Mother, Baby
Residential Admission:
The Mother's
Experience

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DECLARATION

I, Karolyn Vaughan, certify that this thesis contains no material which has been accepted for the award of any other degree or diploma in any university, and that, to the best of my knowledge and belief, it contains no material previously published or written by another person, except where due reference is made in the text of the research.
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ABSTRACT

Becoming a mother is a challenging time and for some women the lifestyle adjustment can be very stressful. In combination with the changes in family structure mothers are increasingly seeking professional support and assistance in the care of their infants and children. Child and family health services in NSW offer varying levels of professional support and education, including 24-hour residential care. The purpose of this study is to explore and describe the mothers’ perceptions and experiences of a residential admission to a Child and Family Health unit – Karitane.

This study is descriptive in nature. Sixteen English speaking mothers admitted to Karitane in 1998, took part in the study. Focus groups were the main source of data for the study. Focus groups were undirected, conversations recorded and written notes taken. Additional data were collected by a questionnaire to determine the demographic characteristics of the mothers. The mothers’ indicators of depression were scored using the Edinburgh Postnatal Depression Scale (EPDS). Each mother completed the EPDS during the admission period and at the time of the focus group and respective comparison was made.

Data analysis revealed that the mothers’ EPDS scores had decreased significantly at the time of the focus group meeting. The key concepts that emerged in the mothers’ descriptions of their experiences were the importance of the development of the professional relationship, equity and access to parenting services, particularly for the partner and the need for services to promote and provide realistic parenting education with an early intervention focus.

The implications of the findings lend support to health care professionals in lobbying government for the necessary funds, in providing increased access to quality parenting services. With such evidence governments must act if the needs of the contemporary Australian family are to be met.
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CHAPTER 1 – INTRODUCTION TO STUDY

Parenting is a lifelong career, which many adults undertake. The caring and provision for the physical, emotional, psychological and spiritual needs of another human must be considered one of the most important roles in one’s life. The majority of parents receive very little training and education for this vocation. Becoming a parent can be a rewarding time but for some families it can be one of the most stressful times. The adjustment to parenting in conjunction with the demands of the changing society and family structures, can lead families to seek professional assistance. To accommodate the families' varying and individual needs, professional services provide distinct levels and intensity of tailored parenting programs and interventions. One such service is residential care for the child and family. This study documents the experiences and perceptions of a group of mothers in such a facility – Karitane.

1.1 BACKGROUND TO THE STUDY

1.1.1 Family

The family members are primarily the most important people in a child’s life. The child relies on the family to provide a secure nurturing environment catering for the physical, emotional and spiritual needs (Bowlby, 1961). One may question what is a family? The concept of ‘family’ tends to be ethnocentric and today is often based on the stereotypical middle class ideal of mother, father and their children. However this structure of family does not paint a true picture
of what a family is today. Robertson (1989) describes a family as "a relatively permanent group of people related by ancestry, marriage, or adoption, who live together, form an economic unit and take care of their young" (p. 247). This definition includes single parent, homosexual, adoptive, blended and defacto families. This is the definition of a family that has been adopted for this study.

1.1.1.1 The Pressures Placed on Family Structures

For centuries the extended family has been acknowledged for primarily providing the emotional and physical support to meet the needs of its members (Gledhill, 1994). The parents are ultimately responsible for ensuring the children’s needs are met. As well as addressing the child’s needs there are many peripheral issues that could interfere with the parenting role such as, cultural, societal expectations, extended family demands, financial burdens and work place stresses. It is now recognised, in today’s society, that no one family has sufficient skills and resources to completely provide these needs, and sourcing outside the family unit is essential. The saying ‘it takes a village to bring up a child’ now needs to include solicited or professional assistance (Gledhill, 1994).

In recent decades, the literature has shown that families will often seek advice for less significant parenting issues from family, friends and community members (Willis, 1992). As the family dynamics change in response to society’s diversification, the identified parenting issues are becoming more complex therefore parents are seeking professional advice and support (Pridham, 1997).
Chapter 1 – Introduction to Study

The needs of the developing family unit, as we know it today, became increasingly evident in the 1960s, which resulted in the reorientation of family focused services. This is reflected in the formation of government committees, such as Family Service Committee 1970, which examined the needs of the Australian family. Family focused services of today, recognise that families have individual needs, in an ever-changing societal context. In an endeavour to reduce or prevent family and individual dysfunction, service provision needs to cater for such needs (Gledhill, 1994).

1.1.2 Child and Family Health Services in NSW

Within child and family health services in the public sector, there are three tiers of service provision: primary, secondary and tertiary level services. The primary level of service is essentially provided by nurses, that is, community nurses, early childhood nurses and general practitioners. At this level of service parents are provided with appropriate education and support. If this level of intervention does not meet the needs of either, or both, the parents and family, or additional assistance and further assessment is required, a referral to the secondary level of service will be made. There are a variety of health professionals involved in providing care at the secondary level such as specialty nurses, psychologists, social workers, physiotherapists, speech pathologists and occupational therapists. At this level of care the parents are often involved in a detailed assessment and provided with a higher level of support than that offered in the primary level of care. The secondary level service is provided within the community that the parents reside or commute to. If the parents require further
input and support the secondary level services may refer to the tertiary level service. These services include the Child and Family Health residential units within New South Wales (NSW). The parents and children are admitted for 24-hour assistance and support, so their parenting issues may be addressed. The care is provided by specialist child and family health nurses, with ancillary support from the allied health team. This team consists of health professionals who have specialized in their field in child and family health. Team members may include psychologists, social workers, speech pathologists and psychiatrists.

Karitane and Tresillian are the only two child and family health organisations in NSW with residential units. The organisations are state-wide tertiary referral centres. Karitane has one residential unit of 20 beds, (of which 12 were fully funded during the period of this study). Tresillian has three residential units within the Sydney Metropolitan Area with a total of 42 beds. Giving a grand total of 54 residential beds to service the entire state of New South Wales.

1.2 PURPOSE AND SIGNIFICANCE OF THE STUDY
The purpose of this study is to describe mothers' perceptions and experiences of a residential admission to Karitane. The significance of this study is that it allows the voices and opinions of the women, who are by far the largest consumers of this type of service, to be heard. The study provides the forum for mothers to play a collaborative role in the provision of services, thereby providing information to health professionals. The information from this study
has the potential to support and improve clinical practices and stimulate further review of service delivery. This in turn will refine the care families receive, ultimately impacting on family centred health and the families well being. The outcome of this study will have further implications for education practices and administration, as well as contributing to the body of nursing knowledge within the child and family health arena.

1.3 DEFINITION OF TERMS

1.3.1 Edinburgh Postnatal Depression Scale (EPDS)

The EPDS is a self-reporting scale, which has been validated (in relationship to standard psychiatric measures) and is currently being used worldwide (Cox & Holden, 1994). The EPDS has 10 questions to which each have 4 possible responses, scored 0 – 3. The mother is asked to mark the one response in each statement which best describes her feelings over the last 7 days. The responses are then added, with the total score ranging from 0 to 30. A score of 12 and above may indicate a low mood. The EPDS is not a substitute for clinical assessment, but should be used in conjunction with clinical indicators. One should note that a mother who scores less than 12 could also indicate undetected depression (Cox & Holden, 1994). The EPDS can be completed in 4 to 5 minutes and is often the key to promote further discussion between the health professional and the mother. The EPDS is usually administered periodically or as indicated in the first year postnatally (New South Wales Health, 1994).
1.3.2 Family

A family is "a relatively permanent group of people related by ancestry, marriage, or adoption, who live together, form an economic unit and take care of their young" (Robertson, 1989, p. 247).

1.3.3 Mothering

Mothering is the process of acting as a carer to a child by providing a nurturing and constructive environment that promotes growth and development in the child or children (Miller-Keane, 1997).

1.3.4 Postnatal Depression

Postnatal depression is a mood disorder affecting 10-20 % of women in the first year following the birth of a baby (Barnett, 1991). The symptoms include diminished pleasure in activities, tearfulness, low self-esteem and anxiety (Boyce, 1988). Barnett (1991) also included symptoms of irritability, feeling of numbness, apathy, inadequacy, shame, guilt and sadness.
CHAPTER 2 – LITERATURE REVIEW

2.1 INTRODUCTION

Parenting today is seen by society as a natural progression in life's journey. It
is an occupation that many adults undertake, yet they receive very little training.
A literature review was undertaken to gain some insight into the advice that is
given to parents now and throughout history, and how this information was
sought. Of interest are the issues surrounding adaptation to motherhood, the
reasons women sought help, the services provided to women now and in the
past. The review also sought to clarify service developed as a result of
mothers' needs.

2.2 PARENTING – MOTHERING

Central to this study is mothering and while the role and responsibilities of
parenting are ideally shared between parents, it appears that the burden of the
role is principally carried by the mother (Briggs, 1994; Gledhill, 1996). Society
views the mother's role as providing the nurturing and constructive environment,
which promotes optimal opportunities for the growth and development of the
child (Miller-Keane, 1997).
2.3 ADAPTATION TO MOTHERING

In recent years the challenge of parenting, but particularly mothering, is being recognised (Rogan; Shimied, Barclay, Everitt, & Wyllie 1997). The adjustment to mothering is often recognised to occur within the first six to eight weeks of the infant's life. These adjustments may only include the physical aspects of infant feeding and involution of the maternal reproductive system (Fowler & Gornell, 1991). Current evidence recognises that the adjustment is not only physical, but is also emotional and psychological, and the period is now thought to be variable in length of time possibly lasting twelve months for some parents (Reece, 1995; Rogan et al., 1997; Pridham & Chang, 1992).

The adjustment to mothering can be a difficult period of time (Rogan et al., 1997). This period of adaptation is considered to include developing relationships, changes in lifestyle and constant learning of new ways which often include the reconstruction of the way the mother views herself in the new role (Rogan et al., 1997). This is supported in the work by Oakley (1980), who describes women as having immense disruptions to their lifestyle, routine and identity. This adaptation and adjustment period is considered to be easier with subsequent children (Oakley, 1980). The literature confirms how parents, but particularly mothers, are mostly unprepared for the reality of parenting. This is particularly evident in the first few weeks following the birth of the infant (Rogan et al., 1997).

The period of adaptation can be hindered by the high expectations mothers place on themselves. These expectations are often a reflection of what society
expects. As Langley and Mudge (1998) highlight "society has huge expectations of mothers, yet at the same time undervalues the role of parenting" (p. 289). To complicate mothering further the westernised world is interwoven with a vast number of norms, myths and ritualistic behaviours to which mothers are expected to conform (Bondas-Salonen, 1998).

The enormity of the external pressures placed upon a mother will to some degree impact on her mothering ability (Bondas-Salonen, 1998). The ability of a mother to manage or cope with mothering difficulties is largely dependent on her personal qualities and capabilities (Pridham & Chang, 1992). Ventura (1986) highlights the coping style and strategies of mothers as being individual to that mother and being influenced by the time and place at which the stress occurs. The parental stresses a mother experiences will be of varying degrees. Ogden Burke, Kauffmann, Harrison, and Wiskin (1999) allude to the fact of stressors often occurring in clusters. The clustering effect of the stressors will vary the mother's ability to cope, and the coping mechanisms chosen will be different than if only one stress occurs. For mothers, sleep deprivation is a major factor that will impact on her coping abilities and capability (Faber, 1985).

Maternal sleep deprivation to varying degrees is experienced by all mothers at some time (Faber, 1985). If a mother and her baby are perceived to be physically well, the factors of fatigue and sleep deprivation are often discounted when considering her mothering ability. Fatigue and sleep deprivation may be the precursors for situational stressors, disruption and dysfunction of the mother's physical and emotional capabilities (Thome & Alder, 1999). It has
been noted that the support structures of the family are most likely to change when placed in a stressful situation (Harrison & Neufeld, 1997). To assist with the period of adaptation, education, advice and support can be sort from outside the family unit. It is not uncommon for a mother to receive unsolicited mothering advice from a myriad of people, from total strangers to close friends (Fowler & Gornell, 1991). Mothers can access professional advice from various health professionals including early childhood nurses, general practitioners, specialist medical and nursing professionals.

2.4 ADVICE GIVEN TO MOTHERS: AN HISTORICAL PERSPECTIVE

2.4.1 Advice Prior to the 19th Century

The earliest academic documentation identified in the review, found that mothers were mostly given unsolicited advice on teething. Fields (1986) identifies various remedies recommended for the condition throughout time. A variety of remedies, some dating back 2000 years, were identified and most were enshrined in folklore and superstition.

The physician, Soranus of Ephesus, in 117 AD suggested the use of hare brain to ease teething and this practice remained popular until the 17th century (Fields, 1986). The use was suggested widely by doctors of the time, yet there was no evidence found for indicating a reason for prescribing. Other noted gentlemen of the time offered good reason and sound advice to mothers on all
manner of ailments, which may have been caused by teething (Herbert et al., 1920).

Herbert et al. (1920) stressed that in the 18th century advice was given by the male doctors, and the doctors would threaten the mothers with the loss of the child if the mother did not follow their prescriptive warnings. Little could be identified prior to the early 19th century of women offering help to other mothers. Following the early history of nursing as described by Dock and Maitland (1932), it is clear that society saw the helpers, mostly women, as coming from the lower class and hence their recommendations would have held little value. On the other hand, doctors were generally male and their advice believably came from scientific reasoning, or so it appeared. Although many of their recommendations were steeped in superstition they were generally accepted as being valid, so what the doctors said was accepted as being the best for the mother and her infant (Dock & Maitland, 1932).

2.4.2 Advice of the 1900-1940s

Florence Dressler, a well renowned gynaecologist of the early 20th century, wrote in 1906 a paper entitled Feminology: A Guide for Womankind Gave Detailed Instructions as to Motherhood, Maidenhood, and the Nursery. This was the first academic paper identified in the review that was written by a woman for women, albeit prescriptive in nature. Dressler (1906/1993) laid down very clear guidelines for mothers in regard to the nursing of their infants. Her writing followed the style of the era in attempting to apportion blame on the mother should she not do everything in the best interest of her infant. Dressler
(1906/1993) wrote "there must be a rare lack of the mother spirit in one who, while able to supply her child's wants, will not do so" (p. 265).

The literature of the early 20th century suggested that the advice given to women came as a directive. Information was given as though it applied to every infant, and there was no indication that alternatives were offered as a way of allowing the mother make a choice in the care that best suited her and her infant (Ehrenreich & English, 1973). Women were considered ignorant and that ignorance was reinforced by a system, which acknowledged the doctor as knowing best. The doctor was in touch with the complex world of science for which many women had been taught was beyond their grasp, (Ehrenreich & English, 1973). Mothers were seen as passive, silent majority and restricted to the womanly business of nurturing and housekeeping. In the world of the science dominated medical profession there was no room for women's instincts and intuition as they were considered as superstition (Ehrenreich & English, 1973).

King (1940) discusses how the advice was not only directive but also how it alludes to the illness that would befall the infant should the mother fail to follow the direction of authorities (Dock & Maitland, 1932; Dressler, 1906/1993). Once again the mother was at fault; for example, "if he is restless, the fault probably lies with the mother's having eaten something that affects the milk" (Dock & Maitland, 1932, p. 318). This opinion is further supported by Dressler (1906/1993) who states, "A baby fed from mother or wet nurse who lives grossly, is liable to skin diseases or other complaints" (p. 266).
Interestingly in the early 20th century, the burden of caring for the infant was ascribed only to the mother (Dressler, 1906/1993). There is no mention of the infant’s father playing any part in the care, supervision, or teaching of the infant. In fact one cannot help but notice that the father may have been considered more of a hindrance than help in infant care. When discussing sleeping arrangements in the family home, Dressler (1906/1993) recommends, “the child for greater safety should be placed at the side of the mother furthest from the husband” (p. 265).

The influence of the mental status of the mother was referred to by a number of writers such as Collins (1968); Dock and Maitland (1932); Dressler (1906/1993); Ehrenreich and English (1973); and King (1940). Their recommendations to maintain the good mental health of the mother were as many as they were contradictory. Sir Ashley Cooper in Dressler (1906/1993) remarked that:

The secretion of milk proceeds from a tranquil state of mind. With a cheerful temper, the milk is regularly abundant and agrees well with the child. On the contrary, a fretful temper lessens the quantity of milk, makes it thin and serous and causes it to disturb the child’s bowels, producing intestinal fevers and much griping. Fits of anger produce a very irritating milk, followed by griping in the infant, with green stools. Grief has a great influence on lactation, and consequently on the child. The loss of a near and dear relative or change of fortune will often so much diminish the secretion of milk as to render adventitious aid necessary for the support of the child. Anxiety of mind diminishes the quantity and alters the quality of the milk. The reception of a letter which leaves the mind in a state of suspense, lessens the draught and the breasts become empty. (p. 266)
In a publication of the early 20th century entitled *Household Physician*, the authors (Herbert et al., 1920) allude to the passions of the nursing woman and stress of that woman who nurses her infant to be careful of her passions. The authors claim that an irritable disposition giving rise to gusts of violent passion may so alter the character of the milk as to throw the child into convulsions. "Grief, envy, hatred, fear, jealousy and peevishness, unfit the milk for nourishing the child and often cause the child's stomach to be much disordered" (Herbert et al., 1920, p. 485).

Instructions on parenting were judgmental and patronising in nature. The weight of responsibility was laid clearly at the feet of mothers of the day and this is highlighted in this statement from Dressler (1906/1993), who states:

> It may be laid down as an axiom that every mother can nourish her offspring in the natural way.... Nature very rarely fails either mother or child in this most sacred and responsible function, it seems to me improbable that the Almighty would endow you with the miraculous power of giving life and yet that your breasts would fail to fill with the milk needed for the continued life and growth of your offspring. (p. 266)

The turn of the 20th century saw what may be considered a dawn of enlightenment in relation to the care of the child, (Snowden, 1950). In America through an act of Congress the Children's Bureau was established to demonstrate the effects of poverty upon the children's lives. It was acknowledged that a specialist must oversee each phase in the cycle of childcare. These phases included antenatal care, the new baby, the infant, and
the preschool child (Dock & Maitland, 1932). With an aim to promote children's health, two organisations were established, namely Karitane and Tresillian.

2.4.2.1 Karitane

In New Zealand the Society for the Health of Women and Children was founded in 1907, by a leading doctor of the time, Dr Truby King, the then medical superintendent of Seacliff Mental Hospital, Dunedin, New Zealand. Dr King later purchased a large block of land in the suburb of Karitane to which he built his home, the Karitane Hospital and milk factory. Under keen medical supervision and management, the Karitane hospital cared for infants who were failing to thrive, and once treated would then return home to their family. New Zealand made history by reducing the infant death rate by 50% over a period of five years by using this method of residential care (Snowden, 1950). The then Governor-General and Lady Plunkett initiated a fund for a special nursing service, which was to provide support to mothers from the antenatal period through to infancy (King, 1948). It was at this time that the cooperation of nurses in these branches of childcare came to be seen as indispensable. In fact, nurses – women, were encouraged to contemplate this opportunity when considering their future positions in life (Snowden, 1950). New Zealand nurses were given responsible posts in overseeing supervision of all children's homes. Later, trained nurses were made assistant inspectors of hospitals. Voluntary women's groups later continued to assist in the reduction of infant mortality through the work with the Government advisory council. The council was then named The Society for the Health of Women and Children, which became
popularly known as the Plunkett Society. Interestingly, the council members were all men.

The enormous positive impact Dr Truby King had on decreasing infant mortality may have been the impetus to disseminate the care model internationally. In 1923, Dr Truby King founded the first Australian Mothercraft Society and in 1924 the doors to the first mothercraft home opened at Coogee – called Karitane.

2.4.2.2 Tresillian

In 1918, the then NSW Minister for Health recognised that Australian infants had a high morbidity and mortality rate and in response the midwives and infant services needed to work in a cooperative way for the promotion of mother and infant health. This directive saw the development of the Royal Society for the Welfare of Mothers and Babies, which established two inner city Baby Health Clinics. In 1921 the first infant care centre was opened. From this time the service has grown and is more commonly known today as Tresillian (Tresillian, 1998).

2.4.3 Advice of the 1940-1950s

By the 1940s mother and baby focused services were well established but the advice given to mothers remained directive and mothers were not acknowledged for any mothering skills or knowledge. This is highlighted by Dr Truby King who was seen as an advocate for mothers and mothering. His writings support the notion that women were not of superior intelligence. This is
illustrated in the early 1940s by his statement: “As doctors... We know that it is the mother who must have the knowledge. She must know all the simple details; absolutely simple and not beyond her powers” (King, 1940, p. 12). King (1940) goes on to describe how parenting issues focused on the infants' general growth and development. This was no doubt because the infant mortality rates had improved and the educators were more able to focus on other aspects of the childcare apart from nutrition, hygiene and disease.

