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An integrated mid-range theory of postpartum family development: a guide for research and practice

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Abstract

Title. An integrated mid-range theory of postpartum family development: a guide for research and practice

Aim. This paper is a report of a study to identify parents' perceptions of postpartum family experiences.

Background. There is a growing worldwide emphasis on family support. Government policy in the United Kingdom advocates a family-centred approach in which a core universal postbirth service is offered to all families with additional support for parents of children with complex needs. Health visitors provide family postpartum care without an agreed theory directing or standardizing practice. There is a need to identify parental experiences to define family-centred care.

Method. A qualitative, exploratory approach was undertaken using a purposive sample of 17 postpartum families. Data were collected in one region of Northern Ireland in 2001–2002. Participants' experiences and views were accessed during two focus groups with a total of seven participants, and six in-depth interviews. Thematic analysis was conducted.

Findings. One core theme, 'thriving and surviving', and three main themes, 'baby nurture', 'life changes', 'coping and adapting resources', were identified to describe how parents developed during the first 8-week postpartum. These were influenced by the physical, the psychosocial and the environmental factors. The identified themes were mapped together to form an Integrated Mid-Range Theory of Postpartum Parent Development.

Conclusion. As parents need to negotiate successfully both present coping and future development during the postpartum period, there is a need for professionals to offer services that are orientated to holistic short- and long-term well-being. The findings, further to additional research, may be used by health visitors and other professionals to direct universal postpartum care.

Keywords: family, focus groups, health visiting, interviews, integrated model, postpartum, public health nursing

Introduction

Becoming a parent brings both rewards and difficulties. Demographic changes in Western societies, such as increasing incidence of single parenthood and reduced extended family support (Goldscheider *et al.* 2001), have amplified parenting challenges. These changes necessitate whole family-oriented support (World Health Organisation 1998). Events during the postpartum period have been described as a 'crisis' (Osofsky & Osofsky 1983) and 'overwhelming' (Nystrom & Ohrling 2004) with around half of mothers experiencing some level of distress during this time (Plastow 2000). Specifically, five main areas of maternal life disruption in the postpartum period were identified by Nelson (2003): 'commitments', 'daily life', 'relationships', 'self' and 'work'. Even second-time mothers need to seek and achieve a new balance in their lives (O'Reilly 2004), managing negative and positives of the 'early days'. Previous reports have underlined the psychosocial challenges of early motherhood and the importance of a holistic approach to postpartum care (World Health Organisation 2003).

Such accounts of maternal perspectives dominate the postpartum literature, although on average fathers carry out 24–35% of the care given to young children (Eurostat 2004), as well as providing maternal support (Orr 1980, Borjesson *et al.* 2004). The role of fathers is increasingly recognized in public health policies and guidelines in the United Kingdom (UK) and worldwide (Dermott *et al.* 2006, Department of Health 2004, World Health Organisation 1998, 2003). There is, however, evidence that a range of service providers may not meet fathers' needs (Plastow 2000, Buckelew *et al.* 2006, Fagerskiold 2006, Garfield & Isacco 2006). The importance of having a holistic nursing approach that empowers both parents' involvement with well-being promotion is globally recognized (Regional Office for Pan American Health Organisation 2003, World Health Organisation 2003).

Background

Public health nurses have an important role in influencing family health (World Health Organisation 2000) and home visiting is a major focus of public health practice (Byrd 1997). In a review of systematic reviews of antenatal and postnatal home visiting, Bull *et al.* (2004) found strongest evidence for the effect of programmes on reducing rates of childhood injury. There was only weak information on the effect of schemes on other family members in terms of maternal postnatal depression incidence and management or parenting behaviours. There is a growing evidence of the effectiveness of multi-faceted home-visiting approaches (Elkan *et al.* 2000b) and schemes that apply ecological theory (Bronfenbrenner 1979) addressing social and material contextual needs are beneficial with vulnerable families (Kearney *et al.* 2000). Following a systematic review of such home-visiting programmes, Elkan *et al.* (2000b) recommended that outcome measures be determined by care recipients. Often, however, reports of home-visiting studies do not describe the underlying philosophy or theories underlying programme implementation (Gough & Taylor 1988).

