to motherhood: reassurance, help seeking, self-efficacy, and changes in the self. Within each of the main themes, various sub-themes depicted how and why social support was perceived to be so crucial in facilitating PTG and adaption. At times of high stress and worry the women’s social support networks were able to intervene in their worry cycles, calm anxieties, build confidence and encourage persistence with trial and error processes as they learned to adapt to their new roles as mothers. Self-efficacy beliefs regarding adaption to the role of a first time mother also seemed to weave throughout participants’ discourses. Also extrapolated from the data were a number of personal expectations pertaining to the transition and their role as a new mother which impacted the women’s experience. Additionally support networks were able to influence the women’s self-efficacy and moderate their self-expectations and thus facilitate PTG. Finally, the women in the study detailed a variety of recommendations and advice to other women who are about to undergo the transition. The following section unites the findings from both Study One and Two in order to elucidate the overall process of PTG as it applies to women’s experience of entering motherhood.

Overall Discussion

The focus of the current paper was to examine PTG across the transition to motherhood; initially via a quantitative investigation as to which factor/s best predicted the experience of PTG, followed by a qualitative exploration of how this process unfolds. Becoming a parent is a life altering transition which involves adaption and modifications to a multitude of areas in an individual's life including: new routines, responsibilities, changes to one's participation in work and often finances, altered socialising patterns, shifts in priorities, goals, and augmentation of the self identity (Shereshefsky & Yarrow, 1973; Smith, 1999; Bost, et. al., 2002; Knoester & Eggebeen, 2006; Milward, 2006). For some people it can be a disorganising incident, whereas others appear to experience it as a developmental opportunity (Osfosky & Osofosky, 1984; Antonucci & Mikus, 1988; Bondas & Eriksson, 2001). The changes involved in the transition to parenthood are especially poignant for women as their lives appear to undergo the greatest amount of change physically, emotionally, and psychosocially (Bost et. al., 2002; Luo, 2006).

The transition to motherhood qualifies as a central event in that it is an experience which prompts a woman to re-organise her view of the world, her 'self', and her life story. Central events are those which deeply challenge or even destroy one's existing schemata, goals, and assumptions regarding the self and one's view of the world (Boals et. al., 2010; Boals & Schuettler, 2011; Pal & McAdam, 2004); ultimately prompting changes to a person's foundational assumptions (Parks, 1975; Kaufmann, 2002). Central events act as organising principles that one's sense of self and purpose orientate around, and therefore become defining moments which often signify the beginning or end of an important phase of life (Conway & PleydellPearce, 2000; Singer, 1995; McAdams, Josselson, & Lieblich, 2006; Boal & Schuettler, 2011). The shattering

of existing foundational assumptions equates to the loss of predictable surroundings and a secure sense of self that may overwhelm the person leaving them without a framework by which the self can orientate and function, consequently resulting in anxiety and other uncomfortable or even painful experiences (Pal & McAdams, 2004; Kaufman, 2002).

It is widely known that becoming a parent is associated with a range of potentially negative mental health outcomes, which not only impact the individual, but may in turn impact the quality of parenting provided and the overall wellbeing of an entire family (Colpin et al., 2000; Luo, 2006; Bost et al., 2002). The transition to parenthood and in particular motherhood is associated with increased risks for anxiety, depression, adjustment difficulties, and other psychiatric symptoms and disorders (Kendell et al., 1981; Campbell et al., 1992; Bost et al., 2002; Luo, 2006; Mallikarjun & Oyeboode, 2005). Although there is a vast array of literature documenting the possible negative outcomes associated with becoming a mother, not all women experience such sequelae. One of the most robust positive findings relates to the beneficial effects of social support, which is believed to serve a cushioning affect or buffer against stressful life events. Social support is frequently associated with better psychological functioning, physical health, and social adjustment in general (Cohen & Wills, 1985; Crnic & Greenberg, 1990; Koeske & Koeske, 1991; Kaplan & Toshima, 1990; Sarason, et. al., 1997). Positive adaption and even PTG from central events such as the transition to motherhood are an emerging area in the literature.

PTG or stress related growth, refers to an individual's experience of significant positive change that occurs as a result of their struggles with highly challenging life crises or traumatic events (Tedeschi & Calhoun, 2004; Calhoun, Cann, Tedeschi, & McMillan, 2000; Durkin & Joseph, 2009). The changes are thought to occur in the self, interpersonal relationships, and one's philosophy of life. PTG does not negate the

existence or the absence of negative effects of traumatic experiences, instead it considers pain and growth as being inextricably linked in the process of recovery (Saakvitne, Tennen & Affleck, 1998, Park, 1999; Pal & McAdams, 2004; Morris et al., 2005; Prati & Pietrantonio, 2009). In 1996, Tedeschi and Calhoun developed the PTGI which identifies five areas in which PTG manifests: (1) increased appreciation for life; (2) more meaningful interpersonal relationships; (3) an increased sense of personal strength; (4) changed priorities; and (5) a richer existential and spiritual life. This psychometric measure has enabled the concept to be applied to a variety of traumatic experiences and has seen a proliferation of research across a wide variety of events (Morris et al., 2005; Linley & Joseph, 2004).

