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Focusing on Maternal Health Beyond Breastfeeding and Depression during the First Year Postpartum

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ABSTRACT

Nursing experts reviewed publications between 2003 and 2013 to identify practices for the care of women during the recovery year after childbirth. They focused on maternal transition, role and function, and psychosocial support. Findings indicated that clarification of the psychosocial meanings of childbirth and motherhood and family support systems that strengthen or hinder optimal wellness and functioning are needed. In addition, evidence is required to promote healthy transitions during this transition year.

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(Continued)

Nurses are the largest group of health care professionals interacting with mothers undergoing complex physiological and psychosocial transitions during the recovery year after childbirth. They and those they supervise are employed in a variety of settings that provide care for mothers during the recovery year after childbirth in the hospital, in the immediate postpartum period, and later in the community. During this period these mothers access care for themselves, their new infants, and their families (McNaughton, 2004; Slaughter & Issel, 2012).

Although nurses are in opportune positions to facilitate knowledge acquisition and role transition for postpartum mothers, the health care system has created barriers and challenges in the provision of these services. The majority of hospital stays are 48-hours postvaginal birth and 4 days postcesarean birth requiring much of nursing care to be focused on physical care of the mother and the infant. Although much literature exists on the dimensions of maternal health related to breastfeeding and postpartum depression, other dimensions of health that provide a holistic understanding to promote optimal maternal health and readiness during the postpartum recovery year are understudied. In 2006, Cheng, Fowles, and Walker reviewed maternal health needs. They recognized gaps in health resources and made recommendations for improving postpartum health for new mothers focusing on improved surveillance and national reporting, reevaluating the content and timeline for postpartum visits, encouraging partner support, and increasing research on maternal health status. Since that time, research focusing on the health of new mothers continues to be inadequate.

A discussion of maternal health in the recovery year after childbirth cannot ignore data that indicate that American women and their infants are at a growing health disadvantage compared to all other countries of comparable wealth (Institute of Medicine, 2013). The United States has the highest maternal and infant mortality rates in the developed world. Based on 2013 data issued by the *World Factbook* (Central Intelligence Agency), the U.S. infant mortality rate (5.9 per 1,000 live births) lags behind 51 countries, and the maternal mortality rate (21 per 100,000 live births) lags behind 47 countries. Especially alarming in recent years is the rising U.S. maternal mortality rates (Centers for Disease Control and Prevention [CDC], 2013). Although much national focus has been on health indicators using maternal and infant mortality outcomes data, health care providers, including nurses, need to focus on what measures can be taken to ensure women enter pregnancies healthy and remain healthy in the recovery period after childbirth. Although not completely understood, the postpartum recovery year is marked by

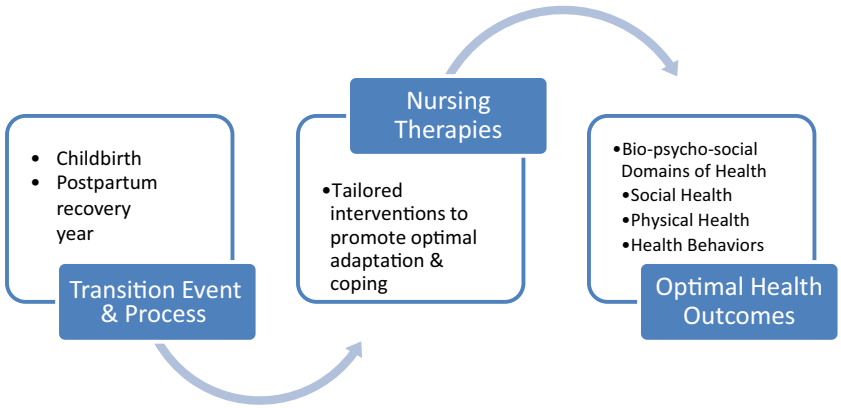

Figure 1. Using the transitions theory approach to promote optimal maternal health during the recovery year after childbirth.

complex processes involving psychoneuroimmunology and an interplay between biological and behavioral factors; this is a vulnerable period that can shape the overall health and well-being of mothers and their families (Groer & Morgan, 2007).

