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“Keeping It Together, Keeping Their Heads Above Water”: Western Australian Child Health Nurses’ Understanding of Resilience in Postpartum Mothers

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Abstract

Assessing the well-being of postpartum mothers is an important aspect of postnatal nursing care. For this reason, Child Health Nurses (CHNs) are charged with the responsibility of identifying postpartum mothers who do/not manifest resilient behavioral qualities. However, little is known about CHNs’ conceptualization of resilience or how they assess resilience in postpartum mothers. This exemplar study addressed this knowledge shortfall by conducting semi-structured interviews with eight practicing CHNs. The study’s findings reveal that although CHNs’ conceptual understanding of resilience is congruent with current theoretical thinking, some variance does exist in the ways in which CHNs assess postpartum resilience, particularly, in relation to CHNs’ use of intuitive assessment techniques to appraise the critical maternal postpartum coping qualities of *adaptation*, *responsiveness*, *self-confidence*, and *social connectedness*.

Keywords

child health nurses, postpartum mothers, resilience, trauma, adversity

Introduction

Assessing the well-being of postpartum mothers is viewed as an important aspect of postnatal care, especially, if long-term negative mother–infant dyad outcomes are to be avoided (Ayers & Ford, 2009; Broomfield, Lamont, Parker, & Horsfall, 2010; Herrman et al., 2011; Milne, Greenway, & Hansen, 2007). Hence, the role of the Child Health Nurse (CHN) is to work directly with mothers during the 36 postpartum period to identify mothers who are, and mothers who are not coping with motherhood (Beyondblue, 2011).

In terms of providing assistance to mothers during this critical postnatal recovery period, CHNs generally try to visit mothers within as soon as feasible after the infant’s birth. During the course of this visit and subsequent home/clinic visits, the CHN conducts an assessment of the mothers’ resilience as well as identifies any situational protective/at-risk factors that may positively/negatively influence the well-being of the mother and child (Collins, 2011). This assessment involves screening for postnatal depression, identifying situational problems, developing individualized visitation schedules, and assisting mothers with their postpartum recovery (Beyondblue, 2011; Department of Health Western Australia, 2006).

Although the Edinburgh Postnatal Depression Scale (EPDS) is a widely recommended postnatal depression

screening device, it is unclear what other measures CHNs are advised to use when assessing maternal resilience. For instance, the Western Australian CHN practice guidelines refer to *An Indicators of Need* guide as being an appropriate assessment tool; however, no clear indication is given as to how it can be sourced (Collins, 2011). Consequently, the accessing of this tool is dependent on each nurse’s time, motivation, and determination to source the relevant information. This individualized assessment situation approach contributes to the variation in service delivery practices that many health authorities seek to eradicate.

A further conundrum is that if CHNs are to be proficient at identifying postpartum resilience, then they need to have both a conceptual understanding of resilience and a practice understanding of how to recognize and evaluate it. This understanding is important not only in terms of their ability to assess maternal resilience, but also in identifying other significant adverse/challenging events that are occurring within the family unit during the postnatal period. Thus, this

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existing approach is somewhat limited by each CHN's training and years of experience (Marron & Maginnis, 2009).

An Understanding of Resilience

Understandably, calls have been made for research that provides a greater understanding of the concept of resilience, how it is made manifest, and how nurses can recognize it in others (Gillespie, Chaboyer, & Wallis, 2009). The need to investigate CHNs' present understanding of the conceptual underpinnings of resilience (and its counterpart thriving) arises because the definitions of these two constructs have undergone considerable revision since their inception. In the case of resilience, it has changed from its original deficit model of being a "resistance to stress" (Garmezy, Masten, & Tellegen, 1984). Indeed, over the last decade, a seismic shift has occurred within the resilience paradigm that has moved it away from its former deficit conceptualization toward the current strength-based model. In this regard, a definitional debate opened around whether resilience could be conceptualized as a state of homeostatic health maintenance during which competent thriving individuals return to their pre-adversity condition following each new adversity experience (O'Leary & Ickovics, 1995). This suggestion gave rise to the notion of resilience being a "better-off-afterwards" experience, which in turn became the catalyst for shifting the research focus towards determining what innate intrapersonal (e.g., social skills) and cognitive competencies (e.g., intelligence, creativity, humor) were common to resilient individuals (Tusaie & Dyer, 2004). During the same period, other researchers focused on determining the stress-resilient personality traits that allow individuals when faced with infrequent severe instances of personal threat to not only cope, but also to so successfully adapt that they are able to regain (and maintain) their pre-adversity level of functioning (Wald, Taylor, & Asmundson, 2006). It was conceptualizations of this nature that gave rise to the "bounce-back" notion of resilience (Darbyshire & Jackson, 2005; Herrman et al., 2011; Luthar, Cicchetti, & Becker, 2000).