Despite a number of conflicting findings (e.g. inconsistent factor structures, cultural variations, possible differences between acute versus chronic events, age, and whether PTG increases over time), PTG appears to tap into a number of core elements relevant to the general human growth process (Tedeschi & Calhoun, 2004). The authors of the PTGI have called for researchers to apply the scale to events outside of those typically and historically considered to be traumatic, such as stressful events and transition points. It is hoped that further research into PTG might elucidate exactly how stress initiates the growth processes and under what circumstances adaption is achieved (Anderson and Lopez-Baez, 2008). One study which seems to have taken up this challenge was conducted by Sawyer and Ayers' (2009) and investigated PTG in women after childbirth. Employing a quantitative methodology and including first and subsequent birth experiences, the researchers discovered moderate levels of PTG in just over half of the participants in their United Kingdom sample. This is the first known study to apply the concept of PTG to childbirth. While it was an important step in reversing the pathologisation of women and the natural events in their lives; there is a

great deal more to be understood about how PTG unfolds in the context of the transition to motherhood.

Hence the current research attempted to build on the work of Sawyer and Ayers' (2009), by investigating PTG across the transition to motherhood in an Australian sample. Two studies employing mixed methods were conducted. Study One of the current research utilised a quantitative methodology of self-report scales to ascertain which factor/s best predicted women's retrospective accounts of PTG in relation to their initial transition into motherhood. Out of the possible predictive factors: perceived social support; self-efficacy; the impact of the event; and the degree of distress; the only variable to significantly predict PTG was perceived social support. Although it is worth mentioning that self-efficacy was very close to reaching significance, it is possible that the self-efficacy scale used in this study was not sensitive enough to adequately capture the concept. Alternatively the beneficial effects of self-efficacy may be subsumed by and more appropriately explained within the variable of perceived social support. None-the-less, Study One substantiates the existing literature regarding the beneficial effects of social support across the transition to motherhood and demonstrates its correlation to PTG (Crnic, et. al., 1983; Hopkins, et. al., 1984; Levitt, et. al., 1986; Tinsley & Parke, 1984; Cox, et al., 1989; Goldstein, et. al., 1996; Goldstein & Genero, 1995; Crnic & Greenberg, 1990; Richardson, et. al., 1995; Bost et al., 2002). The results of Study One lend further support to Lazarus, et. al.'s (1980) belief that social support might assist by sustaining emotional health and well-being of those experiencing stressful or traumatic changes; possibly acting as a buffer for the individual and aiding in adaptive adjustment.

Although Study One identified that higher levels of perceived social support predicted greater amounts of PTG across the transition to motherhood, the quantitative

methodology did not permit an understanding of how or why social support appears to produce growth. Thus Study Two sought to qualitatively explore the nuances of how perceived social support interacted with PTG and thereby provide some explanation and in-depth understanding of the relationship between the two variables. In particular, Study Two was able to discover how the process of growth unfolded across the transition to motherhood, why social support seemed to facilitate it, and which aspects of social support were considered to be beneficial or detrimental. The mixed method design utilised in the current paper is one of its notable strengths and provides a valuable contribution to the PTG literature. Four over-arching themes emerged from participants' semi-structured interviews: Reassurance, help seeking, self-efficacy, and changes in women's identities and priorities. The women also provided a number of expectations and recommendations regarding the transition to motherhood. The following is a summation of Study Two findings.

The first major theme identified from participants' transcripts was reassurance. Upon entering motherhood for the first time, the women reporting finding themselves' in an unfamiliar experience which produced feelings of anxiety and questions about whether they were doing the 'right thing' and whether things were progressing 'normally.' To combat this, the woman described seeking reassurance from their support networks (eliciting commentaries from both professional and personal resources). The women's social networks appeared to take on greater value as they drew upon their support and wisdom. At times of high stress and worry, support networks were able to intervene in the women's cycle of worry, calm their nerves, restore or bolster confidence, and provide practical advice. Support networks seemed to help put things into perspective, and also encouraged the women's capabilities and ongoing attempts to adapt to their new roles as mothers. Furthermore, the support networks

provide a space to vent feelings and process or work through their emotional reactions and thereby make sense of their experiences and enable them to learn from it. The support often provided validation and normalisation particularly in relation to learning from trial and error which seemed to aid in the forming of new foundational assumptions as they learnt how to predict, control, and feel secure in their new life as a mother.

The discourses also seemed to highlight how the members of their support networks helped reduced the pressure the women perceived being under, particularly if the pressure was self imposed. One of the most salient forms of social support came from women who were concurrently experiencing the transition to motherhood which was frequently located in mothers' groups. The fact that the support was perceived as coming from peers or women who were considered equals, seemed to make the new mothers feel more confident in accessing the support. Additionally the women appeared to feel more comfortable exposing their struggles and insecurities about their transition to peers, perceiving less likelihood of being judged or criticised in comparison to if they shared the same information with professionals or other authority figures (e.g. nurses or doctors). Many of the women were concerned that their attempts to seek reassurance could lead others to classify them as a 'panicky-parent' which made them less likely to access support at times. Due to the rapid changes in the development of their babies, the women seemed to experience fluctuating feelings and fears related to incompetence and mastery, which then impacted their feelings of adaption and personal strengths.

Negative aspects of the social support the women perceived were reported as lack of reassurance, criticisms, and horror stories. If the new mothers were required to take on extra responsibilities as a result of network members visiting as well as trying to manage the needs of their infant, the benefits of the social support were reduced or even

negated. In addition to these, if the new mother perceived that members of the support network prematurely rushed in to help it gave the impression that she was not coping and/or not capable of caring for her child. Feelings of isolation or aloneness were also said to cause problems for the new mothers, this was perhaps most evident in terms of the proximity of support networks, with face-to-face support being preferential to telephone support. Factors two: more meaningful interpersonal relationships, and three: increased sense of personal strength, identified in Tedeschi and Calhoun's (1996) PTGI, seemed to be facilitated by the theme of reassurance provided by social support. It appears the innate desire for interpersonal connection in humans may be due to the role they can play in recovery, adjustment, and resilience following traumatic events and/or stressful life transitions.