Dimensions of health that provide a holistic understanding to promote optimal maternal health and readiness during the postpartum year are understudied.

Theoretical Framework

The recovery year following childbirth is a delicate period of physical, emotional, and behavioral changes. The theory of transitions developed by Meleis, Sayer, Im, Hilfinger-Messias, and Schumacher (2000) provides an overall conceptualization with which to view mothers during the postpartum period. The key concepts from Meleis et al.'s theory that guide this article are transitions, nursing therapeutics, and holistic health outcomes as illustrated in Figure 1. Specifically, the pathway to motherhood after hospital discharge encompasses multiple complex health, developmental and situational transitions that occur simultaneously and sequentially throughout the year following childbirth. Meleis et al. noted that the mission of nursing practice is to tailor nursing interventions to facilitate optimal adaptation and coping during vulnerable periods of transition. Applying Meleis's theory to the postpartum period, postpartum conditions that facilitate or inhibit successful coping and adaptation during the vulnerable year following birth are the confluence of personal conditions (cultural beliefs, attitudes and practices, socioeconomic status, readiness, and functional abilities), community (access to resources, available role models, and level of social support), and societal conditions (gender inequality, marginalization, hassles of daily living, and trust or distrust) that can hinder progress toward a healthy transition leading to optimal health outcomes (Meleis, 2010).

In addition to transitional theory, applying a life-course perspective to the recovery year after childbirth provides an avenue for health care providers to view the mother's health holistically. Although the authors did not use life-course theory as a framework for this review, the concept of interconceptual (period between pregnancies) health can also be integrated as a construct during the recovery year. The March of Dimes (2013) and the CDC (2012) recognized the interconceptual period as a time when women continue to need services to assist them with their own health prior to becoming pregnant again. Optimal maternal health is integral to the mother, infant, and family (Slaughter & Issel, 2012). For example, once the mother is discharged, the attention shifts to the infant leaving large gaps in "best practice" knowledge for strengthening the health and well-being of the mother—the key caregiver of the infant and possibly others in the family.

Little research evidence exists to guide health professionals in understanding what the maternal physical, social, and behavioral needs are in the year beyond childbirth. Although the postpartum period has been traditionally defined as the first 6-weeks postdelivery, many clinicians and researchers are exploring the option of the first year as a postpartum "transition" period or recovery year. Although most of the education provided to

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Table 1: Postpartum Biopsychosocial Domains

Social	Physical	Health Behaviors
Maternal role	Acute medical problems	Smoking
Maternal attachment	Hemorrhage	Alcohol
Social support	Diabetes	Contraception
Managing multiple roles[a]	Other	Sexuality
Demands on time[a]	Distressing postpartum	Wellness
Confidence	Symptom clusters	Self-care
Self-efficacy	Sleep	Breast-feeding
Competence	Fatigue	Health care utilization
Functional status	Weight	
Psychosocial support	Pain	
Control[a]		
Transition to the mother role		

Note. [a]not found in the literature as search term.

prepare new mothers prior to discharge focuses on their physical needs, more attention is required for how nurses can intervene assisting with maternal transitional and psychosocial needs after discharge. Therefore, the purpose of this article was to identify what evidence is available to guide nursing practice during the year following childbirth, specifically research related to maternal transition and support. The decision to omit breastfeeding and postpartum depression was purposive as knowledge about current research on these topics is readily available.

Review of Literature

A nursing faculty panel representing midwives, perinatal clinical specialists, and women's health nurse practitioners convened to identify existing gaps in knowledge necessary for the care of new mothers during the year after childbirth and what knowledge is needed to prepare the next generation of nurses and advanced practice nurses. Through an iterative process, discussions focused on knowledge needed to support best nursing practices to optimize maternal health beyond hospital or home birth discharge and throughout the recovery year after childbirth. The panel decided that a broader perspective was needed to approach the biopsychosocial needs of a mother as she transitions physically, psychologically, and socially after childbirth.

