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Published in:
Journal of Clinical Nursing

DOI:
10.1111/jocn.14687

Publication date:
2019

Document version:
Accepted manuscript

Citation for published version (APA):

Go to publication entry in University of Southern Denmark's Research Portal

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Download date: 15. Sep. 2023
Broken expectations of early motherhood: mothers’ experiences of early discharge after birth and readmission of their infants.

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Acknowledgments: We would like to thank the mothers who shared their experiences with us.

Author contribution: All authors have contributed to this article and all three authors have approved the final article. All three authors were involved in the study conception. MMF arranged the data collection and the inclusion of participants. DBD conducted the interviews.

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This article has been accepted for publication and undergone full peer review but has not been through the copyediting, typesetting, pagination and proofreading process, which may lead to differences between this version and the Version of Record. Please cite this article as doi: 10.1111/jocn.14687

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MMF, DBD and IN conducted the data analysis and discussion. IN and DBD have been doing critical revisions of the manuscript.

Funding: No funding.

COI: We wish to confirm that there are no known conflicts of interest associated with this publication and there has been no financial support for this work that could have influenced its outcome. We confirm that the manuscript has been read and approved by all named authors and that there are no other persons who satisfied the criteria for authorship but are not listed. We further confirm that the order of authors listed in the manuscript has been approved by all of us.

Ethical approval: The participants were informed both verbally and in writing about the study, and were included after providing their informed consent in compliance with the Helsinki Declaration. The study was approved by The Danish Data Protection Agency (2012-58-0018), but due to national legislation in Denmark it was not submitted to the Scientific Ethics Committee.

Abstract

Background and aim: Today mothers are discharged early after birth, and national monitoring shows an increase in readmission of infants. Readmission of the infant might diminish the possibility of bonding and weaken maternal confidence in taking care of the infant. The aim is to explore how new mothers experience the time from birth to being discharged after readmission with their infants.

Design: A phenomenological and hermeneutic study. Data were collected through telephone interviews. The study followed the COREQ requirements and was conducted in the Region of Southern Denmark in a University Hospital setting. Convenience sampling was applied, and eight mothers were included from November 2015 to February 2016. Seven were interviewed.

Results: The data analysis revealed the following six themes: ‘Broken expectations of a tranquil beginning of early motherhood’, ‘Early discharge’, ‘Being at home’, ‘Readmission – shock or relief’, ‘Problems with breastfeeding in early motherhood’, ‘Empowering or disempowering guidance’ and ‘Back home with broken expectations’. These six themes were all covered by the overall theme: ‘Broken expectations of a tranquil beginning of early motherhood’.

Conclusions: Our study points out that mothers wish for a tranquil beginning with their infants at home. Some already experienced problems at home while others first were confronted at the check-up at the outpatient clinic. Yet the common denominator was that the mothers experienced broken
expectations regarding early motherhood when facing readmission. Readmission may influence the initial process either positively or negatively, depending on how the mothers experience their challenges and how the health care professionals support them. This highlights the importance of the way in which health care professionals support new mothers when they are readmitted. The study emphasizes the importance of maternal feelings of security and confidence in their maternal role, as they are closely connected to the process of becoming a mother.

**Keywords**: discharge, postpartum, women, unplanned readmission, breast feeding, infant.

**Introduction**

Since hospitalisation of childbirth became the norm in the 1950s to 60s there has been a worldwide tendency to shorten the length of postnatal hospitalization (Brown, Small, Argus, Davis, & Krastev, 2002), and today one third of all mothers in Denmark experience short stays of up to 12 hours following birth (Blinded for Anonymity).

Advocates of early postnatal discharge argue that it is a step towards a more family-centred approach, and a qualitative meta-synthesis concludes that early discharge following birth might influence the initial process of becoming a mother positively or negatively, depending on the organization of postnatal care (Blinded for Anonymity).

Quantitative studies of early postnatal discharge use the proportion of readmission to measure the safety of early discharge (Askelsdottir, Lam-de Jonge, Edman, & Wiklund, 2013; Brown et al., 2002), yet a Cochrane Review of early discharge following birth states that studies had inadequate power to detect ‘increases in rare outcomes’ among other things readmissions (Brown et al., 2002). However, in Denmark an increase of infant readmissions occurring simultaneously with a general shortening of the length of postnatal hospitalization has been identified (Sievertsen & Wust, 2017). This corresponds with new monitoring from The Danish Health Data Authority showing that readmission has increased from 1.6 % in 2007 to 2.2 % in the first half of 2015, while the length of postnatal hospitalization has decreased from 77 hours to 60 hours (Sievertsen & Wust, 2017). The increase in readmissions has been associated with nutritional problems such as excessive weight loss, dehydration and jaundice. With the tendency of early discharge postnatal and the potential risk of readmission, it becomes important to gain more knowledge of potential consequences of a readmission for the mother. Moreover, the time immediately after becoming a mother is a vulnerable period and according to Mercer, it is regarded as a developmental transition that involves psychological, social, and physical effort (Mercer, 2006; Rubin, 1975).