The second major theme that emerged from participants' discourses was help seeking. Initially the women described feeling uncertain, hesitant, and even lost when it came to identifying the type of help that would benefit them across their transition to motherhood. Difficulties related to locating sources of help that would provide the desired resources or information and whether they could trust support networks to adequately care for their babies. Some women seemed to experience separation issues when they entrusted the care of their infant to others, particularly if they held expectations about wanting or needing to do it all on their own. A few of the participants also experienced concerns about over-burdening their support networks and were less likely to utilise networks if they had perceived negative experiences when seeking help in the past. Furthermore feeling overwhelmed by their support networks was said to reduce their help seeking behaviours.

When the new mothers did seek assistance it was generally in regards to practical help and information such as dealing with stress, handling the physical care

and responsibilities of their new born babies. Using social support networks to watch the baby while the women slept or tended to their own needs, and/or household chores were some of the reasons for seeking help; and occasionally some of the mothers delegated chores to network members. The women who relied on their support networks for practical help generally reported less stress and seemed to adjust better across the transition to motherhood. While those that attempted to maintain high self-expectations about managing on their own tended to report more stress and pressure. Another aspect for which women sought out their support networks appeared to relate to their own needs for social contact and stimulation, seemingly in an attempt to balance their feelings of isolation and social deprivation as a result of spending large amounts of time alone with their infants at home.

Mothers' groups were reported as a valuable avenue for seeking information about whether their child's development was on par with others that age. The groups also provided opportunities for discussing challenges and sharing successes with like-minded individuals, and were a place where suggestions and emotional support were freely provided. The women in the study demonstrated there were differential preferences regarding the style and type of knowledge delivered depending on the information being sought and the point along the transition. Leading up to and during the birth event, the women seemed to be seeking knowledge that was directive and factual (e.g. pain management methods, the phases of labour, the size of the baby etc.), whereas after the birth and especially once the baby was home the women seemed to prefer more suggestive, indirect, and experienced based information (e.g. soothing, settling, sleep routines for the baby, and the mother's self care). There also appeared to be variations between the women in the sample regarding self-initiated knowledge seeking, with some seeming to actively seek out the knowledge compared to others who

took a more passive approach. This might be indicative of different loci of control in the women (internal versus external) however this is a speculative conclusion only.

The third major theme identified in the qualitative data related to self-efficacy, the belief that one possesses the necessary skills and abilities to successfully function and manage. Despite falling marginally short of significance for predicting PTG in Study One, self-efficacy appeared to be a very important theme in women's discussions regarding social support and the transition to motherhood. Participants' levels of self-efficacy seemed to vary greatly as they settled into their new role as mothers. There was also variability between individuals in the sample. When discussing the social support they experienced, some women appeared to externally obtain or develop self-efficacy from their network members' encouragement; which again highlighted the value and importance of meaningful interpersonal relationships and personal strengths (factors two and three of Tedeschi and Calhoun's 1996, model of PTG). Support networks that provided resourceful suggestions and expressed faith in the new mother's abilities were vital components that contributed to their self-efficacy and helped strengthen the women's morale.

A few of the new mother's also articulated an intrinsic sense of self-efficacy in their ability to navigate the transition, which suggests possible differences in personality that may have assisted their adjustment and even inflated their likelihood of experiencing higher levels of PTG. The transition to motherhood appeared to present an opportunity for the women to test and assess their capacities for resilience and self-reliance. Although there seems to be a complex relationship between the utilisation of support networks and the concept of self-reliance, whereby excessive self-reliance often reduced or inhibited the new mother from engaging with and relying on social support; which in turn may have reduced the chance of PTG. The women in this sample who

attempted to maintain strong self-efficacy beliefs about managing things on their own, particularly during high stress periods, gave an impression of struggling to allow themselves to utilise support; this is perhaps a valuable area for future research.

Every woman in the sample spoke of their struggles with idealised expectations about mothering and being the 'perfect' wife/partner. This was possibly the source of much stress and pressure in that they were not able to live up to their own unrealistic expectations. The shortfall to what was a realistically achievable standard, negatively impacted women's self-efficacy at least until the new mother was able to re-evaluate her expectations (or foundational assumptions) regarding motherhood. This process appeared to be facilitated via contact with socially supportive people, such as husbands/partners, the women's mothers/in-laws, and particularly via discussions with peers in mothers' groups. As the women came to realise the other people in their lives did not expect such high standards, the new mothers gradually relaxed their expectations and seemed to develop an understanding of a 'good-enough-mother,' which involved more sustainable standards. This then enabled their self-confidence and self-efficacy to increase.

Prior to the transition to motherhood, the women in the sample often perceived themselves as being fairly capable of controlling their lives, and this appeared to be one of the foundations for their self-efficacy. Many explained they had developed skills, strategies, and routines (multi-tasking, time management etc.) in their careers which enabled more effective functioning in their pre-motherhood assumptive worlds. However in the early post-birth phases the new mothers who endeavoured to rigidly maintain their pre-baby methods and routines struggled under the pressure, especially with the initially unpredictable and frequently changing patterns in the baby's behaviours. Understandably this depleted some of the women's self-efficacy beliefs.

(Women whose personality styles involve a high need for control will be likely to experience severe stress and pressure during this period). Across the transition, the women who were able to relinquish a degree of perceived need for control in favour of flexibly adjusting to the baby and each situation, reported better adjustment and it seemed more PTG. Becoming a more relaxed person, was one of the most frequently expressed benefits across the transition to motherhood; with their improved ability to 'go with the flow' and 'just get on with it' seeming to enhance their self-efficacy. Following this adjustment within themselves, the women explained they were more able to enjoy their time with their child.