The first step of this process was to search literature between 2003 and 2013 for research focusing on the postpartum timeframe to identify predominant words and concepts in nursing, maternal/child, medicine, and women's health journals. Each member was assigned several journals to survey. The next step was convening again to review the results to develop a strategy for searching the literature on this broad topic. The authors found that there was a limited amount of literature and felt that search terms needed to be redefined. Finding a gap in the literature, the panel created a multidimensional schematic diagram focusing on the postpartum biopsychosocial dimensions of maternal health domains including 24 potential search terms which were then grouped into three specific domains of maternal health: social, physical, and health behaviors (see Table 1). After much discourse, the panel decided to focus on the social domain of the postpartum recovery year. This domain consisted of concepts based on the transitional theory of Meleis (2010) and the literature, including (a) maternal readiness, (b) functional status, (c) social support, (d) maternal role, (e) competence, (f) self-efficacy, (g) confidence, (h) psychosocial support, (i) control, and (j) maternal transition to the mother role. The inclusion criteria included the main terms *postpartum* and *postnatal,* as the former term is used in the United States and the latter is used internationally. The search was limited to the CINAHL database, original research (excluded meta-analyses, theoretical papers), written in English, published between 2003 and 2013, and peer reviewed. Although efforts to conduct a thorough search of the literature were undertaken,

adding specific search terms most likely limited research that may have pertained to this review.

After all of the searches were completed, the panel reconvened and examined each of the studies for fit. If a study was related to a specific physiological need, specific health behavior, or the mother had pregnancy-related complications (e.g., preterm birth, preeclampsia), it was not included because it was not relevant to the social domain. One hundred eighty-two articles were reviewed and 39 ultimately met the criteria for this review. Three themes that emerged from the serach domains identified included the following: transition to maternal role, maternal role and function, and psychosocial and social support.

Transition to Maternal Role

An important transition after childbirth is assuming the maternal role. Nursing interventions are traditionally directed toward facilitating maternal self-efficacy. Based on a review of the literature, the definition of *maternal self-efficacy* was determined as a woman's belief about her ability to complete a set of tasks related to parenting such as her ability to take care of day-to-day interactions with the infant and to respond to infant cues and needs. In addition, self-efficacy has been associated with the related constructs of self-competence, self-confidence, and self-esteem. Maternal self-efficacy has been reportedly influenced by education, health, lifestyle, and coping. Parenting self-efficacy (PSE) is influenced by physiological state, mood, and self-confidence; attaining PSE is important for success in effective parenting, breastfeeding, and prevention of postpartum depression (Bandura, 1997). Developing PSE assists the mother in the development of maternal competence, maternal role, and positive self-efficacy. The nurse and advanced practice nurse (APN) play an important role in the transition year after childbearing in assisting the mother in developing the maternal role (Bandura, 1997; Dennis, 2006; Logsdon, 2008; Logsdon, Eckert, Tomasulo, & Myers, 2013; Logsdon, Foltz, Scheetz, & Myers, 2010; Salonen et al. 2009).

The transition to motherhood is a complex, challenging process. Developing one's maternal role, a learned social process, is a product of culture influenced by maternal self-confidence, interpersonal relationships, and self-esteem (Copeland & Harbaugh, 2010). The relationship between maternal role and maternal self-efficacy and self-confidence is closely related. A self-confident mother perceives she is able to care for and understand her infant and assumes the maternal role easily. Her transition to the maternal role is seamless and self-confidence is easily attained. According to Chien-Chi, Chen, Yeh, and Hsieh (2011), mothers who are confident in the postpartum period self-reported lower levels of anxiety, less depression, increased self-esteem and self-efficacy, and improved social relationships. Bryanton, Gagnon, Hatem, and Johnston (2008) conducted a nonexperimental exploratory study with 652 Canadian women to determine childbirth perceptions in relation to self-efficacy with parenting. Using the Parent Expectation Survey and the Self-efficacy Scale, data were collected at 12 to 48 hours postpartum and at 1-month postpartum. At 1-month postpartum, greater parenting self-efficacy was noted in women younger than 30 years of age (odds ratio [OR] = .29, 95% confidence interval [CI] [0.11, 0.76]); multiparas compared to first-time mothers (OR = 2.67, CI [1.01, 7.08]); and those who had excellent partner relationships (OR = 3.50, CI [1.10, 11.12]). In addition, the perception of their childbirth experience was also a positive correlate of parenting self-efficacy for early parenting in the postpartum period. The authors noted that nurses have the opportunity to support women during the intrapartum and early postpartum period to create positive birth experiences and provide additional support to women who report less than optimal birth experiences.