The UK National Health Service offers universal care to all families from the antenatal period, from both midwives and health visitors (specialist community public health nurses) through an amalgam of clinic-, hospital- and home-based services. Universal home visiting as provided by UK health visitors or midwives is largely unevaluated by controlled trials (Bull *et al.* 2004) and overlap between these roles during the antenatal and early postpartum periods has been highlighted (Henricson *et al.* 2001). Currently, health visitors offer an antenatal appointment and visit families from 10 days postpartum (Northern Ireland Health and Personal Social Services Management Executive 1995). Professional contact with families with young children forms the dominant part of their usual generic work. However, such health surveillance and prevention work with families forms only one of the three spheres of practice described by Billingham (1991): family health promotion, high intervention work and public health. Contact with families needing routine care is often arranged to coincide with the requirements of universal child health surveillance programmes (Orr 1997).

In the UK, there is a growing policy emphasis on accurate and timely health needs assessment and targeting services to those in greatest need (Department of Health 1998). It has been suggested that the needs of antenatal and postpartum families be identified in a structured and systematic manner (Department of Health 2004) in the context of a core service, with additional support for households with more complex needs (Hall & Elliman 2003). The aim of health visiting was to improve health and social well-being (United Kingdom Central Council for Nursing Midwifery and Health Visiting 2001). The role involves searching for health needs, making clients aware of such needs, facilitating well-being enhancing activities and influencing policies affecting health (Council for the Education and Training of Health Visitors 1977). A health need can be social, psychological and/or disease orientated; in addition, Robinson (1998) stated that health visitor actions may not have been identified prior to a contact, be client- or provider-centred, and long or short term. This breadth of legitimate health visiting activity can lead to diverse care priorities, potentially contributing to

different practice goals, processes, interventions and outcomes of care for individual practitioners.

Health visitor education includes a variety of health and social well-being theories from psychosocial and medico-epidemiological sources. Such theories are not formally tailored or unified into a universal practice framework, but instead are resources from which professionals draw according to client needs and clinical judgement. This allows a flexible client-centred approach (Appleton & Cowley 2003), but has led to the criticism that the profession is unfocused, without a clearly defined role (Abbott & Sapsford 1990). 'Low-risk' or 'routine care' families are the main recipients of core postpartum provision; however, while such mothers are satisfied with current provision (Bowns *et al.* 2000), it has been recommended that all health visitor interventions require clearer theoretical definition (Elkan *et al.* 2000a).

There is a variety of nursing theories that have content consistent with the central 'health-promoting' core of health visiting practice: Roy's model (Roy & Andrews 1999) provides a problem-solving method to assist and support people achieving adaptive change, and Neuman's systems model (Neuman 1995) of stress reaction includes consideration of socio-cultural and developmental variables. Philosophically, Leininger's theory (Leininger & McFarland 2002), derived from anthropology and nursing, focuses on holistic and comprehensive care and is consistent with the wide definition of health used in health visitor care. Health visitors' emphasis on professional relationship-building (Robinson 1982) is consistent with Watson's theory of human caring (Watson 1985), which is based on humanistic altruism. While such models or theories have been used in nursing for clearer theoretical definition (McKenna 1997), most have been rejected by health visitors as focusing on ill-health and requiring modification prior to widespread use by the profession (Carnwell 2000).

The potential tension between individual and family/community orientation by the profession (Dolan & Kitson 1997) also presents difficulty in selection of an appropriate theory for health-visiting practice. Family assessment models have been developed for use by nurses: the Friedman *et al.*'s (2003) Integrated Systems Model considers family stressors, coping and adaptation; and the Calgary Family Model (Wright & Leahey 2005) incorporates structural, developmental and functional assessment of family strengths and resources. These family models have not been widely adopted in the UK.

There is a need to identify the essential elements of a theoretical approach underlying health visitor postpartum care. The necessary components of such provision should be identified by users to ensure a truly family-centred approach.

It has been suggested that all first-time parents should receive postpartum support (Hall & Elliman 2003). Most parents receiving universal postpartum care will have normative needs and therefore be assessed as 'low risk' (Bowns *et al.* 2000). However, it is not known how such parents define their postpartum needs and experiences.

The study

Aim

The aim of this study was to identify parents' perceptions of postpartum family experiences.

Design

A qualitative approach was used employing 'thematic analysis' of data derived from focus groups and in-depth interviews.

Participants

A non-probabilistic and purposive sampling strategy was adopted to identify postpartum parents with normative needs who had infants aged 6–16 weeks (average age 3 months). These parents were over 21 years old and at least one of the partners was in full-time employment; these criteria were used to identify 'lower-risk' families, in accordance with the findings of Browne and Herbert (1997). Health visitors from one health- and social care provider organization identified and helped enrol families by directly nominating parents who were seen as having routine postpartum care and for whom there were no outstanding professional concerns about family well-being. In total, 17 parents (five fathers and 12 mothers) were recruited into the study. Qualitative sample size is subject to researcher judgement (Sandelowski 1995); the current sample allowed generation of themes based on a minimum criterion of three discussions of a concept by different participants, while also promoting deep analysis of parenting experiences. Furthermore, the sample size was judged sufficient to collect the most productive data within the time allowed and investigator resources (Marshall 1996).