Following on from this static notion of resilience, considerable research effort shifted to determining whether resilience is a measureable trait (Herrman et al., 2011). More recently, researchers have begun to postulate whether resilience is the "plastic" intermittent ability, which allows individuals to learn, adapt, and recover from their adversity experiences that occur over the course of the human life span (Atkinson, Martin, & Rankin, 2009; Luthar et al., 2000). More recently still, a consensus view has begun to emerge that resilience is a dynamic relationship between an individual's personal traits, lived experiences, environmental situation, psychosocial support system, and exposure to adversity (Rutter, 2007; Seery, Holman, & Silver, 2010).

In terms of health resilience, it is now accepted that to make a determination of resilience, two conditions need to co-occur, namely, the presence of an adverse experience

and a manifest adaptation/coping competency. In this regard, an ecological framework has been constructed in which resilience is defined as being the human ability to navigate a way forward toward accessing health sustaining resources in culturally meaningful ways (Fergusson, Harms, Pooley, Cohen, & Tomlinson, 2013; Unger, Brown, Liebenberg, Cheung, & Levine, 2008). More specifically, research has shown that resilience manifests itself differently within different families, cultural groups, and community settings. Finally, it has been suggested that resilience is the posttraumatic growth potential to exhibit resourcefulness by using available internal and external resources in response to different contextual and developmental challenges (Pooley & Cohen, 2010). Posttraumatic growth being typified by increases in self-reliance, expressiveness, life appreciation, interpersonal relationships and spirituality, as well as changes to former goals and life priorities (Pooley, Cohen, O'Connor, & Taylor, 2013).

The conceptualization of *thriving* has similarly undergone considerable revision and, like resilience, is now considered to be a multi-dimensional construct. Indeed, there has been some blurring of these two strength-based concepts. For instance, thriving postpartum mothers have been defined as being individuals exhibiting a dynamic psychosocial growth response to the motherhood challenge (Walker & Sterling, 2006). In addition, it is hypothesized that the "gain" aspect derived from overcoming a challenge is what differentiates thriving from the resilient overcoming of a "loss" experience. Regardless of whether it is the thriving lifestyle adaptation to challenge (e.g., coping with a new baby, moving house, planning a large family/community event, or undergoing additional training) or the resilient experience of overcoming traumatic loss (e.g., a traumatic delivery, a newborn with major health issues, relationship breakdowns, death, migration, or financial ruin), the important issue is that CHNs are adequately acquitted to fulfill their role of identifying postpartum mothers who are, or are not coping with the motherhood experience. In light of this need, the present study sought to determine CHNs' understanding of the concept of resilience and how they assess resilience in postpartum mothers.

Method

Research Design

Unlike most qualitative studies that aim to generate theory or findings that are transferable to a larger population, the sole objective of exemplar studies such as this one is to develop an understanding of a hitherto poorly understood phenomenon within a defined context. A key attribute of exemplar studies is that they allow data from within, and across, one or more data sets to be intensely interrogated and rigorously contrasted (Cresswell, 1998; Miles & Huberman, 1994; Stake, 1995). Through this process, one small-scale study