The ability to relax and be flexible seemed to prepare and open the individual for alterations to their assumptive world, allowing for the incorporation of new behaviours, understandings, abilities, and the development of a new 'normal.' The skills the women developed across the transition were eventually integrated into their new assumptive world along with their role as a parent. A shift in priorities seemed to be occurring; for example the demands of getting both herself and the baby ready and to a location on time were sometimes extremely difficult, and thus punctuality often became a lower priority to arriving in a calm and happier state albeit a little late. Additionally the women's pre-baby preferences and goals often changed once they became mothers, the child was then an integral factor when making decisions and considering their present and future plans. This is where participants' descriptions linked in with PTG factor four, changed priorities (Tedeschi & Calhoun, 1996).

Another important element of self-efficacy came from the sense of achievement and pride the women experienced. Achievement related to a variety of things such as validating their fertility, becoming a mother, the baby's growth, and the reaching of milestones. Here women's narratives moved towards existential themes and greater

appreciation for life, which is the fifth PTG factor (Tedeschi & Calhoun, 1996). A profound sense of shock was also reported by a number of the participants during the birth of their babies. For one mother the shock was perhaps exacerbated due to a premature labour, she described experiencing numbed emotions and cognitive patterns associated with moment to moment survival. Despite the build-up over the pregnancy period, it seems the shock women described related to the central event of giving birth, which then became a life defining moment signifying and confirming their transition from a woman, to someone's mother. The weeks and months following the birth appeared to be the period in which the women grappled with the impact of this new role and phase of their lives. Via discussions with support network members, the women seemed to work through challenges, developed new understandings of themselves and their abilities, all the while gradually altering and adjusting their world views, behaviours, routines, and themselves culminating in PTG.

The fourth major theme derived from the qualitative data in Study Two related to changes in the self. Supporting Pal and McAdams (2004) assertion that PTG is a process whereby one constructs a narrative understanding of how the self was positively altered by a 'traumatic' or challenging event, which is then integrated into the overall sense of self and becomes an identity defining life story. The women described a number of changes in their identities, with particular reference to a general feeling of being more relaxed, a more profound and different experience of love, greater appreciation of relationships, increased feelings of responsibility, and changed priorities. Shifts were also reported in their capabilities, preferences about how to spend their money, their time, and how to expend their energy, with greater significance given to their child and family of creation. This finding seemed to link in with Tedeschi and Calhoun's (1996) third and fourth areas of PTG in which people tend to perceive an

increased sense of personal strength or assets, and changes in their priorities. It seemed the transition to motherhood dramatically altered the women's pre-parenthood assumptive worlds, particularly in terms of their self identity. The majority of new mothers noted increases in their tolerance levels, patience, ability to put stressors and incidents into perspective, and described themselves overall as more relaxed. This seemed to parallel the findings of Smith's (1999) study of women across pregnancy and post birth in which they perceived themselves as calmer, more agreeable, and tolerant leading to a more relaxed and cohesive self. The fluctuations in mood reported by the women appeared to correspond with their struggles and successes as they adapted to their new roles as mothers.

Nearly every woman detailed difficulties associated with changes to their sense of independence across the transition to motherhood. Particularly challenging was the adjustments regarding their financial independence and the need to rely on their partner's income. Feelings of guilt, and vulnerability seemed to arise particularly if the women spent money on themselves. Additionally, the loss of financial control and shared income made at least one woman feel as though she was being given pocket money and seemed to impact her feelings of being an autonomous adult. A further impact on the women's identity related to a feeling of losing or having to temporarily pause their occupation and career. For those that had been in the workforce for some years, being a worker seemed to be an integral component of their identity. Although some women seemed to feel a loss of 'self' across the transition to motherhood, others appeared to only alter or integrate aspects of their new role into their existing identity. Those that placed positive value on the role of being a mother and caring for their child seemed to experience an additional facet to their sense of self. The women who tried to cling exclusively to the foundational assumptions of their pre-parenthood world were

often faced with incompatible or competing demands. However those who were more flexible and willing to assimilate new aspects into the 'self' were eventually able to adapt and experience growth.

Physical changes across the transition to mother were often described as having quite an intense impact on the women's sense of self. Prior to motherhood the women reported being aware of their weight, size, and body shape as descriptors of their identity. The natural changes to their physiques across the transition were at least initially perceived as quite challenging. However with the addition of a mother role to their identity, a shift away from valuing their bodies predominantly as an aesthetic in favour of its abilities to grow and nurture a new person seemed to enhance their self-concept and became a source of positive feelings towards their body image; the self became more than simply its physical form. Additionally, the women's selves tended to take on a greater sense of responsibility as a result of the transition to motherhood. There was a profound alteration occurring at a very deep level with a shift from self-focus to others (especially her infant). An increased appreciation for the difficulties other people experience during challenging and stressful situations emerged, developing perhaps a greater capacity for empathy. This may explain how the second PTG factor in Tedeschi and Calhoun's (1996) model occurs; the increased empathy and appreciation of others' experiences may be another reason for why interpersonal relationships are perceived as more meaningful. The women also spoke of experiencing a new type of love and unconditional regard for others, namely their child. This appeared to tie into greater appreciation for life and richer existential experience of life, the first and fifth factors of PTG (Tedeschi & Calhoun, 1996).

Many of the changes the women perceived across the transition to motherhood seemed to parallel those found in the Tedeschi and Calhoun's (1996) PTG model across

all five factors. Perhaps the first three themes from Study Two highlight the processes by which PTG is achieved, and the final theme of changes in the self may be the location in which the growth is stored and understood. The majority of new mothers described increases in their tolerance levels and ability to put stressors and incidents into perspective, which is suggestive of an increase in their capacity to incorporate incidents into their world view.