Both Mercer and Person point out that maternal sense of security is regarded as an important factor as it can influence a mother’s journey towards motherhood (Mercer, 2004), and feelings of insecurity may have a negative impact on parental self-efficacy (E. K. Persson & Dykes, 2009; E. K. Persson, Fridlund, Kvist, & Dykes, 2011). In this light, readmission of the infant due to nutritional problems is likely to be experienced as stressful and might therefore impact the mothers’ confidence and perceived ability to manage maternal tasks. A literature search was conducted, and no literature was found in regard to how mothers experience readmission after early discharge. Several studies have been done in regard to parents’ experience of early discharge after birth and in regard to which complications infants have when readmitted shortly after birth. Yet, it is necessary to gain knowledge

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of how mothers experience the readmission of their infant after early postnatal discharge in order to support women in their early transition to motherhood and thereby increase quality of care.

Aim

How do new mothers experience the time from birth to being discharged after readmission with their infants?

Methods

This qualitative study has a phenomenological and hermeneutic approach. It was aiming at understanding the participants’ lived experiences as well as understanding how new mothers being discharged early postnatal experience the time from birth to being readmitted with their infant.

The starting and focal point of the study has been to describe the mothers’ lived experiences, yet their experiences have been interpreted into a context of existing research and a theoretical frame consisting of the concept Postnatal sense of security (E. K. Persson & Dykes, 2009; E. K. Persson et al., 2011), Self-efficacy (Bandura, 1997) and Becoming a mother (Mercer, 2004). The COREQ requirements for qualitative research were incorporated in the study, except that participants were not asked to validate findings (Tong, Sainsbury, & Craig, 2007).

Context

The study was conducted in the Region of Southern Denmark in a University Hospital setting. The general offer according to the current policy is that mothers who have had an uncomplicated pregnancy and delivery are discharged within 24 hours after delivery (The Region of Southern Denmark, 2013). The postnatal care takes place in the parents’ home environment. The health care professionals evaluate together with the families if they are eligible for early discharge. In order to support new parents after discharge, outpatient clinics are available for check-ups, telephone and online consultations are accessible around the clock, and home visits for primiparous are available, if needed. The check-ups are performed by nurses, health visitors and midwives, working closely together to ensure the well-being of the families. After early discharge all families are offered a check-up at the outpatient clinic, when the infant is between 48 and 72 hours old. The well-being of the mother (e.g. vaginal bleeding, potential breastfeeding problems, stitches) and the infant (e.g. hearing screening, biochemical screening for congenital disease of the infant, number of urinations and colour of faeces, weight) are checked. The health visitor from the municipality visits the families at home when the infant is 4-5 days old and a second time when the infant is around two weeks old. The subsequent visits are tailored according to the needs of each family, why the number of visits vary. All postnatal check-ups are optional.
Sample

Convenience sampling (Polit, Beck, & Hungler, 2001) was applied, i.e. participants were unsystematically recruited when nurses and midwives had time during their working schedule. Inclusion criteria adhere to the postnatal policy, i.e. mothers who had had an uncomplicated pregnancy and birth, and who were eligible for discharge within 24 hours after delivery. Mothers who themselves chose to be discharged within 24 hours though they were offered hospitalisation after birth were also included. Only physically and mentally healthy mothers of term (i.e. infants born in the period between 37 and 42 weeks of gestation) and healthy infants were included. As studies have shown that experiences of primiparous and multiparous mothers might differ (Hauck, Fenwick, Dhaliwal, Butt, & Schmied, 2011), we sought to ensure diversity in participating mothers during recruitment. Inclusion was stopped when both primiparous and multiparous mothers were almost equally represented.

Readmission should mirror infant nutritional complications as defined by The Danish Health Data Authority including the following diagnoses: dehydration, jaundice, failure to thrive or malnutrition or eating problems and should consist of a minimum of one overnight stay at the hospital. The exclusion criteria were mothers who did not speak Danish, Swedish, Norwegian or English. Mothers were invited to participate in the study during their readmission by the first author or the nurse or midwife who provided care for them. They were informed about the aim of the study and were given both oral and written information about the study. If they considered participating in the study, they provided their phone number. Subsequently the research group contacted the mothers to inform further about the study and arrange the interview if the mothers did decide to participate. They were given time to consider their participation, hence informed consent was collected when they were ready; i.e. either during readmission or after discharge sent by mail to the research team. Time of interview was in accordance with what suited each mother. Eight participants were included from November 2015 to February 2016, and seven were interviewed. One did not respond to our enquiry.

Data Collection

Telephone interviews were conducted. We were aware that the families had just experienced a potential stressful and vulnerable situation due to the readmission of their infant, and therefore we decided to try to disturb them as little as possible. All participants were interviewed by phone and were at home during the interview.

The interviews were conducted using open questions in order to let the participants speak freely, and allow for the possibility of asking follow-up question, if the areas of interest for the research had not been covered already (Brinkmann, 2014).

The interview guide focused on three main themes: (a) Mothers’ experiences of early discharge; (b) Mothers’ experiences of readmission (c) Mothers’ perspectives of support options that would provide them with a sense of security and self-efficacy.
The interview guide was inspired by the concepts of Becoming a mother (Mercer, 2004), Postnatal sense of security (E. K. Persson & Dykes, 2009; E. K. Persson et al., 2011) and Self-efficacy (Bandura, 1997).