Data collection

Data were collected using focus groups and in-depth interviews from October 2001 to March 2002. Focus groups provide a means of accessing public accounts of mutual experience (Powel *et al.* 1996, Stevens 1996) and allow the participants to explore collectively and interpret their lives

(Morgan 1998). Two focus groups were conducted with parents of infants 12–16 weeks old, the first with four first-time mothers (coding each participant as FMFG1. 1, 2, 3 or 4) and the second with three mothers of more than one child (second-time or subsequent mothers – coded as SMFG2. 1, 2 or 3). Initially, the focus groups were planned to include 6–8 people for each session but approximately half the potential participants cancelled because of other commitments. While 8–12 people are a suitable number for a focus group, smaller groups of 4–6 have been used (Simm 1997, Michell 1999). At the suggestion of the focus group participants and to recruit newer parents with difficulties in transport or family arrangements for attending the focus groups, parents of younger infants 6–12 weeks were approached for participation in the in-depth home-based interviews.

Six in-depth interviews were used to gain more detailed accounts of the impact of the baby's birth on the first-time family unit from an additional sample: a mother (IM.1), a father (IF.1) and four parenting couples (CIF. 1, 2, 3 or 4; CIM. 1, 2, 3 or 4). On average, single interviews lasted 1 hour, couple interviews 1·5 hours, and the focus groups 2 hours. Interviews and focus group discussions were themed around parents' positive and negative experiences after the birth, including factors that presented difficulties and what helped or supported parents. J. C. was moderator/interviewer at all the sessions and took handwritten notes on the discussions and non-verbal communications. All data were audio-recorded and transcribed by JC, and all tapes were replayed and checked against the typed transcripts for accuracy before analysis was undertaken.

Data analysis and rigour

Thematic analysis involves familiarity and immersion in the text to discern underlying patterns or themes (Boyatzis 1998) and to ensure consistent coding by clearly defining and describing each concept (Burnard 1991). The QRS NVIVO, version 2 computer program facilitated gathering text from focus groups and interviews into codes, and organization and retrieval of coded text. Themes were all based on a minimum criterion of three discussions of a concept by different participants. Themed text concerned both manifest (directly related) comments and latent data (inferred concepts), and each theme was defined into a code that had a title, definition and three narrative exemplars, as suggested by Boyatzis (1998), this process provided an audit trail that allowed a colleague to assess the dependability of coding (Lincoln & Guba 1985).

Once text had been clearly defined and coded, the relationship between codes was analysed in accordance with Boyatzis' (1998) thematic analysis process. Codes were clustered together on the basis of related characteristics and parents' direct or indirect attribution of links between codes. During this process, we took care to ensure that several informants indicated links between coded concepts, and that the suggested relationships between concepts were logically consistent (Miles & Huberman 1994). Review by two parents and two health visitors was used to check the conceptual clarity of the thematic structure. The thematic structure is presented as proposed mid-range theory in the current paper. As J. C. was a health visitor, it was important to consider that this experience may have affected the findings and conclusions. Throughout the reflexivity process, she was careful to undertake measures to reduce potential bias. Credibility of themes was established through peer review with two colleagues. One had experience in qualitative methods and the other had experience as a mother and health visitor. As a result of this process, some codes were amalgamated. Data tables, as suggested by Miles and Huberman (1994), were used to explore, organize and present information on research themes. To assess transferability (wider applicability) of the findings, the coded themes and thematic structure were cross-referenced with the literature and previous research findings.

Ethical considerations

Approval for the study was obtained from a health and social care provider organization in which the research was based and a university ethics committee. Informed consent was obtained from all participants. To preserve confidentiality, all participant data were anonymized, and audit trails were preserved using unique participant identifiers.

Findings

Overview of themes and their inter-relationships

Data analysis produced codes that were then classified into one core theme: 'surviving and thriving', and three main themes 'baby nurture', 'life changes' and 'coping and adapting resources'. These themes were structured on the basis of conceptual relationships between themes into a hypothesized Integrative Mid-Range Theory of Postpartum Family Development (see Figure 1).