becomes the exemplar for other studies investigating the same phenomenon. Flyvbjerg (2006) maintains that exemplar studies are critically important as “a scientific discipline without a large number of thoroughly executed case studies is a discipline without a systematic production of exemplars, and a discipline without exemplars is an ineffective one” (p. 219). Whereas, as alluded to by Flyvbjerg, case studies characteristically involve a single case, which is then studied in depth over a protracted period of time, case studies can also (as in the present study) involve a collective of cases (e.g., a number of employees or work sites conducting the same task) wherein multiple perspectives are studied so as to generate an across-case understanding of the investigated phenomenon. Hence, the collective case study design is sometimes used in workplace situations where it is impractical, impossible, or not permissible for a researcher to observe a worker in action. In such instances, there is a greater reliance on the interviewer’s own workplace knowledge to probe and elicit the necessary rich data that would allow for an across-case investigation. The issue in such exemplar studies is not so much the length of time spent following each individual case, but rather the quality and depth of the data gathered and the strength and expertise of the cross-case analysis.

The strength of exemplar studies is that they generate findings that by weight of their combined numbers produce insights into the investigated phenomenon, which are reflective of the lived experience of the wider population (Punch, 2005; Stake, 1995). Unlike larger theory generating and quantitative studies where tests of objectivity and credibility are judged by the strength of their numerical evaluation or thematic construction, the value of exemplar studies is judged by whether they bring something new or different to the understanding of the investigated phenomenon (Hodkinson & Hodkinson, 2001).

This exemplar study sought to explore the CHNs’ understanding of resilience and their means of assessing resilience in postpartum mothers. Thematic analysis is not a prescriptive research design, but rather is an analytical approach that provides an “accessible and theoretically flexible means of analysing qualitative data” (Braun & Clarke, 2006, p. 77). Primarily because thematic analysis accurately reflects participants’ lived-realities and, in addition, unravels pertinent aspects of these realities. The unraveled data threads become the data categories, subthemes, and themes each of which, according to Braun and Clarke, captures data that are important to the investigated phenomenon. In this regard, thematic analysis was considered to be a process suited to the investigation of this sample of CHNs.

Participants

The sample comprised eight experienced CHNs working within eight different child health clinics in Perth, Western Australia. All the CHNs had between 2 and 30 years of

practice experience and held (or the equivalent of) a Graduate Certificate in Child and Adolescent Health Nursing as well as an additional qualification in the area of maternal, child, and family health (e.g., a postgraduate diploma in child and adolescent health nursing). Their practice experience was derived from working with women across different socio-economic groups and from culturally/linguistically diverse backgrounds in the city’s metropolitan and rural areas.

Procedure

Ethics approval was sought for the study from the administering institution’s Human Ethics Committee and from the Department of Health’s (DOH) Strategic Support Unit for Child and Adolescent Community Health. The DOH granted approval on two stipulations. First, due to workload and time constraints, no more than eight CHNs would participate in the project and, second, the initial CHN contact was to be made via the district clinical nurse manager. As per DOH’s instructions, the nurse manager informed CHNs (via email) of the study and requested prospective volunteers to contact the first author directly.

On making contact, a mutually agreeable time and place for the interview were arranged. In all cases, interviews were conducted within the CHNs’ 45-min lunch break. Prior to the start of the interview, each participant was informed of the intent of the research and of his or her participatory rights. The interview questions were informally delivered in a semi-directive style so as to provide participants with the maximum opportunity to discuss the experiences they deemed important to the understanding of resilience and its practice manifestations in postpartum mothers.

Analysis

The interviews were transcribed verbatim within a few days of having taken place. The accuracy of the transcriptions was assured by having the second author randomly check the accuracy of 50% of the first author’s transcriptions. The transcriptions were subsequently analyzed using thematic analysis, which is the cornerstone of qualitative analysis as it enables connections to be made between people’s expressed statements and their embedded meanings (Stirling, 2001). The initial process required the interview transcripts to be continually reread until salient points of interest emerged. These points were recorded as a series of memos, which were then grouped and ordered into basic units of meaning, namely, categories (Braun & Clarke, 2006). Next, through a synthesizing process of reordering, these categories were clustered into subthemes (Pringle, Drummond, McLafferty, & Hendry, 2011). Finally, through the process of continual abstraction, these subthemes were regrouped into a small number of encapsulating themes. In this way, the analysis process allowed rich, vivid data “nested” in the participants’ real-life social contexts to be uncovered and explored

Table 1. Themes and Subthemes Relating to Child Health Nurses' Conceptualization of Resilience and Observed Resilient Qualities in Postpartum Mothers.