The interviews were conducted between two and five weeks after the infant was born. None of the mothers had trouble recalling the incidents, experiences or emotions from the time of birth to their readmission.

The last author conducted all interviews. The interviews lasted between 21 and 43 minutes, on average 32 minutes, and were audio-recorded and transcribed.

Data analysis

The data analysis was inspired by Malterud’s systematic text condensation (STC) (Malterud, 2001) and structured according to the steps taken in the analysis, as shown in Table 1.

Initially, we captured a general impression of the data and extracted preliminary themes.

Secondly, the data were allocated into meaningful topics led by the study question ‘how do new mothers experience the time from birth to being discharged after readmission with their infants?’.

Next, the meaningful topics were condensed and coded. Finally, the findings were synthesized, including a shift from condensation to descriptions and themes. The codes were developed based on the preliminary themes identified in the first step.

In order to optimise validation, all three authors were involved in the analysis process. Our findings were then interpreted in relation to the theoretical frame: the concept of postnatal sense of security (E. K. Persson & Dykes, 2009; E. K. Persson et al., 2011), Self-efficacy (Bandura, 1997) and Becoming a mother (Mercer, 2004) as well as other relevant literature.

All three authors discussed their pre-understanding at the outset of this study and believed that readmission might have a negative impact on early motherhood and breastfeeding. This made the authors search for data disconfirming these beliefs in an attempt to limit the impact of these beliefs when the analysis was carried out (Polit et al., 2001).

Ethical considerations

The participants were informed both verbally and in writing about the study and were included after providing their informed consent in compliance with the Helsinki Declaration.

The study was approved by The Danish Data Protection Agency (2012-58-0018), but according to Danish law it was not required to be submitted to the Scientific Ethics Committee as it was not a clinical trial or involved human tissue.
Results

Mothers' ages ranged from 20 to 40 years. All mothers lived with their partner. This was by coincidence and not part of the inclusion criteria. Five mothers were employed, two were students. Four of them were primiparous, and three were multiparous. All breastfed before readmission; six out of seven breastfed after readmission. All were readmitted between 12 hours and 4 days after the early discharge. Duration of readmission ranged from 1 day to 4 days (Table 2).

The data analysis revealed the following six themes: ‘Early discharge’, ‘Being at home’, ‘Readmission – shock or relief’, ‘Problems with breastfeeding in early motherhood’, ‘Empowering or disempowering guidance’ and ‘Back home with broken expectations’. These six themes were all covered by the overall theme: ‘Broken expectations of a tranquil beginning of early motherhood’.

Early discharge

It was a common experience among the majority of the mothers that they did not feel the early discharge as pressure. Some had made their decision about choosing early discharge beforehand, while others decided after giving birth. They saw the early discharge as a possibility to get a tranquil beginning with their infant and they explained that they wanted to go home, get some rest, sleep in their own beds and start their new everyday life as an expanded family.

‘Going home, getting some rest, sitting on my own couch. And then nice and quietly figuring it out’ (multiparous, M1).

Two of the mothers had decided beforehand that they wanted to be discharged early because of previous negative experiences with hospitalisation of sick infants.

‘Neither of us is particularly fond of being at the hospital [---]. I have tried breastfeeding before and she (i.e. the infant) nursed well, so we thought we might as well go home instead of staying at the hospital’ (multiparous, M1).

However, three mothers expressed that the situation at the hospital was so distressing because of the other patients with crying infants, noise and a stressful atmosphere that they chose to go home even though they would have preferred to stay at the hospital. One had to move to another hospital right after birth because the postnatal ward was fully occupied, and another mother was placed in a room with other new mothers and their families.
'We could stay at the delivery room for a few hours ... but they could not offer us a room at the postnatal ward, so we had to go to another hospital if we wanted to stay at a hospital after birth. We thought, whew... that is too much, then we might as well drive home’ (primiparous, M5).

One mother had the impression that she had to be discharged if everything seemed to be normal, so she did not ask to stay.

‘I had gotten the impression that it (i.e. postnatal hospitalization) was not expected if everything went well’ (primiparous, M8).

During the interviews these three mothers had reflections on how the readmission might have been avoided if they had not been discharged early.

‘I just think that if there had been room for us at xx hospital, if we had had the opportunity to stay only one night, maybe a short time during the next morning, then it would have saved a lot’ (primiparous, M5).

**Being at home**

Regardless of how the mothers had experienced the first days at home, the common denominator for them after facing readmission was broken expectations: they had all had a wish for a tranquil beginning in their own home.

For some of the mothers the experience of coming home was somewhat ambivalent. They appreciated the calmness, but ended up worrying, experienced breastfeeding problems and being in pain.

‘We weren’t disturbed. There weren’t any crying infants like at the hospital. But it was also hard, because I needed a lot of help; I could barely get out of bed [...]. So in a way it was really nice, and in a way really hard, because... well... we probably needed help with breastfeeding. There was a lot to get familiar with’ (primiparous, M7).