Survive and thrive

Parents generally agreed that the first 6–8 weeks following the birth of their infant were the most difficult because of workload and uncertainty:
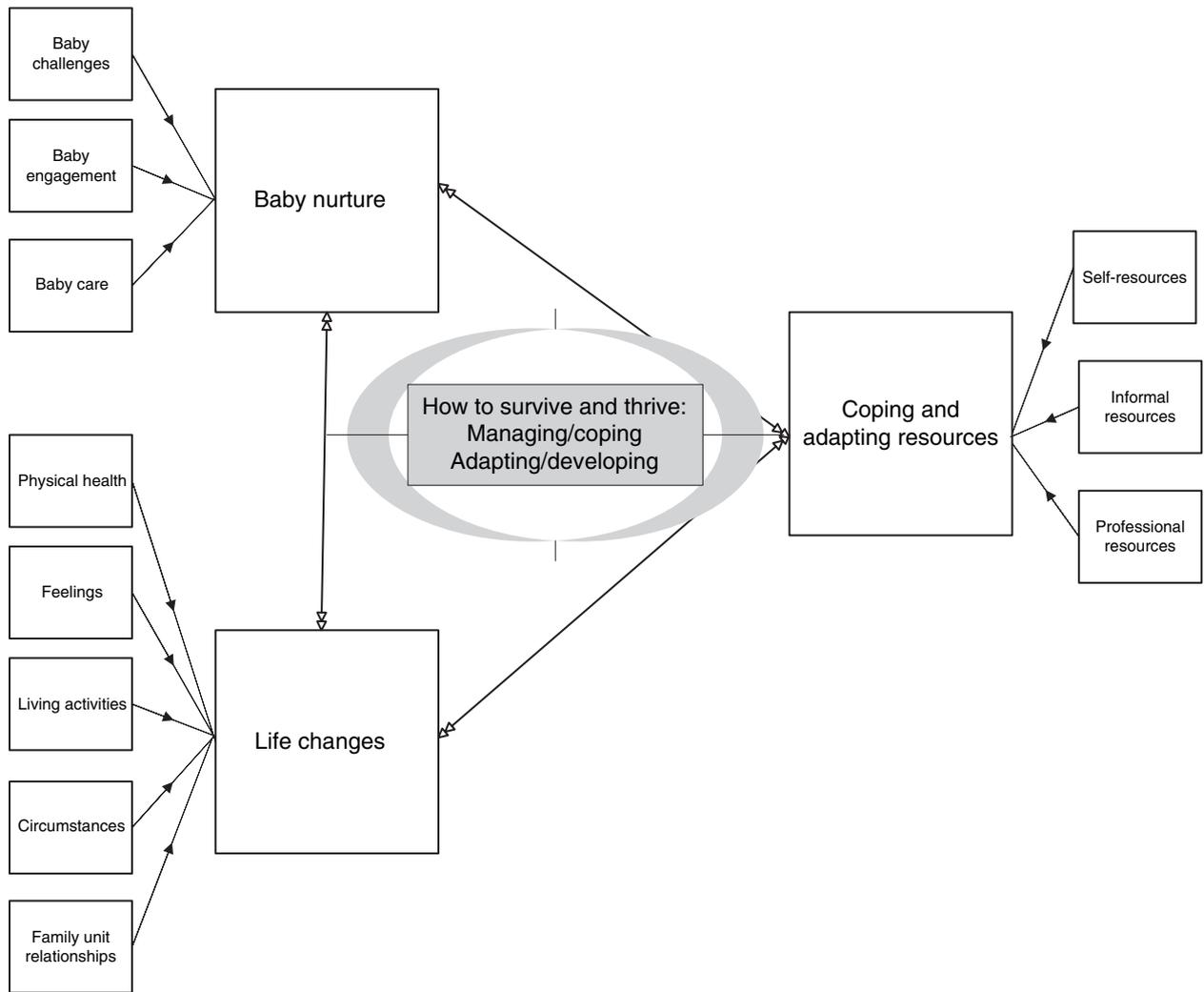
Figure 1 Hypothesized integrative mid-range theory of postpartum family development.