In a review of infant clinic cards dated 1947 and 1948 (The Truby King League of Victoria, 1953) it was noted that the mother would visit the clinic so the infant could be weighed and measured (The Truby King System, 1948). As well as the procedures being prescriptive, so was the access the mother had to the health professional. The mother was told how often and when to visit, and for mothers in the city this was on a weekly basis, Mothers who lived in the country areas were only serviced by a visiting nurse that would arrive in a train fitted out as a clinic. Mothers had to wait for the next train to pass through the town before they could seek the professional help of the nurse (The Truby King League of Victoria, 1953).

At the clinic the mothers were offered advice on infant diet and management of common medical disorders, such as diarrhoea and vomiting. Advice was also given on the modification of cow's milk suitable for the infant and the use of whey in controlling loose stools (The Truby King System, 1948). The introduction of solids was given detailed attention, with the mother being guided week by week on the inclusion of all food groups. A fourteen-step description of
the treatment for increasing the supply of breast milk was regularly handed out to women. This was for fear that if not given detailed instruction the mothers would surrender to the attractive advertising of the time, which espoused the benefits of milk formula (The Truby King System, 1948). In regard to their babies, mothers were instructed to give the babies the opportunity to receive an abundance of fresh air and to never offer night feedings (Dressler, 1906/1993). Bathing was to be done in a cosy corner with no dawdling (The Truby King System, 1948). Regularity of the bowels was seen as essential and the mother must ensure that she secured at least one motion from her infant daily – preferably before 10 am (The Truby King System, 1948). The advice as before was very prescriptive and without consideration of an individual child’s needs.

At this time in the 1940s mothers received directions on how they should care for themselves. The instructions included the need to be regular in habit, to eat healthy food, to drink at least one pint of milk per day and a glass of water at each feed time. The mothers were instructed to rest for half to one hour daily with feet up and must retire early at night. Of course smoking should be avoided at all costs. This directive advice should be conformed to by all good mothers (Angel-Lord et al., 1975).

Mothers were warned that fond and foolish over-indulgence, mismanagement and spoiling may be as harmful to an infant as callous neglect and intentional cruelty (The Truby King System, 1948). Health providers of the time gave explicit instructions to mothers as to the day-to-day care of their infants. These instructions were most likely based on knowledge the authorities have gleamed
from their own sources and did not necessarily relate to the Australian environment or climate. One such issue was the insistence by nurses that mothers should place their infants out in the sun for a period each day. Mothers were encouraged to extend the length of exposure day by day until such time that the baby could be left in the sun for fifteen minutes (The Truby King System, 1948). Of course the mother was strongly advised to stand beside the infant in the pram with a stopwatch to ensure the infant came to no harm (The Truby King System, 1948).

**2.4.4 Advice in the 1960s – Emergence of the Recognition of the Importance of Mothering**

In the 1960’s a prominent doctor by the name of John Bowlby acknowledged the psychological needs of children. Bowlby (1961) identified that the child’s basic development and health depends on the quality of the relationship with the baby and mother in the first few years of life. Bowlby’s (1961) work focused on the effects of maternal deprivation on young children and his writings stressed the need for a child to have a close and continuous relationship with the mother or mother substitute. This relationship should be rich and rewarding to infant and mother alike. Bowlby (1961) believed “this relationship is of vital importance and will influence the child’s future mental health and well being” (p. 11).

The recommendations to mothers in the 1960’s were that they should enjoy the delights of their children, enjoy being in their company, and be open about their feeling toward their children and the pleasures they bring (Bowlby, 1961).
Collins (1968) goes into further detail describing the benefits that infants experience when they are provided with "mother love" (p. 9). This maternal love included the warmth, approval and protectiveness that a mother provides to her child. However the mother was still to blame if the child did not receive mother love (Collins, 1968).

It must be said that the work of Bowlby (1961) not only enhanced the understanding and importance of the mother – infant relationship, but it also caused the medical profession to reacquaint themselves with the natural bond between infant and mother, and the instinctive need of a mother to practice her own mothering style. This groundbreaking work of Bowlby was the basis for further exploration by many researchers such as Ainsworth, Klauss and Kendell as cited in Billings (1995). The refinements of Bowlby’s underpinning principles are the foundation for current clinical parenting practices.

### 2.4.5 The Situation in the 1990s

The last three decades have seen an increasing recognition of the value of parenting. The focus is moving from the physical well being of the infant to addressing the contributing factors of the physical, emotional, social and spiritual needs of the family unit (Langley & Mudge, 1998). The complexity of the family unit has been acknowledged, which places the mother, rather than the health professional, in the optimal position to make family decisions (Fleming, Muton, Clarke, & Strauss 1995). By providing the mother with the information and strategies she will become empowered to make the decision most appropriate to her needs. With this investment of maternal education
comes the reorientation of the power base between the mother and the health professional (Hewison, 1995).

For centuries the extended family unit has been acknowledged as primarily providing the emotional and physical support of the family members. With the lifestyle changes witnessed in the past twenty years, such as increased divorce rates, the blending of established families, more career opportunities for women and families moving away from their social and family support structures has lead to a greater level of social / geographical isolation (Briggs, 1994). These changes in family patterns and lifestyles undoubtedly impact on a mother's ability to parent (Briggs, 1994). It is now recognised, in today's society, that no one family has sufficient skills and resources to completely provide these needs, and sourcing outside the family unit is essential. The saying 'it takes a village to bring up a child' now needs to include solicited or professional assistance (Gledhill, 1996).

2.5 HELP SEEKING BEHAVIOURS OF MOTHERS – 1990S

Little is documented prior to the 1990s about women's help seeking behaviours. The 1990s saw women become more independent and thereby seeking parenting advice and assistance (Gledhill, 1994). The avenues for mothers seeking help will vary depending on the mother's parity, (number of live births), the nature of the problem and its severity (Pridham, 1997). It is noted within the literature that mothers will often take unsolicited advice for their problems if it is of no great consequence. However, if the problems are of a personal nature or
considered serious, professional advice will be sought (Wills, 1992). Although Pridham (1997) has identified mothers with their first child as more likely to access professional advice, a mother with her second or subsequent children relied more on her partner’s support and advice. It has been noted that the advice and support a mother seeks from her partner affects the frequency and type of assistance sought outside the family home (Briggs, 1994).

The expectations of a mother seeking assistance for her parenting issues are very different to that of a mother with an ill child (Pridham, 1997). The mother with the parenting problem expects the nurse to perform in a caring or nurturing manner, to listen and facilitate the mother’s problem solving abilities, not to interfere or solve the problem. The nurse’s functions are not dissimilar to that of a traditional mothering role (Webb & Kevin, 1995). This relationship is one of equal power, rather than that of the dominant professional (Scharer & Brooks, 1994; Webb & Kevin, 1995). Whereas, a mother with an ill child focuses on the nurses’ capabilities and clinical competency levels (Webb & Kevin, 1995). A common factor for all mothers is the need for information and education of the surrounding issues (Price, 1993; Webb & Kevin, 1995).

Parents, but in particular mothers, will actively seek out information and learn as much as they can about the parenting issue or concern they have. This in turn empowers the mother to make the best decisions and manage the situation in the most appropriate manner for her family (Ogden Burke et al., 1999; Pridham & Chang, 1992). It is interesting to note that historically the medical doctor, predominantly male, was considered the professional to whom a mother would
seek parenting advice, whereas today the literature supports the idea that mothers prefer to seek help from nurses who are predominantly female (Pridham, 1997). Mothers perceive doctors to hold a scientific and technical function, associated with illness (Webb & Kevin, 1995). This perception is often reinforced by the low priority a parenting issue holds within the medical profession in comparison to a disease or illness (Bondas Salonen, 1998).

Parenting education can have an enormous impact on a mother by empowering her with knowledge and skills, and undoubtedly increasing her mothering confidence as well as personal self-esteem (Pridham & Chang, 1992; Reece, 1995). An increase in confidence will leave the mother with greater feelings of satisfaction and fulfilment, and more likely to have realistic expectations of herself and her family (Reece, 1995). The literature emphasizes the need to provide parenting education (Pridham & Chang, 1992; Ventura, 1986; Pridham, 1997; Ogden Burke et al., 1999; Reece, 1995). The education would ideally be a preventive measure or prior to the development of parenting problems. Antenatal parenting education would also be a strategy to achieve this goal (Barclay, Everitt, Rogan, Schmied, & Wyllie 1997).

2.6 BARRIERS FOR MOTHERS SEEKING HELP

A mother's concern for her child's behaviour or development will often be the impetus in seeking help and assistance. However, as Pridham (1997) suggests there are varying degrees of concern or worry a mother will endure before seeking help. Mothers may delay seeking help as it is an admission of
inadequacies and may be interpreted by the mother as a reflection on her lack of mothering and caregiving capabilities (Pridham, 1997). Not only does the mother have to admit this inability to herself and maybe to family members, but also, often to a stranger – the health professional (Harrison & Neufield, 1997).

There may be many barriers why mothers delay or avoid seeking help. Harrison and Neufield, (1997) discuss common barriers and these include fear of refusal, fear of exposure, not wanting to burden others, fear that help is not available or the personal cost may be considered too great.

2.7 REASONS FOR SEEKING HELP WITH PARENTING – MOTHERING

The review of the literature revealed an extensive body of knowledge surrounding mothers who had children admitted to an acute care tertiary hospital or residence and mothers who are admitted to psychiatric institution. The causative factors for seeking professional advice in both of these settings are the same. When a mother seeks advice in relationship to the management of a specific behaviour of her child, or an issue surrounding her parenting style, there is not necessarily a medical illness involved. Hence the motivating factor for the parents is the behaviour rather than illness. The literature tends to pathologise parenting, rather than viewing it as a natural and normal process.

A detailed list of specific parenting issues that drive parents to seek help could not be identified in the literature. The two most common reasons identified for
mothers seeking help cited in the literature were the unsettled, sleepless child and maternal postnatal depression.

2.7.1 Unsettled and Sleepless Child

Sleeplessness and settling difficulties in children less than five years are relatively common and stressful problems for the children and the parents (Carpenter, 1990; Errante, 1985; Faber, 1985; Katrina, Swanson, & Trevathon 1987; Kerr, Jowett, & Smith 1996). The majority of sleep difficulties can be improved by appropriate professional intervention (Kerr et al., 1996) although it has been noted that inconsistent and inappropriate maternal management may contribute to the sleep difficulties (Wolfson, Lack, & Futterman 1992). Improving the need for knowledge based practice, maternal education and practical application is essential. If appropriate assistance is not available or sought by mothers, the family and child may encounter long-term affects. Wolfson et al. (1992) state that 6% of ten-year-olds who do not receive appropriate care will continue to have insomnia and sleep disturbances as an adult. Sleep deprivation has been associated with childhood behaviour difficulties (Wolfson et al., 1992) and emotional conflict (Kataria et al., 1987). Settling and sleep difficulties undoubtedly heighten maternal stress (Faber, 1985; Wolfson et al., 1992; Kataria et al., 1987; Kerr et al., 1996), have been associated with maternal depression (Wolfson et al., 1992) and potentially place the child at risk of abuse and neglect (Belsky, 1980; Wolfe, 1994). It can be a struggle to discover the primary cause of the family dysfunction where the infant has sleep disturbances and behaviour difficulties, and the mother has maternal
depression, as one may potentiated the other. To address the child's and subsequently the family's problem, parental education on sleep needs, sleep patterns and appropriate strategies is the most effective from of intervention (Carpenter, 1990).

2.7.1.1 Sleep Patterns

Mothering can be one of the most rewarding and enjoyable experiences any woman could wish for, but for some, mothering can be very stressful and compounded with sleep deprivation can be disastrous for the family unit (Faber, 1985). The sleepless child causes significant stress within the family and if mothers do not obtain sufficient sleep this may have detrimental effects on the their emotional and physical wellbeing (Errante, 1985). A small number of children who are difficult to settle and/or regularly wake at night may be at risk of child abuse (Crawford, Bennett, & Hewitt 1989). The quantity of sleep the child and consequently the mother receives is paramount to the needs of all involved. High parental expectations of a child's sleep requirements can potentiate the resultant stress (Wolfson et al., 1992).

Only a small percentage of children will regularly sleep through the night in the first six months of life (Faber, 1985). This is supported by Sadler (1994) who states that only 16% of six-month-old children will sleep most nights (that is 12am to 6am). Wolfson et al., (1992) suggests between 18-22% of eight-month-old children experience sleeping and settling difficulties and with just fewer than 50% of these children, the problem is concentrated during the night hours. Sleep problems continue as 23% of 14-15 months old children have
regular wakeful periods at night (Hewitt, Heatherly, & Ibrahim, 1996). A further 20-40% of children will continue to have difficulties settling and night waking until five years of age (Balsmeyer, 1990; Lozoff, Abraham, & Davis 1985; Wolfson et al., 1992). With settling difficulties and night waking being such a common behaviour some therapists consider it to be normal to five years of age (Parkinson, 1994; Wolfson et al., 1992).

2.7.1.2 Sleep Education

The goal for most mothers experiencing child orientated sleep deprivation is to get more sleep for their children and themselves (Wolfson, et al., 1992). Sleep and settling advice is one of the most common areas parents ask for help with their preschool child (Kerr et al., 1996). Mothers can benefit from sound knowledge based education and advice (Deller & Walker, 1994; Kerr et al., 1996) as behaviour management has been recognised as the most appropriate and effective form of intervention (Carpenter, 1990). An integral component of parent education is to discuss the wide range of ‘normal’ sleep and settling patterns and to be mindful of mother’s high expectations of their child’s sleep patterns (Deller & Walker, 1994). Hewitt et al. (1996) highlights the need to address the quality of maternal attachment to the child, in combination with maternal attitude, as this will impact on sleep behaviour outcomes.

2.7.2 Postnatal Depression (PND)

Postnatal depression is by no means a disease of the 1990s but was described as early as Hippocrates’ work over 2000 years ago, when it was known as
‘hysteria’ (Cox, 1986). Over time there have been many hypothetical causes debated from hormonally driven (Johnstone, 1993) to marital discord (Stein, 1991). The Australian National Health and Medical Research Council (NH & MRC, 1991) acknowledged the broader scope of the impacting factors to be the biological physiological, psychological social and cultural aspects which contribute to the state of a woman’s mental health.

It is widely recognised that the postnatal period is a time of increased risk of maternal mood disorders (Wisner, Jennings, & Conley 1996). Kendell, Chalmers and Platz’s (1987) research discovered a dramatic rise in the admission rate to an acute care facility in the first three months following childbirth. Although the defined cause is unknown, maternal sleep deprivation due to an unsettled child certainly contributes to the maternal mood disorder – depression (Wolfson et al., 1992). Casting aside the vast spectrum of causes of postnatal mood disorders, but specifically postnatal depression, the effect of this disorder is not limited to the mother and can have a lasting effect on her partner and their relationship and possible lifelong effect on the child (Wiser et al., 1996; Wood, Thomas, Dropleman, & Meighan 1997).

The relationship, which develops between the mother and baby, is of vital importance for the growth and development of the infant (Bowlby, 1992). The failure of this relationship to develop can be due to the mother’s depression and her inability to respond to the infant’s cues (Bowlby, 1983). If the depression continues to become chronic the effects on the infant can be lifelong. Field’s (1992) study concluded that where mothers were depressed for a short period
of time (two-three months) and recovered within six months, their infant had recovered by one year of age. If the mother remained depressed longer than six months the infant also developed a depressive style of interaction. At one year of age the infants also displayed a decrease in physical growth percentiles and delays in gross and fine motor development. In young children this delay is often displayed and interpreted as behaviour problems (Bowlby, 1983; Field, 1992). Persistent maternal depression and the lack of that secure relationship to a carer places the child at risk for personal, interpersonal and social maladaptation (Berndt, 1992; Bowlby, 1992; Cicchetti & Carlson, 1989).

2.8 SUMMARY OF THE LITERATURE

The major issues from the literature review are summarised as follows:

- The adaptation to parenting is the development and adjustment of relationships, as well as a reorientation of lifestyles and expectations.

- For centuries the parenting advice mothers received was mostly given by the male doctor, who considered the mothers to be ignorant. The advice tended to be prescriptive in nature and focused on the physical growth of the child. The blame for all childhood ailments was placed on the mother.

- The early 1900s saw the development of mother baby services to reduce the infant mortality rates.
The 1960s saw the recognition of the importance of the psychological needs of the child and the mother.

The literature revealed the most common reasons for mothers seeking assistance with their parenting in the 1990s are for the unsettled and sleepless child, as well as for maternal postnatal depression.

2.9 RESEARCH QUESTION

To date, there is an abundance of literature that describes mothers' perceptions and experiences with their ill children admitted to an acute care health facility. There is an absence of literature that describes mothers' perceptions and experiences of the parenting education and support they receive during their admission to a child and family health residential unit. This led the author to pose the following research question:

What are mothers’ perceptions and experiences of a residential unit admission to Karitane?
CHAPTER 3 – METHODOLOGY

3.1 INTRODUCTION

In this chapter the design utilised to undertake this research will be described. The study is descriptive in nature. Focus groups were the main source of data for the study. The focus groups were undirected and conversations were recorded as well as notes taken. Additional data were collected in the form of a questionnaire to determine the demographic characteristics of the mothers. A comparison of each mother’s Edinburgh Postnatal Depression Scale (EPDS) score was calculated at the time of the focus group and compared to her score during the admission period at Karitane. In this chapter the details of the methodology are explained.

3.2 SETTING TO THE STUDY

3.2.1 Karitane Services

This study was conducted at Karitane in the residential unit. Karitane is an organisation which was established in 1923 by Sir Truby King to promote the health of sick infants. Since then, Karitane has developed into a family focused organisation, which aims to empower parents through education and skill enhancement to promote effective parenting. Karitane cares for families with children 0 – 5 years experiencing parenting difficulties. A range of family
focused services are provided within the Residential, Family Care and Day Stay facilities.

3.2.2 Residential Unit

Karitane Residential Unit is located at Carramar, South Western Sydney. This area has one of the highest birth rates in NSW, that is, 13% of all births recorded in NSW occur in the South West of Sydney. Furthermore, 20% of all Sydney births are in the South West, and continued growth is expected (Karitane Annual Report, 1996). Although Karitane is located in South West Sydney and largely services the local area health services, the Residential Unit is a state wide tertiary referral centre and admits in excess of 1200 admissions per annum (Karitane Audit, 1998). Primary or secondary level health professionals throughout New South Wales refer families to Karitane Residential Unit.

The Residential Unit is a 20 bed, (of which 12 beds were fully funded at the time of this study) affiliated hospital (previously known as a schedule three hospital), which provides education, advice and support to parents on a short-term residential basis. The families with children ages 0-5 years are admitted for five – seven days to address various stress related issues which include unsettled infants, sleep and behaviour difficulties, feeding problems, children at risk, infants who are failing to thrive and mothers suffering from postnatal stress and depression.
Chapter 3 – Methodology

The primary reason for children being admitted to Karitane is unsettled or difficult sleep behaviours, with 61% (1996), 73% (1997), and 53% (1998) being admitted with these behaviours (Karitane Audit, 1998).

The aim of the residential stay is to facilitate the process of mothers and fathers addressing their parenting issues. Karitane does not offer a standard parenting program but, in consultation with the parents, tailors the care to address the family’s individual needs. While in residence, parents are offered 24-hour support, education and counselling provided by highly skilled nursing staff. A major component of the residential stay is parental education and the provision of a supportive environment in which the suggested strategies can be implemented. Education, support and counselling services are provided on an individual and/or group basis. The clinicians recognise adults have diverse learning styles (Entwistle, 1993), the education throughout Karitane is delivered in various formats. The following styles are utilised: private consultation, practical application, role modelling, informal discussion, interactive group work, audio visual aids, written material, didactic presentations and therapeutic interviews.

As a matter of routine, all mothers are offered the opportunity to complete an EPDS and take part in a psychosocial interview. This private forum provides an avenue for the mother to state how she is feeling and coping. Throughout this interview a multitude of parenting and lifestyle issues are raised. The woman has the opportunity to talk, perhaps for the first time, about her own feelings and can discuss her personal needs. Following the interview, the mother may be
offered further consultation with a member of the Allied Health Team. Alternatively, following the interview the mother may discuss the issues with her partner or family and may then decide to address her issues further with the help of the Allied Health Team. The Allied Health Team can offer a psychological / mental health assessment, as well as counselling and support services. When required a psychiatric consultation can be organised with the Visiting Consultant Psychiatrist.

To promote effective parenting Karitane has embraced the concept of self-care for parents. Karitane provides various strategies such as stress management, promotion of self esteem, relaxation sessions and time out. Alternative therapies are also encouraged. A professional masseur and hairdresser provide services to the parents on a sessional basis.