Being discharged early challenged some mothers as they became insecure when at home.

‘I was really sad. I cried a lot when at home. I was scared, I had a lot of pain and I felt insecure about our situation’ (primiparous, M7).
Those who had been worried and felt insecure reached out for help by calling either the postnatal clinic at the hospital or the health visitor in their municipality. Most mothers experienced that it was easy to get in contact with the health care professionals and to get assistance; both in the form of advice and by being encouraged to come to the hospital for a check-up or to be readmitted.

‘I think that it was fine (to get help). When we came home, and she (i.e. the infant) would sleep, and she wouldn’t really eat, and then she would sleep even more, then I called the postnatal clinic sometime during the night. I would get some good advice, but it didn’t work. And then I called, no then the health visitor actually calls me the day after and asks when she should come and see the baby. When I am done talking to her, I call the postnatal clinic and say that we are coming, because it is not going to work’ (multiparous, M1).

One mother was asked to wait at home for four hours before she could come to the hospital for a check-up as they (i.e. the health care professionals) were occupied. She experienced that her infant would not breastfeed.

‘When it was three o’clock I was so miserable. It was really unpleasant to have an infant that just wants to sleep (mother cries)’ (multiparous, M2).

Others reported that they did not suspect that anything was wrong until they actually came for a routine check-up at the hospital.

‘We are actually on our way to a Christmas party. We thought that everything was perfect, so we hadn’t brought a changing bag or anything. We thought it was just the blood sample and then we could go home again’ (primiparous, M3).

**Readmission – shock or relief**

The mothers experienced the readmission as a shock or relief, depending on how the first days at home had been. The mothers who had been worried at home and had actively requested help looked at the readmission as a relief, where they felt that they were safe because someone else was taking responsibility for the situation.

‘I was so happy, I was just about to collapse at home, all that pain, the breastfeeding that wasn’t working […] It was really good to come to the hospital and talk about the things I had been thinking about, to be examined, to get a competent assessment…’ (primiparous, M7).
Those mothers were also the ones who already experienced broken expectations when at home after giving birth.

Unlike the other mothers who had been at home thinking that everything was just fine and were shocked to find out that something was wrong with their infants.

‘When we went out to the hearing screening and the blood sample (biochemical screening for congenital disease of the infant), I had not in my wildest dreams considered that we weren’t just going home again. I almost said to my husband that he didn’t have to park the car, because I was just going in and it would take 10 minutes. So, I was really shocked’ (multiparous, M4).

These mothers first experienced broken expectations when being confronted with the fact that their baby was not thriving at the check-up at the outpatient clinic.

One mother felt that she failed in her role as a mother as she did not suspect that anything was wrong with her baby.

‘She (i.e. the infant) is weighed [---] and she (i.e. the nurse/midwife) says that she has to talk to a paediatrician and I am thinking ‘oh my god’. I felt like a bad parent. She returned and said that the paediatrician would like to have us readmitted and I thought ‘okay’ (stresses)’ (multiparous, M4).

When mothers were being readmitted they got scared, because it is hard being confronted with the fact that something may be wrong with the infant when they have been at home thinking everything was just fine.

‘But we came in, and he was being weighed to see if everything is ok, and then we were told, that he has lost too much weight. Then we are sent to a different department, where we have to sit and wait for a paediatrician. When we have been waiting for half an hour someone mentions a feeding tube, and I just froze. I didn’t expect that this could happen. No one has prepared you for this’ (primiparous, M3).

When the health care professionals mentioned that this mother’s infant might have a feeding-tube she was ’broken’:

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'I just thought that everything was going wrong. There were so many complications during my pregnancy, and I thought that this would continue forever – that it would never stop. I did not know what to do’ (primiparous, M3).

Readmission left imprints on the mothers, as their expectations towards the postnatal period, breastfeeding and early motherhood were ‘broken’:

‘You have just hoped to have a normal infant that you could bring home […] Yet you end up at the hospital with scheduled meals and extra milk in a cup. Suddenly you have a sick infant again. And you have a child at home that you miss terribly’

(multiparous, M2).

Some mothers experienced the readmission as disempowering as they experienced that the system was rigid and did not leave room for individual treatment. One mother felt they were being examined in regard to their parental role.

‘We thought, isn’t it killing a butterfly with a musket? We felt disempowered. I am capable of giving my baby some milk in a cup, and then come in the day after and have her weighed […], I felt like an imbecile fool, I’m xx years old. I understand that my baby needs to put on weight. And I could have handled it at home in tranquil surroundings’ (multiparous, M4).

They stated that they were not being involved as parents and they experienced that the hospital deprived them of their parental responsibilities. The daily weighing of the infant suddenly made mothers experience a feeling of insecurity, even though they previously had felt a sense of security. This made them doubt their own observations.

The two mothers who had previously experienced being admitted with a sick infant had hoped to have a healthy infant and a ‘normal’ postnatal period. The readmission activated the fear that something was seriously wrong with their infant.

‘Is there something wrong with her? Is that why she won’t eat? Is it something with the intestines?’