I think the first 8 weeks were the most apprehensive and it is simply work. (IF.1)

Participants described their core needs as 'managing/coping' and 'adapting/changing' during this difficult postpartum period. These concepts related both to present and future health and parenting well-being. Regarding managing/coping in the present, a first-time mother said:

You can feel over whelmed at times…for it is just managing everything and coping with everything. (IM.1)

Both fathers and mothers said that they also changed and adapted to infant and life demands:

You get to know all the different wee cries, and you get used to what [the baby] wants. (CIF.3)

Definitely, it gets easier…it is worth it in the end. There are a lot of sleepless nights, and you think…there is no end to this. But usually when they get to 6–8 weeks, they are getting into their own wee routine. (SMFG2.2)

Baby nurture

Three main sub-themes identified regarding 'baby nurture' were: 'baby engagement' 'baby care' and 'baby challenges'. Baby engagement concerned elements of parental commitment, bonding/affection and responsibility. Commitment to the baby had past, present and future orientations:

You couldn't do without her being here and it is as if she has been part of your life for longer, because maybe you are pregnant for so long. (CIF.1)

It is 24 hours [care] and…it is not like work where you 'go to lunch'. When you have a baby, it is 'lunch and baby. (CIM.3)

Even though she is too young, I think it is going to bring Christmas back to us…I'm looking forward to that. (IF.1)

Parents described positive attributes of their offspring and feelings of love or closeness to them as a means of facilitating their commitment:

There are times when babies grow on mothers….But my experience was that I loved her straight away. (IM.1)

One father stated that having limited time off work after the birth had disrupted forming a bond with his baby:

I would say for bonding-wise it [did]…she would look to you [referring to partner] before she would look to me. I would say that I have lost out on that bit of it. (CIF.1)

Three fathers described learning infant care skills as important for promoting feelings of closeness to the child. These parents wanted professional assistance in learning these tasks. In addition to childcare tasks, parents reported a great 'burden of responsibility' as a result of their offspring's dependency upon them:

Yes, you feel as if everything is on your shoulders. (SMFG2.3)

Yes, everything depends on you. (SMFG2.2)

In addition to baby engagement, parents also described issues relating to daily childcare. First-time parents talked of initial uncertainty about practical baby management and not knowing what to expect:

At the start you are worried about what you can do with the baby, and how you should handle the baby, and will you hurt her if you do such and such. (IF.1)

Second-time parents stated that their chief difficulty was finding time to care for more than one child:

It is harder, in that you have got to share your time among more. (SMFG2.3)

First-time mothers were concerned with baby behaviour and physical health changes, while second-time mothers were concerned about family tension and about regulating children and general time demands. Parents identified four main types of baby challenges: sleeping, crying, feeding and baby health issues. These challenges resulted in parental distress or difficulties.

Problems in settling infants to sleep were reported by participants:

Sleep is a big, big thing…especially the first 8 weeks was the most difficult [time]. (IF.1)

When infants cried persistently, they caused parental distress:

Sometimes they cry for no reason and you try everything; and you are just at the end of your tether. (FMFG1.1)

Parents expressed difficulties in bottle or breast feeding their offspring:

I found breast feeding very hard…at the start it was very hard. (FMFG1.3)

Baby ill-health also caused parenting challenges:

It was scary, especially when he looked like a balloon (Gestures and blows out cheeks to demonstrate this). (FMFG1.2)

Life changes

Concurrent with baby nurture demands, parents described undergoing life changes in 'physical health', 'feelings/mental well-being', 'partner relationships', 'social activities' and 'circumstances'. Being tired was a common physical health change that affected their early postpartum weeks:

Exhaustion immediately after the birth and you didn't ever get a chance to physically recover from that. (FMFG1.4)

Some mothers also described the physical impact of birth events during the early weeks:

I think things are quite complicated after you have had a caesarean, for you are relying on other people to help you. (CIM.4)

Both mothers and fathers reported a range of different feelings which emerged during the postpartum period (see Table 1), but no parent described 'feeling down' or 'depressed'. Participants described similar feelings, although first-time parents expressed more anxiety about normative baby behaviours or care during the postpartum period than those with previous parenting experience. Fathers also described strains on their relationships after the baby's birth:

It is a wild stretch on a relationship, you know. We have been just trying to make time for ourselves, and because I see so little of [my partner] it makes me cross. (laughs) (SMFG2.3)

Parents described changes in their living activities post-birth: home tasks, self-care and work (Table 2). For some families, these were pressures, but for others they were positive or had little impact on their lives. No pattern was noticed in the nature of responses, except that only two parents (both fathers) said that the birth had had no impact on their social activities and only mothers said that they felt pressures to complete home tasks and experienced difficulty