3.3 SAMPLE AND POPULATION

It was imperative that all the study participants had experienced and/or shared a similar experience that is, a residential admission. The following guidelines were formulated to provide clarity to the inclusion criteria:

♦ Mothers must have spent a minimum of two days and nights in Karitane Residential Unit at Carramar.

♦ A time lapse of two to four weeks from discharge and attendance at the focus group.

♦ Mothers must be fluent in English.
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The inclusion of mothers only was justified in that mothers are primarily the largest consumers of Karitane’s services and therefore they are the most appropriate people to ask about their experiences. It was also considered that mixed gender groups would change the dynamics of the focus groups and possibly the outcome (Morgan, 1998). Two days and nights were considered to be an acceptable period of time for a mother to be able to form an opinion. The average length of stay (at the time of this study) was five to seven days. As the medium for gathering the mothers’ perceptions and opinions was a group interview, the use of interpreters could potentially change the fluency and the dynamics of the discussion and data collected therefore only mothers fluent in English were included in the study.

3.4 RECRUITMENT

Recruitment took place during the period of 5th October 1998 to the 30th November 1998 – eight calendar weeks. During this period 85 families were admitted to Karitane Residential Unit at Carramar, NSW.

3.5 RECRUITMENT PROCESS

The clinical staff were briefed on the aim and process of the study prior to recruitment taking place. The briefing concentrated mainly on the staff’s involvement in the recruitment process and the importance of not pressuring or coercing the mother into participation.
On admission mothers will often have a heightened anxiety level due to their parenting difficulties and the admission process itself can add to this stress. Some mothers may or may not have an underlying mental illness. It was decided that to approach the mothers on admission might unnecessarily increase their anxieties and possibly decrease the number of potential participants. After discussion with the clinical staff (including Allied Health Team – clinical psychologists), it was decided that the mothers would not be approached before Day three of their stay. This allowed the mothers to settle into the Unit and start to address their goals before they were invited to participate in the study.

On the third day of the mother’s admission, the case manager, a registered nurse, discussed with the mother her progress and plans for the day, (this was done each morning of their stay). At the end of this interview, the registered nurse briefly informed the mother about the research study. Each nurse was given a transcript of a suggested script, as recommended by the Ethics Committee – South Western Sydney Area Health Service (Appendix 1). The registered nurses were given a copy of the suggested script and strongly encouraged to follow it, endeavouring to promote consistency of information. The registered nurse hand the ‘expression of interest form’ to each mother at this stage (Appendix 2).

For mothers who were unable (due to language — literacy issues) to complete the ‘expression of interest form’, the registered nurse would organise a non-clinical staff member to assist the mother to complete the form. The ward clerk
was elected to fill this role, as she routinely assists the mothers with the day-to-day needs. It was considered that if a mother were to disclose her unwillingness to take part in the study to clinical staff, she could be concerned that this may compromise her clinical care. Alternatively, she may also feel pressured into participating in the study and recruitment needed to be voluntary. To reduce the maternal feeling of obligation, clinical staff did not have access to the information of mothers' expressions of interest in the study. However, the mother could choose to disclose this information to the staff.

Once the expression of interest form was completed, the mother was encouraged to return it to a designated box at the nurses' station. The box was emptied daily (Monday to Friday) by the chief investigator. If the mother indicated she was not interested in taking part, no further action was taken and the expression of interest form was filed in a locked cabinet to which only the chief investigator held keys. If the mother indicated interest in the study, the chief investigator then made an appointment to meet privately with her to discuss the study in greater detail and to answer any questions. At this stage, the mother was given the 'information sheet' (Appendix 3). The mothers were encouraged to contact the chief investigator prior to their discharge if they chose to be involved in the study. By asking the mothers to re-contact the chief investigator it reduced the need for mothers to make a decision straight away or feel pressured to participate in the study. Acknowledging that this process may have possibly reduced the number of study participants, it was considered necessary to prevent the mothers feeling pressured or coerced into participating.
Of the 85 mothers admitted to Karitane during the recruitment period, 24 mothers declined the offer to participate. Of those 24 mothers, 9 declined as the travelling back to Karitane to participate in the focus groups was an issue, due to the distance or lack of transport. Three mothers excluded themselves due to their difficulties or perceived difficulties with communicating in English in a group environment. A response was not received from 22 mothers all of whom were reminded to complete the ‘expression of interest form’, therefore it was interpreted that the mothers did not wish to participate (Appendix 2).

Table 1  Summary of the participation rate

<table>
<thead>
<tr>
<th>85 mothers were admitted to Karitane during the recruitment period, of the 85 mothers</th>
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<tbody>
<tr>
<td>24 declined</td>
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<tr>
<td>3 self excluded</td>
</tr>
<tr>
<td>22 no response</td>
</tr>
<tr>
<td>Leaving 36 volunteers</td>
</tr>
<tr>
<td>Of the 36 mothers</td>
</tr>
<tr>
<td>9 mothers participated in the trial focus groups leaving 27 mothers of whom 11 cancelled or failed to attend</td>
</tr>
<tr>
<td>16 mothers participated in the study.</td>
</tr>
</tbody>
</table>

There were 36 mothers who volunteered to participate in the study. Of the 36 mothers, 11 cancelled or failed to attend due to ill health or family circumstances at the time. Of the final sample of 25 mothers, 9 participated in one of two trial focus groups, leaving 16 mothers to participate in the study (the recruitment process is summarised in the previous Table 1. This rate of participation is consistent with Stewart and Shamdasani’s (1990) findings of a high withdrawal or cancellation rate when conducting focus groups.
Chapter 3 – Methodology

Acknowledging the stresses and demands placed upon women who are mothers and considering one third of the mothers who participated had two or more children, this participation rate was considered acceptable.

3.6 DATA COLLECTION

This descriptive study incorporated three forms of data collection. The three tools were, a questionnaire to collect demographic information, a survey to determine EPDS scores and focus groups to elicit experiences of mothers. The following section will describe the three forms of data collection used in this study.

3.6.1 Demographic Information of Participants

3.6.1.1 Rationale

The demographic data were collected to provide an accurate description of the study participants, as well as to determine if this sample was typical of Karitane clientele.

3.6.1.2 Collection of Data

Prior to the commencement of each focus group, mothers were asked to complete the ‘Demographic data collection form’ (Appendix 7). They were reminded that the completion of this form was voluntary. The data collected included residential postcode, number of children, age of children, marital
status, occupation, age of mother, country of birth and length of admission period.

3.6.2 Participants’ Edinburgh Postnatal Depression Scores

3.6.2.1 Rationale

The Edinburgh Postnatal Depression Scale (EPDS) has ten questions. It is a tool which has been validated for use worldwide to screen mothers for depression (Cox et al., 1994). The responses given by the mother provides the health professional with an understanding of how the mother is feeling and coping with parenting. At Karitane the mothers are routinely offered the opportunity to complete the scale and to discuss psychosocial issues that may be impacting on their ability to parent. In some instances, it is the first time they have the opportunity to discuss how they are feeling, thereby focusing on the mother, rather than the infant. It is well founded that the mother’s mental/psychological health will impact on her ability to parent (Barnett, 1991). Therefore, to facilitate optimal parenting, the mother’s psychological as well as physical needs need to be addressed. Comparison of the scores from during the admission period at Karitane with those scored at the focus group, two to four weeks later, were considered an effective way to gain some insight into the effects of a residential admission on their possible depression.

3.6.2.2 Data collection

The mothers were asked to complete an EPDS prior to the commencement of the focus group (Appendix 8). The mothers were reminded that completion of
the EPDS was voluntary and confidentiality would be maintained. All the mothers chose to complete the EPDS and some mothers elected to discuss their score in private following the focus group. For each focus group a residential psychologist was asked to be on stand-by in case a mother indicated she required further psychological input, or her EPDS divulged clinical intervention was necessary. This service was not needed by any of the mothers.

3.6.3 Experiences of Mothers – Focus Groups

3.6.3.1 Rationale

A focus group is a gathering of people who have experienced or shared common characteristics and who are willing to share their perceptions or ideas surrounding the specific issue (Morse & Field, 1996). Seven to twelve participants are recruited to discuss and share their opinions in a semi structured group interview. The number of focus groups conducted is determined by the purpose and the reasons for collecting the data. In a research study, focus groups are conducted until the investigator has reached saturation: that is no new themes and/or ideas are emerging from the forum (Morgan, 1993).

In the late 1930s the social scientists questioned the influences and biases brought by researchers to their studies. As at that time individual structured interviews and closed-ended questions were primarily the qualitative data collection methods used. This led the social scientists to explore the use of
non-directive questioning and leadership styles. In the 1960's marketing researchers grasped the concept of focus groups, as it was recognised as a modality to gather information about their product from a consumer's viewpoint. This allowed products to be modified and refined prior to launch, at considerable financial saving. For many years focus groups were considered solely a strategy used for marketing research (Mullis & Lansing, 1986). In the past 20 years, focus groups have been rediscovered and are not just being used by marketing researchers but by educators, planners, evaluators and social scientists (Morgan, 1993).

Focus groups were considered the most appropriate medium to obtain data to answer the research question for this study, primarily, as there is a sparsity of literature relating to mothers' experiences of a residential admission. Many authors, (Krueger, 1994; Morse & Field, 1996) highlight focus groups as an ideal environment to obtain comprehensive data, especially when "little is known about a particular subject or phenomenon" (Stewart & Shamdasani, 1990, p. 18).

Focus groups were used to allow the participants to tell their story in their own words. This was considered essential for this study to obtain insight into the mothers' perceptions and attitudes in relation to their residential stays (Nyangath & Shuler, 1990). One of the main features of focus group interviews is that it reveals perceptions and attitudes in relation to the given topic (Nyangath & Shuler, 1990). As well, one mother's comment may trigger a chain of responses from the other mothers, this is known as the "snowballing effect"
and is described by Stewart and Shamdasani (1990). The discussion that takes
place within the focus group could provide comfort for some mothers, as it
normalises their experiences, primarily as a mother and woman, (Kingry, Tiedje
& Friedman, 1990). As well, the group discussion allowed the mothers in this
study to bring up issues that they have felt unable to do in an individual
interview as there is a group ownership of the issue rather than an individual
(Stewart & Shamdasani, 1990).

Parenting and the emotions of parenting can be a sensitive issue to discuss,
and disclosure may be difficult. Focus groups were therefore considered the
most appropriate forum to obtain this rich and valuable insightful information
(Krueger, 1994; Morgan, 1993). In the focus group discussions there are no
right or wrong answers, but rather, varying points of view (Krueger, 1994). In
relation to this study it validated or confirmed the reality of the mothers’
experiences. The mothers’ were not compelled to answer each question, but to
be spontaneous and genuine in their replies. This concept is supported by
Vaughn, Schumm and Singub (1996). The group process can generate
excitement and energy amongst the mothers – which may have facilitated
further discussion and thereby improved the depth of understanding of the issue
(Vaughn et al., 1996). Mothers were more likely to share their experiences,
thoughts and attitudes when they were surrounded by other mothers who had
experienced the same situation, that is a residential admission which is noted in
work by Hansler and Cooper (1986). Morgan (1993) suggested that one might
consider this process could produce conformity within the group, but to the
contrary, participants can listen to other participants’ opinions and this assists
them in forming their own point of view. This was demonstrated numerous times in each focus group. One mother would discuss her experiences or feelings and another mother would acknowledge the first mother's statement and then disclose her experience. It is essential that the mothers feel free to express their opinions, without the need to defend their viewpoint or the need to elaborate. At times the varying opinions needed clarification. It was essential that clarification be undertaken in a non-judgemental manner. As Morgan (1998) and Stewart and Shamdasani (1990) highlight, a 'safe' environment for the participants to discuss their experiences is important, as it promotes optimal data collection.

As part of the residential admission, the mothers were encouraged to attend educational, self-awareness and self care groups. Therefore, as the mothers had previously experienced in the group process, this possibly reduced resistance to be involved in a focus group.

Focus groups have limitations, which need to be considered. The interviewer may have less control over the direction of discussion than with an individual interview. This is particularly evident if one of the group members is dominating communication (Roberts & Taylor, 1998). To overcome this dilemma an experienced moderator is required to facilitate the focus groups (Nyamathi & Shuler, 1990; Krueger, 1994; Morgan, 1993). The chief investigator—moderator in this study had extensive experience in facilitating educational, networking and therapeutic groups.
When conducting focus groups the participants need to travel to a central location at a designated time. This potentially poses difficulties in obtaining numbers to conduct a group (Kingry et al., 1990). As Karitane is a state-wide service and the focus groups were held within the residential unit at Carramar, the number of mothers who could attend the groups was determined by their geographical location.

Karitane has undertaken various forms of clinical review and appraisal, but this was the first study investigating the experiences and perceptions of the customer, the mother. It was envisaged that the focus groups would generate impressions of the service, identify potential problems and stimulate new ideas, (Krueger, 1994; Thompson & Rodrick, 1982), as well as testing the reality of clinical anecdotes. Basing service delivery around the customer or community needs is supported by Stewart and Shamdasani’s work in 1990.

3.6.3.2 Developing Questions for Use in the Focus Groups

The focus group questions were designed to obtain the data to meet the purpose of the study. The questions provided the structure for broadly channelling the discussion and to assist in making comparisons across the groups in the analysis of the data (Kingry et al., 1990; Morgan, 1993). There were a total of nine questions, used for each of the four focus groups (Appendix 4), which were refined from the questions utilised in the trial focus groups (Appendix 5). Stewart and Shamdasani (1990) debate the need for the questions to be "simple language, as long, complex, multipart questions are not only difficult to understand, and response is also difficult" (p. 65). The questions
were open ended, and designed to promote the sharing of experiences and stories.

The questions addressed three major areas, the mothers' experiences before admission to Karitane, mothers' perceptions and experiences of Karitane as well as their experiences following discharge. It was vital that mothers felt comfortable within the group therefore, if the process was to progress, the questions could not be seen to be threatening in any way. The first two questions were intended to enquire about the mothers' experiences before admission to Karitane and were designed to assist in promoting commonality and acceptance within the group. The next five questions were designed to enquire into the mothers' experiences of a residential admission to Karitane. These five questions probed the perceptions of the outcomes of the admission for the mother and her family. This body of questions composed the bulk of the discussion. The last two questions brought the group to a close, and allowed the mothers to discuss their overall thoughts, impressions and recommendations. Krueger (1994) recommends that focus group questions be structured in such a way to provide an introduction, body and closure of the group discussion. This principle was considered and applied with the formulation of the focus group questions.

3.6.3.3 *Trial Focus Groups*

All mothers participating in the trial focus groups went through the same recruitment process as the voluntary study participants. The only exception was that they had notified the chief investigator of their interest well before their
discharge date and agreed to be involved in a trial group whilst still residents of Karitane. The mothers all read the information sheet and signed the study consent form. Prior to commencement of the trial focus group, the moderator and scribe introduced themselves and discussed the aim of the group and the information sheet was read.

The aim of the first trial focus group was to determine the acceptability of the focus group questions and to review the group interview process. The questions were modified after the first trial focus group, as two questions were interpreted as being the same by the mothers, and one question was multipart which was a little confusing for the mothers to answer. The questions were modified in preparation for trial focus group two (Appendix 4). The aim of the second trial focus group was for further refinement of the focus group questions. It was deemed that the questions used in the second trial focus group were appropriate for use within the study. This process of testing the questions with further refinement is an acceptable practice according to Krueger (1994) and Morgan (1996).

The trial groups highlighted the importance of the pre-group small talk between the mothers. The pre-group discussion included informal introductions and general topics such as where the mothers lived, age of the children and the weather. This discussion was invaluable in ‘breaking the ice’. Each time small talk was encouraged, the moderator and scribe noted there was an increase in participation and fluency for the first few questions within the group. Both the moderator and scribe believed the mothers appeared to be physically more
comfortable and settled into the group process more quickly when able to take part in an activity before the group started. During the pre-group period the mothers were encouraged to make their own refreshments, (which also promoted small talk) to read and complete the paper work, that is, consent form, demographic data and EPDS. The trial groups highlighted the importance of the need for the pre-group preparations. The focus groups preparation time was extended in comparison to the trial groups, and the importance of this time was considered a priority.

Following the second trial group the chief investigator decided to exclude the trial group data from the study results, as it was unclear if the mothers’ responses were potentially biased, as they were residents at the time of the focus group. The perceived biases may have been the mothers’ concerns for any possible ramifications on the clinical care they received for the remaining period of the admission.

The physical environment of the interview room was considered to ensure the mothers were not distracted from the group process due to physical discomforts. A lounge room with independent air conditioning was chosen to ensure the mothers would be comfortable. The focus groups were planned to be approximately an hour in length. The moderator (who was also the chief investigator for the study) facilitated the focus groups and a scribe was present. The role of the moderator was to facilitate the discussion, by promoting conversation by the use of planned open ended and impromptu probing questions. It is essential that the moderator remains neutral to the group so not
to possibly bias or influence the discussion (Thompson & Rodrick, 1982). The scribe took notes of the discussion including non-verbal communications that could not be captured on an audiotape.

To promote an environment conducive to fluent discussion, it was considered essential that the children were cared for in a nearby room. The childcare was provided within the same building, but at a distance so that the children’s noise could not distract the mothers. Childcare was provided free for each mother who attended the focus groups. The child carers were staff who had possibly cared for the mother and her family during their admission. The underpinning principal being that the mothers could trust and feel comfortable leaving their children to attend the focus group.

3.6.3.4 Collection of Data – Focus Groups

A sample of sixteen mothers formed the four focus groups with each group having of 3 to 5 mothers. Vaughn et al. (1996) states “the number of focus groups conducted is dependant on the purpose, but to obtain sufficient information two to four groups are required, after four groups the rate of repetition increases” (p. 48). This was consistent with clinical findings within this study. After the third group the issues became repetitive and the fourth focus group did not elicit any new issues therefore the moderator believed saturation had occurred (Lo Biondo – Wood & Haber, 1994; Nyamathi & Shuler, 1990).
The four focus groups were held in the lounge area of the Residential Unit at Carramar in Sydney, NSW, Australia. The child carers had the child care environment prepared at least 15 to 20 minutes prior to the commencement time, in order to welcome early mothers and to settle the children. The mothers were often met by the moderator in the childcare room and taken to the focus group room. Informal discussion was encouraged prior to commencing each group, to decrease the mothers' anxieties and create a warm and friendly environment. This period of introductions and 'small talk' was assisted by the provision of light refreshment and time alone, that is without their children. This time facilitated conversation and therefore communication within the group, which is supported by the work of Krueger (1994). The informal discussion often extended into the scheduled time to commence the focus group by approximately 10 minutes. This gave those mothers who were running late time to settle their children into care.

At the commencement of each group a brief overview of the study and the procedure was given, and the role of the moderator and scribe were discussed. The mothers were reminded of their rights in relation to the study (information sheet – Appendix 3). The need for confidentiality and respect of other group members during the group was emphasised as mothers would be telling their own stories, and there are no correct or incorrect answers to the questions. Each mother was asked to read and sign the consent form, if they had not already done so (Appendix 9) and to complete the demographic data sheet (Appendix 7) and an EPDS (Appendix 8). The demographic data sheets were
collected for analysis later. The EPDS were scored following the focus groups and discussed privately with each mother.

The focus groups were audio taped to reduce the loss of data and to ensure the data were captured in context. The recording only posed a problem when mothers spoke too softly, or the mothers became enthusiastic about a topic and more than one person spoke at a time. This resulted in small gaps of conversation in the transcripts. This is one drawback of focus groups (Krueger, 1994). To complement the recorded data, a scribe noted important themes, issues and physical expressions made. This data complemented the transcripts when analysed. Following each focus group the moderator and the scribe debriefed and discussed the interview. The notes taken assisted in comparing and contrasting the group's findings. The notes taken during the debriefing were used to supplement the transcripts in an attempt to capture the true impressions and experiences of the mothers. The collection of this auxiliary information to complement the transcripts is encouraged by Krueger (1994) and Nyamathi and Shuler (1990). A description of the context of each focus group follows.

3.6.3.4.1 Focus Group 1

Eight mothers were recruited for the first focus group. A letter of confirmation for the focus group was sent out one week prior to the group (Appendix 6). Forty-eight hours prior to the focus group each mother received a reminder phone call to confirm attendance. Eight mothers confirmed their attendance. However, five mothers attended the first focus group, one giving her apologies.
as she needed to wait at home until her baby’s oxygen supply arrived (this mother was happy to be reassigned to another focus group), and two mothers being absent without apologies. This group of five mothers did not know each other prior to the focus group.

3.6.3.4.2 Focus Group 2

Six participants were recruited for the second focus group. As before, a letter of confirmation of the focus group was sent out one week prior to the group (Appendix 6). Forty-eight hours prior to the focus group each mother received a reminder phone call to confirm attendance. The six mothers confirmed their attendance. The morning of the focus group two mothers rang and cancelled due to heightened personal anxieties and an ill child. The focus group progressed with four participants. This group of four mothers knew each other as they had met during their residential admissions.