Hung, Yu, Liu, and Stocker (2010) concurred with the previous researchers noting that the transition to motherhood is a time of critical developmental that can result in maternal stress. These researchers conceptualized postpartum stress as attributed to three core deficits: ability to develop the maternal role, negative body image, and lack of social support. They reported that Taiwanese women who attended postpartum nursing centers reported increased maternal satisfaction and improved transition to the maternal role. The centers provided health promotion programs, respite with overnight stays, group education and support. Thome, Orlygsdottir, and Elvarsson (2011) clarified Hung et al.'s research and found that when nurses specifically trained in postpartum distress provided care to women in the immediate postpartum period, management of care was more effective and mothers reported a lower rate of depressive symptoms as compared to mothers who attended health centers with nurses who lacked specific training in postpartum distress.

McComish and Visger (2009) evaluated the effect of postpartum doula support of 13 women and how doulas assist mothers in developing maternal competence. Using an ethnographic research methodology, the researchers interviewed 13 mothers and identified 11 domains of care used by the doula to support the new mothers. These domains included emotional support, physical comfort, self-care, infant care, information, advocacy, referral, partner/father support, support mother/father with infant, support mother/father with sibling care, and household organization. The resachers found that by using the 11 domains of care, postpartum doulas facilitated maternal competence related to infant feeding, infant integration into the family, and the development of care and attachment.

Maternal Role and Function

Nontraditional family structures, such as a family with two lesbian mothers, may encounter unique stressors in attaining a maternal role. Renaud (2007) found that lesbian mothers reported stress related to feeling discriminated against in health care settings. The author noted that the lesbian mother attributed the stress to the "next-of-kin" rules, the refusal of health care providers to recognize the lesbian partner as the other parent, the lack of understanding of the physical and psychosocial needs surrounding the lesbian couple, and the fear that the sperm donor may attempt to claim parental rights even though legal protection was in place.

Military wives experience additional stressors during pregnancy and postpartum, increased difficulty to access support systems, and increased difficulty in maternal role adaption according to McCormish and Visger (2009). These researchers implemented a two-armed intervention study for primigravid military wives. The interventions included a traditional childbirth education program ($n = 47$) versus a baby boot camp ($n = 44$). The baby boot camp intervention included a 4-week childbirth parenting preparation program with a focus on resilience, with strategies on nontraditional external resources and development of internal resources to facilitate maternal role adaptation. Three tools (The Prenatal Self-Evaluation Questionnaire, The Personal Resource Questionnaire, and The Resilience Scale) were administered after the interventions at 32 to 37 weeks of pregnancy and at 6 weeks postpartum. Results found that the baby boot camp participants experienced significantly greater maternal adaptation as reported on the three questionnaires but were not sustained at the 6-week postpartum measure, indicating a need for follow-up support after childbirth.

Researchers have demonstrated that acquiring the maternal role after childbirth changes functional responsibilities of women. Barkin, Wisner, Bromberg, Beach, and Wisniewski (2010) used mixed methods with focus groups and questionnaires to identify components of a patient-centered definition of *maternal functional status* to understand women's experiences during the first postpartum year. The authors identified seven domains of maternal postpartum functioning including adequate social support, the ability to care for one's own physical and mental needs, caring for the infant, maternal infant interaction and attachment, ability to manage all responsibilities, and optimal functioning. They posited that these domains of maternal postpartum functioning developed over time and defined the adjustment to one's new maternal role.