Table 1 Comparison of parents' feelings

Feeling	Mother examples	Father examples
Anxious/stressed	'I would have been wondering about any small wee thing with her, if she was okay…now, I am just not half as anxious at all'. (SMFG2.3)	'The very first night I was jumping up for every wee thing that I could hear…to check was that normal or was that not normal'. (CIF.1)
Guilt	'I felt guilty about it, because I couldn't [breastfeed] with him it was too hard'. (FMFG1.2)	'I feel bad about [my wife] having to get up in the middle of the night, every night'. (CIF.4)
Neglected/left out	'You do take a back seat yourself' (SMFG2.1)	'You definitely do feel left out especially with the breast feeding'. (CIF.1)

Table 2 Living activities after the birth

	Examples
Living activities	
Home tasks	'I was tired and they tell you to sleep when the baby sleeps but you can't do that because you have to do the housework. You have to do your washing (laughs.)'. (FMFG1.1)
Self-care	'You get up in the morning and you don't think about yourself, as long as they are okay that is what matters, I remember when I first came home, it was 1 or 2 o'clock in the day, like, I was still sitting in my pyjamas'. (SMFG2.2)
Social activities	'[It] is hard to get used to, and your social life fairly changes'.(CIM.1)
Work/return to work	'I was off for a fortnight after [the baby] was born…it was a terrible wrench…going back to work… you feel that you are sort of missing out on something'. (CIF.2)
	'There are days that you miss not being at work and talking to the girls and missing out on the latest big scandal'. (C1M.2)
Circumstance changes	
Environmental constraints	'I find that expeditions out and about are difficult'. (CIM.4)
	'You just can't drop everything and go and you just can't run to the garage, if you run out of tea bags or milk…For now you have to pack up this wee thing and carry her in with you, and get everything'. (C1M.2)
Finances	'I actually had to change my car, for it was impractical, and I couldn't get the pram into the boot'. (CIF.2)
	'Finances would be one thing we haven't mentioned – it is very expensive'. (1F.1)

in maintaining self-care. The timing of data collection may have influenced these findings as every father but no mother had returned to work. Parents also described how the arrival of their baby had changed their circumstances by producing environmental/logistic constraints and increased demands on their finances (Table 2).

Coping and adapting resources

Participants described a variety of 'coping and adapting resources' on which they drew postpartum: 'self-resources', 'informal resources' and 'professional resources'. They discussed various self-resources they used: previous experience, ongoing learning, cognitions/beliefs and organizing their workload.

Previous experience in looking after children appeared to help parents adjust to the postpartum period:

I have a lot of friends who have children and I would look after a lot of theirs and I did childcare work…I didn't need as much practical information as someone else would. (FMFG1.2)

Parents reported experiential learning from their baby:

Every baby is very different and the one thing that I have learnt is that you have to find out an awful lot for yourself. (FMFG1.4)

Mothers had cognitions and beliefs that helped them manage with postpartum demands:

You, just do what is possible, you can't do everything. (FMFG1.4)

If the housework doesn't get done, well tomorrow's a new day. (SMFG2.3)

Organizing or managing their workload also helped adjustment:

I am tied with [the baby], for in the mornings and the evenings she just feeds constantly…but in the afternoon she is more settled and…you can get out then. (FMFG1.1)

Parents drew upon a range of informal support resources post-birth. Only women expressed dissatisfaction (chiefly within the focus groups) with partner support during the

Table 3 Comparison of 'within' family management of postpartum tasks

Within family unit, management	Shared	Differentiated
Mothers	'My husband had paternity leave…He was very good, he took off Fridays and Mondays and he did all the washing and all the ironing'. (FMFG1.2)	'The woman runs the house really…he didn't realise how much I did…and now what slips'. (IM.1)
Fathers	'I don't think that you can really say, 'Fathers, you should do such and such' – it is a joint effort…and certainly that is the way that I feel it is'. (CIF.2)	'Because I am at work, really it is easier for you [partner] to sort it out'. (CIF.1)

Table 4 Satisfaction with care

Satisfied with care	Dissatisfied with care
'I found that both the midwives and the health visitors in our practice were spot on…I wouldn't have wanted anything any different. They were all pleasant and you just felt that you could tell them about your concerns and chat to them about things'. (FMFG1.1)	'When I said that I was going to breastfeed, they were hounding me to keep doing it. I feel it was my choice and I didn't feel that was right…Now I'm glad they did encourage me but it was more like hounding me to do it'. (FMFG1.3)
'Health visitors and the midwives who come out afterwards, are very good they talk about all the problems that you might have, on an individual basis'. (CIM.2)	'One [professional] is telling you to do one thing and another [professional] is telling you to do the other'. (CIF.2)

postpartum period; second-time mothers expressed greatest unhappiness:

You sort of feel that the child has two parents but that somehow you are the only one…Fathers can just get up and go and they know that you are there to look after them. (SMFG2.2)