3.6.3.4.3 Focus Group 3

Seven mothers were recruited for focus group three. The procedure was followed as per the two previous groups, the letter of confirmation was sent to the mothers and a reminder phone call forty-eight hours prior to the focus group (Appendix 6). The seven mothers confirmed their attendance. The morning of the focus group three mothers cancelled due to lack of transport, ill child, and unexpected visit from interstate relatives. Four mothers attended this focus group. Of this group of four mothers, three had met each other during their residential admission.
3.6.3.4.4 Focus Group 4

Seven mothers were recruited for focus group four. Following the previous procedure the letter of confirmation of the focus group was sent a week prior to the group and phone contact was made twenty-four hours prior to the focus group (Appendix 6). The seven mothers confirmed their attendance. The morning of the focus group three mothers rang and cancelled due to sick children, and a doctor’s appointment. At this stage another four mothers who voiced their interest whilst in residence were contacted to recruit into this group. Due to short notice none of the four mothers could attend, so it was decided to go ahead with only four participants. Three mothers actually attended the focus group. Following the group the moderator received a phone call from the mother who failed to attend explaining her car had broken down on the way to the focus group. This focus group was held in the second week of December, which may have impacted on attendance numbers. Of this group of three mothers, two had developed a closed friendship since meeting during their residential stay.

3.7 DATA ANALYSIS

3.7.1 Demographic Data

Demographic data were collected to compare and contrast the characteristics of the mothers. This data were collated and tabulated, and are described in the findings.
3.7.2 Edinburgh Postnatal Depression Scale

The mothers' EPDS score at the focus group was calculated and graphed for comparison to the score from during the admission period. The scores of the EPDS were entered into SPSS software package to determine if there was a statistical difference for each mother. The Wilcoxon matched pair rank test was utilised for this comparison.

3.7.3 Focus Groups

An experienced research assistant transcribed the audiotapes for each of the focus groups. Prior to transcribing the chief investigator and the research assistant discussed the importance of not substituting words or guessing if the dialogue was not clear. If a section was unclear the chief investigator listened to the tape in conjunction with the written field notes as a means of deciphering the missing dialogue. If substitution was to occur it could possibly change the essence of the discussion (Morse & Field, 1996; Stewart & Shamdasani, 1990). Krueger (1994) describes a transcript based analysis as "the most rigorous and time-intensive process" (p. 124). The duration of the focus groups was around 60 to 70 minutes and each session took an average of six hours to transcribe. The field notes taken by the scribe were then married up to each focus group and the data then transposed onto the transcripts. As non-verbal communications and gestures cannot be included in the transcripts, the inclusion of the field notes assisted in capturing the picture (Kingry et al., 1990; Nyamathi & Shuler, 1990).
The transcripts were converted from word processing software into Ethnograph V.4 software. Ethnograph allowed each line to be numbered for coding purposes. Two copies of each transcript were made. The original transcripts were read thoroughly and each concept identified was given a code name. The code used identified the essence of the concept. Once the four transcripts were coded they were put to one side and the process was then repeated on the second copy of the transcripts. This process of double coding reduces the risk of missing coding and increases the consistency of the coding process (Stewart & Shamdasani, 1990). Coding of the transcript was not only time consuming, but also an energy intensive process.

By entering the code names, the Ethnograph software was able to sort the data so that the investigator could extrapolate all the data under particular or given code names. There were over 100 codes used to describe issues within the transcripts. Through Ethnograph, it was possible to provide a summary of codes in alphabetical order and frequency listings. These lists assisted in the formulation of the broader themes or categories. Six major themes emerged from the transcripts. The codes were then categorized under the appropriate theme. The transcripts were then printed out under the broad themes for analysis. Ethnograph assisted in the sorting of the codes, which then allowed the investigator to analyse the transcripts under the specific themes. This process was essential to complete a logical and intense analysis with the vast volume of data gathered. By utilising Ethnograph software the cutting and pasting process described by Stewart and Shamdasani (1990) was eliminated,
leaving the challenge of interpretation and analysis of the transcripts to the chief investigator.

The investigator thoroughly read the data relating to each major theme, which revealed many issues, leading to the formulation of minor themes and sub themes. All the issues were described and included under the appropriate theme in the findings. To reduce the possible risk of misinterpreting what the mothers disclosed, the investigator was mindful of several factors such as considering the context surrounding the issue, frequency of the issue, the variance of the issue and the intensity to which the issue was voiced. During the analysis phase the investigator needed to revisit the audiotapes and written field notes to ensure the data were represented in the manner and context to which it was meant. With a synthesis of the major, minor and sub themes a description of the mothers’ experiences at Karitane was written.

3.8 RIGOUR OF THE STUDY

The use of the EPDS provided the study with quantitative data. The EPDS is a validated screening tool (Cox & Holden, 1994), used worldwide, therefore it was considered unnecessary for further justification of the tool. Qualitative rigor is judged differently to quantitative, as the outcomes of the studies are different (Burns & Grove, 1995). This study incorporated both methods but primarily utilises a qualitative methodology.
Chapter 3 – Methodology

As there are many methods utilised to conduct a qualitative study, there is no one way to determine the accuracy of the inquiry, just the most appropriate (Roberts & Taylor, 1998). Burns and Grove (1995) encapsulate this concept by stating “qualitative research rigor is associated with openness, scrupulous adherence to a philosophical perspective, thoroughness in collecting data and consideration of all of the data in the subjective development phase” (p. 397).

It is imperative when conducting research to ensure credibility of the data collected. Sandelowski (1986) emphasizes the need to establish credibility within a study. Researchers must ensure that the participants are identified and described accurately. The mothers’ demographic data provided the means to accurately describe the participants. As previously discussed, each focus group was audio taped which was then transcribed verbatim. Significant issues were noted during the group process by the scribe, as well as during the debriefing between the moderator and scribe following each group. These issues were documented so the spirit of the communication was not lost and could assist in the analysis phase.

The researcher kept a journal which was a living experience of the research process, but also included thoughts, personal reflections and views. The journal entries were made as soon after the focus group or event as possible to ensure an accurate picture was maintained. The journal assisted in developing and understanding perspectives of the mothers’ experiences. This journal was kept for the entire life of the study and write up. The journal assisted the
researcher to identify personal biases, which was crucial when analysing the data as indicated by Roberts and Taylor (1998).

Burns and Grove (1995) recommend the researcher use 'reflective thought'. This is a process whereby the "researcher explores personal feelings and experiences that may influence the study and integrates this understanding into the study" (Burns & Grove, 1995, p. 398). This self-awareness of personal bias can then be acknowledged and addressed without altering the study process or unintentionally misinterpreting the findings. During this study, at the commencement of each focus group, the mothers were reminded that there were no wrong or right answers or responses. Attempts were made to ensure both the moderator and scribe remained impartial to all responses. The use of journals and supervision facilitated this process of self-reflection and external review.

The focus groups audiotapes, once transcribed, were coded as previously discussed. The researcher coded the four transcripts consecutively and once completed, the transcripts were recoded. The codes were then compared and scrutinised by the researcher to ensure continuity throughout the coding process. This intensive process is known as double coding. Stewart and Shamdasani (1990) describe this as a "multiple analysts process that provides an opportunity to assess the reliability of coding" (p.105).

This study described the mothers' perceptions and experiences of mothering, which many mothers in some way could relate to. The researcher, who is a
mother herself, needed to be very definite on her role and responsibilities as there was the threat of “going native” (Sandelowski, 1986, p. 30). With close supervision from the supervisors and the use of various strategies – journals, debriefing, reflection and thinking time, this situation was avoided.

Ethnograph V4.0 software was utilised to organise and manage the data within this study. Current literature supports the use of computer software for the management of study data to ensure content is not lost or left out. Stewart and Shamdasani (1990) state “computer assisted approaches to content analysis are being applied increasingly to focus groups data because they maintain much of the rigor of traditional content analysis” (p. 106).

3.9 ETHICAL CONSIDERATIONS

Application for ethical approval was made and granted by the Ethics Committee of South Western Sydney Area Health Service, University of Western Sydney – Nepean and the Patient Review Committee of Karitane.

An ‘expression of interest’ form was given to every mother admitted to Karitane during the recruitment period (Appendix 2). The mothers were asked to fill in the form prior to discharge and place in a sealed box that only the chief investigator could access. This process was implemented to prevent undue pressure being placed on mothers to participate, and to reassure mothers that the clinician did not know her decision and hence impact on the care she received.
Chapter 3 – Methodology

Once a mother indicated her interest to be involved in the study, the chief investigator would make an appointment to discuss the research. At this stage the ‘information sheet’ was given to the mother and the study was discussed in detail (Appendix 3). The mother was then encouraged to recontact the chief investigator if her interest remained. This gave the mother relevant information and time to make her decision, decreasing the rate of mothers agreeing to participate whom really did not wish to. It was highlighted, verbally and in writing, within the information sheet and consent form, that mothers could withdraw from the study at any time, without any form of repercussion. The principle of voluntary participation was respected and strongly encouraged.

Ethical and confidentiality considerations were discussed with each participant prior to the consent form being signed and at the commencement of each focus group session.

It was recognised that mothers who access Karitane were experiencing a variety of parenting and life difficulties. The possibility of revisiting these issues in a focus group could potentially leave the mother in a vulnerable psychological state. The chief investigator at the time of this study was the senior clinician for Karitane and has vast experience in identifying and managing depressed women. If a mother was in any distress the chief investigator had the insight and skill to manage the mother appropriately. Prior to each focus group, a member of the counselling team at Karitane was placed on standby in case a mother required debriefing or counselling. The mothers were made aware that this service was available at the commencement of each group.
To maintain the privacy of the mothers within the study the names used in the findings are pseudonyms. The chief investigator is the only person who had access to information of the mother’s real name and her pseudonyms, this information was stored in a locked filing cabinet.

The storage of all the study related data is kept by the chief investigator in a key locked filing cabinet to ensure confidentiality and privacy is maintained. All data will be kept for a minimum of five years.

The chief investigator was also employed as the Clinical Nurse Consultant for Karitane during the recruitment and data collection stages of the study. The chief investigator was extremely mindful of the possible conflict of interest that could exist between being the senior clinician and researcher. In an attempt to overcome this issue the chief investigator when consulting with a mother would make it very clear which role she was currently undertaking, and that confidentiality within each role would be maintained.

3.10 METHODOLOGY LIMITATIONS

As with any research this study is not without method limitations. The participation rate within this study was affected by the fact that mothers had to travel back to Karitane to participate. The groups were held in November and December, which was restrictive due to the mother’s preparations for the festive season. There was a reduction in the number of mothers who participated in
the study compared to those who were recruited. If all the mothers who were recruited for the study participated, it may have altered the findings.

The forum of a focus group allowed the researcher to explore the mothers’ feelings, attitudes, experiences and perceptions of a residential admission at Karitane. The information obtained through this process is not intended to be generalised, it reflects specifically the experiences of the mothers in the study (Morgan, 1993).

Kruger (1994) discusses the possible limitations due to an inexperienced moderator who could unintentionally direct or steer the group discussion. If the moderator was not aware of her role and personal biases, the ability to remain objective would be compromised (Stewart & Shamdasani, 1990). The moderator was aware of these issues and had addressed same, as previously discussed.
CHAPTER 4 – STUDY FINDINGS

4.1 INTRODUCTION

In this chapter the findings of the study will be presented. Firstly, the profile of the participating mothers will be described, followed by the comparative results of the mothers' admission and follow-up EPDS. The chapter will conclude after describing the mothers' views and perceptions of their residential admission, which were obtained through the forum of attending one of the four focus groups. The findings will be described under the appropriate theme with supporting quotes from the mothers.

4.2 MOTHERS' CHARACTERISTICS

The 16 mothers who participated in this study had spent a minimum of five nights at Karitane, as summarised in Table 4.1. The mothers were aged between 21 and 41 years with the mean age being 31.8 years. All mothers but one were married or lived in a de facto relationship with the father of their baby. The single mother had been separated from her baby's father and did not have contact with him at the time of the study. The majority of mothers who participated in the study were born in Australia. Other countries represented were United Kingdom, Greece, and Czechoslovakia. All mothers but one were employed (at least on a part time basis) before their last baby was born, although five of the mothers had now decided not to return to paid work.
Chapter 4 – Findings

The majority (ten) of the mothers lived in South Western Sydney Area Health, of the remainder, three lived in the Western and three lived in the Southern Eastern Area Health regions. For nine of the 16 mothers this was their first child. Five mothers had two children, one mother had three children and one mother had four children of which two were biologically her children. The children were aged between three weeks and seven years old, although the age range for admitted children of this study was three weeks to two years.

Table 2  The characteristics of the mothers in the study

<table>
<thead>
<tr>
<th>Characteristics</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No. mothers who participated in the focus groups</td>
<td>16</td>
</tr>
<tr>
<td>Age range of mothers</td>
<td>21-41 years</td>
</tr>
<tr>
<td>Mean age of mothers</td>
<td>31.8 years</td>
</tr>
<tr>
<td>Married or de facto relationship</td>
<td>15</td>
</tr>
<tr>
<td>Single</td>
<td>1</td>
</tr>
<tr>
<td>Employed prior to having this child</td>
<td>16</td>
</tr>
<tr>
<td>Mother’s country of birth</td>
<td></td>
</tr>
<tr>
<td>Australia</td>
<td>12</td>
</tr>
<tr>
<td>Czechoslovakia</td>
<td>2</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>1</td>
</tr>
<tr>
<td>Greece</td>
<td>1</td>
</tr>
<tr>
<td>Geographical location (Health Areas) of residence</td>
<td></td>
</tr>
<tr>
<td>South Western Sydney</td>
<td>10</td>
</tr>
<tr>
<td>Western</td>
<td>3</td>
</tr>
<tr>
<td>South Eastern</td>
<td>3</td>
</tr>
<tr>
<td>No. children</td>
<td></td>
</tr>
<tr>
<td>One child</td>
<td>9</td>
</tr>
<tr>
<td>Two children</td>
<td>5</td>
</tr>
<tr>
<td>Three children</td>
<td>1</td>
</tr>
<tr>
<td>Four or more children</td>
<td>1</td>
</tr>
</tbody>
</table>
Chapter 4 – Findings

The primary reason for admission of all mothers in the study was the management of an unsettled child. This was the first admission to Karitane for all of the mothers, although one mother had spent five nights in another Residential Unit four months prior to her admission to Karitane for the same reason. A summary of the mothers’ characteristics is contained within Table 2.

The study sample population is comparative with the English-speaking clients admitted to Karitane during the year of the study (Karitane Audit, 1998).

4.3 MOTHERS’ LEVEL OF DEPRESSION

During their admission mothers completed the EPDS. The EPDS is a validated tool used to screen women for postnatal depression. The tool is used to promote discussion with the mothers to ascertain their situation and feelings (Barnett, 1991; Cox & Holden, 1994). The EPDS is a self-reporting tool consisting of ten questions, which are scored 0 to 30, according to the mothers’ responses.

An EPDS score of 12 or higher may indicate that the mother requires further intervention from a health professional(s) such as support, on going counselling, or medical assessment for medication (Cox & Holden, 1994). This intervention is initiated during the mother’s stay at Karitane if she is accepting of assistance. The mothers’ admission EPDS were compared to the scale they completed at the focus group. The following is an overview of the Edinburgh Postnatal Depression Scale comparisons – Figure 1.
The admission EPDS ranged from 3 to 21 points, the mean was 12.125 points with the median being 14. The EPDS range conducted at the focus groups ranged from 0 to 11 points, the mean was 5.938 points with the median being 6. The EPDS decreased for every mother except for one with whom it remained constant. This mother was under continuing care of a psychologist and psychiatrist. These results indicate that 94% of the mothers had a decrease in their EPDS, which is a clinically significant finding. This decrease was consistent with the positive outcomes discussed in the focus groups.

Using a Wilcoxon’s matched pair sign rank test the EPDS scores of the mothers were significantly decreased at the time of the focus group. This decrease was statistically significant (p < 0.05), p = 0.0007.
4.4 MOTHERS' EXPERIENCES

Following the synthesis of the data obtained at the four focus groups, six major themes emerged from the mothers' experiences. The themes were used to formulate a structure to describe the focus group findings. The six major themes are, stresses of mothers, mothers' reflections of their residential admission, education and advice mothers received, mothers' interactions with health professionals, mothering mothers and mothers' perceptions of their partners experiences (refer to Table 3). Quotations from the mothers are used to support the themes. The recommendations the mothers made for change are included at the end of each appropriate theme section.

An alias name was given to protect the privacy of the mothers. Names used were Toni, Kara, Sue, Sally, Freda, Kelly, Sam, Megan, Pam, Michelle, Lyn, Kim, Paula, Shelly, Cheryl and Abby.
Table 3  Overview of the major, minor and sub themes

<table>
<thead>
<tr>
<th>MAJOR THEMES</th>
<th>MINOR THEMES</th>
<th>SUB THEMES</th>
</tr>
</thead>
</table>
| Stresses of Mothering | Demands of mothering | • Mothers’ ability to cope and manage  
• Mothers’ self esteem as a parent  
• Support issues |
| Mothering advice | • Not being heard  
• Questionable advice  
• Support |
| The wait list | • Coping until admission  
• Relief |
| The stigma | • Negative connotations of residential admission  
• Desperation / last resort |
| Mothers’ reflections of their residential admission | Mothers’ impressions of Karitane | • First impressions  
• Relief  
• Environment to be nurtured |
| Introduction to the Unit | • Orientation  
• Explanation |
| Mothers’ need for sleep and a settled child | • Desperation for sleep  
• The need to sleep verses separation  
• The demands of settling |
| Food | • Not having to cook!  
• Variety |
| Mothers talking to mothers | • Normalising feelings  
• Isolation |
| Education and advice mothers received | Mothering skills and knowledge | • Expectations  
• Early education  
• Wholistic parenting  
• Confirming learning  
• Regaining control |
| Video education | • Supplementary advice  
• Absorption of information |
| Conflicting advice | • Mothers’ confusion  
• Conflicting advice verses multiple strategies |
| Mothers’ interactions with health professionals | Disempowerment through the manner the advice and education was delivered | • Interpretation of the communication  
• Communication styles |
| Nurses | • Relationships  
• Support and nurturing  
• Nurses’ experiences |
| Playroom staff | • Learning to play  
• Value of play  
• Playroom experiences and attitudes |
| Counsellors | • Strategies  
• Practical advice |
| Paediatrician | • Listened to  
• Advice given |
## 4.4.1 STRESSES OF MOTHERING

All mothers in each of the four focus groups discussed the stresses of mothering. The mothers emphasised how difficult mothering was for them prior to their admission to Karitane. The mothers felt that external factors, such as the attitudes of health professionals and society in general potentiated their stresses. The issues the mothers discussed include the demands of mothering, advice from health professionals, waiting lists and the stigma associated with asking for help.
Chapter 4 – Findings

The following list summarises the minor themes identified. These issues are presented in a descending order of frequency of occurrence within the focus groups.

- The demands of mothering
- Mothering advice
- Waiting list
- The stigma

4.4.1.1 The Demands of Mothering (before Karitane)

The mothers all strongly agreed that they were experiencing parenting difficulties prior to admission at Karitane. The difficulties were the reasons for seeking help. The issues the mothers discussed included their ability to cope and manage, self-esteem as a parent, support structures and the effect of sleep deprivation.

The mothers described a range of emotions and feelings they were experiencing, as well as the expectations they had of themselves as parents. The mothers all had preconceived ideas of how they would parent, which included providing the best for their children and their family. The mothers believed that managing such a complex situation would just naturally occur and that they were expected to manage. The appearance of coping and managing was important to the mothers.
The following comment typifies the mothers’ comments:

I was so paranoid about trying to appear like I had it all together to the outside world, the house still had to be tidy, everything still had to be in its place and tea on the table when he walked in, and the child had to be bathed and in bed or happy, and inside I was just melting. [Kelly]

The need to portray the appearance of coping and managing was taken to the extent where the mother found it difficult to cope at all:

I was at the point of not coping, not seeing the funny side of things, very unhappy, hum drum life, all that kind of thing, I think I was slipping into depression and I just wanted my old life back, and someone to give me a good baby as I didn’t like this one. [Pam]

To disguise their inability to cope some mothers suggested various strategies they would implement to hide or avoid facing the difficulties:

I lost all my confidence whatsoever I wouldn’t even put her to bed if I could help it, as she wouldn’t sleep for me any way. [Shelly]

For some mothers when they finally got the courage to admit to a family member or close friend that they were having difficulties, their hopelessness was once again reinforced. The support they were seeking was not to be found.