Themes	Subthemes
Theme 1: Child health nurses' conceptualization of resilience in postpartum mothers.	Subtheme 1: Resilience is the survival-orientated human ability to rebound from trauma. Subtheme 2: Resilience is the human ability to project an unflustered and future-orientated demeanor. Subtheme 3: Resilience is the human ability to generate a self-expectancy of future recovery. Subtheme 4: Resilience building is a lengthy process. Subtheme 5: The resilience process involves grieving for a personal loss. Subtheme 6: Resilience is the human ability to learn from past experience, reframe the now, and work a way forward.
Theme 2: Child health nurses' intuitive assessment of the personal qualities manifest in resilient postpartum mothers.	Quality 1: Resilient mothers manifest a positive attitude toward their changed postpartum circumstances. Quality 2: Resilient mothers interact with their babies and are responsive to their needs. Quality 3: Resilient mothers appear confident in their ability to overcome adversity. Quality 4: Resilient mothers establish social support networks and demonstrate a willingness to reach out for help.

(Pringle et al., 2011; Smith & Osborne, 2003; Thomas & Harden, 2008).

To enhance the interpretive rigor of the analysis, two authors independently analyzed the data sets. On completion, they crosschecked their themes and subthemes. Where consensus occurred, the identified themes and subthemes were accepted as being representative of the participants' meaning. When differences occurred, these were discussed with the third "judge" author until a consensus of meaning was achieved (Sandelowski, 1986).

Findings

The analysis resulted in the emergence of two themes and eight subthemes, which are displayed in Table 1 with additional illustrative quotes being displayed in Table 2.

Theme 1: CHNs' conceptualization of resilience in postpartum mothers.

Subtheme 1: Resilience is the survival-orientated human ability to rebound from adversity.

The most consistently expressed definition of resilience by the CHNs was the notion that human beings have a survival-orientated ability to rebound from adverse/traumatic experiences. Typically, CHNs commented,

My understanding of resilience is that it's mums, or perhaps even families, who've had a traumatic time, but are yet able to survive. (CHN 8)

Although CHNs perceived resilience to be survival-orientated, they also expressed an opinion that resilience is also recovery-focused. They contended that in the recovery stage, resilient individuals are not only able to "pick themselves up" and "regain control" of their circumstances, but are also able

to apply "coping strategies" learnt during the course of handling previous adversity experiences. One CHN explained,

Resilience is the state in which you're able to cope better with life's traumas and adversities. Um . . . instead of it (the adversity/traumatic experience) knocking you over. You get up and fight on. You cope. You just get through life without every little disaster becoming a major issue. (CHN 4)

Subtheme 2: Resilience is the human ability to project an unflustered and future-orientated demeanor.

A second common perception among CHNs was that resilience is an innate "relaxed personality trait" that allows people to cope. One CHN described resilient mothers as being "the so chilled sort of people who just get on and face life." Another surmised,

Resilience is an innate characteristic that enables people to keep going for want of a better word and to bounce-back when times get tough . . . There's some argument that it can be taught. Maybe it can, but I think it's an innate quality. (CHN 3)

The CHNs asserted that personality alone could not explain why some postpartum mothers were more resilient than others. Especially, as in their observations of postpartum mothers, those who manifested a relaxed attitude and were well supported by their family, friends, and broader community, often had a greater capacity for resilience than those with a more anxious personality and few avenues of support. Although personality was considered to be an important individual factor, CHNs contended that it is "your environment and your experiences that also form you." Typically stating,

We're all people, we've all got personalities and we've all had life experiences. So nature and nurture have made the mother

Table 2. Examples of CHNs' Identified Qualities of a Resilient Mother During the Perinatal Period.