Aside from the four main themes relating to social support and its relationship to PTG, the women in the current study also identified various self-expectations which seemed to impede their adaption to motherhood. These included: the expectation to be a 'perfect' mother and '*Stepford wife*;' comparing themselves to perceptions of other mothers; expecting mothering to come naturally; excessive attempts to meet and preempt the baby's every need; expecting to always have control; and high expectations of the co-parent or other support network members. Overtime the majority of mothers were able to reduce some of their expectations, or once they understood the detrimental impacts of them they were able to abandon them in favor of more relaxed and adaptive self expectations.

Additionally the mothers in the study provided a number of recommendations to other women about to undergo the transition to motherhood. Naturally many of these could be associated with the above mentioned negative expectations and strong instructions to locate and invest in social support networks. Recommendations such as building and sustaining networks; avoiding the trap of trying to be 'perfect'; trialing routines, whilst remembering to be flexible and find what works best for mother and baby; prioritising self-care for new mothers; expecting some money stress and budget changes that need to be discussed with partners; and lots of suggestions to read

books/blogs etc, ask friends and family for advice, and doing courses around birthing and parenting.

Limitations

Although the current research was a preliminary expedition aimed at exploring and uncovering the relationship of PTG and social support across the transition to motherhood, future studies will ideally be able to rectify certain limitations present in this paper. One of the greatest limitations lay in the sample selection, where there were no restrictions on whether the births examined in Study One or Two involved premature labours, birth complications and or defects, emergency procedures and deviations from the women's birth plans. Further studies might be able to insist on more stringent standardisation in sample characteristics which may then expose differential effects. Additionally women in both studies were able to self-select into the sample and this may have been indicative of greater motivation to discuss their experiences. Whereas those with an experience that was less positive or who were more prone to avoidant coping styles may have been reluctant to participate in the research. Furthermore the use of a convenience sample may have created biases in the validity of the sample, for example the fact that some of the participants in Study Two were known to the researcher may have influenced their responses in an attempt to help or please the researcher.

Furthermore the type of family constitution may also influence results; all participants in Study Two were in heterosexual cohabitating relationships however this information was not collected in Study One. It is possible that potential confounding factors such as being a single mother might decrease the amount of in-home support and ease of accessing support networks, thereby restricting PTG. A further limitation of the current study was that the retrospective accounts may also alter results, as found by

Smith (1994) in which women's reconstructive dialogues about their transition to mother were modified over time. The cross-sectional design of the current studies is similar to most other PTG research, a common criticism being it prevents any accurate causal relationships from being concluded (Morris et al., 2005). It would be interesting to determine whether cross-sectional experiences of the transition to motherhood differ from long-term follow-ups with mothers as the transition unfolds. Future studies which seek to elucidate the relationship of social support across the transition to fatherhood might also seek to ascertain whether the areas identified in the PTGI are gender specific.

The regression model only accounted for eight percent of the variance in PTGI scores which although significant it seems there may be other factors which influence women across the transition to motherhood. Previous PTG research on childbirth (conducted by Sawyer & Ayers, 2009; Sawyer et al., 2012) may have arrived at different conclusions, particularly regarding social support due to their inclusion of any childbirth rather than a woman's initial experience only. Subsequent birthing experiences may result in the women constructing different meanings of the event. Additionally the question of whether an acute versus continuous event can produce PTG requires further study as the current research uses a three month time frame one might consider it a more continuous event as opposed to Sawyer and Ayers (2009). Urquhart (2011) investigated a continuous event and discovered PTG in her sample of carers of the mentally ill, thus it does appear PTG can be associated to both acute and continuous traumatic/stressful life experiences. Although it is also possible that the women in the current studies were describing general psychological adjustment after giving birth and entering motherhood which may share some variance with PTG, however it is possible that they may be two separate but overlapping factors. Due to the above mentioned limitations, caution should be taken when generalising the results obtained in this

preliminary investigation, further research is required to gain a greater insight into the factors that contribute to PTG and adjustment across the transition to motherhood.

Conclusion

Overall there is a great deal of change that occurs across the transition to parenthood, much of which parallels the areas of PTG identified by Tedeschi and Calhoun (1996). Specifically in relation to the transition to motherhood, the findings of this research encourage professionals to use Tedeschi and Calhoun's (1996) PTGI as an assessment tool for measuring successful coping and adaptation across the transition to mother. Study One powerfully highlights the importance of support networks, while Study Two brought to light the roles and processes social support provides including reassurance, help seeking behaviours and sources, self-efficacy, and changes in the self of each new mother. Monitoring unhelpful and excessive self-expectations while maximising the use of new and existing networks are also likely to increase adjustment to motherhood.

The PTGI when applied outside of the typically defined areas of trauma seems to be a suitable instrument for measuring general human psychological growth processes in response to stressful life incidents and transition periods across the lifespan. Transitions such as returning to the work force after a period of absence, moving schools or towns, retirement, and relocating to aged care facilities etc can be very distressing events, but may also provide opportunities for PTG and adaptation. Furthermore, therapeutic interventions which incorporate (1) increasing clients' appreciation for life; (2) enhancing the meaningfulness of interpersonal relationships; (3) increasing personal strength; (4) awareness and flexible altering of priorities; and (5) exploration of existential and/or spiritual themes may help target and facilitate PTG and adjustment.