You are supposed to know how to look after your baby, Um, my father, one day told me, but your mother coped, she had two under two basically and she still managed and she did it without all your resources. [Sue]

The mothers felt that significant people in their lives were not always supportive and were also reinforcing the often unrealistic, maternal expectations. This was often to the detriment of the mothers and their family. The mothers described
feelings of guilt, which they recognised as their inability to meet their own expectations:

*I’m a professional woman who coped and managed multi-million dollar accounts and now I can’t even manage the baby or myself... and now I am on a guilt trip about every thing and you know that has an effect on all of us.* [Toni]

The mothers were feeling fragile in relation to their parenting abilities and capabilities. The mothers often measured their parenting ability through their child’s behaviour. They felt even more devalued if someone else could attend to their child’s needs in a more successful manner. This inability to attend to their child’s needs impacted on the mothers’ self esteem:

*Yeah I know, I feel guilty if anyone comes over and Daniel isn’t asleep, as that shows I can’t even settle him and I’m not coping... and if they offer to settle him, well! you know what I mean, I just feel totally useless then.* [Sally]

Lack of sleep impacted on all aspects of the mothers’ lives. This sleep deprivation compounded the mothers’ feelings of hopelessness and inability to cope and manage. The mothers discussed how their feelings were exacerbated by sleep deprivation:

*We were home two days and we didn’t sleep for 48 hours, we didn’t eat for 48 hours and we knew we were desperate and needed help, we couldn’t think or even decide on what to do and we felt written off. We had flunked as parents.* [Michelle]

Some mothers were amazed at how sleep deprivation impacted on their ability to cope:
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It’s amazing how off ya get without sleep, ya just look, feel and act like a zombie. Your just useless to anyone. [Abby]

As I didn’t get enough sleep I became snappy and on the edge all the time. [Freda]

The discussion of the parenting difficulties escalated to such an extent that some mothers found it difficult to explain in just a few words. One mother didn’t feel that there was a word in the English vocabulary that could explain the pain and agony she felt. The mothers used words such as, ‘unbearable’, ‘miserable’ and a ‘nightmare’ to describe how they felt their lives were as parents.

For one mother her parenting experience was so traumatic that adoption was a realistic consideration. The thought of the baby being a huge mistake and adoption being an escape was a common theme throughout the focus groups:

We were truly looking at adoption, as it was that bad, we loved her but felt so trapped and this was the only answer, and you know we had waited for her for two years. [Kara]

Sleep deprivation impacted on every aspect of the mothers’ lives including their relationship with the father. One mother stated that they had seriously contemplated divorce:

Borderline divorce before (admission to Karitane). Very very close to separation. [Abby]

Sadly enough the period of sleep deprivation could be lengthy. This is often due to parents allowing the problem to escalate until the situation was
unbearable or the time they had to wait for assistance. Putting aside the reason for the delay the effects on the mother intensified:

_ I didn’t get a good sleep for months – it was pure torture, I looked horrible, I felt horrible, oh I wanted to dig a hole and bury myself in there. That’s how I felt and then I came in here. [Sam]_

A common feeling amongst the mothers was that only other parents could understand their situation. They believed that there is no other life experience to which parenting and sleep deprivation could be compared:

_ You just can’t believe how demanding parenting is until you are a parent. [Megan]_

When the mothers reached the stage of seeking assistance and professional help they often approached their primary health provider, that is Early Childhood Nurse, General Practitioner. Even at this stage it wasn’t until the health professional discussed Karitane that mothers were aware of the service provided. Most of the mothers in the focus groups were aware of Tresillian and the services they provided:

_ I’d heard of Tresillian and it wasn’t until I asked my community nurse for a referral that she asked why I didn’t want to go to Karitane? and I said what is a Karitane? It worked out well as this place is closer to home. [Freda]_

All of the mothers agreed that parenting services needed to be discussed early postnatally or even during the antenatal classes and not left until a problem arises. Most of the mothers felt that if they were aware of support services they would have accessed them earlier:
They should tell you about Karitane before you have the baby, I didn't know places like this existed. [Cheryl]

4.4.1.2 Mothering Advice

This next section will discuss the mothers’ perceptions of their interactions with health professionals prior to admission to Karitane. The mothers discussed issues such as not being heard, how the advice was questionable and the issues surrounding their support needs.

The mothers discussed the type of advice they received from various health professionals prior to their admission to Karitane. Recurrent themes included feelings that they had not been listened to by the health professional and nor were they able to get a direct answer to their questions:

I saw the nurse and she was more interested in completing her notes than listening to me.... The paediatrician well, within 10 minutes I was in and out of his surgery with two new scripts in my hand and a new feeding regime. It wasn't until I came in here that someone said what's been happening? And she listened. Thank God someone wants to listen to me. [Megan]

It was not uncommon that mothers had visited more than one health professional in an attempt to seek help for their family:

Over the last month I saw the paediatrician, GP, and two relieving nurses, no one could tell me why he was unsettled, I was told he could be teething, he is having a growth spurt, he could be sick, and my milk supply wasn't good enough. No one knew they were all just guessing. [Sally]
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Some mothers, when seeking help from health professionals felt that their problems were being trivialised and the true intensity of the problem was not understood:

\[
\text{They have no idea of what I was going through, nor do I think they wanted to know, the only decent advice I got was to come here. [Toni]}\]

Not all of the mothers were unhappy with the service they received from the health professionals. Some mothers had built a good relationship with their health professional and felt supported:

\[
\text{Well my nurse was very nice, she was only young, but she saw me whenever I needed to, and she tried to find out if she didn't know something. [Lyn]}\]

\[
\text{I thought I had a good nurse until she sent me to see a psychologist, at first I thought she was the one who needed to go, but now I know she was right and I'm grateful to her. [Freda]}\]

4.4.1.3 Waiting List for Residential Unit Admission

Each focus group discussed issues surrounding the waiting list for admission to Karitane. The mothers’ concerns varied from how they had to cope until their admission to the relief they experienced once given an admission date.

The majority of the mothers expressed their concerns of how long they had to wait between referral to the residential unit and their admission date. The mothers believed that this wait increased their stress and often the problems got worse.
For some mothers their lifestyle was chaotic and the best they could do was to maintain their style of life until their admission:

I was just out of control. No routine, no sort of knowing what you were doing from one minute to the next and not knowing if she was all right or like unhealthy or if it was something I was doing or she was doing. Well then they tell me they can give me the 16th of November, and you think, Oh what do I do now in the mean time? ...I think I was getting really anxious and everything, like a week before coming in I remember thinking like that's 5 more sleeps, you know? That's how desperate I was. [Abby]

Even when mothers did not have a long wait for admission they found it difficult. One mother suggested that it could be due to the mothers trying to survive the best they could and when they finally did seek help that they were desperate or in a state of crisis:

I didn't know how I was going to survive until my date even though it was only two weeks away, we were just so desperate... looking back we should have come for help earlier. [Freda]

Some mothers found relief when knowing they had an admission date:

I thought then it was only three weeks, I can cope with this for another three weeks. [Sally]

4.4.1.4 The Stigma of Seeking Help

In the four focus groups the issues of the negative stigma associated with the need to spend time in a residential unit were discussed.

Prior to admission the mothers perceived themselves as 'inadequate parents', who needed to ask for help as they were unable to cope or manage their
children the way they expected they could. The mothers discussed how 'desperate' they were before admitting defeat and agreeing to be admitted to Karitane. Coming to a residential unit was considered as the last resort:

'It took me 10 weeks to decide to come here, I became so desperate.... However on the way over I cried, as I felt a great sense of loss and failure as a mother. [Sam]

I think we've all come in here as we needed help, but for me it was the very last resort, I was desperate. [Lyn]

The mothers all agreed in hindsight that they had benefited from their admission, and some mothers suggested they wished they had come in earlier or with their first child:

I was lacking everything in the end (before admission to Karitane). For me, now I'm getting a lot more sleep so I'm more energetic, I'm more talkative, I'm even smiling now. So I have a lot more everything. I have more patience with him (the baby), I play with him, and I just should have done it earlier as I have a lot more time for him and me. [Kim]

For some mothers the admission that they needed help was overwhelming and stirred up many emotions, and one of the most common was the feeling of guilt:

I didn't want anyone to know I was coming in here, as they would think I couldn't cope or had lost it.... I couldn't even tell my mother. [Freda]

The mothers believed that generally the public associates negative connotations with admission to residential units:

I don't think people really know what places like this really do I think they think it is just for nutters. [Michelle]
4.4.1.5 Mothers' Recommendations

Throughout the focus groups the mothers offered suggestions and recommendations for improving support while waiting for admission. The following are the mothers' recommendations:

♦ More realistic antenatal parenting programs and education.

♦ More physical and emotional support for parents.

♦ Less conflicting parenting advice from professionals.

The mothers' suggestions and recommendations related directly to the pre admission period were:

♦ Reduce the length of time between referral and admission.

♦ Morning admission time rather than evening, so that mothers can make the most of that day.

♦ Wider publicity within the community of Karitane's.

♦ Public education on the needs of parents and what the services provide.

4.4.2 MOTHERS' REFLECTIONS OF THEIR RESIDENTIAL ADMISSION

The mothers discussed many issues surrounding their stay at Karitane, from the physical environment to the way they were introduced to the service and
the personal benefits for them. The list below provides an overview of the minor themes described by the mothers. The minor themes are presented in a descending order of frequency of occurrence within the focus groups.

- Mothers' impressions of Karitane
- Introduction to the Unit
- Mothers' need for sleep and a settled child
- Food
- Mothers talking to mothers

4.4.2.1 Mothers' Impressions of Karitane

The mothers’ described their first impressions and the general environment of Karitane. The mothers highlighted the relief they felt once they were admitted to the unit.

Some mothers voiced the relief and feelings of calm they felt from the moment they walked in the front door. All the mothers found the residential unit environment and atmosphere positive, nurturing and safe:

From the moment of walking in the door, for me it was just like ooh just amazing, it was so calm and relaxing. [Lyn]

As I walked in here it felt like the whole world just lifted off my shoulders it was a relief. [Abby]

The mothers felt this positive nurturing atmosphere continued throughout their admission:
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I loved it. I didn’t want it to end. I found the environment to be so nurturing and it’s like you’re walking around with someone wrapping their arms around you everywhere you went. And if ever you got a bit stressed or you thought stressed there was someone there for you. [Sue]

It was a common belief for mothers (prior to admission) that the residential unit would be like going to an acute care hospital facility. For some mothers to find out the residential unit to be more like a home than hospital was a relief:

This place is more like a home than a hospital, I think that also helps you feel more comfortable. [Pam]

The mothers considered the physical surroundings of the residential unit to be comfortable:

The rooms were nice and you can tell they tried to make them a homely, I expected them to be like the hospital ward, hard starchy beds and uncomfortable. [Kara]

4.4.2.2 Introduction to the Unit

When the mothers were asked about their orientation to the unit, they had a range of comments. The comments included the mothers’ feelings in regards to the orientation process, their experiences and the explanations they received.

The majority of mothers felt that this orientation time was a good ‘ice breaker’ as it allowed the parents to start to get to know the staff and assisted the parents in settling into the unit:

When we arrived, and after the paperwork the nurse took me around, and showed me everything, I felt a little better after that. [Freda]
Some mothers really did not know what the next week in the unit would hold for them even though it was discussed with them before admission:

_The introductions were helpful, as you get an idea what you really in for… but I still had to ask a lot of questions…. The community nurse and the intake lady both explained what would happen but I had no idea until I came in, I just knew I had to do it._ [Sally]

During the orientation to the unit, some mothers found particular areas required more of an explanation than others. The one area that was frequently highlighted as needing more explanation was the kitchen area:

_I felt they did a good job but they should have told me more, about the kitchen areas._ [Cheryl]

### 4.4.2.3 Mothers’ Need for Settled Children and Sleep

All the children of the mothers in this study had a primary admission diagnosis of unsettledness. All mothers in the focus groups agreed that their sleep and their child’s sleep was a vital issue in their situations. Each group discussed the use of night nurseries and the demands of settling their children to sleep. Some mothers debated the dilemma between separating from their sleepless child and their need for sleep.

The majority of mothers were grateful for the opportunity to have an uninterrupted sleep:

_I think we welcomed the night, the first night, so you could catch up on sleep and the focus on re-learning what to do, and it was good just to have a break._ [Shelly]
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After a period of sleep deprivation mothers became desperate for some sleep:

*By the time you’d got in here, you just needed to have a break. I was desperate for some sleep, so I was grateful for the first night.* [Kelly]

*Knowing you are going to have a nights sleep is so exciting!* [Sam]

The thought of a good night sleep or time out for some parents is blissful. As one mother explained when the intensity of the maternal demands are released they are often missed:

*Well we thought it would be a nice break to get some sleep the first night and we sat down in the lounge and all the other parents were dashing out whenever they heard a baby crying and we sat there twiddling our thumbs – before this we were all ready to get rid of this baby, adopting her out or even fostering, we’ve made a mistake having a second one, you know we found out we did actually miss her when she wasn’t around and we really did want her.* [Pam]

The desperation for sleep outweighed the separation anxiety for some mothers:

*On the first night I was so pleased that she was down with the nurses as I was so desperate for some sleep, and I couldn’t hear her if she did cry.* [Paula]

For some sleep-deprived mothers even when offered a night sleep the separation from their children kept them awake:

*That’s the thing I had. I couldn’t sleep on the first night, I don’t know if it was the strange room, and strange environment, also I was thinking, What’s happening down the end of the corridor? .... you’re willing yourself to sleep, because you are so used to having broken sleep, and I was so worried about what she was doing, that’s what kept me awake.* [Abby]
You’re too unsettled to enjoy that first night sleep. I mean it certainly is lovely to think of a full night’s sleep, but I couldn’t I lay there worrying and wondering what he was doing. [Megan]

Other mothers as they couldn’t sleep would check on their children regularly throughout the night – often to find the child asleep:

I checked on my baby regularly through the night, and each time the nurse would say he’s fine I’ll give you a call if he wakes. [Toni]

For some mothers the night nurseries were physically too far away from their unit, and therefore did not feel they could separate from their children:

The night nurseries are too far down the corridor from the parent’s bedrooms, I wasn’t prepared to leave him down there. [Freda]

Some mothers would have preferred to have their children with them every night:

I insisted on my child being with me as we have this situation at home, and I needed to do this. I said if she was down there (in the night nursery) I’d be down there every hour to see if she’s OK anyway, but you know the nurses were quite insistent that she goes into the nursery. Finally they agreed to leave her with me if I promised to ring if I needed help. And I did ring. [Michelle]

The mothers found the settling to be emotionally draining and at times physically wearing. The support from the nurses assisted the mothers through the settling:

Listening to the screaming is bad, not knowing that she’s not actually going to sleep is distressing. The nurses stayed with me, and talked me through each screaming match, and gradually she got a little better. Now I put her down and she knows, she has a whinge and off to sleep she goes. [Lyn]
The mothers believed the support and education they received during their stay had prepared them to work through the demanding needs of settling their child:

> Oh the baby’s crying. Now I am actually able to relax and I can think she’s not distressed, I’ll just let her go, and usually she settles. I couldn’t have done it without them. [Kelly]

> It’s probably the hardest thing I have had to do to him, but I had to do it, I had to do it, I had to do it for us.... I’m so glad it’s over, I couldn’t have done it alone though. [Freda]

4.4.2.4 Food

In three of the four groups the issue of the food in the unit was raised. The mothers who discussed the food thought this was an important issue and not having to cook was valued. For a few of the mothers the variety of the food was questioned.

The mothers acknowledged the freedom from the routine of cooking and cleaning for the family:

> It was like a holiday, as I didn’t have to think or worry about the meals and the housework. [Kim]

Most of the mothers found relief in not needing to prepare the meals:

> You would walk into the dinning room and think; what am I going to have? Really it's only just a plain salad but gosh it looks good though. Some of the ladies (Hotel Service Assistants) presented the food better than others. [Toni]
Other mothers felt the food lacked variety, and the occasional comfort food would have been nice:

_The food wasn’t bad, it was always fresh, but salad every day for lunch is a bit much... one night the lady (Hotel Services Staff) brought out a mud cake, it was just pure delight, you know what I mean, I was hanging out for something sweet. I think we need some more, not junk food but you know. [Pam]_

Most of the mothers remarked how their partner would assist in meal preparation at home, when they were unable to attend to it. The mothers believed that their partner appreciated not having to worry about the meals during their stay:

_My husband really appreciated not having to cook the hot meal each night._ [Lyn]

4.4.2.5 _Mothers Talking to Mothers_

The mothers were asked about the informal interactions with the other mothers in the unit. The discussions highlighted two main points of how the interactions normalised the mothers’ feelings, as well as decreased their feelings of being alone and isolated.

The mothers believed the interaction with other mothers were valuable and necessary, as they could share experiences which normalised their feelings:

_Talking to the other mothers in the dining room was wonderful, because it showed me that there were other girls in the same situation. That I'm not the only one and that some were worse off than me._ [Paula]
Talking to other mothers about their family issues decreased the feeling of isolation for some mothers:

*It was OK when I got up for the 2am feed as other mothers were up feeding and we would often sit around and chat, it was nice to know I wasn't the only one. [Cheryl]*

*It was nice to find out that I'm not the only mother that needs help and is not coping, and I'm not the only one that is 10 kilos overweight and has bags under my eyes. All these things you think about yourself, it doesn't seem so important now. [Freda]*

Talking to the other mothers about their problems helped to normalise the mothers' feelings and lighten the emotional load of their parenting:

*You're here you talk to other mothers here about their babies and children who have exactly the same problem and you thought you were the only person in the whole world that's got it. It was really good to talk to about it, I'm not the only one and I'm not that bad after all! [Abby]*

4.4.2.6 Mothers' Recommendations

The mothers’ cited recommendations, which they believed, would have improved their residential admission. The recommendations included:

- Greater detail of particular areas during the orientation.

- Increased quantities of food to ensure that there was always enough for everyone

- Increased variety of foods served, and the occasional 'comfort food'
Review the forcible manner of persuading parents to use the night nurseries.

Choice over which night the parents want to utilise the night nursery.

4.4.3 EDUCATION AND ADVICE MOTHERS RECEIVED

Education was a major component of the mothers residential stays. Each focus group discussed their opinions about the education they received. The issues included mothering skills and knowledge, video advice, conflicting advice and disempowerment through advice and education. The minor themes are presented in a descending order of frequency of occurrence within the mothers’ focus groups.

- Mothering skills and knowledge
- Video education
- Conflicting advice
- Mothers’ feelings of disempowerment through advice and education

4.4.3.1 Mothering Skills and Knowledge

The mothers voiced their opinions of their knowledge of parenting prior to having children and during their difficult times. They voiced how their expectations of mothering were unrealistic and how they recognised their need for earlier education. The mothers acknowledged the importance of looking at
the family unit rather than just the presenting problem and the need for mothers
to regain control over their mothering.