Analysis of 'within family unit' management of household and baby care for first-time parents revealed no consistent pattern (see Table 3); however, evidence of different patterns of shared care and differentiated family roles was found. Parents described practical and emotional help that they had received from family and friends:

[My wife is] a lot more involved with her family – they see her more and support her a lot. (IF.1)

A friend of mine had a baby in the summer and it is great to talk to her. (CIM.4)

Participants also described the importance of feedback/ responses from the baby:

You have been trying to do a hundred and one things at once…and [the baby] smiles up at you and…makes it all worth it. (SMFG2.1)

Parents generally described professional care provided by their family doctor, community midwife and health visitor. Routine care professionals were viewed as providing a needed continuum of support:

The community midwife came out to the house for the first week, everyday – she was very good…You still sort of felt that it was like a comfort blanket…and you are gradually getting weaned off

that…[then] the health visitor was out a few times…and explained a lot of stuff to us. (CIF.2)

Most parents were satisfied with the midwifery or health visiting care they received (see Table 4). Dissatisfaction was related to conflicting advice or a poor professional manner/ communication.

Discussion

Study limitations

The method of sample selection and small number of participants limit the transferability of this study. Study families were selected by health visitors and approximately half of potential focus group respondents withdrew or cancelled, necessitating data collection by home-based interviews. As a purposive sample of families receiving routine care was required, at least three participants discussed each code and no new themes were identified in later interviews, these issues are not believed to have compromised the rigour of the study. Methodological strengths include careful independent checks to assure the quality of data analysis and findings; however, further field testing of the findings is recommended.

Discussion of findings

The core theme identified was 'surviving' and 'thriving', and this concerned managing the present and investing in the

future. This present and future orientation is consistent with public health nurses' care, which is both problem/risk management and preventative. Choi *et al.* (2005), in a qualitative study, found that maternal postpartum coping involved managing many tasks: being a 'supermum, super-wife and super-everything'. 'Surviving' and 'thriving' in the present study were found to be determined by demands of 'baby nurture' and 'life changes'; the effects of such demands were tempered by 'coping and adapting resources'. In this study, things were most difficult for the 'low-risk' parents during the first 8 weeks. These findings offer some evidence to support offering universal health visitor care that promotes both present and future parent and child well-being in the early postpartum period.

Parents in the present study identified that commitment, feeling responsible and bonding/affection with their infants were important in engaging with 'baby nurture' demands. Similarly, Mercer (2004) proposed that 'becoming a mother' was a process that involved postnatal acquaintance and practice before the ultimate formation of a maternal identity. Parental commitment, followed by engagement in continuing care processes, was also described by LaRossa and LaRossa (1981). We found that looking after a helpless infant induced feelings of parental responsibility which, in addition to commitment and bonding/affection, facilitated the provision of 24-hour parenting care. Qualitative reports of new, second-time and depressed mothers have all identified the 'burden' of responsibility that parents experience as a result of their offspring's dependency upon them (Thurtle 2003, Nystrom & Ohrling 2004, O'Reilly 2004). One father in the present study felt that early return to work had disrupted the formation of a bond with his infant. Fathers in the present study and those participating in Barclay and Lupton's (1999) research stated that learning and engaging in infant care skills promoted feelings of closeness to their children. This provides some evidence for health visitor support and facilitation of male and female parents' bonding, commitment and engagement with childcare.

We identified that first-time mothers were most concerned with interpreting their baby's behaviour and health indicators, but second-time mothers expressed most needs arising from balancing family and workload/time demands. Such findings concur with those of previous studies that second-time mothers strive to balance commitments (O'Reilly 2004) and first-time parents are more anxious about childcare (Snelson *et al.* 1990).

While our parents were receiving routine health visiting care, they still reported that they had experienced infant feeding, crying, sleeping or health difficulties. Similarly, Orr (1980) reported that 97% of mothers had child-rearing concerns about crying, feeding and handling. Infant crying has been reported as the most common complaint brought to physicians in the first few months of life (Forsyth *et al.* 1985), and an association with maternal pregnancy sleep patterns and postnatal level of distress and depression has been found (Armstrong *et al.* 1998). Nurses engaging in postpartum care need to have the necessary skills and knowledge to help parents interpret child well-being cues and manage common infant behaviour concerns.