(multiparous, M1).
Problems with breastfeeding in early motherhood

All mothers were breastfeeding before readmission, and all, but one, breastfed at the time of the interview. The one mother who stopped breastfeeding explained that the experience with the readmission where she was using lact-aid because of the breastfeeding problems reminded her of feeding her first infant through a feeding tube.

‘I was resolved from the beginning, and it doesn’t matter that much to me, well of course I would like to breastfeed, I will give it a go, I try, but I will not go home with something that I found uncomfortable. It ended up with the bottle, because I could not make it work emotionally’ (multiparous, M1).

The mothers experienced that breastfeeding required contact and help from the health care professionals, and they all needed different aids, such as nipple shields, breast pump, bottles etc.

They had a hard time positioning the infant and needed guidance and help. Some of the mothers were in pain after pregnancy and birth, which made it difficult to breastfeed as they could not sit up during breastfeeding. It complicated otherwise simple, practical things during readmission, such as milk expression etc., and it made the mothers dependent on help from the health care professionals or their partner.

‘It was awkward to sit on half a buttock or lying halfway down. And then the baby, but I did, and then I got the breast pump, and I had to sit there for ten minutes, and then I had to call her (i.e. the nurse/midwife) again, because we couldn’t go into the kitchen due to hygiene rules’ (multiparous, M4).

The focus on how much milk the infant got made mothers experience breastfeeding as a ‘duty’ and not cosy as they had expected. Due to the treatment regimens, breastfeeding was reduced to a procedure which just needed to be carried out.

‘Then it was weighing, breastfeeding, weight, giving extra milk in cup that I had expressed, and extra, if I hadn’t expressed enough, and this was every third hour, that is, from when you start. That means that there wasn’t much time to go down to get something to eat for yourself, and then return and start all over…’ (multiparous, M4).

The mothers experienced it as a never-ending regime. Everything was centred on feeding, the constant fear that the infant was not getting enough and maybe needed to have a feeding tube.

Still, the mothers were heavily engaged with breastfeeding, and when they experienced problems it brought more problems such as being dependent on others and having doubts as to whether they could manage. The mothers stated how it also affected their relationship with their partner.
'All the little things, they get to you, and then you start to blame each other [...]. Well, it creates a discord, and to begin with you are tired, and you cannot cope with that much, because he (i.e. the infant) is awake at night’ (primiparous, M3).

Some of the mothers said that they started to question everything because the breastfeeding problems made them insecure.

‘I started to question the little things, for instance, is it really normal that she filled the diaper every time she gets the bottle? Is it really normal that she can have filled diapers 8-10 times a day?’ (multiparous, M1).

**Empowering or disempowering guidance**

For most of the mothers the first few hours at the hospital following birth were characterized by concentrating on the first breastfeeding. Most of the time the mother and the father were alone without any health care professionals to support them. They seemed to enjoy being just the three of them.

‘Most of the time we were alone, where we just had the time to be us’ (primiparous, M8)

Several mothers expressed that the midwife only had a quick look at the infant sucking at the breast before they were discharged.

‘She (i.e. the midwife) was not very much present in the delivery room. She often left the room. But I didn’t know that there was anything to pay attention to about breastfeeding. She just looked if it went well’ (primiparous, M3)

One mother described how she was told that the infant probably had a little nausea because it wouldn’t suck at the breast, but they were discharged anyway.

When asked about details of the time at the hospital before discharge, several mothers expressed that they could not remember all that was said and done during that period. And some mothers experienced that they got too much information which was impossible to remember or recall afterwards.
“Well I don’t remember half of what she said – I just said ‘yes yes’ and thought if I could only get some sleep. But I guess it is something she has to say before we are discharged. And all the things she rattled off, it was like a machine gun. But it was fine, we were told what we had to be informed about, but we just don’t remember any of it’ (multiparous, M4).

During the readmission most of the mothers experienced the information and guidance from health care professionals as supporting.

‘They were really fast to come and help you, when you consider how busy they were. They were really nice, they explained how things had to be done, and they were always helpful. If you called, because you had doubts in relation to the breastfeeding position, they hurried down to see if she was positioned correctly. I think it was good to be there’ (primiparous, M3).

The understanding health care professionals helped mothers manage the difficult time with worries about their infants’ health.

‘I was in tears when we were readmitted, so we had many talks about how to do everything. They were very understanding about why things were as they were and why I was so upset’ (primiparous, M3).

However, how the health care professionals communicated information could also discourage some mothers. Due to the precarious situation the mothers experienced during readmission they were very sensitive regarding what was said or done by the health care professionals, their partner etc.

‘She (i.e. nurse/midwife) says: ‘I can see that you have polycystic ovaries (PCO) and when you have PCO, sometimes you don’t produce enough milk’. Then we asked her why, to get some kind of explanation, and can you change your diet, like with other PCO related things. She couldn’t account for that [...] We hadn’t asked for that information, so it just blew my mind’ (primiparous, M5).

Not only could the information have a negative impact on the mothers and their belief that they could manage breastfeeding, but it could also appear detached and not easy to translate into practice. Almost like something out of a textbook if it is not elaborated with more practical guidelines.

The mothers also reported that they received conflicting information at the different departments and by the different health care professionals. It confused the mothers, because they did not know what to rely on, and this induced insecurity.