The mothers discussed that prior to having any problems with their children
their perceptions were that parenting would come naturally:

_We (mothers) are expected to know how to look after our baby. I
read all the books, and spoke to many parents and the only way to
learn is to go through it. [Shelly]_

The mothers agreed that not only did they expect themselves to know how to
parent, but also others, such as friends and relatives, expected them to know
what to do. The feelings of inadequacy were amplified with the mothers not
meeting their own, or other people’s expectations:

_But sometimes you’re made to feel stupid, as they expect you to
know what to do. You feel like as if you should know better but you
really don’t. [Kelly]_

The mothers highlighted the need for increased opportunity and time to access
parenting education prior to becoming a parent:

_Really they tell you certain things (antenatal classes) but it’s not even
5% of what you need to know. You should be told more about
parenting and this type of stuff... labour is just one day, and this
(parenting) can be a life time of suffering if you don’t know. [Sam]_

The mothers felt that the education they did receive prior to having the baby
was not only restrictive but also unrealistic:

_The antenatal classes only showed you how to bath the baby and
change a nappy, they didn’t tell us about all of this and how hard it is

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to be a parent, and nothing about the lack of sleep, it was all nice and
glossy straight out of one of those glossy magazines you see at the
checkouts. [Toni]

The mothers felt that the parenting education component of the antenatal
classes were limiting as if you missed a session, you missed the education.
This was the reality for one of the mothers in the study:

They did the bathing lesson and the parenting the night I went into
prem. labour, so I missed it all. [Freda]

The mothers discussed the benefits of the intense education they received
during their residential admission. The benefits included, regaining the control
back into their life, increased confidence with their parenting and within
themselves as women and mothers. In many instances the education
empowered the mothers to make changes or refocus their emotions, energy
and therefore parenting strategies. The extent of the positive changes the
mothers made could not be understated as without the intense input some
children would have been at risk of physical and/or emotional abuse:

I've just learnt so much here and it's just made me – well I feel better
and I'm back in control of my life… I now know other strategies,
rather than just physically lashing out at him. [Kim]

Most of the mothers felt the pace of learning in the unit was realistic and timely:

Every night we focused on another aspect of the settling, it went well
and it worked, the girls (nurses) are wonderful, the way they help
you. [Lyn]
The mothers appreciated the various methods and strategies they could learn for dealing with their child, which highlighted to some mothers that there was no one-way of addressing an issue, but many:

"I think they gave us some really good ideas and different, just different things to try at home, I was really impressed with them. You know you need lots of ideas, as a mum as you do something one way and the next time it doesn’t work. So it’s good to have a few extra tricks left up your sleeve, and they are really working, you know." [Megan]

Mothers found aspects of their education in the unit more helpful than others. For some mothers the group experiences were very powerful:

"The group education was great, especially the lecture on toddler management, it was brilliant and so true to what’s been happening for us." [Sally]

"I learnt a lot which now means I can relax more and enjoy my baby, but I do spend more time with him now, it was life changing for us." [Freda]

The advice and the education the mothers received was not always new information, but confirming what they already knew – confirming learning. These confirmations of knowledge gave the mothers back their confidence and therefore control:

"When you come in here certain things are consolidated, which increased my confidence, it also makes you feel more comfortable." [Cheryl]
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The mothers stated the control they regained was not just in regards to their parenting ability, but over their own life which increased their self esteem as mothers and women:

Oh well to me it's like knowledge. I've just learnt so much here and it's just made me, it's given back me. [Kara]

The mothers found it reassuring that staff followed through with the advice they gave. Knowing this increased their confidence in the staff:

I think it's good to see that they actually practice what they preach, as one day I came back from a group and my toddler was having 'time out', as he was naughty. I then knew it must work as she responded so well and if they do it, it must work. [Sally]

The mothers often addressed not only the presenting problem but also relevant parenting issues:

I think all the advice is really good, I came in there for settling and the breastfeeding wasn't really the issue it wasn't going well, but I was prepared to give it up. I really didn't want to but it just wasn't working... Not only is he now sleeping and settling but also we fixed the breastfeeding problem. It was my saving grace and probably the only reason why I could continue to breastfeed the advice really works it was fantastic and Thankyou. [Megan]

An issue that the mothers discussed was the previous lack of understanding by the mothers on how a single behaviour affects many, and the need to refocus on the complete picture rather than the focal point:

I didn't realise when we worked on the sleep problem it also improved her feeding and playtime. The nurses showed me how they all relate to each other, they were right, I wish some one would have told me two children ago. [Paula]
For some mothers they had seen many health professionals prior to admission, and not had their questions answered. The mothers agreed that the nurses in the unit covered all aspects, starting from the very basics before progressing:

_The nurse started from the beginning and covered everything with me, right down to making up the formula, it was reassuring to know that at least I was doing something right. [Toni]_

_It took me until I got in here until someone could give me a clear answer, thank god some one finally told me. [Kim]_

Most of the mothers believed the information they received from the nurses was reasonably clear and workable:

_The nurses always explained themselves and then checked out if we understood, they made their advice very clear, and usually it was doable, although some knew their stuff better than others and did it better than others, but overall the advise was clear. [Freda]_

Some mothers' perceptions were that by leaving their home and coming into the residential unit their basis of power and control shifted onto the nurses. One mother felt this shift was disempowering their parenting ability:

_Your like coming into someone else's territory, when you come in here, and they ask you to do things you may have tried at home and didn’t work, and if you were at home you wouldn't try again, but in here you give it a go with the nurses help, and of course it works! I felt like a real goose. [Freda]_

Another mother questioned if her feelings of disempowerment could be attributed to her increased anxieties surrounding the admission, the acknowledgement of requiring assistance and the challenge of implementing parenting strategies that she could not achieve at home:
You come in to Karitane feeling a little bit nervous and you know you will have to try things that you may not of at home by yourself. Thank-goodness the nurses are so wonderful, they’re always around to help when you need, especially in the first few days. [Pam]

For some mothers the pure exhaustion and decreased parenting self esteem led them to believe the nurses knew more about them than they did:

I felt that they [the nurses] knew more than me about my child, but looking back now I needed to hand him over to someone. [Sally]

Some mothers recognised that some previously trialed strategies would be tried again:

When we first came in here, the nurse asked us to wrap her again, we tried it before and it didn’t work, but when she explained it’s importance we thought it couldn’t hurt to give it another go, we needed it to work. [Lyn]

Whereas some parents were so sleep deprived and lacking in personal energy they want to offload their responsibility of decision-making and have someone ‘fix’ their problem:

I must say I was looking to come in here and for someone to tell me how to do it and to fix the problems. I was so tired I couldn’t remember my name, let alone make decision about how to do it. I needed my sleep too. [Sam]

4.4.3.2 Video Education

Videos were utilized to support the information and education given to the mothers by the unit staff. The mothers commented on the use of the videos in each focus group. The mother felt the videos were used to supplement the
information they were given although at times they felt the volume of information was overwhelming.

All of the mothers in the focus groups had access to the educational video library in the unit. Some mothers stated that they found the video education supplementary to the advice received from the nurses:

*I think the videos were just trying to enhance what they'd said and to give you more detail.* [Shelly]

The majority of mothers found the videos helpful to some degree:

*I thought the videos – I watched, as many videos as I could here and I think all of them were so useful.* [Paula]

The videos were not considered to be a substitute for nursing interaction but enhanced the mothers' knowledge:

*The videos weren't trying to replace what they [nurses] were offering verbally, it was just as a reinforcement, as an extension.* [Kara]

The mothers highlighted the benefit of being able to share the information, at their convenience, with family members, usually their partner:

*I got my husband when he came in to watch it as well, so he could understand why our baby was crying, and this meant I didn't have to be responsible for telling him, and he had his questions answered too.* [Lyn]

Most of the mothers felt if they had received the parenting information earlier on, that the problems may not have escalated to the extent they had:
The videos were great but some of the information came too late, I needed to see the video before I came to Karitane, and maybe I wouldn’t have weaned my baby, and things would be very different now. Why can’t the community have these resources? I needed to know then not now! [Pam]

The commonality amongst the mothers in the study included sleep deprivation that parenting induces. The mothers voiced that the sleep deprivation they experienced not only affected their parenting ability but also their cognitive ability to concentrate and digest information:

I just can’t concentrate. I mean I must have watched one video at least three times. I think it was all too much to absorb. I mean especially when you’re so tired... I mean your brain’s not really functioning. [Freda]

One mother felt so sleep deprived and exhausted that she could not help falling asleep when she sat to view the videos:

I was falling asleep in the middle of the first video, I had to watch them all again. [Cheryl]

Some mothers felt overwhelmed purely by the number of videos, which they had been given to view. Mothers stated they had been given three to four videos a day to view. The large number of videos in combination with exhaustion made it difficult for mothers to maximize the viewing experience:

They had a video on everything, and every time I spoke to the nurses they would give me another video on what we were talking about, I had so many to watch... The videos I did get to see were good but one night I had to stay up late just to get through a few of them there were so many, I couldn’t get to see all of them, and I was so tired. I really don’t know if that was help at all. [Michelle]
4.4.3.3 Conflicting Advice

A common complaint from parents was the amount of conflicting advice they received on how they should parent. There are many parenting options available to mothers and for some mothers in the study, the diverse parenting strategies were found to be confusing. Alternatively, other mothers were able to view the options as other possible parenting strategies.

The mothers in the focus group debated that they received conflicting advice from the health professionals within Karitane:

> I was getting contradictory information in the end, and I got so confused, so I decided to stick to one plan of action and it worked. [Sue]

For some mothers although they received conflicting advice it was not an issue for them:

> When I’m talking about inconsistencies, I’m talking about little things, details, I’m not talking overall. [Kim]

Some mothers did not view the advice as different or conflicting but an offer of more strategies:

> I got a lot of ideas and strategies form the nurses that I have tried since I’ve been at home. You might have taken these ideas as conflicting advice, but I think they were just different ideas on how to cope in a situation. You know you try one way one time and it works the next time it won’t, so I need a few more ideas of what to do. [Kara]

> The nurses had so many great ideas. [Abby]
Another mother viewed the varying information as the need to be flexible with children:

*I think their [nurse’s] advice was flexible, and that’s what we need to be as parents, I can’t be rigid and strict with Blaine, she’s only little you know.* [Lyn]

Other mothers saw a need to adopt various parenting strategies, as they believed that there was not just one way to parent:

*There was a whole heap of options that you could take and help so if that doesn’t work well here’s something else.* [Abby]

The mother’s emotional vulnerability affected their perceptions of the advice:

*I think it is done with the best intentions and sometimes you can feel a little sensitive, you know.* [Lyn]

*There is a fine line between being flexible and giving advice that sounds like it’s contradictory. On a good day I would think the advice is flexible but if I’ve had a bad night or stressed it would be contradictory.* [Shelly]

4.4.3.4 *Disempowerment through the Delivery of Advice and Education*

In one focus group the mothers discussed how they felt disempowered by the manner in which some of the advice they received was given. The main issues included the interpretations of the communications and communication styles.

For one mother the interaction had such an impact that she expressed her anger within the study group:
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It wasn’t what she [staff] said, but the manner in which she said it. [Freda]

The mothers were not questioning the content of the advice they received, but the manner in which it was delivered. In hindsight one mother acknowledged the emotional exhaustion she felt which would have coloured her interpretation of the message:

There’s a nice way of putting things across, I think that comes with experience, but they’re [staff] dealing with overtired and emotional women they need to take that into consideration. Although I suppose they’re entitled to a bad hair day too, but some need to be more mindful of who they are talking to too. [Lyn]

One mother felt disempowered after an interaction with a nurse. The mother interpreted the message within the interaction to be, that a formal qualification is worth or valued more than being the child’s mother:

I thought it was quite insulting when just because she has qualifications she thinks she can tell you what to do, and who am I? Just his mother! [Sally]

4.4.3.5 Mothers’ Recommendations

Parenting education and advice was exceptionally important to parents and for mothers who were experiencing the difficulties the information was valuable. The following are the mothers’ recommendations in relation to their experiences:

♦ Review of the number of videos given at any one time to a mother.

♦ Review the timing of when videos are given to mothers.
♦ Increase the partner and father-focused education and support.

♦ Increase the education on time management skills and strategies.

♦ Review nurse allocation to families, to reduce conflicting advice.

♦ Nurse allocation to families one wing rather than having them spread throughout the unit.

4.5 MOTHERS’ INTERACTIONS WITH HEALTH PROFESSIONALS

During a residential stay a mother would have had contact with various members from the multidisciplinary team. The team members include nurses, a paediatrician, counsellors and support staff such as the playroom coordinator. The mothers in each focus group discussed their experiences and impressions of their interactions with the staff. The list below presents in a descending order of frequency, the health professionals to whom the mothers have highlighted issues surrounding their interactions, as well as the issue of confidentiality.

♦ Nurses
♦ Playroom Staff
♦ Counsellors
♦ Paediatrician
♦ Staff and confidentiality
4.5.1.1 Nurses

The majority of contact the families had with staff during their admission to Karitane was with nursing staff. Nurses make up the bulk of employees within the organisation. The mothers discussed the issues they had with the nurses, including the nurse - mother relationship, the support they received, the level of perceived experience the nurse had and the value the nurses placed upon parenting.

The mothers discussed how they felt reassured by knowing they could approach the nurses with any issue they had. For some mothers this feeling of reassurance progressed to feelings of comfort and being nurtured:

*It's knowing they are professionals caring for you and your baby, and if anything goes wrong they are there, it sort of calmed me down... I'd be sort of Ooh, and next thing a nurse would say 'are you ok?' it was just what I needed.* [Sam]

When the mothers questioned the reassurance they felt during their stay some mothers believed it was due to the respect they received from the nurses. The mothers voiced how they felt they had been listened to, and heard, and were part of the decision making process, rather than having the decisions made for them:

*I think we were given a lot of respect as parents, even being new parents and not knowing, the respect for our position was still there from the nurses. I think this added to my confidence and self-esteem.* [Lyn]
Involving the mothers in the decision making process increased their confidence in their parenting abilities. They found this process very empowering:

*I had confidence in what they [nurses] said it made sense to me. They always checked out everything with me, giving me the final say.* [Paula]

Other mothers felt confident in their care as they were consulted in the process and it made sense to them:

*The nurses here really know what they are doing and can explain why and how it all works.* [Kelly]

The mothers felt the nurses were approachable and listened to them. One mother felt so comfortable that she disclosed much more than she had planned:

*They [nurses] really listened to me, and before you know it your telling them everything and I didn’t feel judged by it at all.* [Pam]

The relationship the mothers had built with the nurses allowed them to feel comfortable and safe:

*I felt quite safe here. With each change of shift I didn’t even worry who would be looking after me as I felt I could trust them all.* [Lyn]

Mothers took comfort in the fact that they did not feel judged, but were accepted for who and what they are. This acceptance allowed the mothers to progress with their parenting:

*I just found the nurses really supportive and sort of making you feel it’s OK what you’re going through and where you’re at.* [Lyn]
Some mothers acknowledged that they had disclosed to the nurses issues which they had not disclosed before. This over-disclosure may have been taken as an intrusion into their personal life, but one mother said:

I think the thing about Karitane was there was help and support there, but you never thought the nurses were intrusive, even when I told them things I never thought I would, or that I have told many people.... Maybe some people did but I never thought that, I found them so helpful with all that stuff. [Megan]

A few mothers felt that they needed to be selective of which nurse they would discuss issues with or seek advice from. When the mothers were asked how they knew or chose the right nurse they all agreed it came back to the relationship they had built up with that nurse:

Most of the nurses really listened to me and I liked, but there were a few which didn’t want to hear what you had to say. I think if someone approaches you badly from the beginning, well that’s it for them for the whole stay, do you know what I mean? [Michelle]

One mother commented on how she could tell the level of experience the nurse had by the way they communicated:

You could tell which nurses knew their stuff, they stood back and let you have your say first, and if they thought there was a better way they would nicely suggest it, but with the others where inexperienced they would say it in such a way that you felt it was a put down, or you’d feel stupid. [Shelly]

In the nurses’ defence another mother replied:

That’s very true, but there’s a nice way of putting things across I think that it must come with experience, but we are all entitled to a bad day and that includes the nurses. [Kim]
The mothers reflected on the relationship between the nurses:

*Oh they all get on well with each other and that makes you feel very at ease and so therefore it helps with the information being passed on to the mothers and I think it adds to the atmosphere in here.* [Kim]

The mothers discussed the nurse led interview on the second day of their admission. At this interview the mothers were asked to complete the EPDS. The mothers were generally relieved that the nurse was prepared to address sensitive parenting issues and emotions. For some mothers they were unclear if their feelings were normal or if they were having a mental health crisis. Other mothers disclosed issues that they may never have revealed before to anyone:

*I’m glad she [nurse] gave me that form. I think it was more than just reassurance in knowing I wasn’t going nuts, but relief as my mother and sister both had postnatal [depression] really bad... Until we sat down and really talked about what was happening for me I was unsure if I was going nuts or just trying to adjust to being a mother.* [Sally]

The administration of the EPDS was not completely understood by all the mothers until after the nurse had added up the score and started to address the issues:

*I thought she [nurse] had given me some type of service survey, I didn’t realise what it was until she started going through it with me.* [Freda]

Over the admission period the mothers had built up a strong and trusting relationship with the nursing staff. In some instances the mothers voiced their concerns regarding how they were feeling about being discharged and leaving the nurses:
Karitane was so supportive and nurturing for me I really didn’t want to leave, and I don’t think she did either, as she knew her mummy was happy here. [Kara]

The staff has been wonderful to me, I don’t know how I will manage without them... but I’m doin’ OK... [Megan]

Mothers agreed that they would and have remained in contact through the telephone counselling line:

I still ring if I need their help, or support. [Sue]

4.5.1.2 Playroom

All of the mothers were encouraged to spend some time each day in the playroom with their children. The mothers stated they learnt how to play and felt this time was valuable. One mother disclosed her disappointment with her playroom experiences.

The majority of mothers in the study discussed many positive aspects of the playroom:

The playroom was god’s gift, the toys were good, and the different ideas for games and crafty things were wonderful. [Sally]

The mothers felt that by spending time in the playroom they had learnt about play and its importance. For many mothers they learnt how to play with their children. One mother discussed how she had reprioritised her home activities so she could maximise her time with her child:
I learnt how to play with Blaine, I really had no idea before, and now we play all the time, she’s a lot of fun…. I don’t even do the house work instead of playing with her, now I have the problem I don’t get enough time to do the house work as I’m too busy playing with her. [Lyn]

Most of the mothers felt confident to leave their children in the playroom:

The girl in the playroom talked to Paul and really interacted well with him, he never wanted to leave the playroom. I felt very confident with what happened in the playroom. [Kim]

One mother found the playroom disappointing for her older child:

I felt my 4 year old was bored in there, and when I tried to discuss it with the staff, I felt she was aggressive, I thought she favoured particular children, I didn’t feel safe leaving her alone. [Paula]

4.5.1.3 Counsellors

The mothers were able to access the counsellors throughout their stay. As the mothers in this study were not specifically asked if they accessed the services of the Counselling Team, it is not possible to give specific numbers of attendance rates. The issues that arose due to an interaction with a member of the counselling team were about the strategies suggested and how practical and realistic they were.

Of those mothers who accessed the counsellors they were pleased with the service received. All of the mothers agreed it gave them time to focus on their needs as mothers and gave them more strategies to deal with their issues:
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I felt it was very good being able to talk to allied health people about some of my issues, she was able to give me some inroads into looking at my family problems. [Freda]

One mother did feel that some of the strategies weren't always practical for her:

Generally I think she was pretty good, but some of her suggestions weren’t always possible in my world. [Sam]

The mothers valued the group sessions that counsellors facilitated:

The toddler group was so practical, I got a lot out of it, it really made me rethink what I was doing and that woman who ran the group, well she’s just brilliant. [Paula]

4.5.1.4  Paediatrician

The mothers were all seen by the paediatrician during their admission and as required throughout their stay. The mothers debated the level to which they felt they had been listened to by the paediatrician.

Most mothers voiced how they felt valued by the paediatrician, as the paediatrician listened to the parents. In some cases this was different to previous experiences with doctors:

You know you go to a paediatrician and you might get 10 minutes, but here he really listened to me and we must have been in there with him for a good 45 minutes. For once I didn’t feel rushed and pushed out. [Pam]
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The paediatrician remained in close and regular contact with the registered nurses about each family’s progress. This was not always evident, to one mother, who stated:

_The doctor didn’t even see me or the baby but I got a message via the nurse he changed the medication dosage._ [Kelly]

4.5.1.5 Staff and Confidentiality

An essential component of providing quality of care is the aspect of confidentiality. The issue of confidentiality was brought up in two of the four focus groups. Some of the mothers voiced how they had not considered the issue of confidentiality until the group discussion:

_I really hadn’t thought about it, but it wasn’t a problem that really came up, so it must have been OK… cause you know I was so sensitive when I was in here that if it wasn’t OK I would have known about it._ [Freda]

Most of the mothers did not have any concerns:

_I believe they all handled my information discreetly._ [Megan]

One mother did voice her concern over an incident she observed:

_I felt dreadful for another mother as they told her that her little boy was sick and she had to go home or she would make all the other kids sick too. The thing was they told her in the middle of lunch in the dining room. I felt bad for her._ [Sue]
4.5.1.6 Mothers' Recommendations

The majority of mothers in the focus groups insisted that a follow up contact by phone call or home visit would have been extremely valuable. The last contact the mothers believed would have been for reassurance or final clarification of parenting issues. The other recommendation made was the need to review confidentiality. As one mother felt she did not have her confidentiality maintained.

4.5.2 MOTHERING MOTHERS

Mothering can be physically and emotionally demanding. A significant issue that emerged from this study was the support and nurturing the mothers received during their admission. The mothers used the terms 'support' and 'nurturing' in a dynamic way. They described varying aspects of their stay, which they believed contributed to the support, and nurturing they received during the admission. The mothers described the issue of support and nurturing as multidimensional. They voiced the benefits for them of the support they received. The following list provides an overview of the minor themes that emerged from the focus groups surrounding the issue of support for the mothers.

- Mothers' perceptions of support
- Mothers' perceptions of the benefits of support
- Mothers' perceptions of life without an admission to Karitane
4.5.2.1 Mothers’ Perception of Support

The mothers viewed support in various ways. These included providing consistent advice, someone physically being present to assist the mother, emotional support, as well as being accepted and acknowledged for who they are. The mothers made comment on how they appreciated the individual and personal attention they received from the nurses.