Implications

In light of the findings that social support plays a vital role in assisting women to positively adjust and grow following the transition to motherhood, it is imperative that women about to undertake this transition are encouraged to heavily invest in support networks. Promoting the beneficial effects of remaining connected to existing networks such as friends, work colleagues, immediate and extended family members, and professionals such as a regular doctor will aid in women's adaptation. Additionally emphasizing the benefits of joining mothers' groups where women can interact with social peers and can illicit informal information, support, and guidance are imperative. Every mother in the current study strongly recommended women who were about to undertake the transition remain in contact with and develop their support networks. The increasing work hours, fast paced lifestyles, and geographic spread of friends and family members common in modern day Australia can often result in passive isolation. It is also not unusual that in most large cities one does not know or interact with their neighbours on a personal level. Thus it is not surprising that many people overlook and undervalue the importance of remaining connected to their support networks.

The widespread access and uptake of electronic media such as facebook and twitter give the impression that our support networks are at our finger tips. However posting a comment on a website is unlikely to compare to, or enable the full range of benefits that connecting with social support systems in real life can. Although social media may provide some benefits, conversing with a supportive person face-to-face was perceived as important and beneficial in the current study. Additionally, concerns about privacy, fears of being judged, and the ease with which written comments can be misconstrued may lead to censoring one's needs, feelings, insecurities, or even inhibiting their expression altogether.

Any health professional working with a client or patient who is embarking on the transition to motherhood would be wise to routinely encourage women towards investing in and nurturing their support networks. In addition to encouraging maintenance of their current networks, linking women into mothers' groups is particularly vital as many of the social support themes identified in the current study were regularly provided through this network. Professionals would be wise in their interactions to provide reassurance, build confidence, and to normalise learning and the adjustment process across motherhood. Facilitating new mothers to comfortably express their worries and emotions whilst refraining from making judgments, or being too directive when providing advice are also likely to assist new mothers. Making suggestions about resources and community contacts and emphasizing the importance of socialization for the mother's own needs are important as she is especially likely to de-prioritise her self-care at least initially. Identifying unrealistic expectations, excessive control needs, and encouraging flexibility will also be beneficial.

Whilst doctors and nurses might be able to assist in some ways with the impact on women's identity experienced across the transition to motherhood, their consultations are generally time-limited and may not be conducive for this important aspect. Additionally if a woman is perceived to be or identifies herself as struggling immensely following the birth of their child, a referral to a psychologist (or social worker etc) might be necessary. If there is a (suspected or confirmed) diagnosis of Post-natal Depression it is imperative to link the new mother into psychological assistance as soon as possible. Psychotherapy is likely to be extremely helpful, as it provides an additional support person and focuses on facilitating emotional expression and intervening in worry cycles. Psychotherapies such as psychodynamic therapy are likely to be extremely beneficial in assisting clients such as new mothers to explore and

understand the impact events have on their identity and 'self' awareness (Shedler, 2010). Identifying relational patterns and perceptions regarding a new mother's access and usage of support systems, her expectations regarding motherhood, changes to her independence, body image, and priorities, and developing healthy self-care behaviours could be fruitful avenues in therapy. By providing a non-judgmental and safe place for the new mother to explore both the negatives and positives of her experience, she may be able to work through her transition and further evolve her self-identity and experience PTG as a result.

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Appendix A

Study One Information Letter
(Edith Cowan University letterhead paper)

Dear Participant,

My name is Jillian Millar and I am currently researching, as part of my Masters in Psychology, the phenomenon of post-traumatic growth. In undertaking this research we hope to better understand the factors that contribute to personal growth following trauma or a crisis event in a person's life. This information can offer a measure of hope to people who experience trauma or a crisis event and provide therapists with knowledge and tools to help encourage positive outcomes in their clients. This study has been granted ethics approval by the Faculty of Computing Health and Sciences at Edith Cowan University.

I would be very pleased if you were able to participate in this study. If you are willing to participate and fit the criteria indicated on the front of the envelope, then you will be required to think of the birth of your first child and in relation to this one specific event, fill in the following surveys. Please base all answers on a time frame beginning at the birth and up to the first three months post-birth. The surveys will take approximately 20-30 minutes to complete. They can then be returned to me via the reply- paid envelope enclosed. The return date for this survey is the 15th of August 2007.

Due to the nature of the study, recollection of the event may cause some distress. If you do experience a measure of distress, I have listed at the end of this letter names and phone numbers of centres' with which you will be able to call and talk it through. Please let me assure you that your participation is totally confidential, voluntary, anonymous and that you may withdraw from participating at any time without penalty. I am not collecting any information that will enable me to identify you personally.

I would greatly appreciate your participation in this study and would encourage you to contact me via email (jmillar0@student.ecu.edu.au) if you have any queries at all. Alternatively you may contact my supervisor Dr. Julie Ann Pooley on 08 6304 5591 or email j.pooley@ecu.edu.au. If you would like to speak to a person who is independent of this research, please contact Kim Gifkins (Research Ethics Officer) 08 6304 2170 or, research.ethics@ecu.edu.au

I wish to thank you in advance, for your time and participation.

Regards,

Jillian Millar BA. Psy., PG Dip. Psy.
(Researcher)

Dr. Julie Ann Pooley
(Supervisor)

The following is a list of 24-hour phone counseling services

Life Line: **131 114**
Family Helpline: **9223 1100**
Salvo Care Line: **9442 5777**
Care Line-98.5 Sonshine FM: **927508422**

Appendix B

Study One Consent Letter
(Edith Cowan University letterhead paper)

I have read the letter outlining the research project being conducted by Jillian Millar through Edith Cowan University and any questions which I have asked have been answered to my satisfaction.

I volunteer to participate in this research and agree to complete the surveys involved in this study.