In addition to 'baby nurture' issues, we identified 'life changes' that affected parental postpartum adjustment and development. The impact of maternal physical health, such as fatigue, has been identified previously (Smith 1989, Nystrom & Ohrling 2004). Past researchers have tended to investigate the emotional components of either motherhood or father-hood (Jordan 1990, Barclay *et al.* 1997, Plastow 2000, Goodman 2005); however, parents in our study described similar feelings in the postpartum period. We also identified different demands within households and varied accounts of what individual parents perceived as problems. This illustrates the importance of tailoring postpartum care to individual families. In the National Framework for Children, Young People and Maternity Service, the Department of Health (2004) stated that care should be structured and systematic. As had been reported previously, most couples in our study described relationship changes after the birth which could potentially increase parental confidence or reduce stress or depression (Feinberg 2002). It has been suggested that discrepancies between a mother's expectations and the reality of her relationship with her partner can adversely affect adjustment to motherhood (Kalmuss *et al.* 1992). Our findings add further credence to the move towards more family centred-care that facilitates father-oriented practices in health visiting (Department of Health 2001, Department of Health 2004).

'Previous experience', 'on-going learning', 'cognitions/ beliefs' and 'organization of workload' were sub-themes that related to personal coping and adaptation resources. These resources are consistent with Pearlin and Schooler's (1978) theory that protective coping can occur by eliminating or modifying conditions that cause problems, changing the meaning of an experience or managing the emotional impact of difficulties. Our findings concur with those reported by Durkin *et al.* (2001) in that women stated that they gained practical help from their families and emotional support from friends. Mothers with additional children were found to report less partner help with household tasks in the postpartum period, this was also found by Lederman *et al.* (1981). Similar to previous research findings, we found that midwifery and health visiting postpartum care was

What is already known about this topic

- The importance of having a holistic nursing approach that empowers both parents' involvement with well-being promotion is globally recognized.
- Public health nurses are ideally placed to make a significant contribution to family well-being in the postpartum period.
- An overt theory of professional practice for health visiting is needed.

What this paper adds

- The first 6–8 weeks following the birth of their infant were the most difficult for parents, because of workload and uncertainty.
- For second-time parents, the chief difficulty was finding time to care for more than one child.
- Subject to further verification, a mid-range theory is presented that may inform health visitors' postpartum practice.

well-received (Bowns *et al.* 2000, Biro *et al.* 2003); however, non-standardized advice or poor communication resulted in dissatisfaction. This underlines a need for more intra- and inter-professional agreement about postpartum care components. Professional adoption of national postpartum care guidelines forms a first step in this process (Demott *et al.* 2006, National Collaborating Centre for Mental Health 2007).

All the themes and sub-themes were drawn together as an Integrative Mid-Range Theory of Postpartum Parent Development (see Figure 1). The emphasis within this mid-range theory on 'present' and 'future' is a similar conception to the two main themes derived by Nelson (2003) from a synthesis of nine qualitative transition-to-motherhood studies, namely 'engagement' and 'growth/transformation'. The various components in the proposed integrated theory present a range of holistic health issues that include looking after the baby and parental physical/psychosocial well-being. This mid-range theory, therefore, develops the Robertson (1988) Family Health Needs model, which identified health visitors' search for environmental, physical, mental and social needs within households. Further testing of the mid-range theory is suggested, using structural equation modelling (a statistical procedure to investigate the relationship between latent variables) with a larger and different sample of postpartum families. The proposed mid-range theory, however, offers the opportunity to clarify the purposes of health visitor

postpartum care; Elkan *et al.* (2000b) identified that such clarification was a necessary first step towards service evaluation. It also provides an assessment framework that identifies present and potential difficulties within a family unit from a holistic viewpoint. The theory could potentially form a basis for inter-professional continuity of care.

Conclusion

Our findings are consistent with the global early family intervention priorities, which are to develop family awareness of well-being, determine and develop self-care capacity by strengthening linkages with support networks and improving the quality of care from services provided (World Health Organisation 2003). Parents' experiences encompassed the physical, the psycho-social and the environmental factors influencing health that are consistent with current well-being conceptualizations (World Health Organisation 1998) and encouragement of family use of quality health services drawing on existing social and personal resources (World Health Organisation 2003). Our proposed mid-range theory includes consideration of family coping/adapting resources and parental development and therefore it provides a basis for health care that acknowledges the wider ecological influences on household health which form basis for successful home-visiting schemes worldwide (Kearney *et al.* 2000).

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Author contributions

JC, BCP and BPB were responsible for the study conception and design and JC was responsible for the drafting of the manuscript. JC performed the data collection and data analysis. JC, BCP and BPB obtained funding. BPB provided statistical expertise. BCP and BPB supervised the study.

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