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'We have talked about that they should coordinate. At the maternity ward they say that you mustn’t give anything extra (i.e. infant formula) before the breastfeeding is well established. Then you think: ‘ok’, and then you have to let the baby nurse more often. And then we are readmitted, and they say: ‘now we have to give her extra’, and you think: ‘you must make up your minds’” (multiparous, M4).

**Back home with broken expectations**

In general, the mothers experienced that it was fine to be discharged after the readmission. They explained that they had received useful information and guidance during the readmission, so they did not worry about being back home. Yet being readmitted left imprints, and besides broken expectations, it had also made them feel insecure. As one mother said,

’In the beginning I wasn’t insecure, but we sure became insecure while we were at the hospital. It was like being at an exam for 24 hours’ (multiparous, M4).

The majority did stress that they felt secure again when back home again. Yet some of the mothers reported that they, once in a while, still were insecure and this was in relation to the problems experienced earlier.

’I can feel that if he doesn’t want to eat right away, then we start to blame each other’ (primiparous, M3).

In relation to breastfeeding most of the mothers felt that it was working out. The health visitor was furthermore a resource that they could rely on if they had any doubts after being discharged.

’It is fine. She (i.e. the health visitor) was very clear, that we could just contact her if we had any questions […] I have gotten so much advice that I will figure it out now (laughs)’ (primiparous, M7).

**Broken expectations of a tranquil beginning of early motherhood**

The experiences of broken expectations were found in all six identified themes and thereby formed the overall theme ‘Broken expectations of a tranquil beginning of early motherhood’. We found that most of the mothers wanted to be discharged early, as they had an idea that it would give them a tranquil beginning with their new infant. However, this was not what they experienced and regardless of whether the mothers had experienced the readmission as a shock or relief, the common denominator for them after facing readmission was broken expectations. Also their experiences of breastfeeding caused broken expectations. Most of the mothers expected a cosy time breastfeeding their new-borns, but several described how breastfeeding became a duty and a mechanical action far from their expectations. During the readmission the mothers felt very sensitive and the way health
professionals supported them had an impact on their maternal confidence. Yet, the readmission left imprints of broken expectations and insecurity when they came home again.

Discussion

**Broken expectations of early motherhood**

We found that most of the mothers experienced a series of broken expectation from the early discharge, being at home, the readmission, breastfeeding, the help from health care professionals and finally when they returned at home after the readmission. These first negative experiences with motherhood may have an impact on the women’s journey to motherhood. Becoming a mother is regarded as a developmental transition that involves psychological, social, and physical effort. A woman experiences vulnerability and faces tremendous challenges as she makes this transition (Mercer, 2006; Rubin, 1975), wherefore Rubin defines the postnatal period as the most vulnerable time in a woman’s maternity period. Empirical studies have described becoming a mother as a process starting by realizing and facing the new situation. During this stage mothers may experience the new responsibility as overwhelming (Barclay, Everitt, Rogan, Schmied, & Wyllie, 1997). A meta-synthesis found that if new parents were not ready to be discharged, it seemed to trap the parents in the first developmental stages of being a parent; some were left with feeling overwhelmed and exhausted by the responsibility (Blinded for Anonymity). Mercer underlines that there could be a risk that the mothers are ‘trapped’ at this stage of being a mother. Mercer describes that the mother at this stage becomes acquainted with and learns to read her infant’s cues, and underlines that the length of time needed to learn to care for her infant is extended considerably if the mother experienced complications. By not being capable of interpreting the infant’s cues, the mothers may continue to feel overwhelmed and insecure and may not transition to what Mercer calls *a new normal* (Mercer, 2004, 2006).

How the mothers experienced being readmitted and the time during readmission was related to how they had experienced the first days at home. Some mothers were relieved to be readmitted, whereas others experienced it as a shock and felt examined during the readmission. The experience did not depend on parity. It can be overwhelming to feel that you have not lived up to your responsibility as a mother (Nyström & Öhrling, 2004). According to Stern it is crucial for a new mother to experience the capability of nourishing her new-born (Stern, 1995). Likewise, a recent qualitative meta-synthesis found that the experience of responsibility is dependent on the level of confidence and security that the parents experience in their new role, why having negative experiences of responsibility can make parents feel insecure in their parental role (Blinded for Anonymity).

Our findings might also reflect decreased maternal self-efficacy. According to Bandura mastery experiences are the most powerful source to influence self-efficacy. The mothers’ negative experiences might therefore have a negative impact on maternal self-efficacy, particularly if they occur before parental self-efficacy is established (Bandura, 1997; Salonen et al., 2011). This puts an emphasis on the importance of gaining positive experiences in the early postnatal period. It is documented that negative experiences with breastfeeding strongly determine the next breastfeeding course (de Jager, Skouteris, Broadbent, Amir, & Mellor, 2013). The results from our study are in line with this, as the two mothers, who had previously had negative experiences with sick infants, were
now insecure and doubting if they could succeed at breastfeeding. Some first-time mothers became insecure due to their lack of experience in infant behaviour and/or breastfeeding.