I realise that I may withdraw my participation in this project at any time without reason and without prejudice.

I understand that any information I provide will be treated as strictly confidential, it will only be viewed by the post-graduate student undertaking the research and the Supervisor, and will not be released to any other party unless required to do so by law.

I agree that research data gathered from this interview may be published provided that no identifying data is used.

I understand that any future use that Edith Cowan University makes of the interview data is subject to separate approval by the Faculty of Computing Health and Sciences at Edith Cowan University.

Researcher

Date

Participant

Date

Appendix C

Study One Demographic Information

Please fill in the following details by ticking the appropriate box (only tick one box per-a-question).

(1) Age:

- 1 = 20 and under
- 2 = 21- 30
- 3 = 31- 40
- 4 = 41- 50
- 5 = 51 and over

(2) Focus on the birth of your first child. Please rate the severity of the distress that you experienced:

- 0= not at all distressing
- 1= a little distressing
- 2= moderately distressing
- 3= very distressing
- 4= extremely distressing
- 5= unbearably distressing

(3) Time lapse since the birth of your first child:

- 1 = One year or less
- 2 = 1 – 5 years
- 4 = 5 – 10 years
- 5 = Over 10 years

Appendix D

Questionnaire Pack

The Impact of Event Scale - Revised
Weiss & Marmar, (1997)

Below is a list of difficulties people sometimes have after a traumatic life altering event. Please read each item and then indicate how distressing each difficulty has been for you with respect to a specific event. How much were you distressed or bothered by these difficulties?

- 0 = Not at all
- 1 = A little bit
- 2 = Moderately
- 3 = Quite a bit
- 4 = Extremely

1. Any reminders brought back feeling about it.
2. I had trouble falling asleep or staying asleep because of pictures or thoughts that came into my mind.
3. Other things kept making me think about it.
4. I felt irritable and angry.
5. I avoided letting myself get upset when I thought about it or was reminded of it.
6. I thought about it when I didn't mean to.
7. I felt as if it hadn't happened or wasn't real.
8. I stayed away from reminders of it.
9. Pictures about it popped into my mind.
10. I was jumpy and easily startled.
11. I tried not to think about it.
12. I was aware that I still had a lot of feelings about it but I didn't deal with them.
13. My feelings about it were kind of numb.
14. I found myself acting or feeling like I was back at that time.
15. I had trouble falling asleep.
16. I had waves of strong feeling about it.
17. I tried to remove it from memory.
18. I had trouble concentrating.
19. Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea or a pounding heart.
20. I had dreams about it.
21. I felt watchful and on guard.
22. I tried not to talk about it.

Multidimensional Scale of Perceived Social Support
Zimet, Dahlem, Zimet & Farley (1988)

Focus on one traumatic life altering event that has occurred. How true were the following statements at the time of the crisis event?

- 1= very strongly disagree
- 2= strongly disagree
- 3= mildly disagree
- 4= neutral
- 5= mildly agree
- 6= strongly agree
- 7= very strongly agree

1. There is a special person who is around when I am in need.
2. There is a special person with whom I can share my joys and sorrows.
3. My family really tries to help me.
4. I get the emotional help and support I need from my family.
5. I have a special person who is a real source of comfort to me.
6. My friends really try to help me.
7. I can count on my friends when things go wrong.
8. I can talk about my problems with my family.
9. I have friends with whom I can share my joys and sorrows.
10. There is a special person in my life who cares about my feelings.
11. My family is willing to help me make decisions.
12. I can talk about my problems with my friends.

Mastery – Self Efficacy

(Pearlin & Schooler, 1978; Pearlin, Menaghan, Lieberman, & Mullan, 1981)

How strongly do you agree or disagree
1 2 3 4 5

1. I have little control over the things that happen to me.
2. There is really no way I can solve some of the problems I have.
3. There is little I can do to change many important things in my life.
4. I often feel helpless in dealing with the problems of life.
5. Sometimes I feel that I am being pushed around in life.
6. What happens to me in the future mostly depends on me.
7. I can do just about anything I really set my mind to do.

The Posttraumatic Growth Inventory
Tedeschi & Calhoun (1996)

To what extent have you experienced the following changes as a result of the stressful life altering event?

0= I did not experience this change as a result of my crisis

1= very small degree

2= a small degree

3= a moderate degree

4= a great degree

5= I experienced this change to a very great degree as a result of my crisis

1. I changed my priorities about what is important in life.
2. I have a greater appreciation for the value of my own life.
3. I developed new interests.
4. I have a greater feeling of self-reliance.
5. I have a better understanding of spiritual matters.
6. I more clearly see that I can count on people in times of trouble.
7. I established a new path for my life.
8. I have a greater sense of closeness with others.
9. I am more willing to express my emotions.
10. I know better that I can handle difficulties.
11. I am able to do better things with my life.
12. I am better able to accept the way things work out.
13. I can better appreciate each day.
14. New opportunities are available which wouldn't have been otherwise.
15. I have more compassion for others.
16. I put more effort into my relationships.
17. I am more likely to try to change things which need changing.
18. I have a stronger religious faith.
19. I have discovered that I am stronger than I thought I was.
20. I learned a great deal about how wonderful people are.
21. I better accept needing others.

Appendix E
Study Two Information Letter

Dear Participant,

My name is Jillian Millar and I am currently researching, as part of my Doctorate in Clinical Psychology, the phenomenon of post-traumatic growth. This research is being undertaken to facilitate greater understanding of the factors that contribute to personal growth following traumas, crisis events, and/or transition points in people's lives. This information can provide therapists with knowledge, understanding, and tools to help encourage positive outcomes in their clients. This study has been granted ethics approval by the Edith Cowan University Human Research Ethics Committee (Western Australia).