Maternal quality	CHNs' perceptions
Positive	"With the (resilient) mums they enjoy their children and seem to be able to manage and have that positive outlook." (CHN 6) "I certainly think it (positive outlook) does seem to make it easier for them. I think it's all a case of it (coping) just builds up and builds up and if you have that (resilient) sort of personality you might get through it (adversity) quite well." (CHN 4)
Responsive	"She delights in the baby . . . Is very interested in the baby . . . Picking up on the cues of the baby, communicating with the baby . . . understanding the baby's need." (CHN 2)
Engaged	"The sort of people who just get on and face life." (CHN 4) "She's more aware of resources . . . She's not socially isolate and she's prepared to sort of engage with services." (CHN 7)
Reflective	"Think, oh yeah, that was what I've learnt from that, no that's okay . . . I did an okay type job . . . I did handle that well." (CHN 3) "Looks at the bigger picture . . . reframes what has happened to them . . . yes this is hard but it will pass. In a few months it will get easier." (CHN 4)
Self-confidence	"Have better abilities, less levels of anxiety . . . more confident . . . less fearful of things that might happen, that could have happened, that did happen . . . and have the confidence to think, actually yeah I'm doing a pretty good job here." (CHN 4) "Not hard on themselves." (CHN 7) "Keeps her life normal." (CHN 8). "Knows you have to have that order . . . to build on it and has the confidence that they can deal with the adversity they face." (CHN 3) "Knows how to access information and knows how to use it." (CHN 5)
Pragmatic	"Not over dramatizing (problems) . . . and look at things in a problem solving approach." (CHN 1) "They're prepared to work through it (traumatic event) without actually giving up . . . knowing that what they're going through is only a very temporary time." (CHN 4) "Can actually see what her day to day life is like." (CHN 2)
Communicative	"Can express this (thoughts)." (CHN 2). "Can have a bit of a laugh while we are chatting." (CHN 5) "She's able to ask for help." (CHN 4) "The fact that she's presenting and talking about it (adversity) is probably a sign that she's pretty resilient." (CHN 7) "Laughing to me that is resilience." (CHN 1) "Is comfortable talking about it (problem)." (CHN 7)
Receptive	"More relaxed . . . open to advice." (CHN 8) "She's thinking well." (CHN 3)

Note. CHN = Child Health Nurse.

the person she is . . . so whatever has shaped her has made her, and her coping strategies would've moulded her. (CHN 6)

Subtheme 3: Resilience is the human ability to generate a self-expectancy of future recovery.

A third consistently voiced interpretation of resilience was that motherhood and resilience occur in tandem. The CHNs asserted that mothers for millenniums have been adept at coping with family-related adversities and personal traumas and, reflected that a maternal coping expectancy not only exists, but because it is so embedded within society it has become self-reinforcing and, therefore, has become normalized. One CHN reasoned,

Women are perceived as being resilient in society. We're meant to cope because we're mothers. I think lots of mothers think they have to cope because that's life. (CHN 4)

Another CHN asserted that when mothers are provided with examples of their own coping qualities, then this maternal resilience expectancy is further reinforced:

I think if other people have a belief in you and give you examples of when you've bounced-back . . . then as a mother you're expected . . . to deal with what's coming. (CHN 3)

Subtheme 4: Resilience building is a lengthy process.

Although in the CHNs' experience, well-supported postpartum mothers generally displayed adequate levels of coping, they also commented that this resilience is a finite quality. For example, one CHS explained,

I've worked with people who've gone through lots of trauma and torture in Sudan and I've thought they would have had resilience. Some had and some hadn't. I think that's because

some have been through so much they're just not able to go on anymore. (CHN 3)

The CHNs also considered resilience to be a lengthy process that took different mothers different amounts of time to achieve. For instance, they explained that in their experience, mothers whose exposure to adversity was recent were more likely to display lower levels of resiliency than mothers who had had a longer time to adjust. One CHN explained,

I think time has a lot to do with resilience. I mean you're not resilient close to the event and some people take longer to bounce-back. (CHN 2)

Subtheme 5: The resilience process involves grieving for a personal loss.