**Breastfeeding**

In our study we found that the mothers’ view of breastfeeding changed during readmission, as breastfeeding became associated with ‘something that needed to be done’, and not the cozy intimate situation they had expected it to be. The fact that everything related to breastfeeding is measured and scheduled can create insecurity in the mothers - it is no longer natural, but something that needs to be controlled. This was found by Larsen et al., who also emphasize that when breastfeeding experts (i.e. the health care professionals) talk about breastfeeding as milk production and focusing on timing, duration and amount, this could make the mothers even more insecure (Larsen, Hall, & Aagaard, 2008) and further complicate mother-infant interactions during breastfeeding (Palmer, Carlsson, Mollberg, & Nystrom, 2012). Hence, breastfeeding is regarded as something ‘instrumental’, where the female body is conceptualized as a machine and breastfeeding is reduced to production of breast milk regulated by demand. This might make the woman question whether she is capable of breastfeeding, as machines are at risk of breaking down and must be supplemented, repaired and controlled.

The mothers also experienced that problems related to breastfeeding made them insecure. The mothers started to question not only if they were able to breastfeed, but also other aspects connected to taking care of their infant. For instance they became afraid that their infant was sick. This was also found in a meta-synthesis of mothers’ experiences of breastfeeding (Larsen et al., 2008).

It was distinct for the multiparous mothers, who had had negative breastfeeding experiences with their first child.

Discrepancies between the mother’s expectations of breastfeeding and reality might create a feeling of not being in control, which could affect the mothers’ judgment and make them question other aspects of motherhood. Studies have found that mothers who did not succeed in breastfeeding feel like a failure and a bad mother (Palmer et al., 2012; Spencer, Greatrex-White, & Fraser, 2014; Williamson, Leeming, Lyttle, & Johnson, 2012). Studies point out when breastfeeding and motherhood are experienced as two sides of the same coin, expectations concerning breastfeeding will affect the experience of motherhood and vice versa (Larsen et al., 2008; Palmer et al., 2012).

**When guidance empowers or disempowers**

We found that the way in which the health care professionals communicate and provide guidance may either encourage or discourage the mothers. This is supported by other studies as well (Blinded for Anonymity)(Backstrom, Wahn, & Ekstrom, 2010) and stresses the importance of the way in which the health care professionals support new parents, since it might have essential impact on the mother’s sense of security (Blinded for Anonymity) (E. K. Persson et al., 2011). Empowering guidance includes encouragement, and a positive, enabling and helping attitude with attention towards the mother’s individual situation when providing postnatal guidance (Blinded for Anonymity)(Renfrew, McCormick, Wade, Quinn, & Dowswell, 2012). Feelings of insecurity can have a negative impact on
parental self-efficacy (Bandura, 1997). Therefore the health care professionals play an important role in encouraging the new mothers given the fact that parental self-efficacy is based on support and verbal persuasion among other things, and where the health care professionals signal that ‘you can do it’.

The results show that some of the mothers experienced the readmission as disempowering. During the readmission some of the mothers felt that they lost the responsibility of caring for their child because the health care professionals took over. They were depending on help from the health care professionals, for instance during breastfeeding, which made them feel disempowered even though the majority of mothers felt that they had received guidance that made them believe that they could manage the situation when returning home. The mothers underlined that even though they, to some extent, felt disempowered, they did at the same time receive useful advice from the health care professionals, and therefore they felt secure when back home again. This can also be related to the experience they had had before the readmission, where we found that the mothers experienced that is was easy to get help and support from the healthcare system when at home. As Persons et al point out, it is essential that new mothers have access to support because knowing where to turn to for help is of importance for the parents’ sense of security (Eva K Persson & Dykes, 2002; E. K. Persson, Fridlund, & Dykes, 2007; E. K. Persson et al., 2011).

We also found that the mothers in our study received too much information before being discharged after birth. This is also found in other studies (Blinded for Anonymity – 2 studies), where the early discharge put pressure on the possibility for providing new families with individualised information, and the new families experienced that they received a lot of information that they could not relate to. There is a risk of making new parents feel insecure when overloading them with too much information, as it can have the opposite effect. Instead of feeling well informed they experienced doubt. A new intervention study on breastfeeding counselling in an early discharge setting shows that limiting information to the individual mother’s specific situation increases breastfeeding duration and reduces readmission of infants due to nutritional problems (Blinded for Anonymity).

This also addresses an important issue on how information and guidance is provided. Technology can be a new way to inform and guide new mothers after they have been discharged. Studies have investigated the use of technology in the postnatal period, where findings by Lindberg have shown that the use of video calls can provide information and guidance after the new mothers have been discharged (Lindberg, Christensson, & Öhrling, 2009). A study has investigated the use of an app, where automatic messages sent out every 12 hours from the time of birth provided the new parents with timely information and making the new parents feel supported and in control of the situation (Blinded for Anonymity).