Mothers desire "hands-on help" and emotional support to facilitate maternal role attainment. Razuerl, Brucheon-Schweitzer, Dupanloup, Irion, and Epiney (2011) interviewed 60 French speaking Swiss women 6-weeks postpartum. Women reported that in the hospital they wanted emotional and social support to enhance self-esteem, but after returning home they found coping alone more difficult and would have liked to receive more material support (though not clearly defined by the authors). The women also identified that they felt hospital care providers provided information rather than emotional support and once home, their partners did not fully understand their needs. Logsdon and Usui (2006) reported that an African American adolescent's partner was usually identified as the most important individual in providing emotional support, whereas the patient's mother identified to be the best in providing material support defined as hands-on help with the multiple of tasks facing a new mother as well as providing food and financial support. Home visitation by trained nursing professionals and paraprofessionals during pregnancy and up to 3 years postdelivery was assessed by de la Rosa, Perry, and Johnson in New Mexico (2009). They found that pregnant women and new mothers with a high degree of social support, emotional support, and material support (help with food, clothing, shelter, and utilities) adapted better postpartum to the maternal role than those who reported low levels of support.

Psychosocial and Social Support

When the search terms *psychosocial support* and *social support* were used, several articles were cross referenced and therefore are presented together in this section. The definition of *psychosocial* refers to the interaction between social and psychological factors; whereas the definition of *social support* relates to having a perception of available assistance from other people.

Primary sources of support were identified in several studies. Divito (2007) found that adolescents between age 13 and 19 identified their mothers as the primary source of social support, defined as a composite of emotional and tangible support. If their mother provided higher levels of emotional support, the adolescents felt more competent as mothers; whereas increased levels of tangible support from their mothers decreased the young mother's self-perception as parents. Divito found that when the adolescents received social support, emotional and or tangible, from the father of the baby, their self-perception of parenting increased. Aktan (2012) conducted a secondary analysis on surveys obtained from 177 mothers at 6-weeks postpartum capturing anxiety and social support. The majority of women were White, educated, and reported that their husbands were their primary source of support. The author found that state and trait anxiety and social support were inversely related in the postpartum period—the more social support a mother had, the less anxiety she experienced. Warren (2005) in a descriptive correlational design of 135 first-time Irish mothers at 6-weeks postpartum identified the husband/significant other and the mother of the new mother as primary sources of support. The mothers in this study also described receiving informational support not only from their mothers but also public health nurses.

Emmanuel and colleagues (Emmanuel, Creedy, St. John, Gamble, & Brown, 2008; Emmanuel, Creedy, Winsome, & Brown, 2011; Emanuel & St. John, 2010) examined several demographics and the effects of social support and maternal distress on maternal role development. In a prospective study conducted in Australia by Emmanuel et al. (2008), the researchers administered the Maternal Social Support Scale and What Being the Parent of a Baby is Like. Women self-reported at 36-weeks gestation ($n = 605$) and 12 weeks postpartum ($n = 473$). The researchers reported that women who were in shorter relationships reported poor social support and had

Postpartum needs change over time following the immediate postpartum hospitalization.

greater difficulty in the development of maternal role. Older women and women who had longer hospital stays (3 – 4 days) as well as women who attended childbirth education sessions reported an easier transition to the maternal role.

Emmanuel and St. John (2010) analyzed the concept of maternal distress. They defined *maternal distress* as a cluster of symptoms based upon well-being that was described as a sense of isolation, feeling as not having enough time, not being ready to transition to motherhood, and realizing that life is altered. The authors reported that maternal distress results from physiological and psychological changes, the new demands of learning the mothering role, balancing work, and managing social activities. They reported that a clearer understanding of maternal distress can inform and assist healthcare providers in developing best practice guidelines for improved interventions.

In a quantitative study of Australian women (n-473), Emmanuel et al. (2011) administered the Prenatal Maternal Expectations Scale and reported that social support eased maternal role development. The researchers also found a significant relationship between maternal role development and maternal distress in the third trimester and at 6-weeks postpartum. Women whose expectations for parenting were high were more likely to be distressed ($p < .01$), and psychological distress in women who are transitioning into the role of motherhood can make maternal role development more challenging ($p < .01$).