A fifth commonly articulated perception of resilience was that it is a process that involves some degree of grieving for something lost. For, in the CHNs' experience, well-supported mothers tended to come to terms with their sense of loss quicker than did mothers with little/no avenue of support:

I think resilience is the ability to bounce-back after a very critical life event whether it's giving birth, a death in the family or a loss of any sort. So resilience is the ability to grieve over what you've lost and, then, move on to a state of normality. (CHN 2)

Subtheme 6: Resilience is the human ability to learn from past experience, reframe the now, and work forward.

The CHNs additionally described resilience as being the post-adversity human ability to learn from "looking back" at prior adversity experiences, "accepting" the new changed circumstances, and, then, having the depth of "understanding" and "inner strength" to "work forward" and "reframe" their life. This reframing was seen to be critical not only to maternal resilience but also to the well-being of the infant. One CHN provided the following explanation of "reframing":

They reframe things . . . not completely but enough to take a perspective other than the emotional one. Maybe, even a rational one. That helps them get over the hurt, the anger or whatever it is that stops them from bouncing-back. (CHN 2)

Theme 2: CHNs' intuitive assessment of four protective qualities manifest in resilient postpartum mothers

Although the CHNs articulated a theoretical understanding of resilience, when it came to identifying resilience in postpartum mothers, they suggested that this was an intuitive skill that required years on the job observations. In this regard, they described four protective qualities they believed were indicative of maternal resilience, which are listed in Table 2 and described in greater detail below.

Quality 1: Resilient mothers manifest positive attitudes toward their changed postpartum circumstances.

One of the qualities in postpartum mothers that CHNs considered to be a prime indicator of resilience was whether the mother projected a positive attitude toward her present circumstances. In particular, CHNs looked to see whether the mother was pragmatic in her thinking, organized, adept at "juggling things," and whether her speech was positive and forward looking (e.g., "today is bad, but something cool might happen tomorrow"). One CHN explained,

I'm thinking of one particular family, they've actually lost everything. Their house is going to be sold and they're looking at where they're going to live. They've got four children and yet mum's resilience is I'm going to take this one day at a time and we'll get through this. I'm amazed because it's pretty tough. They're a resilient family as they're able to survive with their heads up and their family together. She (mother) said to me: "Even if we lose every cent we've got, we've still got the kids and we're gonna survive. I call that resilience." (CHN 8)

Quality 2: Resilient mothers interact and communicate with their babies and are responsive to their needs.

In terms of bonding with their baby, the CHNs stated that when a mother first enters the child health clinic, one of the key indicators of whether she is resilient or not is how she interacts and communicates with her baby. They explained that the most resilient mothers were those who genuinely were responsive to their baby's needs and were not putting on a show. Two CHNs explained,

You can just watch them . . . the way they talk about the baby. When the baby cries they respond. They talk to it as they're coming into the clinic, they're encouraging it to look at things, and they're telling it what they're doing. There's smiling, there's cooing, they actually stop talking to you to coo at their lovely baby. You can just see the whole relationship between the mum and baby is working well. (CHN 4)

If she's resilient and has bounced-back after a traumatic birth then she's very interested in the baby. She's responsive to baby and to a big extent her thoughts are about baby and not about what she has suffered. She handles baby gently, caring for baby. She says positive things about baby and you can see there is a good attachment there. (CHN 2)

Quality 3: Resilient mothers exude confidence in their ability to overcome adversity.

The CHNs stated that another postpartum resilience indicator is whether mothers exude self-confidence. Particularly, whether they can see the bigger picture and not be overwhelmed by issues of the moment. One CHN explained,

It's them knowing that the time they're going through now is only temporary. That it'll get easier. They're looking at the bigger picture. I think some mums are really good at doing that and knowing that yes this is hard, but it'll pass. In a few months it'll get easier and so to just take each day at a time and think, I can cope, each day isn't gonna be like this hard. (CHN 4)

Quality 4: Resilient mothers establish social support networks and demonstrate a receptive willingness to reach out for help and engage with local support networks.