The mothers voiced how they found the consultative management style and the consistency of the advice supportive:

*I found the staff supportive, as they were consistent with their advice, and they listened to me, they really heard what I was saying, I felt I could trust them.* [Lyn]

Another mother agreed, and believed the support she received contributed to her confidence level:

*I felt really supported. I thought this was – I came in here completely and utterly devoid of confidence and it was virtually restored. I mean I was basically being listened to and it was taken into account, and methods were changed to suit me, not me change to suit their methods. I felt they genuinely cared and wanted to help me.* [Sam]

One mother believed by having the physical presence of the nurse during the settling process was supportive for her:

*I sat in the hallway with the nurse for a few hours, which wasn’t too unexpected that I would be sitting there as she takes hours to settle... But it was that I received that constant support from the nurses who sat with me, they were with me every step of the settling, and I found that incredible.* [Paula]
Other mothers found the emotional and psychological support valuable. For one mother this aspect of support was not expected from her residential admission, but was warmly welcomed:

_In hospital they focus on your physical well being... when I came to Karitane it was more your emotional state, how are you coping? I know I can do the physical stuff, but it was all that emotional support I needed._ [Michelle]

One mother felt the coordination and the teamwork of the individual care she received from the nurses contributed towards her feeling of being supported:

_Everyone was so clever and they communicated so well... everyone knew exactly what was going on with me, it was such personal attention, and well organised, it released that feeling of intense responsibility._ [Cheryl]

The non-judgmental attitude of the staff comforted some mothers:

_I think part of it was I never felt judged, so I could just enjoy the attention and support._ [Toni]

The opportunity to get some sleep and feeling like a special individual was how one mother described her view of the supported she received:

_I was really exhausted and without sleep, I became a little paranoid, but here I was made to feel very special, and I got some sleep that was the support I needed. ... I cope with everything a lot better and the baby is better looked after if I feel OK._ [Shelly]

The mothers described an important component of the support was the nurturing and caring the nurses had shown:
Nurturing and caring is what I saw the support to be. It's not like; oh your baby's crying put him in the corner, and leave him there. No, if a baby cried, they would attend to that baby and if necessary would hold that baby for 2 hours if need be. But it was also the way they cared, they really did care if you know what I mean. [Kim]

There's a lot of focus on the mum when you come in. Like have you had your lunch yet today? And that's so – the focus is off the baby somewhat and just onto you. Are you OK? And let me get you a cup of tea and you're like just about in tears because you haven't had a decent feed or cup of tea for like 3 weeks or something. [Cheryl]

The mothers highlighted how supportive they found having some attention focused on them and their needs rather than the child:

It's just sort of like being thought of, you know? recognised and acknowledged. [Sue]

It was just amazing the feeling of it all and just having the reassurance of everybody being there and coming to you all the time and asking is there anything that you need? [Sally]

One mother felt supported by having her needs met in a respectful manner:

I thought they [nurses] supported me excellently. I thought everyone has individual needs, which were catered for, and common needs weren't trivialised but discussed and put into perspective and normalised. [Abby]

One factor that all of the mothers stated they took comfort in, was that they were not alone. The mothers shared their feelings of not enjoying this stage of their parenting, feeling out of control and having the difficulties acknowledged and valued. They believed by sharing their feelings it normalised their experiences and decreased their burden:
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It’s been wonderful, because it showed me that there were other girls in the same situation. That I’m not the only one, it seemed to lessen the burden, and make it feel more normal. [Sam]

All of the mothers enjoyed their time out for self-care and pampering. For one mother it was an opportunity she had not previously experienced:

The massage was terrific, absolutely beautiful. I’ve never had one before, but I think I will make it a regular thing. [Michelle]

The massage was just what I needed, I couldn’t believe how good I felt, and that really changed the way I looked at things that day. [Sam]

Not all of the mothers in the study visited the hairdresser. The mothers who did attend the hairdresser were pleased with their experience and the other mothers agreed it was a good service to provide to mothers and their families:

The hairdresser was fabulous, and I didn’t have to stress out about the price, she was cheap too. [Kara]

The mothers commented on the difficulties associated with attending the evening relaxation sessions. This was the time of the evening that often the child required settling. Most of the mothers found the nightly relaxation sessions valuable:

The relaxation really helped me get to sleep of a night, and when I get stressed at home I do it again. I found it really good. [Toni]

One mother had not thought about her needs of support and nurturing prior to the focus group:
Well I never felt that there was anything lacking so they must have fulfilled my needs for support and nurturing, I just didn’t think of it in that way, it just came across so naturally. [Pam]

4.5.2.2 Mothers’ Perceptions of the Benefits of Support

The mothers believed that the support and nurturing they felt during their residential admission impacted on many aspects of their lives. These included: caring for the children, altering attitudes, enhancing their coping mechanisms and strengthening of their self esteem and therefore confidence. The mothers stated the support allowed them to plan, regain control of their life and to enjoy their family once again.

A comment that was heard regularly throughout the four focus groups was that the mothers felt that they were able to cope and manage better since their residential admission:

*I feel much better in myself now, so I can cope with everything much better, and that includes caring for the kids.* [Kim]

The impact of a residential admission had not only changed the mothers’ physical ability to care for their children but also had a major lifestyle impact:

*The nurses have given me a whole new life, a sense of freedom that I didn’t experience before because I was too tired and stressed and didn’t know what I was doing.* [Toni]

*I guess once your lifestyle changes there is no reason to be stuck at home, but it’s [residential admission to Karitane] given me more confidence to venture out and live.* [Abby]
The mothers believed they had regained control, and felt equipped to deal with situations as they arose:

*I can plan the whole day cause you know what she is up to [with sleep and settle routine], and if it doesn’t work out it’s not a disaster, I now have the know how to cope and manage it.* [Lyn]

One mother voiced how the support she received allowed her to achieve a goal that was impossible alone. By achieving this goal the mother felt her parenting confidence had increased:

*By coming to Karitane we were able to fix it [sleepless nights], but beforehand I was a little unsure and didn’t have the confidence to do it… I know what to do if it happens again.* [Sue]

Not only did the admission affect the mothers parenting ability. Some mothers noticed increased confidence and energy levels allowed them to attend to needs outside the family home:

*It’s [Karitane admission] given me confidence to venture out, I can go shopping, and have a life, it’s because I now have energy to do that.* [Paula]

The mothers spoke about an increased personal energy level, which allowed them to continue to implement self-care strategies:

*I can either do some sewing or housework or whatever, cause that time is for me.* [Kelly]

*There was no housework to do, no cooking, so I had time to focus on me and my baby.* [Abby]
I have energy now. Before I had no energy to make myself a cup of coffee or nothing. Yesterday I had three people over for lunch, there is no way I could have done that before... I can now enjoy my friends again. [Freda]

The increase in the mothers' personal energy has allowed the mothers to refocus and believe in themselves:

Before I came in here I was such a mess that if someone said you look dreadful, I would have just melted away, now I will tell them were to get off.... I know I'm the best person to care for Daniel, I didn't know that before. [Megan]

4.5.2.3 Mothers' Perceptions of Life Without an Admission to Karitane

The mothers were asked to describe what they thought their lives would have been like if they had not come to Karitane. All the mothers exclaimed how life changing the admission had been for them and their family, even when the mother had not totally achieved all of her goals. Some mothers stated they feared to think about the possible outcome if they had not come to Karitane. It was interesting to note in each focus group when this question was asked there was a pause before anyone answered, the energy level within the room and conversation suddenly dropped. The moderator believes the mothers answered with sincere honesty.

The mothers were very clear about their feelings in relationship to their perceptions on how they would feel and cope if they had not been admitted to Karitane. The mothers voiced their responses with such an intensity, which was amplified by the tone of their voices:
Worse than it was before, it couldn't have got better without help. [Toni]

I fear to think about it, it would be so bad. [Sue]

I don't think we all would have survived. [Abby]

I hate to think, unbearable. [Kelly]

I won't allow myself to think about it. [Freda]

I would have hung myself by now. [Kim]

The intensity of the parenting experience was so great that one mother could not even find the words to describe it:

I can't put the extent of my distress into words, if I hadn't come in here when I did. [Shelly]

4.5.3 MOTHERS’ IMPRESSIONS OF THEIR PARTNER’S EXPERIENCES

Partners are welcome and encouraged to stay throughout the mother’s admission. The majority of the mothers in the study encouraged their partners to stay, most of whom stayed for a minimum of two nights. The mothers’ impressions of their partners’ stay were primarily positive.
The following list provides an overview of the issues, which arose from this theme.

- The need for the partner to stay
- Partners have needs too!
- Father friendly
- The benefits of team work

Most of the mothers felt that their partners were happy to stay at Karitane:

*My husband was quite happy, he was really happy with Karitane, with the whole set up and he was quite happy to stay.* [Paula]

For some partners they felt so comfortable and relieved to catch up on their sleep that they did not want to leave:

*My husband was very happy he didn’t want to leave, he found it extremely relaxing and now we can catch up on our sleep.* [Megan]

The reality of the partner often being the financial provider for the family (particularly in the first 12 months of the child’s life) sometimes dictated whether the partner could stay or visit his family during the residential admission:
That’s the beauty of here, the men can stay, which unfortunately reality states that not all men can stay here due to their work commitments. [Cheryl]

Some partners had to balance their paid work commitments and staying at Karitane of a night. The mothers reported that even though the partners could only participate on a part time basis it was of a great benefit to the family:

My husband stayed and went to work during the day and I was glad we could do that so we could do it altogether as a family. [Abby]

For some mothers in the focus group it was not clear that their partners could stay until the admission, one mother stated:

My husband wanted to stay here. We didn’t know initially that he could … and then Dean arrived that night and the nurse said; Are you staying? So they moved us to a double room and made us feel as comfortable as they could. [Freda]

Some mothers reported that their partners had viewed the residential stay in a different light. One partner could relate the residential unit to a psychiatric unit, and another related it to a prison stay. Their comments and justification is as follows:

He had a really negative picture… I think it was because he saw the mothers doing controlled crying… there was mothers sitting out on the floor or out on chairs outside the rooms and the kids were inside screaming… he thought it was a psycho ward with all these spin out mums. [Michelle]

It was funny when my husband came over he actually stayed here a couple of nights with me, he said he felt like we were in prison… maybe it was the door, he had to buzz to get in and he had to buzz to get out, and we had to tell the nurses our whereabouts. He felt that
they were checking up on us all the time. I didn’t feel like that at all. [Sally]

The mothers all assertively voiced the importance of having partners involved in the care of the children. Generally the mothers acknowledged their partners have needs too, and at times their needs were not met or they had been left out of the consultative process of the family care:

_They need a facility here just for men, for counselling and for men’s stuff._ [Kim]

_They really did listen to me. They did listen to him too, but most of the time they explained things to me more so than him._ [Kara]

One mother voiced her concerns and they were addressed:

_I let them know that I wanted them to involve him in all of it and to let him know he’s got a part of it as well, and they did from then on._ [Pam]

The issue surrounding the partner being left out was obvious in each focus group. The mothers stated that in their opinion their partners needed more parenting input than what they received, not only from Karitane but also from community services, both antenatally and postnatally:

_They need to learn it for the start, not later down the track._ [Lyn]

Generally the mothers’ impressions were that the partners were left out to varying degrees of the family care. The mothers believed the impact of the admission had positive outcomes for the partners. The mothers reported that their partners are now more involved in the care of the children, and they too
are not so sleep deprived and therefore can cope and manage better in their home and work lives:

    *My husband now puts our daughter down each night that's their time together, he would have never done that before.* [Shelly]

    *We can now start to catch up on our sleep, as well as he is now being involved as much as he wanted to be involved in the baby's care and yeah he very much enjoys it, now.* [Kara]

    *Now we both have more sleep under our belt, I can cope better at home and Graham is much happier at home, and I guess at work too.* [Sue]

4.5.3.1 Mothers' Recommendations Based on Partner's Experiences

Within the four focus groups the issues of the partners' needs were highlighted. The following are the mothers' recommendations which would have improved their residential admission:

- Modifying the education times to cater for those working partners
- Involving partners and fathers more in discussion and case management
- Facilitating time for the partners to meet and discuss relevant issues
CHAPTER 5 – DISCUSSION AND CONCLUSIONS

5.1 INTRODUCTION

A discussion of the research findings will be presented in this chapter. Similarities and differences between the findings of this study and other research will be discussed. The limitations, final recommendations and the implications for further study will be presented.

5.2 DISCUSSION OF FINDINGS

Mothering can be a challenging time, and for some this lifestyle adjustment can be very stressful, which was the case for the mothers in this study. The mothers believed that this transitional period could have been facilitated if professional services provided realistic parenting support and education programs. There continues to be misconceptions held by the community in relation to seeking professional assistance, or as the mothers' described, 'a stigma', which contributes to the barriers that parents need to address before they are able to access services. Developing a professional relationship is also a vital ingredient in maximising service delivery and facilitating the parenting process with the mother.
5.2.1 Adaptation to Parenting

The adjustment to mothering can be a challenging period for women (Rogan, et al., 1997). The mothers in the study described how they found the period of adaptation to be very difficult and at times stressful. They explained that during this time they experienced many changes, not only physical, but also emotional and psychological. As indicated in Oakley (1980) these changes create an immense disruption to a mother’s lifestyle, routine and identity. This period of adaptation includes the development of the relationship between the mother and her child (Reece, 1995) and as the women in the study explained this process was often delayed, due to the parenting difficulties they experienced. The mothers voiced how unprepared they were for the reality of mothering. Rogan et al. (1997) suggests that this is particularly evident in the first few weeks and months following the birth of the infant. The stresses new parents experience are well documented in the literature (eg. Barclay et al., 1997; Langley & Mudge, 1996; Oakley, 1980; Pridham & Chang, 1992; Rogan et al., 1997) all emphasise the need for early intervention support and education services, which currently are very limited. The benefit of such services is well documented by Olds, et al., (1998). The provision of early intervention services needs to be available for families to access.

There are many changes occurring for the family during the period of adaptation to parenting, including the reorientation of the relationship between the mother and her partner, and the development of the relationship between the father and his infant. Today parenting is increasingly being viewed as a partnership between people rather than, as previously, the sole responsibility of the mother.
Despite this understanding the vast majority of parenting education and information remains directed towards the mother (Nolan, 1997; Pridham, 1997). The mothers within the study were able to confirm this concept when discussing their personal experiences of parenting services. The mothers believed that the range of services they had accessed, including the local doctor, early childhood nurse, paediatricians and the residential unit, had more often than not focused on the mother as the parent, rather than the mother and father equally sharing the parenting responsibilities. The mothers acknowledged that it was often due to family and work commitments that prevented their partners from attending or participating in standard education programs. On the rare occasion the father could attend the service, the mothers reported how the service did not meet his needs and their partners often felt excluded from the process. One mother in the study found herself requesting that her partner be involved and this had positive outcomes for herself and her family. The mothers strongly agreed that from their experiences the more their partners were involved in the parenting role the greater the benefit for the family, as well as for each individual within the family unit.

Measures need to be set in place to promote the involvement and education of partners within the child and family health arena. The mothers believed that their partners would have benefited if they could have accessed services to address their particular stresses and needs.

The mothers were keen to see their partners participate in specific educational and therapeutic sessions. Where possible clinical service delivery needs to
accommodate both parents. Such services as evening education and therapeutic groups, after-hours and weekend counselling sessions and fathering groups are strategies that would be a starting point in addressing this identified need.

5.2.2 Barriers

Mothers in the study discussed various reasons for not seeking help earlier and the most common barrier included the mother's personal denial of the magnitude of her issues. Other identified barriers included those previously cited by Willis (1992) such as family and friends negative attitudes towards seeking professional assistance and the health professional's inability or oversight in providing information on child and family services or agencies. Once the barrier was overcome and the service accessed, then the barrier was often viewed as being of lesser importance. This was evident when some mothers described how they had endured a lengthy period of distress but once they had sought assistance they questioned why they had not sought professional support sooner. This was particularly evident for mothers with their subsequent children.

The mothers in this study were offered a referral to the residential unit by their health professional, but some actively requested a referral and for one mother who was so distressed she demanded a referral to Karitane. Even though the mothers agreed and welcomed an admission, they all agreed that they really did not know what would take place during their stay. They knew that the stay would help their mothering situation, but they were not aware of the process to
be undertaken, nor the staff who would be involved. They all agreed that if they were given more information prior to admission it might have allayed many unnecessary fears and anxieties. One mother explained how she had rung to cancel her admission but after receiving more information she changed her mind. This is yet another example of the importance of not only educating parents, but also of informing them of the processes and anticipated outcomes of a service to which they are being referred.

5.2.3 Seeking Help

Parents, but in particular mothers, will actively seek information and learn as much as they can about the parenting issue or concern they have (Price, 1993; Webb & Kevin, 1995). Some mothers involved in this study had actively sought help and assistance from many sources before reaching Karitane. These services included family, friends, alternative and complementary therapists, and various health professionals. Some mothers had sought second and third opinions about the advice they were given. Webb and Kevin (1995) discuss how mothers of the 1990s no longer associate doctors with providing parenting advice. They perceive doctors to hold a scientific and technical function, associated with illness. It is interesting to note that the majority of mothers in the study did seek assistance from their doctor. For some mothers they were not aware that an alternative avenue for parenting assistance was available.
5.2.4 Advice Given to Mothers

Historically, the professional advice mothers receive was from a male doctor. The advice from the doctor was often enshrined in personal biases, myth and folklore ( Ehrenreich & English, 1973). The doctors considered mothers to be ignorant so the advice prescribed was directive in nature ( Dressler, 1906/1993; Ehrenreich & English, 1973). Mothers were warned of the ill that would befall the infant if she did not comply with the orders, casting blame and guilt onto the mother ( Dressler, 1906/1993; Dock & Maitland, 1932; King, 1940). Within the child and family health professions today, this style of practice is considered to be antiquated, preferring to base knowledge on fact, respecting parents for who they are and empowering parents with skills, knowledge and to support them along their parenting journey. The mothers in this study believed that generally they had been treated with respect and felt empowered to continue mothering. However, they did agree that at times they had been treated in a similar manner to those mothers in the early 1900s, as the advice was directive and consideration was not always given for their individual needs.

The mothers described how the process of seeking assistance was time consuming and difficult as the advice they received was often varied and at times contradictive. The mothers felt at times they doubted themselves and their maternal intuition in an attempt to follow strategies. One mother explained how she was given advice from a health professional, which was incorrect and totally unrealistic for her and her family. Although knowing this, and in her state of desperation she tried to implement the inappropriate strategies. The mothers believed that the poor advice they received was often due to the fact that
parenting is viewed as a low priority and professionals did not see this area as a priority to update their knowledge. The mothers believed that this attitude was not exclusive to one profession, but from their encounters, was held by many professions, as well as by the community. Bondas-Salonen (1998) suggests that this perception is often reinforced by the low priority parenting issues hold within the health industry in comparison to that of a disease or illness. The mothers believed a change in this attitude would have countless positive outcomes for the parents, children and community.

There is an obvious need to address the perceived low priority of parenting in health and the general community. Health professionals and organisations need to take responsibility by strategically developing and implementing education programs with key stakeholders in order to address this vital issue.

5.2.5 Parenting Education

The need for parenting education has been emphasised by many authors such as Ogden Burke et al. (1999); Pridham (1997); Pridham and Chang (1992); Reece (1995); and Ventura (1986). The mothers in this study believed that parenting education is essential. They highlighted education as one of the major strategies utilised throughout their residential admission. They believed once they were given the opportunity to objectively explore their issues, complemented with the appropriate education, they were able to make the best decisions and manage the situation in the most suitable manner for their family. With consistent replication of the parenting strategies, the mothers reported they saw positive results. As the mothers moved closer to achieving their goals,
they explained that their confidence in their parenting ability returned. The mothers described how this increased confidence was also reflected in their self-esteem. Pridham and Chang (1992) and Reece (1995) support the concept of parenting education impacting on the mother’s confidence and self-esteem. With increased mothering confidence, some mothers felt that their parenting expectations had been reorientated and were now realistic. This was also noted by Reece (1995).

The mothers emphasised the need for parenting education, but the timing of this information was just as important. The mothers believed if they were aware of particular parenting issues and strategies earlier, it clearly could have reduced the stress and distress suffered by the mother and family, and possibly prevented an admission to the residential unit. The need to provide timely parenting education is well documented by Ogden Burke et al. (1999); Pridham and Chang (1992); Pridham (1997); Reece (1995); and Ventura (1986). The mothers strongly believed in the need for parenting education and equitable access to such services. They recommended the need for preventive and early intervention programs which, as they suggested, could be incorporated into the primary health care model.

The preventive and early intervention model of care is the basis for many of the key goals from the recently published Start of good health – improving the health of children in New South Wales (NSW Health, 1999). One could argue that parenting education programs should begin in the antenatal period, rather than specifically focusing just as the problems arise.
Chapter 5 – Discussion and Conclusions

The literature is unclear whether intensive antenatal parenting education is of benefit or not. The mothers in the study who did participate in antenatal parenting education believed the information they received was not necessarily realistic and did not address much more than the physical aspects of caring for an infant, such as how to change a nappy. Nolan (1997) states, "antenatal classes often fail to provide women with a realistic account of birthing and parenting" (p. 1198). Certainly the mothers felt parenting education in the antenatal period or prior to falling pregnant is important, but the current strategies need to be reviewed and made more realistic to meet the needs of parents.