Ngai and Chan (2012) confirmed the significant impact of learned resourcefulness, social support, and stress on maternal role competence, satisfaction, and postpartum depression among 181 Chinese first-time mothers in Hong Kong. Findings showed that women ($N = 181$) in the early postpartum period experienced a decline of role confidence and an increase in maternal stress compared to their levels during the antepartum period. In Chinese tradition, the mother-in-law has great influence over the new mother during "doing the month," the cultural ritual practices in the month following birth when the mother-in-law cares for the new mother and the newborn. These investigators reported that the relationship between the pregnant mother and the in-laws

was reported to be a great source of maternal stress particularly if the relationship was not a supportive one.

Hung (2006) added that women identified mothering as a learned process. Further research examined the relationship between social support and postpartum stress, depression, and health status among Taiwanese women. All of the 432 postpartum women in the study reported a high level of social support with most of the support identified from family members. The investigator also found that increased social support was related to satisfaction in the parenting role and decreased depression. Later, Hung, Yu, Chang, and Stocker (2011) compared psychosocial changes of new mothers compared to experienced mothers. Each of the 859 women were interviewed once between Weeks 1 to 6 of the postpartum period. These researchers found that inexperienced mothers had significantly higher scores related to maternal role attainment concerns compared to experienced mothers at all of the time frames measured ($p < .01$). Social support was only significant during Week 5 for the inexperienced mother ($p = .02$). The authors conclude that this might have been the result of the ending of the period known as "Tso-Yueh-Tzu" (doing the month) where the new mother might have needed more support after this time frame.

Data on social support and socioeconomically disadvantaged mothers were derived from two different study samples:- one from Canada and one from the United States. Women from Canada were interviewed in a qualitative study by Kurtz Landy, Sword, and Valaitis (2009). The researchers reported two general themes:- the ongoing burden of their day-to-day lives and their ongoing struggles to adjust to life with a new baby. These mothers described social issues of poverty; lack of proper housing, food, and transportation; the stigmatization of others; complex relationships with the infant's father; and the lack of social support especially during the first weeks at home. Keating-Lefler and Wilson (2004) interviewed 20 new mothers in the United States who were single and qualified for Medicaid conducting three interviews over the course of 3-months postpartum. These women spoke of "reformulating life" that included a social support component. They discussed loss of relationships with their families, friends, and themselves; their struggle with finances, transportation, and security; and their ability to attempt new roles and believe in their own abilities. Women who are economically disadvantaged may have additional burdens in the postpartum period and require additional social support.

The social support of mothers who returned to work was discussed by several authors. Nichols and Roiux (2004) interviewed women postpartum, in six states of the United States, to identify maternal needs upon returning to work. Evaluating data from a large mixed-method descriptive study these researchers identified that role conflict/overload, family stress, family/child issues, financial issues, and psychosocial issues presented challenges to adjustment upon returning to work. Spiteri and Xuereb (2012) in a study conducted in Malta focused on the new mothers' thoughts after returning to work. These authors found that women were unprepared for life changes associated with having a baby and returning to work. Maternity leave was a time for preparing and planning ahead as well as a time of letting go of their previous life and gaining control in their new life. Returning to work was described as lightning striking, which stressed relationships with spouse, infant, and self. Both studies found that women needed more preparation and support to deal with issues confronting them than they received to have an easier transition back to work. Moreover, Kaitz (2007) reported that maternal distress derives from concerns about returning to work and being separated from the infant, concerns for the infant's future well-being and health, attempting to balance personal and social relationships, and returning to prepregnancy health status.

Castlea, Sladea, Barranco-Wadlow, and Rogers (2008) in the United Kingdom surveyed 86 first-time mothers and 66 first-time fathers at approximately 30 weeks of pregnancy and again at 6-weeks postpartum. They found that men and women who reported a high level of antepartum social support also reported lower levels of distress postpartum. In addition, though both partners perceived lower levels of social support postpartum, this finding was not correlated with maternal distress. In another study focused on partner satisfaction of 128 primarily White couples at 6-months postdelivery, Gjerdingen and Center (2005) found that caring and partner satisfaction decreased significantly after birth ($p < .01$). Practical support, that is, participation in housework by their partner, was identified as important for women participants.