The final postpartum resilience indicator that CHNs look for is whether a mother has established a viable family/friend support network. For, in their experience those mothers who establish connections with local support networks (particularly female support networks), engage with those support networks on a regular basis, and are receptive to change. Possibly, because they tend to have greater resources at their disposal to assist them in making a swift recovery. One CHN reasoned,

Women who talk about it (adversity) are aware that they'll get out of their stressful situation a lot faster than will women who don't talk about it. Generally, if the woman is more resilient . . . they'll have more resources . . . more social supports. They're probably engaging in services . . . as that's the thing that's going to help them. (CHN 7)

Finally, the CHNs explained that mothers who "come from places where they're used to handing babies over to grandmas, aunts and other women then they've grown up with the attitude that their child belongs to the community, not just them." Moreover, such community connected mothers they maintained were more resilient than their socially isolated counterparts, as they were more self-assured about reaching out and asking for help. One CHN concluded,

It's all about confidence . . . confidence in their abilities to deal with things . . . It's just having confidence in their abilities to know to ask for help and not thinking they've to do everything on their own. (CHN 4)

Discussion

Childbirth is a significant event for women (Kendall-Tackett, 2014) and a negative experience can affect their long-term mental health outcomes (see Henderson & Redshaw, 2013). For, the mothers' perceptions of their delivery experience and other circumstances occurring at the time of the delivery not only affect the strength of the bonded relationship they form with their infants, but also affect adaption to their parenting role. Consequently, there is a cost health benefit to society in identifying early on and remediating confounding issues that occur in postpartum mothers' lives. It is no wonder then that since CHNs are the frontline interface with new mothers they are tasked with the responsibility of identifying

mothers who are, and who are not, coping with their motherhood experience (i.e., are resilient). What is somewhat surprising though is that although this CHN role is widely recognized, little research endeavor has been focused on examining the practice abilities of CHNs to fulfill the role. Hence, this study sought to address this knowledge gap by determining both CHNs' conceptual understanding of resilience and the means by which they assess resilience in postpartum mothers.

Resilience is conceptualized in the literature as being a stability of psychological and social functioning following an experience of high stress/trauma (Windle, 2011). It is clear from this study's findings that CHNs' conceptualization of resilience is largely congruent with this thinking. For, they described resilience as being a composite of human abilities, which allows individuals to work through the psychosocial process of recovering from an adverse/traumatic experience. Indeed, the most commonly articulated aptitude described by CHNs was the human ability to "bounce-back" post adversity to their pre-trauma state of normalcy. This adaptive conceptualization of resilience is widely referred to as being the manifest competency of individuals to cope with severe experiences of stress (Connor, 2006). The second and third human resilience abilities identified by CHNs were those of projecting an unflustered future-orientated demeanor and having an expectancy of recovery. Interestingly, these two abilities have been listed as being central protective factors, which facilitate human resilience (Earvolino-Ramirez, 2007). The CHNs' fourth commonly expressed conceptualization was that resilience is a lengthy process, which involves grieving for and overcoming some form of loss. This "loss" conceptualization of resilience is again consistent with the resilience literature, which views resilience not as a "one off," "get over it," obtain "closure" experience, but rather as a gradual process of recovery (Walsh, 2007).

Interestingly, the CHNs conceptualized resilience as being the human ability to learn from their loss experiences and to reframe them in a more positive light. This reframing conceptualization of resilience has been conceptualized as being a recovery from loss ability that "involves making meaning of the experience, putting it in perspective and weaving the experience of loss and recovery into the fabric of individual and collective identity and passage" (Walsh, 2007, p. 210). It is worthy to note, however, that none of the study's CHNs linked resilience to the postadversity/trauma experience of personal growth. This may be indicative that the most recent advances in the conceptualization of resilience have not been adequately conveyed to practicing CHNs. The need to keep practicing CHNs informed of recent advances in the understanding of recovery concepts (i.e., thriving and resilience) is pertinent given that it has been determined that highly resilient women are not only capable of posttraumatic growth, but are also less prone to serious mental illness than are less resilient women (Harville, Xiong, Buekens, Pridjian, & Elkind-Hirsch, 2010). (Also, the need

to keep CHN informed of advances in the conceptual understanding of resilience is important because such knowledge will help inform their health care delivery practices.)