The provision of preventative and early intervention parenting education must be considered a priority within the child and family health field. It is not only the provision of such services, but the equity and access for all parents that is an issue. Parenting services need to consider not just parental education, but the promotion of these services and the education of the community on parenting needs. This may be a start to normalise the processes of seeking parenting education and address the stigma associated with asking for professional assistance.

5.2.6 Professional Relationships and Care

Responding to a mother's needs in a tailored and individual manner is the basis for the development of a caring relationship (Webb & Kevin, 1995). The development of this unique relationship is an integral component of the professional nurse caring for a mother (Price, 1993). The mothers in this study
believed their experiences of the relationships they had built with the staff were
generally positive warm and constructive. The mothers believed their
relationships with the staff of Karitane, but in particular with the nurses, were
essential ingredients to be able to address their parenting issues.

It must be recognised that the care expectations of a mother seeking assistance
for her parenting issues is very different to that of a mother with an ill child
(Webb & Kevin, 1995). The relationship between the nurse and mother who is
seeking parenting education is one which Webb and Kevin (1995) see as
having an equal power basis, being supportive and nurturing, not dissimilar to
that of a traditional mothering role. In contrast, Webb and Kevin (1995)
describe a mother with an ill child focuses on the nurses’ capabilities and
competency levels as paramount. The mothers in the study identified these
differences. They found the staff took the time to listen to them, which gave
them a feeling of being respected. The mothers voiced how they felt the nurses
cared and nurtured them as women and mothers. One mother described how
different the Karitane staff’s attitudes and practices were to that of an acute care
hospital. She went on to discuss the differences in the physical surroundings of
the residential unit. The mothers voiced how they thought Karitane would be a
clinical, sterile, hospital like residence; instead they felt the environment to be
warm, calming and homely. In addition, with the mother focused self-care
groups and services such as expressive arts groups, the masseuse and
hairdresser, they felt comfortable and valued. The ability to ensure mothers feel
comfortable within the professional relationship and the physical surroundings is
an imperative issue for organisations and health professionals to address.
Chapter 5 – Discussion and Conclusions

For a few mothers their experiences of relationships with a Karitane staff member, was not as constructive or helpful. The mothers commented on the ability and depth of care the nurse demonstrated. The mothers believed it was not that the information was different in content, but the delivery mode, as well as the inability of the novice practitioner to be flexible within the work practices which interfere with the nurse – mother relationship. This is consistent with Webb and Kevin’s findings (1995). The mothers believed they could determine a nurse’s level of skill and knowledge by the manner in which the care was provided. At times, the mothers felt the interactions were disempowering and devaluing their role as mother when caring for their children. With this knowledge the mothers described how they were then able to choose when to discuss issues and with which staff member. This highlights the need for all professionals to be mindful of all communications and interactions with clients, which is discussed by Hewison (1995). This issue also needs to be taken up at an organisational level, as strategies need to be implemented to address such an important matter.

A mother may seek parenting education, but alongside that is the need for support. Price (1993) described the importance of support as a major focus of nurturing in professional relationships. Support can be displayed by, metaphorically, walking with the mother along her journey. It does not include resuming responsibility and taking control but rather being with the mother when she does. The mothers described their varying experiences of the support they received, such as; the emotional support within a therapeutic session, sitting with a mother until her baby settles, or simply listening to her when she needs
to be heard. The mothers believed the staff were able to meet their need of support in so many ways. One mother commented that the support she received was not belittling or degrading, but gave her feelings of warmth, care and gave her the inspiration to continue. This type of relationship is one of empowerment and equal power base, rather than that of the dominant professional (Scharer & Brooks, 1994; Webb & Kevin, 1995), that was evident historically. The professional supportive relationship is a skill that can be developed but the forum for professional growth needs to be provided. This is an important issue for all clinicians and administrators but particularly for new staff members. Staff education needs to include the elements surrounding the building of professional relationships. Following the education, staff need a supportive forum so they can reflect, review and enhance clinical practices.

The mothers spoke at length of the relationship between themselves and the staff. One focus group recognised the support and care shown within the team of staff members. They believed this support and care was magnified in the staff’s clinical practices. The mothers identified the value of the relationships they had developed with other mothers who were in residence at the same time. The mothers went on to discuss how they continue to meet with some of the mothers following discharge. The mothers believed that this newly developed friendship offers support and often normalises their parenting experiences. This emphasises the need for mothers to have the opportunity to meet and develop their own support networks. This strategy could be implemented in many community settings by gathering parents within an educational framework and facilitating the networking processes. As professional education and support
have there place in parenting so too does the development of social network systems.

5.2.7 Importance of the Family and Early Intervention

Particularly in the last decade the literature has recognised the importance of the family unit for the developing child (Berndt, 1992; Briggs, 1994; Field, 1992; Gledhill, 1994; Langley & Mudge, 1998; Pridham & Chang, 1992; and Wisner et al., 1996). As shown from the longitudinal study by Olds et al. (1998) the provision of early intervention, parent education and support can reduce, if not prevent, harmful and anti social behaviours in the children such as reducing substance abuse, criminal activities and decreasing the number of children in an abusive and neglectful relationship. All of the mothers involved in this study believed that by having the opportunity to address their parenting issues, and being equipped with skills and knowledge, they had improved their relationship with their child. Some mothers in the focus group voiced how they had, or thought of, physically and/or emotionally harming their children prior to admission. The mothers confidently discussed that following discharge they felt equipped to deal with their child’s behaviours in a positive manner and their children were no longer at risk of harm or abuse. With such valuable evidence of the benefits of early intervention, the main component being parent education and support, one can no longer ignore the powerful impact it has on a child’s and the family’s life. One may question why parenting services remain under resourced, offering limited hours of operation and providing restricted services. To alter the status quo there needs to be a reorientation of the health dollar into
early identification, parent education and intervention of parenting services (Gledhill, 1996). Even though Olds et al. (1998) has undoubtedly proven that investing health dollars into early intervention programs actually saves money in comparison with investing in curative treatments. Until this change occurs one could consider the societal value placed on families is just tokenism.

5.2.8 Conclusions

This study has revealed many issues particular to the mothers who participated in the study, but which are not uncommon to all parents. With continuing defraying of the extended family, there will be an increasing need for professional intervention. The underpinning principles of professional intervention in the child and family health arena are parental education and support. To maximise the effectiveness of intervention the focus should be on the prevention rather than the current curative model. The delivery of such a service needs to be grounded in the positive development of relationships between professionals and parents. In conclusion the key concepts are the development of professional relationships, which act as the vehicle for prevention, and early intervention of parenting education.

5.3 SUMMARY OF RECOMMENDATIONS FROM THE STUDY

5.3.1 Organisational Recommendations

The organisational recommendations that have arisen as a result of this study are to:
Consider equity and access to parenting services for parents that is, at times and venues acceptable for them, for example, after-hours and weekend clinics, parenting groups, counselling and therapeutic sessions.

Increase the community and public's awareness of the child and family health services offered to parents. This may involve increasing participation in appropriate health weeks, developing a multimedia package to be utilised in antenatal and postnatal education sessions with parents.

Enhance formal partnerships with other child and family health and related agencies throughout NSW to facilitate the dissemination of child and family health education and promote professional networks.

Increase the community's participation within child and family health organisations, which may assist in dispelling the perceived stigma, for example, volunteer support.

Expand outreach services to support parents in their homes prior to admission to residential units, as well as for short-term follow-up upon discharge.

Enhance staff orientation and continuing education programs to incorporate topics related to the development and maintenance of the professional relationship and communication styles.
Facilitate the prevention or reduction of parental stresses by offering distance-learning package, weekend workshops – short-term intense education, which will enhance the dissemination of knowledge to antenatal and postnatal educators.

Provide a formal consultative service to other health professionals for example, isolated, rural clinicians. The tertiary level child and family health services could provide this service.

Increase the opportunities for clinicians to experience other spectrums within child and family health field, such as promote staff secondment programs to facilitate cross fertilisation of clinical skills and knowledge.

5.3.2 Clinical Recommendations

The clinical recommendations from this study are to:

Modify clinical service delivery to promote access for both parents for example, offering after hours and weekend parenting education and therapeutic sessions.

Increase father/partner participation in education by implementing strategies such as regular partners groups to addresses their particular stresses and needs.

Provide consistent allocation of clinician to care for the families, this will promote the development of the professional relationship.
Chapter 5 – Discussion and Conclusions

- Ensure all parents receive a comprehensive orientation to the organisation including processes and anticipated outcomes.

- Increase opportunities for individual staff to clinically reflect on their practices. This form of supervision could be scheduled on a regular basis and take place in an individual or group format with the senior clinician.

- Use educational aids to complement clinical service provision, rather than overload and overwhelm the parents.

- Increase accessibility of self care facilities for the partners.

5.4 LIMITATIONS OF THE STUDY

The main limitation of this study is that the data were collected through a qualitative process of focus groups, and therefore no generalisations to other populations can be made. To participate within this study the mothers needed to be able to interact in an English speaking discussion, therefore the possible lack of the multicultural aspects may have affected the results. The participants were also restricted to being mothers of children admitted to Karitane. This limited the study to maternal perspectives and viewpoints.

As the study was conducted in the grounds of the residential unit at Carramar, this may have posed a geographical boundary to a number of potential participants who did not reside within a close proximity.
5.5 RECOMMENDATIONS FOR FURTHER RESEARCH

This study focused on the exploration of mother's perceptions and experiences of a residential admission to Karitane. Further studies could examine the long-term impact a residential admission has on parents and their family.

In comparison to the research on mothering, there is very little research on fathering – although there has been a noticeable increase in the last decade. Nevertheless, the author was unable to locate any research on fathers and fathering in relationship to an admission to a residential unit. This highlights an area worthy of further research, which is the investigation of the impact and value of a residential admission on the father. The research could also include the identification of the issues to be addressed to meet the needs of the father thereby promoting an optimal outcome for the family.
REFERENCES


References


References


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APPENDIX 1

The following is a script for the registered nurse to use when introducing the study to mothers on Day 3 of their residential admission.

The registered nurse would say:

*Karitane is currently undertaking a research study, looking at the effects or impact of a residential stay on the mother and her family. All Mothers admitted this month will be invited to participate in the study. Mothers who elect to be involved will be asked to attend an informal group discussion approximately two to four weeks after discharge. The group discussion will be held at Karitane and childcare will be offered free of charge. The information obtained from this study may not necessarily benefit the study participants, but will benefit families in the future using our service. So I will leave you this form for you to complete. This ‘Expression of Interest Form’ will give you a brief overview of the study and you can then indicate your preference to be involved or not. You are under no obligation to be involved in the study, and if you choose to be involved you can withdraw at any stage without any repercussions to your care. Could I ask you complete this form prior to discharge and mail it in the “Research Box” located at the nurses’ station. The Chief investigator only accesses this box so we the clinicians are not aware of your preference. Thank you for your consideration.*
APPENDIX 2

MOTHER, BABY RESIDENTIAL ADMISSION: THE MOTHER’S EXPERIENCE

Expression of Interest Form.

Karitane aims to provide a high standard of care, but to do this we need to hear from families who have used the service. Therefore I would like to invite you to participate in Karitane’s research study, which is focusing on women’s experiences of their residential stay. This study will give mothers the opportunity to discuss all aspects of their stay so that we may review, develop and improve service delivery.

If you choose to be involved in this study, you will be asked to attend a one-hour discussion session at Karitane 3 to 4 weeks after discharge with other mothers you may have met during your stay. Childcare will be provided free of charge.

Your participation to the research will be strictly confidential.

Your participation is voluntary, and you may withdraw from the study at any time without any interruption or repercussion to the service you are currently receiving from Karitane or South Western Sydney Area Health Service.

I am interested in participating in this study,

☐ Yes, but require more information

☐ No, not at this stage

.................................................. ..................................................
Name Room Number

Thank you.

Karolyn Vaughan
Clinical Nurse Consultant & Chief Investigator
APPENDIX 3
MOTHER, BABY RESIDENTIAL ADMISSION:
THE MOTHER'S EXPERIENCE.

Information Sheet

Dear Mother,

I would like to invite you to participate in a research study investigating the impact of a residential stay on women. Describing women’s experiences of a residential stay will provide Karitane with valuable information to review, develop and improve service delivery. The information acquired throughout this study may not necessarily benefit you, but will assist Karitane in providing a better service to in the future.

If you choose to be involved in this study, you will be asked to attend a one-hour focus group at Karitane. The group will consist of myself (the chief investigator), another person who will be taking notes, (a scribe) and three to six other mothers who have also spent some time at Karitane. The group will discuss issues relating to your residential admission.

The group discussion will be audio taped for research purposes only. General demographic details will be collected about each mother in the group. This information will include postcode of residence, number of children, age of children, marital status of mother, occupation, age of mother, country of birth, and length of admission period. Additionally your Edinburgh Postnatal Depression Scale score from your admission will be recorded and then compared to the Edinburgh Postnatal Depression Scale score you will be asked to complete at the focus group. Your contribution to the research and focus group will be strictly confidential, and in no way will your input be able to be traced to you. All the research data will be stored in a locked cabinet, which only the chief investigator can access.

Childcare can be provided free of charge while you attend the focus group. Childcare will be provided within Karitane premises by carers who comply with the NSW Health and Karitane child care requirements.

Your participation is voluntary, and you may withdraw from the study at any time without any interruption or repercussion to the service you are currently receiving from Karitane or South Western Sydney Area Health Service. The decision to withdraw will be respected.
All participants will be able to obtain a copy of the final report.

The research is being conducted by Karolyin Vaughan, Clinical Nurse Consultant, Karitane. The approval to conduct this study has been gained from the Ethics Committee – South Western Sydney Area Health Service.

If you have any concerns or questions please don't hesitate to contact Karolyin Vaughan, Clinical Nurse Consultant – Karitane, (02) 97941800.

Thank you for your participation in this study.

Regards,

Karolyin Vaughan.
APPENDIX 4
FOCUS GROUPS QUESTIONS – MOTHER, BABY
RESIDENTIAL ADMISSION: THE MOTHER’S
EXPERIENCE

1. What are your memories of life prior to coming to Karitane?

2. Can you tell me about your experiences at Karitane, what happened for you? What was the stay at Karitane like for you?

3. Can you tell me how your needs/problems were handled by the staff?

4. Tell me about the staff who cared for you.

5. How do you feel your partners and families needs were addressed?

6. What did you think of the advice you received during your stay?

7. In what way has your stay at Karitane influenced your parenting?

8. Had you not come to Karitane how do you think your life would be?

9. What suggestions could you give Karitane to improve the service for future families?
APPENDIX 5

TRIAL FOCUS GROUPS QUESTIONS – MOTHER, BABY
RESIDENTIAL ADMISSION: THE MOTHER’S
EXPERIENCE

1. What are your memories of how your life was before coming to Karitane?

2. What did you achieve from your stay at Karitane? or What if anything did you achieve from your stay?

3. What happened and changed when you came to Karitane? Can you discuss your positive and negative experiences?

4. In what way has your stay at Karitane influenced / changed your parenting?

5. Did you feel Karitane staff understood your needs? Were your needs met during your stay?

6. What were your needs when you came to Karitane? How do you feel your needs were addressed by the staff?

7. How do you feel your partners needs where addressed during your stay?

8. In what way has Karitane had an impact on your life?

9. In what way is Karitane still having an impact on your life?

10. Had you not come to Karitane how do you think your life would be?

11. What suggestions could you give Karitane to improve the service for future families?
APPENDIX 6
LETTER OF CONFIRMATION TO THE MOTHERS

Dear

Thank you for agreeing to participate in the “Mother, Baby Residential Admission: The Mother’s Experience” study. As we have previously discussed, the group will be held,

[Insert time]

[Insert date]

at

Karitane Residential Unit

Cnr The Horsley Drive & Mitchell Street

Carramar.

Parenting can be a very demanding time, your participation in this study is greatly appreciated and families in the future will benefit from your input.

Karitane staff (at no cost to you) will provide childcare. You will need to bring anything your child will need during this time e.g., nappies, change lotions, and any milk/food.

I look forward to seeing you on the [insert date].

Kind regards,

Karolyn Vaughan.

Clinical Nurse Consultant.

P.S. If for any reason you can’t make the group or have any problems, please give me a call (02) 9794 1800
APPENDIX 7
MOTHER, BABY RESIDENTIAL ADMISSION:
THE MOTHERS’ EXPERIENCES RESEARCH

Demographic Data

An important component of any research is to describe the participants who took part in the study. Therefore I am asking each mother who attends a focus group to complete the information below.

This information will remain STRICTLY CONFIDENTIAL and you will NOT be able to be linked in any way to the research data.

<table>
<thead>
<tr>
<th>Mothers</th>
<th>Answers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother’s First Name</td>
<td></td>
</tr>
<tr>
<td>Mother’s Age</td>
<td></td>
</tr>
<tr>
<td>Country of birth</td>
<td></td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
</tr>
<tr>
<td>Occupation</td>
<td></td>
</tr>
<tr>
<td>Where you in the paid workforce before this baby?</td>
<td></td>
</tr>
<tr>
<td>Who many children do you have?</td>
<td></td>
</tr>
<tr>
<td>How old is/are your child(ren)?</td>
<td></td>
</tr>
<tr>
<td>Postcode of your home</td>
<td></td>
</tr>
<tr>
<td>How many days did you spend in Karitane?</td>
<td></td>
</tr>
<tr>
<td>What was the main reason for admission to Karitane?</td>
<td></td>
</tr>
<tr>
<td>What was your Edinburgh Scale during your admission?</td>
<td></td>
</tr>
<tr>
<td>What was your Edinburgh Scale today?</td>
<td></td>
</tr>
</tbody>
</table>

Thank you.
EDINBURGH POSTNATAL DEPRESSION SCALE (EPDS)

J L Cox, J M Holdon, R Sagovsky
Department of Psychiatry, University of Edinburgh

As you have recently had a baby we would like to know how you are feeling. Please UNDERLINE the answer which comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

Here is an example already completed:

I have felt happy
Yes, all the time
Yes, most of the time
No, not very often
No, not at all

This would mean "I have felt happy most of the time during the past week". Please complete the other questions in the same way.

IN THE PAST 7 DAYS

1. I have been able to laugh and see the funny side of things
   As much as I always could
   Not quite so much now
   Definitely not so much now
   Not at all

2. I have looked forward with enjoyment to things
   As much as I always did
   Rather less than I used to
   Definitely less than I used to
   Hardly at all

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3. I have blamed myself unnecessarily when things went wrong
   Yes, most of the time
   Yes, some of the time
   Not very often
   No, never

4. I have been anxious or worried for no good reason
   No, not at all
   Hardly ever
   Yes, sometimes
   Yes, very often

5. I have felt scared or panicky for no very good reason
   Yes, quite a lot
   Yes, sometimes
   No not much
   No, not at all

6. Things have been getting on top of me
   Yes, most of the time I haven't been able to cope at all
   Yes, sometimes I haven't been coping as well as usual
   No, most of the time I have coped quite well
   No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping
   Yes, most of the time
   Yes, sometimes
   Not very often
   No, not at all

8. I have felt sad or miserable
   Yes, most of the time
   Yes, quite often
   Not very often
   No, not at all

9. I have been so unhappy that I have been crying
   Yes, most of the time
   Yes, quite often
   Only occasionally
   No, not at all

10. The thought of harming myself has occurred to me
    Yes, quite often
    Sometimes
    Hardly ever
    Never
APPENDIX 9
CONSENT TO PARTICIPATE IN THE RESEARCH STUDY

Mother, Baby Residential Admission:  
The Mother's Experience

I ............................................................ have read and understand the consent and attached information sheet. I understand I have the right not to participate in, or subsequently withdraw from the study. Any decision not to participate will not affect my current or future treatment, or my relationship with the South Western Sydney Area Health Service, or any person treating me.

I freely consent to participate in this study I understand that my information will remain strictly confidential and I will not be able to be linked in any way to the research data.

I understand that the study involves me attending a one-hour focus group held at Karitane and completing an Edinburgh Postnatal Depression Scale, which will be used for research purposes only.

I understand the involvement in this research will not bear any financial cost/gain to me personally.

I understand I can request a copy of the summary of the research findings upon completion of the research.

I understand the purpose of the study and what is being asked of me, and that I can stop participating at any time. With this understanding I agree to take place in this research study.

Name ..................................................................................................................

Address..........................................................................................................................postcode........

Telephone (……) .........................

Signature .......................................................... Date …/…/1998.

Witness Name ..........................................................

Witness’s Signature ......................................................... Date …/…/1998.