If you would like to be involved in this study and fit the criteria (a female over the age of 18 who has given birth at least once) your participation would involve a recorded interview approximately 45 minutes in duration. (The recordings will be used to transcribe the content of the interviews before being wiped. Please note no identifying information about you will be kept, and you will not be identifiable in any publication). Interview times and locations will be arranged to fit in with your schedule. During the interview you will be asked to respond to questions and discuss your experience of social support around the time of the birth of your first child. This study will be completed around November 2009, if you would like a copy of the findings from this study please contact the School of Psychology, Faculty of Computing Health and Sciences at Edith Cowan University (WA).

Due to the nature of the study, recollection of the event might cause some people distress. If you do experience a measure of distress, I have listed at the end of this letter names and phone numbers of centres which you will be able to call and talk it through. Please be assured that your participation is voluntary and all information will be kept confidential. You may withdraw from the study at any time without penalty.

I would greatly appreciate your participation in this study and encourage you to contact me via email: jmillar0@student.ecu.edu.au or phone: 0438 936 833 to arrange an interview or to discuss any queries you might have. Alternatively you may contact my supervisor Dr. Julie Ann Pooley on (08) 6304 5591 or email j.pooley@ecu.edu.au for more information. If you would like to speak to a person who is independent of this research, please contact Kim Gifkins (Research Ethics Officer) (08) 6304 2170 or research.ethics@ecu.edu.au

I wish to thank you for taking the time to read this letter. I look forward to hearing from you.

Regards,

Jillian Millar BA. Psych., Post Grad. Dip. Psych.
(Researcher)

Dr. Julie Ann Pooley
(Supervisor)

The following is a list of 24-hour phone counselling services

Life Line: **13 11 14**

Salvo Care Line: **(07) 3831 9016**

Pregnancy Counselling Link **1800 777 690**
Alcohol & Drug Information Service **(07) 3236 2414**

Appendix F
Study Two Consent Form

I have read the letter outlining the research project being conducted by Jillian Millar through Edith Cowan University (WA) and any questions which I have asked have been answered to my satisfaction.

I volunteer to participate in this research and agree to my interview with the researcher being audio-taped for the purpose of transcribing what was said.

I realise that I may withdraw my participation in this project at any time without reason and without prejudice.

I understand that any information I provide will be treated as strictly confidential, it will only be viewed by the post-graduate student undertaking the research and the Supervisor, and will not be released to any other party unless required to do so by law.

I agree that research data gathered from this interview may be published provided that no identifying data is used.

I understand that any future use that Edith Cowan University makes of the interview data is subject to separate approval by the Faculty of Computing Health and Sciences at Edith Cowan University.

Researcher**Jillian Millar**.....

Date**08/05/2009**.....

Participant

Date

Appendix G
Study Two Interview Schedule

In this interview I will be asking you to discuss your experience and perceptions about the social support you did or did not receive during your transition to parenthood (after the birth of your first baby only) I'll also be asking questions about 'Positive Outcomes'. So that we both have the same idea in mind, please use the following definitions when discussing these two concepts.

* **Social support or a support network** - can include spouses, parents, siblings, grandparents and other family members, friends, work colleagues, mother's groups, neighbours, neighbourhood centres, day care staff, doctors and medical staff, midwives, psychologists and other allied health professionals, church members and/or priests, etc.

* **Positive Outcomes** – refers to any positive changes, including newly developed skills, behaviours, or methods of coping, new understandings or appreciations that are experienced as a result of, or in response to challenging transitions, stressful or traumatic events. (In this instance, please think of your transition to parenthood as the event). Some people have described this type of growth as an increased appreciation for life, more meaningful interpersonal relationships, increased sense of personal strength, changed priorities, a richer spiritual life, a sense of purpose in life, and/or strengthened relationships with yourself or others.

Please try to base all of your answers on a time frame beginning around the final 2 weeks of your pregnancy, through to approximately 3 months after your child's birth. As a general starting point, I'll begin by asking you some questions about your experience of social support, but I'd like you to feel free to discuss the subject broadly (even if it doesn't completely relate to my question).

Do you have any questions before we begin?

If you're ready now, I'll switch on the tape-recorder?

[*Note: following question 1 and 2, the remaining questions will only be used as prompts if required, as it is the participants' own perception and presentation of their experience that I wish to illicit].

Question 1 – Please tell me about your experience of the social support you did or did not feel around the time of your first child's birth?

Question 2 – In regards to your experience of social support and your support networks during your transition to parenthood, who were the people and what were their relationships to you?

- how did these people come into your life?

Question 3 – Please tell me about any of the good or beneficial aspects of the social support you felt around this time?

- how and why was it helpful?

Question 4 – Please tell me about any of the unhelpful or negative aspects of the social support you felt during your transition to parenthood with your first child?

Question 5 – Could your social support networks have been improved around this time, and if so how?

- do you have any suggestions or recommendations for women about to make their transition to motherhood?

Question 6 - What were the stresses you felt around this period in your life?

- please explain how this was stressful for you or impacted you?

Question 7 – Do you think there was an interaction or a relationship between the stresses you felt and the social support you received?

- do you think it would have made a difference if you'd had more/less social support?

- if so, how? Please describe?

Question 8 – In your opinion, do you think you experienced any positive outcomes as a result of your transition to parenthood?

- what aspects of your life did you experience the growth in?
- in what way / how did this impact you and your life?

Question 9 – Do you think there were any links between the amount of support you felt around your transition to parenthood and the positive outcomes you experienced?

- Please describe this?