Another interesting finding emanating from this study was that when it came to assessing resilience in postpartum mothers, CHNs relied on their intuitive knowledge rather than on a formal means of assessment such as EPDS. Their intuition was largely based on their years of on-the-job training, which in turn enabled them to recognize four key resilient qualities. First, was whether the mothers manifested a positive attitude toward their changed circumstances. Second was whether the mothers interacted with their baby and were responsive to its needs. Third was whether the mothers exuded confidence in their ability to overcome any changes in their postpartum life, and fourth, whether the mothers had established a support network and exhibited a willingness to reach out for help. The CHNs maintained that the presentation of these four qualities was an indicator of the mother's resilience. Although their contention is consistent with the theoretical notion that resilience is a set of personality traits, it should also be noted that such traits do differ in their presentation from person to person depending on the individual's situational circumstances and his or her adversity/trauma experience (Newman, 2005; Wald et al., 2006). Finally, CHNs' four observed four "protective" qualities in resilient postpartum mothers (i.e., *adaptation, responsiveness, self-confidence, and social connectedness*). Interestingly, these observed "protective" qualities align with the contention that resilience is a dynamic lifelong process of adapting to and coping with hardship (Atkinson et al., 2009; Rutter, 2007).

Although much of the study's CHNs' intuitive assessment of resilience in postpartum mothers was based on outward manifestations of coping, only one of the CHNs alluded to the types of coping skills used by mothers as being rational (problem focused) and emotional (reframing) in nature (see Maud, 2004). The possibility that resilient mothers use both adaptive (rational) and maladaptive (emotional) forms of coping is an area that requires further investigation. Hence, future research may seek to evaluate the coping styles of postpartum mothers so as to determine whether resilient mothers do indeed use predominantly adaptive styles of coping (i.e., rational and detached coping) and, conversely, whether less resilient mothers predominantly use maladaptive coping styles (i.e., emotional and avoidance coping). Or, indeed, whether mothers use a combination of coping styles as suggested by this study. It is posited that engagement in such a determination of postpartum coping styles will be beneficial to nursing practices in terms of shaping how CHNs may best interact with postpartum mothers.

Limitations of the Study

One limitation of this study was that data collection was limited to a single 45 minute interview period. This constraint is

understandable given the interviews were conducted in the CHNs lunch breaks. This restriction prevented the researchers from confirming the emerged themes with the CHNs.

A second limitation of this study's small homogeneous sample is its size. Although eight participants are entirely acceptable for a small-scale qualitative study, it should be noted that its data lack sufficient power to generate substantive theory, which in turn could be applied to other populations. Rather, this study's themes and subthemes should be seen as mega-categories (Bazeley, 2009). The benefit of developing such meta-categories is that they can be subsequently used in future empirical studies to determine whether the perceptions of this study's participants hold true in different settings. Thus, although this study's findings are suggestive of current practices, they should not be construed as being generalizable to the wider CHN population.

Conclusion

Until future research in the field of resilience resolves the definitional debate on whether resilience is a set of traits, a dynamic process, or some combination of both and develops appropriate measures for testing resilience, it is likely that CHNs will continue to base their maternal resilience assessments on their intuitive observations. Undoubtedly, the ideal would be for CHNs to use a combination of both intuitive observations and formal resilience testing measures. For, a combination approach would increase practice consistency. Another ideal would be for greater practice/research collaboration in the effort to determine not only where the boundaries of postpartum resilience lies, but also what balance of human abilities/qualities determines whether postpartum mothers are (or are not) operating within the same functional range of resilience as are non-postpartum women. The benefit of such research endeavor would be the enhancement of CHNs' capabilities to reach out to mothers and facilitate positive mental health outcomes (e.g., resourcefulness, hardiness, and growth) during the postnatal period (Herrman et al., 2011). This critical CHN reaching-out connecting role is particularly important in instances where mothers have situational, social, and cultural challenges.

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