Strengths and limitations

The limitation of our study is that it was a small-scale study. The intention of this study was to understand and explain how new mothers experience the time from early discharge after birth to readmission of their infant. We have provided rich descriptions of the mothers’ experiences, which will hopefully allow the readers to judge whether the work is potentially transferable to their own contexts. The results cannot claim statistical generalizability, but analytical generalization (Brinkmann, 2014) which emerges by means of the dialectic between theory and practice.
We conducted telephone interviews, where the participants were asked open-ended questions and encouraging them to unfold their experiences. Shuy underlines several advantages of doing the interviews face-to-face instead such as more precise responses, time to think thoroughly about responses, and more self-generating answers (Gubrium & Holstein, 2002). However, we experienced that some of the mothers revealed very personal information, and two of them were crying during the interview, hence it is concluded that the telephone interviews generated interesting, personal and varied data that matched the in-person interviews. These women were all offered an extra follow-up visit at the postnatal clinic if needed, but both declined and stated that they were okay with talking about their experiences.

The analysis was conducted together with co-researchers to increase the reliability, and we presented the analysis process in a table to make the analysis transparent. Quotations from the interviews were used to make connections to the participants’ original statements to ensure validity.

**Conclusion and relevance to clinical practice**

Our study shows that mothers wish for a tranquil beginning with their infant at home, and they would therefore be comfortable with early discharge. Some already experienced problems at home prior to readmission while others first were confronted during the check-up at the outpatient clinic, but no matter how the mothers experienced the time after early discharge and the readmission, it was common to the mothers that they all experienced broken expectations. This experience may have a negative impact on the women’s process of becoming a mother.

Breastfeeding problems made the mothers feel insecure and out of control and affected their judgment, which might make the mothers question other aspects of motherhood. Disempowering guidance by health care professionals increased their insecurity.

Readmission may influence the initial process positively or negatively, depending on how the mothers experience their challenges and how the health care professionals support them.

The study is relevant to clinical practice as it highlights the importance of the way in which health care professionals support and inform new mothers when they are readmitted, so they will not feel disempowered. A clinical implication is that supporting the mothers the first days after early discharge is important to avoid readmission as it ‘breaks’ mothers’ expectations of early motherhood. Health care professionals should encourage and signal ‘you can do it’ to increase mothers’ self-efficacy when unexpected problems occur early postnatal.

This study emphasizes the importance of maternal feelings of security and confidence in their maternal role, as they are closely connected to the process of becoming a mother.

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References


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### Table 1 Process of Analysis – examples from the analysis

<table>
<thead>
<tr>
<th>Step 1: From medley to themes: Superior themes extracted after the first open reading.</th>
<th>Step 2: From themes to codes. Identifying meaningful units. The meaningful units are coded based on the superior themes.</th>
<th>Step 3: From codes to meaning. The meaningful units are sorted into groups; hereby overall themes arise from the coding process.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Shock – Fool</strong></td>
<td><strong>QUOTATIONS</strong></td>
<td><strong>[code]</strong></td>
</tr>
<tr>
<td>'We thought, isn’t it killing a butterfly with a musket. We felt disempowered. I am capable of giving my baby some milk in a cup, and then come in the day after and have her weighed [...], I felt like an imbecile fool, I’m xx years old. I understand that my baby needs to put on weight. And I could have handled it at home in tranquil surroundings’ (multiparous, M4).</td>
<td><strong>Readmission – shock or relief</strong></td>
<td></td>
</tr>
<tr>
<td>I started to question the little things, for instance is it really normal, that she filled the diaper every time she gets the bottle, is it really normal that she can have filled diapers 8-10 times a day’ (multiparous, M1).</td>
<td><strong>[Disempowered]</strong></td>
<td></td>
</tr>
<tr>
<td>'It is fine. She (i.e. the health visitor) was very clear, that we could just contact her if we had any questions [...] I have gotten so many advice that I will figure it out now</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Question**
<table>
<thead>
<tr>
<th>Lots of advice</th>
<th>Back home with broken expectations</th>
</tr>
</thead>
<tbody>
<tr>
<td>(laughs)”(primiparous, M1)</td>
<td>[Secure]</td>
</tr>
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# Table 2: Study population (N=7)

<table>
<thead>
<tr>
<th>Parity</th>
<th>4</th>
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<tbody>
<tr>
<td>Primiparous</td>
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<tr>
<td>Multiparous</td>
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<tr>
<th>Age range</th>
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<table>
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<tr>
<th>Breastfeeding status of infant</th>
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<tbody>
<tr>
<td>Breastfed before readmission</td>
<td></td>
</tr>
<tr>
<td>Breastfed after readmission</td>
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<table>
<thead>
<tr>
<th>Reason for readmission</th>
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<tbody>
<tr>
<td>Nutritional problems such as excessive weight loss, dehydration</td>
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<tr>
<td>Jaundice</td>
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</table>

<table>
<thead>
<tr>
<th>Age of newborn when readmitted</th>
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<td>- &lt; 24 hours</td>
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<tr>
<td>- 24 - 48 hours</td>
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</tr>
<tr>
<td>- &gt; 48 hours</td>
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</table>

<table>
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<th>Duration of readmission</th>
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<td>- 24 - 48 hours</td>
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<tr>
<td>- &gt; 48 hours</td>
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</table>

<table>
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<tbody>
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<tr>
<td>Student</td>
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