Postpartum social needs change over time following the immediate postpartum hospitalization. Several researchers reported on the social domain, addressing the needs of new mothers up until the first year following birth. Social support during the postpartum recovery year is an important component in successful maternal role attainment whether it comes from the new mother's own mother, the father of the baby, or a community service.

Discussion

Implications for Nursing Practice

Evidence-based nursing care requires a holistic approach to maternal health and the well-being of the mother and her family in the context of her life and community. This approach requires that providers have an extensive body of knowledge about postpartum health and wellness and how to ensure the mother is prepared and ready for the transitions she undergoes in her maternal role. Beyond breastfeeding and depression, the researchers found a plethora of related, overlapping keywords associated with the postpartum recovery year and the facilitation of optimal maternal health. Many of the varied keywords brought the researchers to the same group of articles that were reviewed. Cheng et al. (2006) found it disappointing that the literature lacked longitudinal or interventional research that addressed recommendations to reevaluate and reform the program of routine postpartum health care, encourage family support, offer support groups, design long-term educational programs, and conduct research focused on postpartum maternal health. Seven years later, this expert panel of women's health nursing faculty found that Cheng et al.'s concerns persist and concur that it is disappointing.

As educators prepare the next generation of nurses, practitioners, and scholars, it is vital that gaps in knowledge be identified so new research endeavors can be pursued. Recommendations for future research based on this review include the following: (a) the development of intervention studies seeking answers to women's specific social needs, (b) conceptual-theoretical discourse on terminology used to describe this period of time, (c) studies that compare specific ethnic populations to make sure that cultural maternal transitional issues are being addressed, and (d) long-range studies identifying maternal needs over time throughout the first postpartum year. Best practices for identifying types of education focusing on the social domain during hospitalization, the postpartum visit, and during the recovery year warrants attention. Lastly, framing future research conceptually using a robust transitions theory framework to guide subsequent maternal health and wellness research is suggested. These strategies would be instrumental to fill important gaps in nursing knowledge to develop the evidence needed to guide postpartum nursing practice.

Evidence-based nursing care requires a holistic approach to ensure the well-being of the mother and her family in the context of her life and community.

Nurses can also become more proficient in connecting women to social support systems within their own communities. Currently, women receive their postpartum check-up appointment and pediatric infant appointment prior to discharge. Empowering women to expect optimal social health is important during transitions such as childbirth. Addressing women's social needs are crucial when providing holistic care. Community services do exist; however many women, including perinatal nurses, are not aware of them. Clinical models such as the Nurse Family Partnership (Olds et al., 2007) have had good outcomes. One must ask, how are nurses in the hospital exposed to these resources so they can provide them to those in need? Nurses providing discharge teaching should provide referrals and connections for their patients within the community.

Another venue for addressing the maternal social domain involves the pediatric visit. Although the primary focus of the visit is the infant, interactions between mothers and nurses could potentially elicit what additional types of resources the mother could benefit from receiving. Some research has used the pediatric visit as a site to address maternal health behavior change; however more assessment and education could potentially be provided by nurses who are employed in these community settings. In our search of the literature the authors did not come across any studies that focused on assessing social support of mothers during the pediatric visit.

Conclusion

Elucidating the psychosocial meanings of childbirth and motherhood for women and their social health and well-being with the conditions

and circumstances that support or hinder optimal wellness and functioning is needed for holistic understandings. Declercq, Sakala, Corry, Applebaum, and Herrlich (2013) concluded "Mothers of young children in the United States have diverse, demanding responsibilities; experience notable social, physical, and emotional challenges; and face inadequate policies, services, and support" (p. 69). Further research is needed to provide clinicians with better evidence to promote optimal health, well-being, and functioning as they care for women during the transitional year following birth.

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